LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into Recovery Plan for Nursing and Midwifery Workers)

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 14 JUNE 2023

Secretary to the committee:
Dr A Chynoweth (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

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While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 11.15 am.

JOSHI, MR ROJAN, Undergraduate Researcher, South Asian Research and Advocacy Hub, Australian National University
LIYANAGE, MISS SASHINI, Undergraduate Researcher, South Asian Research and Advocacy Hub, Australian National University
TITUS, MR ALEXANDER, Undergraduate Researcher, South Asian Research and Advocacy Hub, Australian National University

THE CHAIR: Good morning, guys, gals and non-binary pals. Welcome to this public hearing of the Standing Committee on Health and Community Wellbeing's inquiry into the recovery plan needed for nursing and midwifery workers.

Before we begin, the committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to life in this city and in this region. We would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be attending today's hearing.

We are going to hear from six groups of public witnesses throughout the day. We are now joined by representatives of the South Asian Research and Advocacy Hub. We welcome you. Thank you so much for appearing today. Would you acknowledge for the record that you have read and understood the privilege statement.

Mr Joshi: Thank you for having us. I would like to acknowledge the privilege statement.

THE CHAIR: Thank you, Mr Joshi.

Mr Titus: Hi. I have read the privilege statement.

THE CHAIR: Thank you.

Miss Liyanage: I have also read the privilege statement.

THE CHAIR: Thank you, Miss Liyanage. Do you have an opening statement of a couple of minutes that you would like to provide to the committee?

Mr Joshi: Yes.

THE CHAIR: Tremendous. Is that you, Mr Joshi?

Mr Joshi: Yes.

THE CHAIR: Take it away.

Mr Joshi: Thank you. Good morning. First of all, thank you to the committee for setting up the inquiry and for receiving our submission so warmly. We are from the

South Asian Research and Advocacy Hub, a student research group based at the ANU College of Law. First of all, we would like to set out a bit of context behind our submission. SARAH exists because we, as students, care about issues that affect the South Asian community. We are not a representative body, and our perspective is not the perspective of the South Asian community. Indeed, there is no one perspective in our broad and diverse diaspora.

Our submission is not a substitute for real nursing and midwifery experience, and we defer to other submissions when it comes to developing a holistic view of the profession. We are not speaking on behalf of South Asian nurses but offering our thoughts as young South Asian Australian researchers. Having said that, as people within the community we do have an understanding of how South Asians feel about certain issues, and we want to bring this to you for consideration, as policymakers. Our submission is a data-driven inquiry that we hope will direct your focus to some key issues affecting the nursing and midwifery profession, and especially highlight gaps in our knowledge where further study will be essential.

I would like to give a brief summary of our submission. There is a significant shortage of nurses in the ACT and across Australia, and this demand is not being met domestically. This shortage has been an issue for a very long time. It was in 2014 that Health Workforce Australia forecast a shortage of 123,000 nurses by 2030. In the decade since, this issue has not been resolved and we still see shortages and long hospital wait times in Canberra—the worst in the country.

We support investing in domestic graduates, but it will take at least several years before they enter the nursing system and there is a lack of experienced staff right now. In fact, when Health Workforce Australia modelled an improved retention of students, improved employment rates and increased early career retentions, the nursing shortfall fell but still remained 45,000 in 2030.

Immigration can help plug the gap, but only if the environment is conducive to supporting migrant nurses and helping them stay in the profession. We fear the continuation of a vicious cycle, where a shortage of nurses leads to overwork and burnout for existing nurses, leading them to leave the profession, which creates a larger shortage and leads to more overwork and burnout.

If migrant nurses leave then the issue cannot be resolved in the short run or the long run. We therefore want to emphasise the importance of supporting our nurses, and we would especially like to draw attention to South Asian nurses, who are a prominent part of the workforce. In Australia 40 per cent of registered nurses were born overseas, and India and Nepal alone make up 20 per cent of this number.

Our submission focuses on a number of issues that are important to the community. I will not go into extensive detail now, as we can probably expand on these in our responses, but we suggest prioritising nurses in the ACT government's Skilled Migration Program, conducting an inquiry into skills qualification and recognition frameworks, and investigating discrimination in the workplace. Thank you, once again. We would be happy to take questions.

THE CHAIR: Thank you, Mr Joshi. I made a mistake; I did not read out a very important statement that I am obligated to read out to ensure that we are all singing from the same song sheet. I would like to stress that there are protections and obligations that are afforded by parliamentary privilege, which was noted in the privilege statement that you agreed to before. Witnesses must tell the truth. The giving of false or misleading evidence is treated as a serious matter and may be considered contempt of the Assembly.

I remind all of our participants today that you should feel free to speak without fear of reprisal or intimidation. But please exercise caution in your comments so that individuals are not adversely identified. If we ask a question today that you require to take on notice, we ask that you clearly say the words: "I will take that question on notice." It helps our wonderful team in the committee secretariat to follow up with you after today's hearing.

We really appreciate your opening statement. I will lead on with questions. The most obvious one relates to the pandemic. We are hearing the conversation a lot nationally about how the pandemic put pressures on Australia's usual immigration processes, particularly the recruitment of a skilled workforce, and the healthcare sector is no exception.

For the benefit of the layperson observing today's committee hearing, would you proffer any wisdom on what the impacts of the pandemic on our immigration cycle have meant for nursing and midwifery workers. Would you give us any observation you have, broadly, on the community conversation we are seeing at the moment around some—for lack of a better word—resistance or concern about the rate of immigration proposed to meet that pent-up demand?

Mr Joshi: I might start with a small point.

THE CHAIR: Please.

Mr Joshi: The modelling from 2014 showed a forecast shortage of 123,000. The pandemic has worsened this because it has increased burnout. Here are some stats for you: 42 per cent of nurses are less willing to work than before. One-fifth of Australia's essential workers, including nurses, are considering quitting their job because of stresses brought on by the COVID-19 pandemic. The number of nurses and midwives who are registered but not practising increased by 63 per cent in the five years to 2021. So I think the COVID-19 pandemic really exacerbated what was already a significant issue.

Mr Titus: It also put a huge gap in the number of nurses coming into the country. In the COVID-19 period there was a significant decrease in the number of people coming into Australia. That has also widened the gap that we have in our nursing and midwifery workforce. That is the second important part.

It also heightened a lot of issues around discrimination against particular groups. I am sure many of you would be aware of the Asian-Australian hate cycle that was coming in. That affected a significant contingent of the workforce that makes up the nursing and midwifery scene, particularly being east-Asian migrants. The impacts of that we

outlined in our submission. It essentially leads to more of the same kind of burnout and dropout, and ultimately a reduction in productivity and general wellbeing.

Mr Joshi: I would like to make one more point about the community response to immigration. We cannot profess to being experts on this topic, but some of the key concerns that people raise are about housing and wages. I wanted to speak to those very briefly.

Housing is a difficult question. That is one that is outside the scope of our submission and our expertise. But I would just like to make the point that I do not think immigration is the problem. The situation is already clearly quite bad and it needs to be properly addressed. But we are not in a position where the housing situation is perfect and immigration might ruin it. It is already in a bad situation, and immigration is not the problem. It might make the problem worse, but the key issue is resolving it domestically.

On wages, there may be fears that letting more migrant workers in might put downward pressure on wages. But without further research being done, which would be necessary, while there is a lack of demand, I do not think that there should be worries about putting downward pressure on wages. Secondly, wages are not the only thing that nurses want. Working conditions are also very important to making sure that nurses want to stay in the job.

THE CHAIR: Thank you very much.

MR MILLIGAN: In your submission you mentioned that the ACT offers fewer vocational education training programs, extensive programs, compared to other states and territories around the country. I am wondering if you could elaborate a little more on what those extensive programs are. What do they look like? And what is being offered in other states that we should be offering here?

Mr Titus: Yes. I think I can speak to that a bit more. Essentially, when international nurses come into Australia there is a decision made as to whether their degrees are equivalent or not. Where they are found not to be equivalent, they are required to take bridging courses or further study. From memory, at the time that we were looking at it, it was either one or two courses. I would have to look into that again because I cannot remember exactly. I know that there are proposals to increase so called micro-courses that have come out very recently. That would also contribute towards reskilling the labour force. That is effectively what we are talking about. We are talking about programs that enable international nurses to bring their qualifications into the territory and then use them.

Essentially, the reason that these are important—particularly bridging courses, which are usually around three to four months—is that a large contingent of international nurses come with families and they do not necessarily come from a particularly advantageous financial position. They are having to feed kids, feed spouses or partners and maybe even feed elders. Therefore, it is very important that they find work quickly and find well-paid work as quickly as possible. That will determine, largely, whether or not they even have the time to go into longer degree education that would then enable them to be considered.

MR MILLIGAN: You mentioned that other states offer more bridging courses for international students than we do here in the ACT.

Mr Titus: Yes. If it is okay, I would like to provide a more definitive answer. I do not have that in my papers right now. I believe Victoria and New South Wales are probably the best. They offer the most, particularly in Victoria, if I remember correctly. But I do not know that for certain. Rather than me giving an answer that is incorrect, would we be able to take this on notice and provide you with a better answer?

THE CHAIR: Sounds great. I have a supplementary on that, just stepping back a bit and demonstrating my naivety. Someone comes to Australia on a working visa because the Australian government has identified that they have skills that we need. They come here on that visa, with those skills, only to be told once they are here that those skills are not commensurate and they need to take on additional training.

Mr Titus: Yes; that is something that does happen.

THE CHAIR: When you say it does happen, with what kind of frequency?

Mr Titus: I believe there are some recent studies. There is a lot of evidence. I cannot remember the statistics off the top of my head. Do you have them?

Mr Joshi: I am not sure. I would like to make a point on that. There are certain countries whose qualifications are automatically recognised in Australia: the UK, Ireland, and those kind of countries. For migrants from South Asia, I do not think their qualifications are recognised. One thing that we would like to call for is an extensive, serious empirical study into seeing how the qualification recognition works, if it is appropriate or if there are certain institutions within certain countries that might offer that level of quality. As we see it, this is a sort of remnant from the past, where Britain and Ireland were said to have commensurate, appropriate or approximate standards to Australia and other countries were not. We would like to see a contemporary study into whether this is still true.

THE CHAIR: I do not want to diminish that point, because that sounds like a very good idea, but I am trying to narrow our focus to what can be done at a territory level. These things appear to be at a national immigration level. I am just trying to—out loud, for the benefit of the group—work this out. The Australian government determines that we need a certain skill set. The Australian government goes into the global market with a certain number of visas available and brings people here. They are then relatively evenly distributed across the states and territories. Then different states and territories are making a judgement about whether or not their skills are commensurate and then there is this sort of patchwork quilt around how their skills are backfilled to meet the need. Am I understanding that correctly?

Mr Titus: No, no, no. So—

THE CHAIR: No?

Mr Titus: No. We would like to acknowledge that—and we put this in our submission—a lot of the stuff that needs to be done is not necessarily within the scope or the power of the ACT Legislative Assembly. That is why we believe it is important, from a territory perspective, that the ACT is more vocal in advocating for the changes that it needs within its own borders.

THE CHAIR: I see.

Mr Titus: It is not necessarily something that you can do. At the moment, the determination as to whether a degree is equivalent is made by AHPRA. That is done on a national level. From my understanding of how the visas work, there are broad, general visas and skilled visas, and there are criteria as to who is able to come into the country.

But the ACT does have a critical skills list, which is used for the 190 visas and another visa for temporary workers. Essentially, with those visas, the ACT sets a determination for how many skilled workers it wants, those particular numbers. At the moment it is set for 30 or fewer nursing professionals or registered nurses. They are the numbers of people that the ACT nominates to come to the territory.

What the ACT can do is alter its critical skills list in order to reflect a greater number of nurses required for the territory. That is what we are getting at, with regard to what the ACT can do. With regard to other stuff, like national immigration policy and qualification equivalency, the ACT cannot necessarily pass legislation to alter that, but what it can do is encourage change or even commission reports specifically into how this might affect the ACT more domestically.

THE CHAIR: That makes perfect sense. In terms of, very specifically, what the ACT can do, say we make a determination that we want to increase the number of skilled visa holders in nursing and midwifery in particular. Your evidence suggests that a substantial portion of those would then come to the ACT and, based on AHPRA's determination, would not have the appropriate skills. It then becomes, as I understand it, the job of state and territory governments to support those workers to upskill so that they are ready to enter the workforce. Is that correct?

Mr Titus: Yes; that is correct. The education policy, as I remember it, is provided by the particular region and locality, but it must be up to AHPRA standards. That is kind of how these two things interplay.

THE CHAIR: You have mentioned that other subnational governments are doing slightly different and arguably better jobs than the ACT to support those workers. What are some of the really tangible things that the territory government could do for a visa holder who has been determined by AHPRA to have skills but is not yet ready to start working in a hospital?

Mr Titus: There are a couple of different things you could do. You could provide subsidies for those courses in order to encourage them—reduce the entry cost to enter into those degrees. The other thing is to provide more of them or to have partnerships with other states to offer, for example, online courses and things like that. I think the more comprehensive solution is to open up some kind of inquiry or commission into

understanding degree equivalency between Australia, specifically the ACT, and other countries, so that ultimately you would not need to do these bridging courses because they would already be considered equivalent.

Mr Joshi: Can I just make one further point on this discussion. Competition for nurses to come to Australia is both domestic and international—that is, within states and Australia-wide. Domestically, I do not think the ACT can compete with bigger states like New South Wales and Victoria, who offer significant financial incentives. For example, in Victoria they pay a $13,000 reallocation bonus for moving to regional areas and $10,000 for metropolitan areas, and they recently made a $270 million commitment to paying the HECS fees of nursing students. Those are financial outlays that I am not sure the ACT government can compete with, but where the ACT can have a comparative advantage is in facilitating an easier transition for migrant nurses coming to Australia.

Mr Titus: Also, we would like to note that quality of life is something that appears overwhelmingly, even above pay matters, so if the ACT is able to provide a workplace that is inclusive, sustainable and healthy then that will be a very attractive incentive in and of itself. There are a bunch of other things that can be done as well, with greater clarity on which degrees are considered equivalent. If you take a look at the AHPRA website, it is quite confusing as to which degrees are considered internationally recognised within Australia. That lack of clarity then translates into uncertainty for migrants, and continued uncertainty about the pathway after they come into the country. Increasing clarity and making ease of access and ease of understanding a priority will definitely alleviate a significant chunk of the uncertainty around these issues and these problems.

MR PETTERSSON: What is the effect in these South-East Asian communities when skilled, qualified healthcare professionals leave their communities and come to Australia?

Miss Liyanage: Sorry; could you repeat the question, please?

MR PETTERSSON: What is the effect in South-East Asia when skilled, qualified health professionals leave South-East Asia and come to Australia?

Miss Liyanage: You may be familiar with the phenomenon of brain drain, which I cannot particularly speak on. I am not super across that. Do either of you want to jump in?

Mr Titus: We cannot speak on South-East Asia. We are not researchers on South-East Asia. We focus primarily on South Asia. I think there are a number of things that should be taken into consideration. If you look at the OECD statistics and the World Health Organisation statistics, you can see that there is a shortage of nurses across the world. I think it is quite a significant number. In the OECD it is nine million, if I remember correctly, but please take me under caution on that one.

When nurses leave the country, it does cause the effect of brain drain, which can have a negative impact on the local and domestic economy. The important thing to understand is that that is not necessarily caused by Australia alone. These

professionals intend to leave, and because there are other countries that are able and willing to accept them, they will be able to leave. This is an effect that is happening because of international policy and international considerations.

The question is whether we are able to take some kind of advantage from that to address our own problems. So, yes, there are implications that should be taken into consideration, but it is not necessarily something that we are causing or that we are affecting in a particular way that might make us culpable or that might make it problematic. The reason these nurses leave is that they are looking for a better standard of life, typically for their children. That is a stereotype; it is not all of them. Some people are looking for professional advancement in other areas, so they do intend to leave. The question is where, really.

Mr Joshi: One more point on that: it is not necessarily always a bad thing. I know that, definitely in South Asia, many workers go overseas and then send remittances back to their families in their home countries, so that can also be a positive effect.

Mr Titus: If we look at economies such as Fiji, a large part of their economic development strategy is a remittance economy: essentially, providing labour workforces for regional areas and then sending the remittances back to develop their economy. It is a complicated issue. It is something that we should be mindful of and be aware of, but at the same time it is also important to take into consideration the fact that it is part of a larger and more internationally embedded phenomenon whereby people leave countries and migrate around the world.

MR MILLIGAN: You mentioned earlier that there are a large number of registered nurses, but they are not practising. Do you have any information on why that may be the case?

Mr Joshi: I think the main reason would be burnout. That can be from COVID and also from before COVID, when a shortage leads to overwork and overwork leads to burnout. I think that is the key reason. In terms of other reasons, as we alluded to at the start, we do not want to speak for nurses. We can only speak to what the data is saying. I think some of the nurses who have made submissions would be very well placed to answer.

MR PETTERSSON: Circling back to qualification recognition, is it outdated and there is no role for it or is qualification recognition just in need of revitalisation and maybe some standards to be lowered, potentially?

Mr Titus: I would not say standards lowered. If you look at educational changes in places like South Asia, Singapore and Malaysia, you are seeing a monumental economic growth that is leading to an also monumental increase in the quality of nurses produced in these particular regions. I would not say that the system needs to be thrown out, necessarily. I think the system needs to be made more accessible, perhaps, even to people who might not necessarily be recognised. A review is perhaps in order, because you are looking at a particular list—and I think the list was the UK, Ireland, the US, Canada and Hong Kong.

MR PETTERSSON: Hong Kong, Canada, America; that was your list.

Mr Titus: Yes, that was the list that we provided. We are looking at economies like Singapore, where they have exemplary medical professionals, and we are looking at places in India. Of course, we are not necessarily talking about the entire continent, but we are looking at all these different places—even Europe more broadly, or Japan or South Korea. If we are not seriously taking into consideration the fact that now people are going from Australia to study in these particular institutions because of the quality, then we are definitely losing out on a lot of professionals that might otherwise go to other places.

Australia is actually not as competitive as we like to think it is when it comes to the international migration scheme. Canada is far, far more attractive because it is a lot better at recognising qualifications and it has a lot more clarity around that. So are places like the UAE and other gulf countries. They attract an incredibly large number of skilled workers. Obviously, there are other things that they also attract, but it is important to understand that these places often are first preferences, and then Australia becomes a second preference.

There was a recent study that came out of Sydney that looked at the attractiveness of particular locations. Basically, everywhere except for India, Australia was considered a second or third-rate option when it came to migration. So unless we take an international outlook and start to really align ourselves with international standards, we are going to lose out on a lot of opportunities to attract quite brilliant people who would otherwise go to somewhere like Canada.

MR MILLIGAN: In terms of those international standards of attracting health professionals from other countries that are not necessarily recognised by Australia, is it not in Australia's best interest to ensure that whoever does come over here meets our standard, meets our level of health care? Would it not be up those other countries to adjust their education training to maybe include the areas that Australia is requesting, that they may not provide?

Mr Joshi: Just to clarify: do you mean that countries that provide the training overseas would lift their standards?

MR MILLIGAN: Yes.

Mr Joshi: I think that may be an Australia-centric perspective. As Alex has mentioned, we are not necessarily the most attractive option anymore. If people from those countries can go to Canada or to the UAE instead then there is no reason for the providers to meet Australian standards. Another point is that we do not necessarily know that they do not meet Australian standards. One of the key issues is that there is no real empirical testing to see if there is a gap in quality. To my understanding, this stems from a historical understanding of the two countries. As Alex was alluding to, there has been significant development, and very quick development, over the last few decades, and that gap may not necessarily be the case anymore.

Mr Titus: We should definitely do a review into: what are the standards we are looking at? Are we looking specifically at acceptance rates of universities or are we specifically looking at the criteria? There are a couple of studies available on the

differences between the education that you might receive as a nurse in Australia, versus the education you might receive in, say, China, or in comparison to the UK. One of the things they talked about was the pedagogy of the nursing training. They talked about the difference between having a focus on testing and having a focus on holistic, whole-of-care training. Understanding what that means in practice will be very important because it is a broad-based pedagogy, based on understanding the competitiveness. We are not talking about how they empirically test when they come and perform in Australia.

MR PETTERSON: In your submission there is a particular line:

> … migrant communities are full of anecdotal stories of doctors and engineers being forced to work as taxi drivers …

You have cited a study to back that up. I have heard those anecdotes as well. Why do these migrants choose to stay in Australia if their qualifications are not recognised?

Mr Titus: Education for their children, typically. That is one big reason. There is a perception of a better quality of life in store. Often you see that, when you look at the academic test scores, they perform incredibly well and have very particular places within our selective school education across the country. It is a particular mentality: there is a perception that Australia will provide, ultimately, better qualifications and better opportunities for their children, so they are willing to take a significant quality of life hit in order to provide that lifestyle for their children and the generations after them. It is a self-sacrificing thing. That is the primary reason.

THE CHAIR: Your submission speaks to unused visa sponsorships, in part, and the reallocation of those unused visa sponsorships towards critical professions. I wonder if you might expand on that. I was surprised to read that there were unused visa sponsorships. Do you know how many there are?

Mr Titus: I think that might be a lack of clarity in the way that we wrote the submission. Basically, what we were saying was that, if we were to readjust the way that the critical skills list was to work, what one might do is adjust it so that certain professions initially get a lower headcount. For example, you would reduce the number of gardeners that you want to get into the territory from five to four and then reallocate it to nurses.

THE CHAIR: I see.

Mr Titus: Because those professions are still required, still necessary and still important, you would then, if those quotas were unused at the end of the year or the end of the month, re-allow people from those other professions to come in.

THE CHAIR: I see.

Mr Titus: The term that we used was a "human-centric" migration program. Basically, we put the priority on degrees and professions that provide a better quality of life and/or provide life-saving care, and then open it up to other professions that provide either economic or social benefits.

THE CHAIR: I see.

Mr Titus: That is where we were heading with that.

Miss Liyanage: Something that is very much within the power of the ACT to do is to make those workplaces better. While the ACT does have numerous laws and really good resources for dealing with discriminatory practices, something that we suggest in our submission is to have an inquiry into seeing, first of all, how extensive those experiences of racism or discrimination are. I know there are lots of studies about discrimination based on sex and sexual harassment and things like that, but this could be specific to discrimination based on racism or place of origin. There could also be an inquiry to see how that affects the retention of those workers. We know, at least from anecdotal evidence, that workers who have those skills and go into those jobs may not stick around for long because of the general workplace culture.

Mr Titus: Alternatively, they are stunted in their professional development, which is another thing that is not great.

THE CHAIR: I appreciate that. I appreciate that we have gone slightly over time, but I would like to give you a minute, if there is anything else that you think is really important to get on the record or that we have not covered in our questioning today that you would like to draw our attention to.

Mr Titus: Yes. The primary thing that we would like to draw attention to is the significant potential for a considerable amount of racial discrimination within the nursing profession. In our submission we highlighted that, in essence, there is a lot of strong evidence in allied professions, particularly aged care and a whole bunch of other professions around Australia, that this exists, but there is not necessarily the same kind of extensive study or empirical data relating specifically to nurses. It is not as current and it does have some methodological problems. If migration is to play a considerable role in the recovery plan for nurses, the effects of what it actually means to come and live in the country need to be explored in their entirety. That needs to be properly understood. That is the essence of it. Otherwise, you will ultimately be setting them up for failure.

THE CHAIR: We appreciate that. That is a great way to leave off. To the South Asian Research and Advocacy Hub at the ANU: we really appreciate your time. We will send a copy of the proof of transcript to you, providing an opportunity to verify it for accuracy. There were a couple of questions taken on notice. Our committee secretary will liaise with you to source that information, within a week of the hearing. We really appreciate your submission and your time today. Enjoy the rest of your day. This hearing is suspended, and we will reconvene at 1 pm.

Hearing suspended from 11.47 am to 1.00 pm.

DAVIDSON, MS LINDA, National Director, Professional Practice, Australian College of Nursing
WARD, ADJUNCT PROFESSOR KYLIE, Chief Executive Officer, Australian College of Nursing

THE CHAIR: Good afternoon everybody. Welcome back to this public hearing of the Standing Committee on Health and Community Wellbeing's inquiry into a recovery plan for nursing and midwifery workers.

All our proceedings today are being recorded and transcribed by Hansard. They will be published, and they are also being broadcast and webstreamed live—for a big, adoring audience, I am sure.

I now welcome representatives from the Australian College of Nursing, Adjunct Professor Kylie Ward and Ms Linda Davidson. On behalf of the committee, we would like to thank you for appearing today and for your detailed written submission.

Could you please acknowledge the privilege statement, which sits on the pink laminated card on your table? This privilege statement obligates all witnesses to tell the truth. I remind you that giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly.

Ms Davidson: I acknowledge that I have read and I agree with the privilege statement.

THE CHAIR: Thank you, Ms Davidson.

Prof Ward: I also acknowledge that I have read the statement.

THE CHAIR: Thank you, Professor Ward, I appreciate that. Do you have an opening statement for us today?

Prof Ward: Yes, we do.

THE CHAIR: Take it away, Professor.

Prof Ward: Thank you. As the peak professional body and leader of the nursing profession, the Australian College of Nursing is committed to our mission of shaping health and advancing nursing. We support nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct and professionalism through our advocacy, membership, leadership and policy work.

I have over 30 years experience as a registered nurse and Linda has, we will say, more than 59 years experience as a registered nurse and a registered midwife.

The Australian College of Nursing is a member-based organisation with a corporate and individual membership reach of well over 150,000 nurses in all states and territories. Our membership consists of clinical nurse experts, organisational leaders, academics, educators, and researchers as well as early and mid-career nurses looking to move into leadership roles within the profession.

The Australian College of Nursing is also an accredited higher education provider and registered training organisation, graduating far more than 100,000 nurses in the past 15 years with postgraduate qualifications. We have also provided hundreds of thousands of clinicians with clinical professional development and training in all settings, including immunisation qualifications and vaccination training, which was essential over the last few years for all clinicians.

I would like to thank the Select Committee on Health and Community Wellbeing for this opportunity to provide an opening statement concerning the inquiry as well as answer questions from the perspective of the Australian College of Nursing. I will now pass over to Ms Davidson to provide the Australian College of Nursing's specific responses.

Ms Davidson: You will notice that there are several recommendations that we have put in our response, but I would like to highlight the three key concerns of our ACT members.

The impact of the fires, floods and pandemics challenged everyone. The challenges for emergency services and healthcare workers have been relentless. Throughout the worst days of the pandemic, nurses were subjected to unimaginable pressures. It is true that nurses are the backbone of our healthcare system. They are there for the first breath and there with the last breath.

They are committed to supporting patients and providing quality care regardless of challenging circumstances. Over the past few years, nurses have quickly adapted to changing situations, learning new skills, knowledge and accepting an uncertain work environment. However, nurses' resilience and adaptability cannot and should not be taken for granted.

Improved workforce planning is essential in all areas of the health workforce, particularly given the global shortage of healthcare workers. Having a workforce that meets the needs of the patient and the community is essential, and the knowledge of and skills to develop an appropriate workforce is vital.

Secondly, retention strategies are key to retaining workforces that are currently carrying the burden. As mentioned previously, supporting nurses to work to their top of scope is essential to facilitate access for patients in the community. Enabling highly experienced registered nurses and nurse practitioners to work at their full scope of practice as part of a team to deliver care is very important. Most importantly, nurses need to feel valued, as they have invested their time and money in attaining the skills and knowledge to work autonomously.

I would like to add that ACN understands that the ACT government has committed to five more walk-in centres, though the practice arrangements and models of care have not been decided. ACN supports any opportunity to expand the role of nurses in delivering primary care.

Finally, ACN stresses the importance of providing nurses with a safe working environment, free from bullying, harassment and intimidation. Let us not forget that

workplace culture in health services has a significant impact on how staff can perform their jobs effectively. Research suggests that a good workplace culture is consistent with positive patient outcomes.

Nurses are experiencing this workplace violence with alarming frequency. Currently, there is no consistent whole-of-system approach to eradicate the occupational violence. ACN advocates for ACT government to become leaders in supporting research into ways to prevent, mitigate and safely report and address violence in all its guises in the health workplace.

The solution is that ACT government could provide this support through the funding of scholarships for nursing unit managers and nursing managers to undertake nursing leadership programs that cover all aspects, including leadership in research. Nurses are the largest clinical workforce professional group in Australia with over 6,000 nurses and midwives in the ACT.

Nurses live in the communities they serve and have trusting and therapeutic relationships with consumers of all ages and demographics. They need to be supported for their own and the community's ongoing wellbeing. We look forward to any questions.

THE CHAIR: Thank you, Ms Davidson and Professor Ward. As the chair of the committee I will start with questioning, and members may have supplementary questions. I will try and keep it orderly and not waffle too much—though I am prone to do that—and then move down in a fair and equitable way.

I would like to put a macro question to you. We keep hearing about recruitment and retention of nurses and midwives. While I imagine it is impossible to prioritise between the two, I wonder if you might proffer any wisdom around which at the moment is more important. While stressing both are important, where should government be focusing and concentrating its resources on those two streams of work?

Prof Ward: This is a valid question, and I am going to preface by saying that they are both important. But, if you are asking me to weight one more than the other, it has to be retention. The reality is that, over the last few years and during COVID, what we have seen nationally—and the ACT is no different—is a loss of the workforce in their mid to senior years.

People are selecting, not only in nursing and health but also in all other industries, to retire early—to select a lifestyle. The real concern for the nursing profession in delivering care to all Canberrans is the expertise, with the years of knowledge and experience, walking out the door or taking part-time options over full-time. If we do not have that capacity then we do not have the mentoring in place.

To retain anybody at any stage in their career is important. The way that people are valued and invested in is absolutely important—not only if they choose to stay in Canberra but also other states and territories are getting very competitive. We now have a situation where we do not have a national workforce plan, and we are seeing jurisdictions competing for a finite resource of nursing.

THE CHAIR: On the retention front, obviously you represent your organisation nationally, so you have got a good look at what other subnational governments are doing to retain. I would like to concentrate particularly on the most senior and experienced nursing unit managers and nursing managers who appear to be leaving. What are some other things happening in other jurisdictions that you would recommend the ACT government take on to particularly retain that specialist and experienced workforce?

Prof Ward: There is definitely an incredible pressure leaving the clinical interface and moving into management. You are particularly talking management. Nurse unit managers are the most influential over the retention of the workforce—your directors of nursing and your divisional directors—whatever structure you have got that are executive.

As to what other jurisdictions are doing, we have the Institute of Leadership for the Australian College of Nursing. We have for several years been running a midcareer leadership program and a nurse executive leadership program and we have developed a nurse executive capability framework.

This year—in fact, next month—we are introducing a nurse unit manager intensive leadership course specifically because of the demand in other jurisdictions. I would strongly advocate that the ACT get involved in this, because we have got nurse unit managers from all around the country coming in and places are limited. That is a program by nurses, for nurses, especially to invest in a generation of supporting and stabilising nurse unit managers and beyond.

THE CHAIR: So other subnational governments are subsidising either in part or in full the cost, and I imagine associated costs, for nurses to participate in these programs?

Prof Ward: Yes.

THE CHAIR: Does the ACT government do that at all with your organisation currently?

Prof Ward: They do invest in clinical professional development with the Australian College of Nursing. As I mentioned, we are a higher education provider and a registered training authority. We are the largest provider of postgraduate education. I think you might have had a couple of nurses in the ACT who have self-funded to attend our courses. I do not even think the health service have invested. Sometimes we might get health services sending nurses and nurse leaders to our courses, and other times it will be governments bulk purchasing.

THE CHAIR: For this midcareer nurse, this sort of moving into specialty or leadership, on average, about how much are they personally or another government in the country forking out for them to participate in these programs?

Ms Ward: Obviously if you go to any kind of program, like graduate school programs and intensive residential programs—I went to Harvard last year—we know

what we are paying. We have been very conservative to keep our price as conducive as possible, and it is only $5,000 to attend for a week's residential. Then, in the midcareer and the nurse exec, you enter into a program, you graduate and you get extensive mentoring for the nine months of that program.

The midcareer is probably around $5,000 or $6,000 and the nurse exec would be up to $10,000. But, again, with the bulk purchasing, we would give governments discounts because it is supporting the nurses in their health system.

Let me preface that as well. We have the Australian College of Nursing Foundation. We have people who donate to the foundation, and we are providing scholarships for nurses to attend. But some nurses do self-fund and some governments do invest. But we are also providing an opportunity to get nurses there. We fill every position, and we have a waiting list of people applying. So we know the demand is there.

MS CASTLEY: As this is definitely face-to-face, I assume that there is also the cost of travel?

Prof Ward: Yes. We actually have held courses and programs in Canberra. We have not had the support of local Canberrans, but people fly into Canberra. In June-July the nurse unit managers course will be in Sydney—so it is not that far. We have also held it in Melbourne and we are looking at taking that around the country. So, in fact, because our national headquarters is here we usually, because our national headquarters is here—it is usually held here or in Sydney and the country is coming in to us to do these courses. So right in our own backyard here it would be a great opportunity to take advantage of being close.

MR MILLIGAN: I noticed in your submission you mentioned that you do not necessarily advocate for nurse-patient ratios. It is a bit of a mix really between the submissions—some people do and some people do not. I was just wondering if you could elaborate a little bit more on your position on nurse ratios.

Prof Ward: Yes. I will start and then hand over to Linda. This is a great question. As the reason that we do not advocate for ratios, I will tell you the reason why and then I will tell you what we advocate for. We strongly support a reasonable workload—a tool to measure the ability as nurses as clinicians to provide care. The reason that we do not support ratios is because it is a blunt tool.

We have fought incredibly hard as the leader of the profession—and we are not industrial; we are professional—for nurses to be treated and respected as professionals. We are not all the same. We come with different qualifications and different experience. So when you say one nurse to four patients, a new graduate cannot be treated the same as an experienced registered nurse.

Equally, we are very passionate about respecting the consumers and patients, clients and residents, that we care for, and it is not okay to say that four patients can have one nurse, because your loved one could be deteriorating and need all of my skill and expertise—and what would happen to the other three?

So, whilst I understand where our colleagues in the union are coming from, I do not

advocate for any government to legislate ratios. What we should be doing is understanding that there is no health care without nursing. The nursing workforce is the only reason that wards and beds are opened in our acute sector. To prevent a build-up in the emergency department we need to have a strong primary and community health system and a strong aged-care system. So, while we work in multiple health care systems, we understand how they are all integrated.

Reducing us to numbers concerns me around our ability to be treated and respected as professionals. Linda and I and our colleagues in the room are all very senior. We have invested years into our education and professional development and should be respected as professionals for what we bring to the table. But, with my background, being aged care and intensive care, I would not expect to go to a paediatric ward or an area of me not being an expert and being able to pick up the same as somebody.

What we do support and endorse and promote is the International Council of Nursing's position statement on skill and skill mix and safe staffing.

MR MILLIGAN: What was that again? International—

Prof Ward: The International Council of Nurses. We are the Australia member in collaboration with the ANMF. I appreciate you asking your question, because we do need a baseline of staffing. It is not okay to not provide enough nursing staff. But when people get a one to four or a ratio in mind, they do not understand our clinical judgment, expert decision-making; the need for therapeutic relationships, our assessment and our observation, particularly if there is a deteriorating patient or if we are supporting somebody to have a dignified death. That may take all my resources that shift.

MR MILLIGAN: You mentioned baseline of staffing. Are we meeting that baseline of staffing, in your opinion and to the best of your knowledge, here in our hospital system in terms of nurses and patients?

Ms Davidson: I think that is a really good question. It is a hard time to answer it, having just gone through a really hard time with the pandemic. That was an emergency situation, and nobody met it anywhere because everybody had to pull together.

The furloughing of staff, the vacancies and the absolute role of nursing to expand to the levels that it expanded to during the pandemic put an extra load on the need for nurses. In every part of the pandemic they grew to. So it sort of changed the role of the nurse, as we needed them everywhere.

So I think that it is really difficult at the moment to say whether we have got it right. I do not know that anybody has got it right. The important thing is how we measure it and how we understand what it says. Our members are feeling tired and feeling burnt out. However, they are actually buoyed as well with the thought that things are getting better, things are starting to settle down, and they can work through it.

I have worked in other states, and I think you can use the ratios. You see them being used in other states as well. But then the ratios become you need 30, 30, 30. Then you

look at your skill mix. Then you need above and below the bed numbers. So it becomes this real minimalist counting machine and it is not really indicative of what the patient needs.

As Kylie said, if a patient is deteriorating, they are going to need all hands on deck, so you are needed and your numbers are not necessarily there. In different jurisdictions, assistants in nurses are counted as nurses. You cannot have an AIN doing the same as a registered nurse.

Prof Ward: Just to complement that, we do not run the health service. As the professional body we can hear back from our members. We put in the nurse executive capability framework. Quite often in Health Services the nursing executive and the nursing leadership does not hold the budget. That is a huge concern because then you do not have the flexibility to actually employ who you need to.

So every scenario is a little bit different in that it does depend on the indirect positions of support. At different times of the year you have nursing students who will be in the environments and there will be clinical facilitators and educators. So you can have a core number of staff—but what is the number of indirect staff needed to make sure that that care delivery is being provided as a nurse needs to?

In my career as a nurse executive over multiple sites and multiple services, when you go home at night, how do you know every nurse on every shift is delivering the care to the standards that the community require? Alternatively, how do you know that every patient and their family at every entry point into the system is receiving the care they deserve, that is safe and appropriate? So there is a significant amount of resource that needs to go from our end to make sure that, at that point of care delivery, our nurses are as skilled as they need to be. So there needs to be consideration given to the model of care, the acuity of patients, the skill and the skill mix—so we could not give you a one size fits all.

What we do know, though, is that there is probably a few hundred vacancies in the territory that, in the staffing establishments—which I would hope that our colleagues at the union fight for—is not the consideration of leave liability. When a roster is delivered in staffing establishments, it is for the core requirements. You may have 30, 40 or 100 people on a roster, but that does not take into consideration your annual leave, potential maternity—X number of staff will have maternity leave—and sick leave.

When you look at a 24-hour roster and workforce planning, let us just say for clean numbers you have got 20 staff, you may need three or four FTE on top of that to cover the leave. We do not staff anywhere in the country for that. So, as soon as somebody takes leave, you are needing agency or extra shifts. Then there is the burden of overtime, particularly with the furloughing, the isolation or just trying to get a holiday or leave. We are always working in a deficit.

You can have any number of vacancies, whether it is 10 or 100 or 200—or thousands in the country. They appear to be vacancies, but I would say that the system is working beyond that anyway and is stretched. My concern is that we are stretched so far we are going to break the elastic.

THE CHAIR: I will now go to Mr Pettersson.

MR PETTERSSON: Thank you. How do we encourage former nurses back into the profession? What specifically can the ACT government do to help with that?

Ms Davidson: I think it is about making it attractive. It is about understanding why some of the former nurses left and dealing with that. As we have talked about, it is about making the workplace supportive—so providing support for education and providing the time and a replacement for that.

It is also about flexibility. At the moment, some of our ageing staff are leaving. If we provide the ability to work fewer hours and some flexibility around time, we would be able to transfer some of those skills. Also, if a retiree goes off on a pension, they have got a limit around the wages they can earn. So, if there could be some flexibility around that, we would be able to attract others back into the workforce.

Prof Ward: Linda has made some great points. Why are you going to work incredibly hard and probably not feel appreciated if there is no financial gain? That is definitely one part of it. Having said that, as we know, nurses are the most respected and ethical profession—and have been for decades. We are not motivated by money but we deserve to be paid appropriately. So the other component to marry with that is value.

Value is more than a token "Love you all; you have done a great job." The way that we would see value is an investment in leadership. In fact, what we hear is that people leave an area because they are struggling with the culture, and with the lack of leadership. There is immense pressure in management in nursing, particularly in coordinating many dynamics, including families, individuals and the whole cohort of management and leadership.

So I would say probably the most important thing that the government can do is invest in management at that NUM level, or aspiring to be NUM and above, to make sure that they understand not only how to manage multiple millions of dollars and probably hundreds of thousands of occasions of a service, but also how challenging it is to then meet all of the needs of individuals—and it does require skills.

If I think of similar or comparable industries, even account managers would be supported with MBAs. All we are looking at and asking for is support to develop leadership capabilities. Because nurses do not have any clinical professional development provisions made, unfortunately, unlike our medical colleagues, they have to self-fund. So investment in professional development in those capabilities is the most important thing that I would say, based off the history and where we are at now.

MR PETTERSSON: Is international qualification recognition an issue for the profession in Australia?

Prof Ward: Tell me what you mean by that question?

MR PETTERSSON: Are there nursing qualifications from overseas that you would

like to see recognised in Australia that are not currently?

Prof Ward: It is very important that I disclose to you that we are an organisation that welcomes international recruitment of nurses. In fact, we have a bridging and re-entry program. We believe that nursing has been a longstanding profession that is female dominated that is prefaced on global travel, internally and externally, in and out of the country.

Our waiting lists reduced by 90 per cent during COVID. We lost thousands of nurses wanting to get visas and get support and do our bridging and re-entry program and get registered to work in Australia, because of the challenges that we are probably all aware of nationally. We know—because I have employed staff to continue to follow the relationship—that they did not stay in their countries of origin and in fact went to Canada and the UK. The UK are looking for 60,000 internationally qualified nurses.

If the government at a federal level—and if ACT can have any input into this—can extend our opportunity to keep doing bridging and re-entry programs, we can fill every seat. It is an accredited program. There is definitely demand to be in Australia—and we understand the ethics around that—but, at the moment, those numbers are limited because of an OSCE program that we are moving towards.

THE CHAIR: Thank you so much. I feel like we could have many more questions if we had more time. But, unfortunately, we do not have more time. Professor Ward and Ms Davidson, thank you so much for your time. Thank you so much for your submission and being so frank and open with the committee. The committee will send you a copy of the proof transcript of today's proceedings for you to verify for accuracy. If you took any questions on notice or want to provide any further information to help with our deliberations, feel free to have a chat to the committee secretary. Otherwise, have a good rest of your day and thank you for your time.

Ms Ward: Thank you.

Ms Davidson: Thank you.

Short suspension.

BAZARGAN, DR MARYAM, Senior Lecturer, Midwifery, University of Canberra

THE CHAIR: I now welcome Dr Maryam Bazargan, from Midwifery at the University of Canberra. Thank you so much for your time. I will just remind you, as I remind everybody, of the protections and obligations that are afforded by parliamentary privilege, and I draw your attention to the privilege statement, which is in the pink laminate card on your desk. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Could you please acknowledge that you have read and understood that privilege statement.

Dr Bazargan: I read and understood that. As you mentioned, my name is Maryam. I recently joined the University of Canberra. My colleagues, Kai and Marjorie, submitted the application. Both of them are in Indonesia at the moment for the International Confederation of Midwives. So I got this opportunity, which I appreciate. Thank you.

THE CHAIR: Thank you for being here today. Would you like to make an opening statement?

Dr Bazargan: Yes. Thank you for this opportunity. Considering that I am an academic and also a practising midwife, when I was listening to my nursing colleagues, I could relate some of that stuff to midwifery as well.

I would like to bring your attention to item 3 of the submission to the committee's inquiry into the recovery plan for nursing and midwifery workers developed by the Discipline of Midwifery at the University of Canberra.

In the ACT, there is a shortage of midwives. The number of midwifery graduates from the university is currently insufficient to meet the demand for new graduate positions in ACT hospitals. This presents a significant concern for the midwifery workforce in the region.

Despite the University of Canberra having a substantial intake in recent years—for example, 44 in 2022 and 61 offers in 2023—the number of graduates remains small. The primary issue lies in the attrition rate that occurs after students commence their midwifery course. Many students withdraw from the course and others choose to go part-time, resulting in a prolonged duration of five years or more before entering the workforce.

The unique nature of the midwifery course is characterised by a year-round continuity of care program that deviates from the traditional rostered practice. This deviation is justified by the fact that human pregnancy and birth do not adhere to a university semester pattern. Additionally, midwifery students are required to complete a higher number of practical hours compared to other healthcare courses. They also have specific requirements such as attending at least three normal births during their course.

Due to the nature of the midwifery course, students face challenges in balancing work and finances. Being on call for the continuity of care program means students may need to attend the birth or appointments with pregnant clients during their working

hours. However, students still need financial resources for essential needs, for increased transportation costs of continuity appointments and placements and for other personal expenses.

The majority of our students are mature-aged individuals with family, children and financial responsibilities. Consequently, financial constraints become a significant factor in students' decisions to withdraw from the course or go part-time. Informal conversation with the students that we had highlighted the critical need for financial supports during their course.

As we know, research supports the improved outcomes of continuity of care for women and also more job satisfaction for midwives. Maternity models are shifting towards this approach. It is crucial that our students are adequately prepared for this model of care. Therefore, reducing the required hours of continuity of care experience is not a viable option. It is essential for students to engage with continuity of care experience to become ready for future midwifery work.

To summarise, the financial challenges associated with the unique nature and demands of the midwifery course pose significant obstacles for students. It is crucial to address these concerns and provide financial support to ensure the successful completion of the course. By doing so, we can ensure the futureproofing of the midwifery workforce with competent and prepared midwives.

THE CHAIR: Thank you. My first question is around data. I absolutely trust what you have presented today—that there is this financial barrier for midwifery students and that is leading to a higher rate of attrition. Were the committee to make recommendations to the government in that space, the government would likely expect us to present datasets. So I wonder if, at the University of Canberra, this is anecdotal in conversations with students who start to take on a midwifery course, or if there is some sort of formal exit interview process when they choose to 'unenrol' where you have identified these barriers to continued training.

Dr Bazargan: I am not sure if they had a formal survey or studies around this. But we can provide clear data about the intake of students and the withdrawal of students. As I said, I am not sure if there is a formal survey or a study; however, even during the course, we have to adjust our classrooms, teaching and also placement of students because of the challenges that they write in emails.

They are mainly financial challenges that they have. As I mentioned, usually, they are not able to work and have proper income, because most employers will not allow their employees come and go whenever they want during their working hours. But I can do a search around this with my colleagues and can provide the information for you.

THE CHAIR: That would be wonderful. I ask because I suspect most Canberrans, when they hear about the pressures on the workforce, would instinctively think the government should hire more people. I think people would be surprised by your evidence that there are actually a lot of positions available, funded by the government, through the graduate program, and just not enough people graduating. Is that a fair summary of the point you were making in your opening statement, if I am not mistaken?

Dr Bazargan: I am not sure if our students at the University of Canberra are doing the course for free or whether it is a funded course. What I was trying to present to you is that the problem that we have at the moment is not, for example, their HECS debt or if students are paying money for their course. At the moment, our students are struggling to pay for day-to-day living expenses. Sometimes it is having petrol money or having money to pay for their mortgages—the kinds of current and urgent needs that they have.

I am not confident that all of our students are doing their study through a funded course. But, as I said, we talked with the students. It has been informal. But they are not worried about HECS debts, because they are confident that, after graduation and earning money, they will be able to pay that.

THE CHAIR: I will not hold you to this, because it might be a question on notice. In rough numbers, how many midwives have we missed out on having in our hospitals because the reason they have left studying is it is too expensive to study? I am interested over a period of time. Over the last couple of years, how many students took up midwifery studies and wanted to keep doing midwifery studies, and said to you, "I am leaving because I cannot afford it"?

Dr Bazargan: Again, because half of me is a scientist as well—not just a midwife—when I am talking, it should be black and white and based on the research.

THE CHAIR: Okay.

Dr Bazargan: We do not have research around this to give you proof numbers. However, based on my experience before here—I have been in South Australia and I have been the course coordinator on midwifery in one of the universities over there—I would say 99 per cent of our students withdraw from the course because of its nature and because of the hardship that it causes them. I would say that one or two per cent of students feel they are not interested in the course and they change their study.

Most of the time, the reason is, as I mentioned, the nature of the course, which it is not semester limited. Usually students do placements and do continuity of care over the year. So, for three years, they do not have a kind of set life or exact details of their appointments because of the nature of the course.

Therefore, I would suggest—again, informal information, not proven by formal data—that 90 per cent withdraw from the course because of the difficulty of the course, including the nature of the study and the financial strains. There are not only financial strains but also family issues because when students are rostered for practice they do a rostered shift, which means that they may need a babysitter or child care. Again, that costs money. Everything goes back in the end, I think, to financial strains.

THE CHAIR: Thank you.

MR PETTERSSON: Do you have any figures or data on graduation rates for midwifery students?

Dr Bazargan: We have. We can provide the exact graduation rates of the last few years. As I said, I am new at the University of Canberra, but this year we are looking at the graduation of a maximum of 18 students. Last year, I think they had around 22. But we have this data and we can provide you with that formal and accurate data.

MR PETTERSSON: That data would be very useful. In your submission you talk about how recruitment and retention have changed in the past 10 years and that, previously, midwifery staffing was stable and we had local graduates that actually have to move interstate to try to find a job. When did that start to take place? I would be very curious to know.

Dr Bazargan: My information about the ACT will be very limited, considering I just moved here in January.

MR PETTERSSON: Welcome to town.

Dr Bazargan: I can give you the example of another estate where our students had to compete for graduate entry positions. But recently all of the graduates can easily get the positions because we have more positions than the graduates.

In the ACT, what I have learnt during the period that I have been here, for the last three or four years, the number of graduates is much smaller than the number of graduate positions.

We know that a few graduates would love to move interstate or move overseas, especially to New Zealand, because of the model of care that they have. But, fortunately, Australia is moving to the same model of care gradually, and, hopefully, more of those graduates will want to stay here.

MR PETTERSSON: Thank you.

MS CASTLEY: My question is on recruitment and retention. In your submission you talked about the financial pressure—which you have talked about here. I understand that, when they are training, if they have a part-time job, sometimes they either have to leave that or they forego two full weeks worth of pay in order to do their training.

Dr Bazargan: Exactly.

MS CASTLEY: And I think that financial pressure is the reason that they leave. That is my understanding. What would you like the ACT government to do in this area, if anything?

Dr Bazargan: I think students would love and would appreciate it if they could get some financial support. We have an apprenticeship model for many other courses, and it would be of benefit if students could get a tiny bit of money for their work placements. In reality, when students are in a placement they are in the workforce—they are an extra hand, especially when there is a shortage of staff, as you heard. In reality, sometimes they work as aid staff but are under supervision.
If they could get the opportunity to get some money for the time when they are attending placements—including to support their families—I am sure they would

appreciate it. Also, it will help them to concentrate on their study skills and learning, not being worried about the finances and other stuff.

MS CASTLEY: Have you done any modelling, or do you have any idea of what you would like that amount per student to look like?

Dr Bazargan: No. But we are happy to get back to you with that as well.

MS CASTLEY: Thank you.

THE CHAIR: Dr Bazargan, there are a lot of questions on notice today. So there is a lot of homework. I am so sorry. I will hand to Mr Pettersson.

MR PETTERSSON: Please forgive me—I do not have kids—but what is the over-medicalisation of childbirth?

Dr Bazargan: That is a very good question. It has been happening due, I would say, the models of care which we currently have. Every woman—low risk or high risk—comes through the hospital system. I think changing the model of care, it will be normalised. At the moment, because of the system that we have, we consider every woman who is coming through the door as a patient—although, we are not allowed to call them patients because most of the time a pregnant woman is a healthy, young, completely fine person who is passing through a physiological stage of her life.

When we are considering them as a patient and we are doing the same thing routinely to everyone, irrespective of whether they are high risk or low risk, unfortunately it starts a cascade of lots of intervention and medicalising of that. In one sentence, I would summarise by saying that we are doing stuff which is not necessary for healthy, low-risk pregnant women. For women who can give birth at home or in a freestanding birth centre, there is no need to come to a hospital, which will have higher expenses for government as well.

MR PETTERSSON: How has the over-medicalisation of childbirth come to be what it is? If midwives seemingly are not supportive of this, how has it become the status quo?

Dr Bazargan: There is a history about that which I learnt about when I attended a conference and a lawyer, interestingly, explained what happened after World War II. The hospitals were empty because there were no war casualties, so they brought in women into the war casualty wards. I think that is the historical story behind this. It was a lawyer who explained this, as I said. As a scientist, I am not sure how accurate it is.

In the system that we have at the moment, midwives do not autonomy. In most settings, we are following the order of obstetricians and registrars. As I mentioned, there is definitely research around a continuity of care model where midwives have autonomy. Research has already demonstrated that, with this model, the satisfaction of women is higher, the C-section rate is lower and there are so many other relevant soft midwifery kept in a very physiological stage. I think, at this stage, the maternity

models of care are imposing this over-medicalisation and also the lack of autonomy of midwives when we have low-risk women.

THE CHAIR: The ACT government has committed to building and staffing a freestanding birth centre. Is that something you would support?

Dr Bazargan: Yes; we are very happy. As I mentioned, it was the first item in the original submission. It will bring about the autonomy of midwifery, more satisfaction, better staff to women ratios, make it less medicalised and, in the end, it will be more economical for the health system.

THE CHAIR: Do you think it will increase the territory's ability to recruit? You mentioned that there are people who are learning midwifery at the University Canberra and then not only going interstate but also overseas for other models of care, particularly in New Zealand. Do you think there might be scope to encourage those people back if we are actually able to provide this more modern model of care?

Dr Bazargan: Definitely; because it is the philosophy of midwifery to be with women when everything is normal—and midwives are well equipped with referral knowledge systems if they need help. So, definitely, yes. It will be, I think, one of the areas which will solve some part of the workforce issue and medicalised birth and midwifery satisfaction.

THE CHAIR: For this new freestanding birth centre, what are some of the things that the government has developed since initial scoping of where that is going to go and what it is going to look like that this committee should be particularly mindful of? If we were going to make recommendations to the government on how to set up a freestanding birth centre and do it just right, what are some of the things you would recommend to the government?

Dr Bazargan: I think it will need more than the recommendations of one person; it will need a group of midwives, managers of midwifery and the people who already run similar systems to come together and provide accurate information.

For me, if you want to ask my opinion, firstly, it will be free standing, away from everywhere. Considering that in Canberra we have easy access to every hospital, there should be a good arrangement in place to make sure that any referral will work well. It should be free standing. If it is somewhere outside of any hospital, it will do the job much better than if it is adjunct to a hospital.

THE CHAIR: I want to explore that a little bit more. I can hear the economists in Treasury probably arguing for the efficiencies created by co-locating medical facilities—which goes back to medical model of care I suppose—in the same location. Would you be able to proffer some wisdom about why it is so important that a freestanding birth centre be very physically detached from a hospital or a medical environment?

Dr Bazargan: My opinion about that is around the nature of midwifery and births. For thousands of years, it has been freestanding outside hospitals and going with the physiology and nature of the births. Again we have data from continuity of care on

who they provide home births to. The risks, the mortality or morbidity are, I would say, lower compared to when a low-risk woman is in hospital. We have data to show that, when a woman is giving birth in her own house, it is as safe as when she is giving birth in a hospital. Therefore, there is no, I would say, necessity for a freestanding birth centre to be close to the hospital—maybe to create and gradually bring women back to a normal physiology pregnancy and birth nature.

MS CASTLEY: I have a supplementary. I am interested in the statistics of other freestanding birth centres. In an emergency, how far away from a hospital should you be or should you not be? How close do they need to be, I suppose?

Dr Bazargan: Assessments for this are already in place in the continuity of care model. When providing home births, we have some criteria. First of all, women should be low risk. We will not encourage high-risk women. When a woman is a low risk, the need for a transfer will be low—although we know that pregnancy and birth is an area where we can go from normal to emergency.

However, as I said, there are criteria in place. For example, women or birth centres should have ambulance cover. They should be not more than 20 minutes away from hospitals. Considering the size of Canberra and accessibility everywhere, the ACT will be a nice suitable place to have a birth centre.

THE CHAIR: Thank you, Dr Bazargan. I think, given the time, we can wrap it up there. The committee would like to thank you for your time and your group for your submission. It is much appreciated. A copy of the proof transcript will be sent to you in the coming days to verify the accuracy.

There were quite a number of questions you were kind enough to take on notice. I would just ask that you collaborate with the committee secretary after today's hearing to ensure we receive that information.

Dr Bazargan: Thanks for the opportunity.

Hearing suspended from 2.00 pm to 2.31 pm.

WONG, MS ALISON, Professional Officer, Australian Nursing and Midwifery Federation, ACT Branch

FROST, MS SAMANTHA, Member, Australian Nursing and Midwifery Federation, ACT Branch

DANIEL, MR MATTHEW, Branch Secretary, Australian Nursing and Midwifery Federation, ACT Branch

CULLEN, MR THOMAS, Legal Counsel, Australian Nursing and Midwifery Federation, ACT Branch

THE CHAIR: Good afternoon, everybody, and welcome back to this public hearing of the Standing Committee on Health and Community Wellbeing's inquiry into a recovery plan for the nursing and midwifery workforce here in the ACT. We are now going to hear from our friends at the Australian Nursing and Midwifery Federation, ACT Branch. On behalf of the committee, thank you all for your time today and for your detailed and thorough submission. It is much appreciated.

First of all, I would like to remind you of the protections and obligations that are afforded to you all today by parliamentary privilege. We ask that witnesses tell the truth and remind you that the giving of false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Would you acknowledge that you have read and understood the privilege statement.

Ms Wong: I acknowledge the statement and agree to it.

Ms Frost: I have read and understand the statement.

Mr Daniel: I have read and understand the privilege statement.

Mr Cullen: Good afternoon. I have read the statement and agree to be bound by it.

THE CHAIR: Do you have an opening statement to start with?

Mr Daniel: I do; thank you.

THE CHAIR: Please take it away, Mr Daniel.

Mr Daniel: Good afternoon. The ANMF ACT thanks the committee for providing the opportunity to discuss the critical need for a recovery plan for the nursing and midwifery workforce in the ACT. The ANMF submission focuses on the public sector, but we would anticipate that a recovery plan would have implications for health care across the ACT. ANMF nurses and midwives lobbied for this inquiry to be established because they are tired, burnt out and do not feel valued. They have done it hard for years, being at the front line of the pandemic, providing COVID testing and vaccinations, and caring for patients in the most challenging of circumstances.

They did not get to work from the safety of their own home during the pandemic, and they often worked short-staffed and with increased risk to their own health. Nurses and midwives are angry at the government's failure to recognise this work. They are demanding more than thanks. Nurses and midwives know that many issues facing the

health system are not unique to the ACT, but they believe that the ACT government is not keeping up with other state and territory governments that are responding to their nursing and midwifery workforce.

The professions of nursing and midwifery can be supported in many ways, but the ANMF submission has focused on two key initiatives: workforce planning and the implementation of enforceable positive practice environment standards. The ANMF's submission to the inquiry provides considerable detail on these two initiatives, but I do wish to briefly add further context. The ANMF acknowledges that work is finally underway on workforce planning by the ACT government. In fact, we are involved in the process of developing a plan. However, the ANMF remains concerned that the plan will not adequately deal with workforce from a nursing and midwifery perspective.

The need for the ACT government to act to support the nursing and midwifery professions is urgent. The building blocks of workforce planning in the public health system have disintegrated over time to the point where, for example, the public system has difficulty providing basic workforce information such as nursing and midwifery vacancy rates. Projected separation rates due to retirement over the coming years are not known, and the ANMF is not aware of a single source of information about the scope of practice of nurses and midwives in the public health system upon which to expand health services and develop new ones.

Without a strategic understanding of the collective scope of the practice of the nursing and midwifery workforce, the call for expanding the scope of practice lacks an evidence base. Nurses and midwives already have the education, preparation and skills to expand their scope of practice, but there has been a failure of the ACT government and public sector health leaders to identify and utilise the wealth of unlocked potential amongst the nursing and midwifery workforce through effective workforce planning.

The second recommendation of the ANMF is the implementation of enforceable positive practice environment standards. While we can see many of the features of positive practice environment standards already reflected in workplaces, enforceable standards will elevate their importance and provide a focus on developing supportive, safe workplaces at the local level. Developing positive practice environments at the ward or clinical level is key, and nurses and midwives are well versed in the importance and application of standards more broadly. While there are many facets of culture to be addressed, the ANMF is of the view that the implementation of enforceable positive practice environment standards at the local level will positively influence culture where ACT Health culture reform has failed for nurses and midwives. Thank you.

THE CHAIR: Thank you, Mr Daniel. Just for a bit of context, I understand that this committee inquiry is a consequence of a petition that came before the Assembly. The petition spoke about stress, fatigue and burnout across the nursing and midwifery workforce, particularly attributable to some of those pandemic pressures. But I have to ask about the elephant in the room. Time has passed since this committee inquiry commenced, and a rather sizeable public health policy decision has been made by the ACT government to acquire Calvary Public Hospital Bruce.

I would like your insights on what are some of the current unique and particular pressures on the nursing and midwifery workforce at that facility, and what advice you would proffer for the committee to encourage government to accommodate and adapt to some of those current pressures that I imagine the workforce are feeling. Tell me if I am wrong, but I imagine the workforce are feeling some stress, and I would appreciate some of your advice and feedback on that.

Mr Daniel: At Calvary in particular?

THE CHAIR: Yes, please.

Mr Daniel: The ANMF conducted two face-to-face sessions with members at Calvary Public Hospital Bruce. That was kindly facilitated by Calvary. We invited members at Calvary Public Hospital to email us with their concerns. It is fair to say that members are of course concerned about their employment and conditions in the move. What does it mean for, for example, a nurse or midwife who sought to leave CHS because of culture or workload to go to Calvary? What does that mean for them now? They are concerned about those sorts of issues in the takeover of Calvary Public Hospital Bruce.

Apart from those very real issues around employment conditions, what they seem to be most concerned about, or what came through loudly, is what happens on day one of the takeover, when CHS takes on responsibility for services and service delivery. In particular, it goes to the coalface issues for nurses and midwives. They want to know simple things like: what practice standards will we work to? To date, I am not aware that we have got any answers on that for our members.

The type of care will be articulated in a policy. They are very different at Calvary, compared to CHS. Will Canberra Health Services take on any liability or risk that might be associated with a policy that might be of a different standard from what CHS has in its policy? What does it mean for those people who are undertaking higher education to upskill themselves, to expand their scope of practice—those sorts of things? What does it mean for them and their patients in terms of that ongoing improvement in care through education and those sorts of things?

There are very real implications as a result of the takeover. That is also reflected at Clare Holland House. In particular, with Calvary Public Hospital Bruce, our members are concerned that they are not sure what their obligations will be in terms of the care that they are going to provide. Of course, they want to provide the best care possible. But care, in terms of scope of practice, is articulated through policy.

THE CHAIR: Right. So it would be fair to deduce—not to summarise, although that is quite useful—that the conversation in the media and the public seems to be around the pastoral care, emotional support and psychosocial wellbeing of nurses and midwives. It sounds like what you are saying to me is that a lot—not all, but a lot—of that could be satisfied for the workforce at Calvary right now by just having clear answers to clear questions.

Mr Daniel: Clear answers would be very useful; yes. They would not only be useful; nurses and midwives deserve that.

MS CASTLEY: Do you have a feel of how many staff will transition?

Mr Daniel: We do not have a sense of the numbers. How our membership were feeling about the change—and this is probably going back two or three weeks now—certainly reflected the broader views in the community that are being reported in the media. Some of our members are welcoming the fact that they will be working under the government banner, with public funds for publicly operated hospitals. Some members are welcoming that. Other members feel that there is more to this. Some have expressed that this is part of a view to the next election. They were very clear on that, some members. And some members do not want to leave the Calvary family.

MS CASTLEY: We heard this week that the government have said at least 85 per cent is the staffing level that they are hoping for. What are your thoughts on that? Is that enough?

Mr Daniel: Staffing levels are so thin that even the loss of one nurse or midwife has real implications for a ward or clinical unit. That will increase the pressure on already existing short-staffing levels, which are widespread. While the ratios are being reported around the 80 or 90 per cent mark, sometimes down as low as 70 per cent compliance, that is not accurate reporting. It is a point in time and it does not reflect that ratios are being met for the whole of the shift. That reporting does not actually reflect what is required under the ratios framework.

We already know that, in that point of time, ratios are not being met. If we lose a single member of staff it could have real implications for some services. We have been talking to the government and Canberra Health Services for some time about particular areas that are of great concern: the intensive care unit at the Canberra Hospital, and the ED department at both Canberra Hospital and Calvary Public Bruce.

We are becoming more concerned about the walk-in centres, where workforce planning has not been undertaken properly for many, many years. There have been a lot of stop-gap measures to try to make sure that they have enough nurse practitioners. We would say that there are not nearly enough nurse practitioners in those walk-in centres. We are relying heavily on the advanced practice nurses, who are an excellent addition to the walk-in centres but they do not replace nurse practitioners.

So there are all sorts of areas where there are pressures. What the health services themselves have told us is that we are not growing the pie for nursing and midwifery. We are simply shuffling nurses and midwives around the system. So it will be interesting to see what happens now that Calvary is being taken over. The issues that were at Calvary, I expect, will continue. That is particularly in the midwifery area, where they were consistently short-staffed over many, many hundreds of shifts. I have to say, though, that a lot of midwives left CHS, because of culture, to work in Calvary. There are some significant issues in terms of the availability of nurses and midwives.

MR PETTERSSON: You mentioned a new integrated public health system for the ACT. Are there opportunities for nurses and midwives in that integrated system?

Mr Daniel: We would hope that there would be. Certainly, the evidence around public sector funding of health services, to run and operate those services, versus a shared model, is that there could be greater efficiencies. What that looks like for nurses and midwives, we are not sure. But we are certainly concerned that there might be an importing of an already poor culture at CHS to Calvary.

MR MILLIGAN: I was hoping that you might be able to elaborate a little more on the positive practice environment standards. What are they?

Mr Daniel: Sure. They are a set of standards that are well known in the nursing and midwifery professions. The International Council of Nurses has information about positive practice environment standards. The example that we like to look to is the standards being used in Queensland. They were developed by our sister branch, the Queensland Nurses and Midwives Union, and they implemented them throughout Queensland. They were very successful in improving culture, ratios, safety, leadership—all sorts of areas. They have been so successful that I believe now they are going to be jointly implemented, through the enterprise agreement with the government, across Queensland.

We have got really good examples of how they can be used. Why we point to them as a critical possibility for the way forward is that if they were to be mandated then they would set the standard that has to be reached. There could be programs that would be implemented to make sure that standards were worked towards. There could be reporting around those standards, and we would like to see them enforceable across the public system.

So many of these things are already dealt with: leadership, workforce laws and stuff. But if we have enforcement standards it really elevates their importance. It also provides a really clear narrative for nurses and midwives at a ward level. There are a whole heap of things that tend to become noise, because there is lots of information on wards and in clinical areas, and the standards tend to provide a clear narrative for nurses and midwives about what we are all striving to achieve. Most things that we can think of that hospitals and health services do would fit neatly within practice standards.

MR MILLIGAN: And this is implemented in Queensland?

Mr Daniel. Yes.

MR MILLIGAN: Anywhere else in the country? That is one question. A second one is: if this was implemented here, do you think it might retain nurses? Do you think it might actually attract nurses back into the industry if we had something like this here in the ACT?

Mr Daniel: If they were implemented well, we believe that they would address some of the retention issues. What we also know, through positive practice environments, is that, because they operate at the local level, they can improve culture at the local level. We can see that it would improve or support the positive cultures that already exist at a ward level. When we did our psychosocial wellbeing surveys of our members in

2021 and 2022, one of the positive things that came through was that our members told us that they drew strength and resilience from their colleagues. So if we can supercharge that positive influence at a ward level, or at a clinical unit level, through standards, we believe that that could impact at least on retention and, with time, on recruitment as well.

MR MILLIGAN: Regarding the cultural issues that it might help to address, is that cultural issues between nurses and other nurses or is it cultural issues in relation to nurses and doctors or specialists or the health department generally?

Mr Daniel: It is the bigger issues facing our members around people practices. There are problems around overtime. Positive practice standards look at ratios and reasonable workforce. Overtime and flexible work arrangements are as rare as hen's teeth. Our members, being a predominantly female workforce who have caring roles at home, really do need to be supported and to have flexible work arrangements. A four-day working week would certainly assist them in that. Tom, you might be able to add some additional points on overtime and flexible work arrangements.

Mr Cullen: Yes. I would take the committee to page 18 in our submission. It sets out exactly what we are going to. On the issue of culture, it has been a widely documented subject, particularly across the ACT, for three years. There was an inquiry for three years, which has just finalised. So they are well-known issues.

The standards could be implemented, particularly if they are enforceable, through existing legislative mechanisms. We note that there is the Health Act in this jurisdiction, which is an interesting piece of legislation. It seems to carve out a number of different things, but if you go to the objectives of the Health Act, they are very clear in ensuring top quality public health care. The standards could sit very nicely in there.

We could also have a review mechanism, perhaps an administrative review mechanism, through either ACAT or a similar tribunal. I must admit that when we were writing this we were not aware that Queensland were looking at it in the enterprise agreement context as well. That is something that we would definitely be open to exploring, if that was the will of the government.

MR MILLIGAN: Could these standards potentially include the nurse to patient ratios?

Mr Cullen: Sorry; I was just going to say that the nurse to patient ratios are currently in the enterprise agreement. So they are already—

MR MILLIGAN: In Queensland?

Mr Cullen: No, here in the ACT. They are already an enforceable provision under the terms of the enterprise agreement, but that is not to say they could not perhaps form a broader set of standards that is in an annex or an appendix to the enterprise agreement. Absolutely, they could form part of it, within the enterprise agreement, through that particular provision. But currently we have mandated minimum nurse to patient ratios through the ACT Public Sector Nursing and Midwifery Enterprise Agreement.

MR MILLIGAN: Okay.

THE CHAIR: You hit on culture, which is a recurring theme. This Assembly talks often about hospitals and healthcare facilities and healthcare policy more broadly. I am yet to understand—and I have been wondering for a little while now—whether there is a very specific answer to what we attribute our unique cultural problems to. We heard from the Australian College of Nursing earlier today; we spoke about culture nationally. It appears to be a challenge that exists in hospitals and healthcare environments across the board, but we seem to have had a particular issue for a particularly long time. I wonder if you would proffer any wisdom as to why that is, in the ACT uniquely?

Mr Daniel: I would say one of the contributing factors is that nursing and midwifery has not been supported properly for many, many, many years. What I mean by that is that there have been fewer graduates, for example, given jobs over many years than actually graduated. There has been a very good supply of nurses to the territory, but for, I think, financial reasons related to that, there has been this attempt to get nursing and midwifery numbers to the bare minimum, driven by cost. That has left us in a really difficult position, in that we are now playing catch-up. The ratios policy seeks to address that and, to a large extent, is turning that around.

There have been greater benefits of ratios than the obvious, and one of those is that there has been a focus on recruitment. Where both Canberra Health Services and Calvary Public Bruce have been successful in recruiting to the numbers that they need to meet ratios, that has been a very positive outcome. But, at the same time, we are losing nurses and midwives out of the system, often very experienced nurses and midwives, for those other reasons of culture.

They do not feel valued. They often have to negotiate for improvements through agreements. We have had to negotiate for patient safety through ratios. Why should it be up to nurses and midwives to have to negotiate patient safety through staffing numbers? It is just not right. It does not give the proper regard to that issue. But nurses and midwives, nonetheless, are doing that. We are arguing for ratios to protect patient safety.

That is just one example of why we have been left in such a difficult position. I think there are all sorts of areas in the health service that have unfortunately been neglected for too long. That has had an impact on how nurses and midwives feel valued or not and whether they are supported to provide the care that they believe they need to provide. I do not know if you want to offer any thoughts on that.

THE CHAIR: I am happy for anyone else to make some observations.

Ms Wong: I can speak a little bit to that. I think down here in the ACT nurses and midwives are very much not respected as a profession. We are not even seen sometimes as a profession. We are a number on the floor. That has led to a poor culture. Again, the scope of practice always comes to the fore. We are not given the opportunities to work to our full scope of practice, unless something dire happens like the pandemic, and then it is nurses and midwives to the rescue. Then, after something

like that happens, you go back to doing your normal job.

We are fighting for everything that we want. It is always a fight to get educational leave. Our medical and allied health colleagues have the privilege of having allocated money and funds and days to go and do that ongoing education. We, as the biggest profession in health, also want to expand our knowledge, to ensure that we have safe care for our patients. But we are constantly fighting. We fund our ways to education. We fund our own ways to conferences. We take annual leave to go to conferences to increase our educational needs, to then provide safe and effective care to our patients.

Our culture is very well known across Australia, and I do not think people quite understand that down here. When you talk to nurses and midwives across Australia—and even internationally, from my experience—they understand that the ACT is not the place to work because the culture is so bad and has not improved.

THE CHAIR: I am going to go to each person. I have to ask: there is no improvement? I accept the evidence you are presenting that it is not good enough and that it is far away from being good enough. But I would hope that, given how long we have been talking in this place about culture in Canberra Health Services, there is some improvement, some hope you can proffer on where things are, even if incrementally, getting better.

Ms Wong: There is probably a minute amount of improvement. Obviously, things are being done, but we are well behind, even in the succession planning, even in career progression. You see nurse practitioners, for example, across a lot of hospitals in other jurisdictions. We, as a jurisdiction, are only just talking about nurse practitioners being implemented in the acute hospital setting. We are well behind; we are 20 years behind. When I brought this up, five, 10 years ago, I was told there was no position for a nurse practitioner in an acute hospital setting. So we are 10, 15, 20 years behind every other jurisdiction. Yes, there are things being done, such as the talk about nurse practitioners being brought into the hospital system, but it is too little too late when we have such a large number of staff leaving.

Mr Daniel: When there are initiatives, they are too little too late. I point to the undergraduate student of nursing and midwifery. That was an initiative of the ANMF. We brought that to the negotiating table and said we wanted it inserted into the agreement because it could help bolster the nursing and midwifery professions, getting students much earlier and getting more practice within a paid setting. That was inserted into our agreement at the beginning of last year, January 2022. We are still waiting for that to be rolled out. Why has it taken so long?

There has been some work done on expanding the scope of practice of nurse practitioners in the ACT. It has been months and months and months, and we do not know where that is at. When I talk about the sense of urgency, there are things that could be done, but who is sitting on their hands? Who is not working on the scope of practice? It seems to be the flavour of the month; everyone is talking about expanding the scope of practice of nurses and midwives. That will be the cure-all. It will actually bring a lot of benefits. But it takes some initiative and someone to take responsibility for undertaking this level of work.

You asked about the evidence about whether culture has improved. I point the committee to annex A in our submission, which includes a lot of comments from our members. We asked them how they feel about nursing and midwifery at the moment. It is not a happy place. We can see other evidence, in our submission, that we have one of the lowest rates of applications to vacant jobs in the country. That is put out by the National Skills Commission, I think. A whole raft of indicators are saying that we are not getting it right, and our members tell us that it is actually worse.

The evidence was that our members, nurses and midwives, generally did not participate in a recent survey by CHS. That spoke volumes. CHS tried to present it as though there was a good response rate. There was not. Nurses and midwives did not participate in that survey. Our workplace delegates, our counsellors and our leaders tell us that people could not be bothered because they thought there was no point.

MR PETTERSSON: Following on from Mr Milligan's question about examples from other jurisdictions, do you have any further examples of initiatives in other jurisdictions to recruit or retain new staff that should be replicated here in the ACT?

Ms Frost: On retention, I know that both the health services are currently working on team midwifery as an adjunct to continuity. *Maternity in Focus* talks about increasing continuity in the ACT to 70 per cent. At the moment it is about 30 per cent. This is taking quite a long time. I believe Calvary recruited to that at the start of the year, but I do not believe that that service is up off the ground yet. CHS, similarly, is talking about it. They wanted to get it off the ground in January as well, but it is not. It may be out for comment.

That is a kind of model of care that midwives will work in. It is good, but it does not necessarily meet the International Confederation of Midwives definition of continuity in the pure sense, in that it is not one-to-one continuity. But there is still evidence around team continuity for women and the benefits of that to women and babies, so it is good for women, as well as a better way to work for midwives, without all of the on-call. But it is taking a long time. Everyone wants it. It is something that will attract midwives who want to work in continuity but do not want to do on-call.

The other one would be midwifery prescribing. Midwives can currently do a one-semester course and you become an endorsed midwife and you can prescribe, within your scope of practice, as a midwife. Currently, this is in practice in South Australia, in the public health service, and in some areas of Queensland, particularly rural and remote areas, where midwives are able to prescribe. There has been a little bit of talk about this from the Nursing and Midwifery Office, but nothing further. With our current staffing issues, having a solid midwifery-led service, I think, would take a lot of the pressure off.

THE CHAIR: When you say a solid midwifery service, are you referring to the freestanding birth clinic the government has proposed?

Ms Frost: No.

THE CHAIR: No?

Ms Frost: No.

MS CASTLEY: Just midwives being able to prescribe within their scope—

Ms Frost: Just midwives being able to prescribe and work to their full scope of practice within the whole.

Mr Daniel: If we look to Victoria, who are doing a lot of progressive things in their nursing and midwifery workforce, the government and the ANMF Victorian branch currently have running a pilot project where they are looking to see if they can support contracts of employment that mirror the needs of their nurses and midwives. Again, it is about taking into account that we are predominantly a female workforce with caring responsibilities and so on. They are looking, in conjunction with Safer Care Victoria, I think it is, to see if they can get three hospitals to have contracts of employment that will set the days that a nurse or midwife would work, to meet nurses' and midwives' needs. It means that you do not have the problems of changing rosters all the time. Child care can be better organised; parental care can be better organised. It really means that you know, for the entirety of your employment: "I have got these days that I will work."

There are all the flow-on benefits if you do not have the overhead costs of nurse managers sitting in rooms, trying to juggle rosters, trying to adjust to the needs of nurses and midwives. I am personally aware, and I suspect my colleagues might be aware, that it can get so difficult to meet the care requirements or other needs of nurses and midwives that they are sometimes told, "You will just have to take sick leave so that you can do that." That is not effective people management. You have got reality being ignored by our current employment framework in the ACT. I fear that that would be very revolutionary, given the current state of affairs in the ACT. It would be too difficult for some people to get their minds around. But we need to go there.

MR PETTERSSON: Is it in pilot form in Victoria?

Mr Daniel: Yes.

MR PETTERSSON: Any early feedback?

Mr Daniel: No, I have not got any at this stage. But we will look closely at that because that could have huge implications. Again, if Victoria are doing that and we do not, we might lose more nurses and midwives to Victoria. From our own data on our membership, we know that the greatest loss of our members is to other states. It is not retirement and not because they do not want to work in nursing and midwifery anymore. They are reasons, but the vast majority of losses of our members are to other states.

MR PETTERSSON: I am assuming you talk to the other state branches. Is that similar in the other states and territories?

Mr Daniel: It was during the pandemic for New South Wales. They lost thousands of their members. It seemed to be that everyone was heading north. I do not think it is

the case at the moment. Initiatives like ratios are being implemented in New South Wales. One of the reasons, I guess, is that it is aimed at stopping that exodus of nurses and midwives by giving them reasonable workloads.

MR PETTERSSON: The ANMF called for an ACT Health Workforce Strategy for a long time. It has recently been released. I am wondering if you have any comments on the strategy. Are there any actions or priorities that need to be further included?

Mr Daniel: We need to see accountabilities made obvious, in terms of deliverables and who is accountable for them. Unless the workforce plans incorporate those elements, they will just sit on a shelf.

THE CHAIR: The workforce strategy was held up as a union victory. You asked for it and you got it. I want to know if there is anything in that document that is problematic, that should not be there, or if it is broadly good and our reservations are, to quote you, Mr Daniel, around the accountability and who is actually responsible for delivering?

Mr Daniel: Yes—

Mr Cullen: Can we just confirm that the ACT Health Workforce Strategy 2023-2032 is what we are talking about?

THE CHAIR: Yes.

MR PETTERSSON: Yes.

THE CHAIR: That is what we are both talking about. Very good. Yes, that is the one.

Mr Cullen: Good; yes.

Mr Daniel: I am just familiarising myself with it again. We did provide feedback. Yes, it is clear to me now. There were lots of good statements of intent.

THE CHAIR: Okay. Good statements of intent. What advice would you give to the committee so as to inform its recommendations to government on how to make sure that some of those statements are prioritised and the intent is actually delivered on? You used the word "accountability" before. How would you recommend, practically, who should be accountable? How does that accountability happen?

Mr Daniel: We would like to cede the accountability down to each ward level, because that is where services are delivered. That is where you need to understand what your skills are, at that level, amongst your nurses and midwives: their seniority, all the demographic data, their age and when they might be looking to retire—all those sorts of things We really need to get back to those fundamentals, which I spoke about before, the building blocks of workforce planning, and understanding, down to that service delivery ward level, what the workforce looks like. What do you want that service to develop into and what is the gap, in terms of numbers and skills? How are we going to address our retirement rates as our workforce gets older? How will we

make sure that we provide a positive workplace for nurses and midwives, with all the demands that they have, both professionally and personally?

Unless we articulate that at a ward level, we will not understand the true problem or the opportunities that can be obtained by understanding the workforce at that ward or clinical unit level. We have been pushing for that for some time. I have heard some comments that that will not necessarily provide useful information. We disagree. Unless you have those fundamentals, you will not understand what the opportunities and the threats are at that clinical service delivery level.

MS CASTLEY: On the workforce plan, I will paraphrase a comment that is written in your submission. It says that the ACT government holds insufficient and inconsistent data, which means there are gaps in being able to provide a clear workforce plan and so they have decided to go with the strategy. I am wondering how long the ANMF has been fighting for a workforce plan. How long have you been asking the government to do this and how long have you been aware that there is insufficient data to formulate a workforce plan or strategy?

Mr Daniel: I would say it is patchy. Probably five to eight years ago we were looking at almost knee-jerk reactions, but we could see that things were on the horizon. We could see that there was a problem with attraction and retention of nurse practitioners into that space. There were some bandaid solutions to try and get nurses into that space through education programs and so on. But there was not a really comprehensive approach to understanding what the workforce need was, and for the walk-in centres, and what would need to be done to address those needs. We were sending up the red flag about that six or seven years ago, from memory. In terms of the call for a comprehensive workforce strategy—Tom, do you want to help me?

Mr Cullen: I would like to take that one on notice. It has been some time.

MS CASTLEY: Okay.

Mr Cullen: We would have to review over the years to ascertain what we called for specifically. In terms of a comprehensive plan, I know that Mr Daniel has been on record several times saying, “Where are the two, five and 10-year plans for these things?” That is what we have consistently sought for a number of years: clear, long-term plans.

MS CASTLEY: What are the ANMFs thoughts on the fact that the government does not seem to have the data to be able to create the workforce plan, that there are the gaps?

Mr Daniel: Without the data we are seeing those workforce shortages, which then results in rosters that are published short. There have been hundreds of shortfalls on rosters, over time. And we are talking hundreds; that is not an exaggeration. That concerns me for our members, for nurses and midwives, for their wellbeing and the care that is provided to the Canberra community. They deserve better than that.

I just do not see the effort or the right focus on making sure that decisions are evidence based. To set up a new service, say, in the midwifery space, there are already

shortages. Everyone is talking about the shortages, yet there are these new programs being developed and trying to be rolled out. We are already in dispute around staffing levels. The evidence is there that the lack of workforce planning, the lack of understanding of what that will result in, is now playing out, day to day.

MR PETTERSSON: We talk about the ACT Health Workforce Strategy. I wonder if you have any comments on the ACT Mental Health Workforce Strategy and its action plan? Are you involved in formulating the action plan at all?

Mr Daniel: I have to admit, early on we were invited to participate and have had some input into it. Again, we are concerned: how does that fit in with the broader planning for the workforce? In isolation, we have concerns about how much it can achieve.

MR PETTERSSON: Thank you.

THE CHAIR: I want to ask about nurse-led walk-in clinics, in particular. We are the only place in the country that has them. They seem to be very popular within the community. The committee has heard evidence about the cultural difference between nurse-led walk-in centres and the hospital. I wonder if you might proffer any wisdom about the benefits, about what is good about the walk-in centres that you want us to protect when developing a recovery plan and what are some of the risks and threats to those walk-in centres? What are you hearing from your members who work in those centres, compared to what you are hearing in other healthcare settings, like the hospital?

Ms Wong: I can talk to that. I have come from the walk-in centres.

THE CHAIR: Great.

Ms Wong: The staff obviously love our nurse-led walk-in centres, and so do our patients. We pride ourselves on the fact that, as nurses, we are holistic in how we treat patients. We will take as much time as needed for our patients at the walk-in centres. We have that luxury at the walk-in centres to really be able to treat you as a whole person, and if you come in for one thing and a second thing comes up, we have got ability to deal with all of the issues there.

We have grown as a service but very much also have been stuck, from 10 years ago, and not grown enough as a service. As for the issues that lie within the walk-in centres, again, we are back to the scope of practice and being limited in what we can and cannot do in the APN space and the NP, nurse practitioner, space as well. Our nurse practitioners at the moment are not able to work to full scope. That is a restriction of local policies—some kind of other legislation, too, but mainly local policies—and not being given that opportunity to provide the care that they could potentially provide to the public.

We are very concerned about losing nurse-led care. There is the potential to implement other health professionals into the space that will not supplement our care but will take over our care. We very much pride ourselves on being autonomous in the way we work and being able to make decisions. While we are happy to collaborate

with other health professionals—it would be great to have a physio come on board and work with us—our fear for the walk-in centres is that another health profession will come in, run the service, take over and delegate to nurses, versus allowing us to do what we know how to do best.

THE CHAIR: If our ambition here today is to recruit and retain nurses and midwives, would it be fair to deduce that expanding the professionals working out of a nurse-led walk-in centre and diluting the nurse-led element would be a threat to the ambition of recruiting and retaining?

Ms Wong: It would. I do not think the concept of nurse practitioners is well known, and what nurse practitioners can do is not truly understood by a lot of other professions and by a lot of other people. Realistically, a nurse practitioner could do anything. A nurse practitioner has the ability to formulate, to get competencies in all sorts of things and to deliver that care, the same as a GP, to someone in the public.

It is the same with an APN. As APNs, we are highly skilled, highly knowledgeable, and we have been practising for many, many years. We do have that ability, if given the chance, to expand our scope of practice to deliver that care. We have got nurses working with chronic illness patients in the community. We currently do not do that at the walk-in centres. Given that opportunity, we could do that. Nurses lead wound care in Australia and internationally. You know, we could lead that service. Bringing in other health professionals could potentially threaten the nurse-led component and the idea of a nurse-led centre and that holistic nature that nurses bring to health care. It could see nurses leaving the system.

THE CHAIR: When it was originally pitched to have nurse-led walk-in centres in the ACT, the pitch from government was that this would reduce the demand on the emergency room and the hospitals more broadly. How much do the limitations on nurse practitioners' scope of practice mean that people are coming in the door of a nurse-led walk-in centre and being sent to the ED? Is that happening as often as I might think?

Ms Wong: It is probably not happening as much as you think. Our redirection rate to ED, from memory—do not quote me on this—is eight to 13 per cent. It is really not that high. But some of the things that we send to ED could potentially be dealt with at the walk-in centres if we were given the opportunity to expand our scope. We do have a high redirection rate of about 20 per cent to GPs. But, again, that is because we are not given the opportunity to treat those patients within our scope at the walk-in centres.

THE CHAIR: This committee has also heard, in a different inquiry, about the demand on primary care and GPs. Twenty per cent is a big number. Would nurse practitioners, working to their full scope of practice, do you think, be able to meet the health needs of that 20 per cent that is currently being referred out of the nurse-led walk-in clinic to see a GP? Many of them already have quite a waitlist.

Ms Wong: I would not want to see that entire 20 per cent being taken away, only because we very much, as a profession, recognise the need for GPs and the role the GP plays. Because of the nature of the walk-in centres, people walk-in who just do not

know where they need to go. There are some things that we should not deal with or cannot deal with at the walk-in centres that really do need to go to a GP or do need to go to emergency. So I do not think that redirection rate will ever hit zero, nor should it, because we expect some people to come in with things that we just cannot treat. But, given the opportunity to expand that scope, we could definitely reduce that redirection to both ED and GPs from the walk-in centres because we could do some of the things that we currently redirect.

THE CHAIR: To be very clear: the point you made at the beginning was that it is currently local policy settings, so it is the ACT government's limitations at the moment that are restricting nurses working to their full scope of practice.

Ms Wong: That is the biggest barrier. There are obviously things like the collaborative arrangement, but it was promised in the recent budget to be dissolved. There are little things like that that will affect how nurse practitioners work, not just at the walk-in centres but across the country. There are things that potentially need to be looked into. But, at the moment, a lot of it is about local restrictions and not being able to work to full scope. That is the same not just with nurse practitioners but with APNs too. A lot of them, like me, for example, come from ICU or things like that. We cannot potentially perform skills that we have already learnt and been competent in because we are in a walk-in centre setting.

THE CHAIR: Right.

MR PETTERSSON: Can I get some examples of things that you are limited from doing?

Ms Wong: I will split it into nurse practitioners and APNs. Nurse practitioners, for example, cannot currently, at the walk-in centres, X-ray a clavicle if it is broken or has a suspected break. Very few clavicles now get sent to interventions; usually a sling is conservative management. We do not have the ability to X-ray. That needs to go to either ED or a GP, when the X-ray results come back within two days. So it is a long wait. With things like simple finger dislocations it is the same thing: we usually nominate for X-ray before we relocate. It is a really simple procedure that a nurse practitioner could do. Currently, they cannot do that—not within their scope—so it goes to ED instead. These are things that we could potentially do.

From an APN point of view, in terms of not allowing us to work to competencies that we have brought in from other places, a clear example would be that, when the COVID clinic opened up in Garran, a lot of our nurses had to go through re-accreditation for cannulation. These were nurses that had just come from ED, where they cannulated daily, yet they were forced to re-accredit themselves to insert a cannula, for no apparent reason. I do not know whether that was just because they were now in a new environment. Things just do not translate across services at the moment, in terms of our abilities and our competence.

Mr Daniel: If we think about the elements that make up scope of practice, they are: what is lawful, what a nurse or midwife is educationally prepared to undertake and what policies and procedures exist in an organisation to support the scope of practice. Those three elements are all within the control of the territory.

THE CHAIR: Thank you.

MS CASTLEY: I have a fairly quick question about the wellbeing fund and the Culture Reform Oversight Group. When talking about that, I believe you called it a bandaid solution. You said that you wrote to the health minister about the group, saying that there was a lack of urgency or ability to achieve real change in the culture through that body. Do you think that the ACT government has, over the past years, put in place the appropriate measures—I know we have talked about culture, but this is specifically for this group—to ensure that nurses and midwives have been cared for during and after the pandemic?

Mr Daniel: There have been some attempts to develop wellbeing strategies and so on, but we do not see that they really hit the mark of the issues raised. Again, thinking through our psychosocial wellbeing survey, the elements that were raised in that, for our members, were the workload and what causes the level of distress and burnout. We have clearly told the government over a long period of time, over many years, what the workforce is asking for. Some of those strategies do not hit the mark. They are not properly supported or they end up being some sort of document that does not lead to changed practices.

MS CASTLEY: With regard to the wellbeing fund, have the staff taken up their access to the fund?

Mr Daniel: When I did a bit of a litmus test and asked members that came through the door, or our own leadership branch counsellors or workplace delegates, many of them were not aware that it existed. They do not believe that that is the government taking responsibility for creating good workplaces. It puts the onus back onto members to come up with ideas.

I am particularly concerned about the support roles that have been established. I understand that they are current employees who are taking on this role in addition to their existing responsibilities. Many nurses and midwives are already stretched, so I am not quite sure where they are going to get the time to take on this additional role. Given the state of the culture at CHS at the moment, I would be referring our members to an appropriate external service. There is a service that is funded by the Nursing and Midwifery Board of Australia that is a free, 24-7 service, independent of CHS, that can deal with all of these issues.

Is it money well spent? I do not know absolutely the ins and outs of the program, but I am concerned that it could replicate existing services, so is it a good use of money?

MS CASTLEY: Okay.

THE CHAIR: Can I ask the $8.75 million question? If you, Mr Daniel, had $8.75 million and you were asked to use that money to improve the health and psychosocial wellbeing of nurses and midwives, what would be the first thing you would spend that on, roughly?

Mr Daniel: I would also probably take the money back from the online recruitment service, because I am not quite sure that it has delivered.

THE CHAIR: Okay.

Mr Daniel: We do not know—

THE CHAIR: We love a cost saving. That sounds good. We will bring that back.

Mr Daniel: We will add that money to the $8.75 million. I think it was $250,000 or so for the online recruitment service—

THE CHAIR: Great. So we are at $9 million.

Mr Daniel: And if we cut back on the directorate, because we will not need such a big directorate with one health service now, then we are getting some good money that we can throw at some really significant issues. I would be looking at making sure that ratios are implemented properly and that we roll them out like many other states and territories around the country are. They know that ratios work. They are not a blunt instrument. In fact, the international and national research shows otherwise. So they are fit for purpose.

We need to make sure that nurses and midwives have all the necessary resources that they need in terms of increasing the scope of practice policies and procedures. We can look at supporting undergraduate student nurses and midwives, through their employment, to bolster the workforce. We could undertake a couple of projects around, say, scope of practice again. We would get that underway. There are things around overtime and rostering practices: looking at those seriously and addressing the problems of that.

Mr Cullen: Yes. We would probably look to our current log of claims, through our enterprise agreement negotiations, and look to fund a number of the initiatives that currently sit there. Obviously, we would look to implement the initiatives that we have put forward to the committee today.

Ms Frost: I think Western Australia is paying off nurse and midwife HECS debts.

Mr Cullen: I was going to circle back to the question that Mr Pettersson raised about other jurisdictions.

MR PETTERSSON: I was angling for that one. I am surprised it did not come up.

Mr Cullen: I know; I was biding my time. Yes, other jurisdictions are offering to pay for study, for tertiary education for nurses and midwives. We would support free education and also sign-on bonuses for new graduates. A $5,000 sign-on bonus in Victoria has recently been announced. There are also recognition payments in other jurisdictions for the work done during COVID.

THE CHAIR: We have gone over time, but I would be remiss if I did not ask this, only because it was evidence presented to us earlier today. For midwives, you have

suggested HECS debt waivers and sign-on bonuses. The committee had it put to us earlier today that the cost of living through the period of studying was a reason that the University of Canberra was seeing midwives drop out of study. In those lists of good things like HECS debt waivers and sign-on bonuses, would you agree that that would be an area to prioritise?

Ms Frost: Yes; absolutely. Student midwives undertake unpaid clinical placement. As part of their clinical placement they have to be on call and they have to do a number of continuity experiences. It used to be 30. I think they have brought it down to 12, which is in line with the AMA guidelines. This means that the student midwives are on call 24-7 for their women, and it is part of their course requirement that they are at the birth for this woman and they do a number of antenatal and postnatal visits. Trying to fit on-call work around your home caring responsibilities—because a lot of the students are mothers—and work and study is really, really difficult for a lot of them.

THE CHAIR: So they are not paid for this placement?

Ms Frost: No.

THE CHAIR: Should they be?

Ms Frost: I think that some kind of payment would really help the retention of students and get them through that degree feeling like they are not burnt out. Currently, a lot of the graduates are exhausted from their studies. I really feel like that contributes to the attrition rate of new graduates, particularly in midwifery.

THE CHAIR: We have gone over time, but I feel like we could talk all day. Thank you very much for your time, Mr Cullen, Mr Daniel, Ms Frost and Ms Wong. Thank you for your submission. Thank you for your work on the petition that led to the committee's inquiry and thank you for your time today. Take care.

Short suspension.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health
CROSS, MS REBECCA, Director-General, ACT Health Directorate
DOMBKINS, MR ANTHONY, ACT Chief Nursing and Midwifery Officer, ACT Health Directorate
PEFFER, MR DAVE, Chief Executive Officer, Canberra Health Services
LANG, MS KELLIE, Executive Director, Nursing, Midwifery and Patient Support Services, Canberra Health Services
COULTON, MS JANETTE, Executive Branch Manager, People and Culture, Canberra Health Services

THE CHAIR: Welcome back, everybody, to the last session in the Standing Committee on Health and Community Wellbeing's public hearing on our inquiry into a recovery plan for nursing and midwifery workers here in the ACT. We are joined by Minister Rachel Stephen-Smith, the ACT Minister for Health, and officials. I would like to remind everyone here today of the rights and responsibilities afforded to you all by parliamentary privilege. I ask each of you to familiarise yourself with the privilege statement and to acknowledge that you have read and understood it.

Ms Lang: Hi. I have read and acknowledge the privilege statement.

THE CHAIR: Thank you, Ms Lang.

Mr Peffer: Good afternoon. I have read and acknowledge the statement.

THE CHAIR: Thank you, Mr Peffer.

Ms Stephen-Smith: I have read and acknowledge the privilege statement.

THE CHAIR: Thank you, Minister.

Ms Cross: I have read and acknowledge the privilege statement.

THE CHAIR: Thank you, Ms Cross. Tremendous. Minister, have you a brief opening statement?

Ms Stephen-Smith: A very brief opening statement.

THE CHAIR: Very brief would be wonderful.

Ms Stephen-Smith: I want to recognise that all around the country and around the world there are challenges in the recruitment and retention of nurses and midwives. That reflects ongoing issues, but it also reflects the great challenges that all healthcare workers have faced over the last three years—and in the ACT we had the bushfires followed by the pandemic—so there is work to do in recovery.

There is also ongoing work in relation to developing a positive culture in our health services and ensuring that they are safe places to work. Our colleges and the union have been important partners in doing that work over many years. I cite, for example,

the Towards a Safer Culture Strategy that has been developed in partnership with the ANMF. That was funded again in the last budget, as part of a $7.2 million commitment to nurse and midwife safety and support.

That is just one example of where we have been able to work collaboratively with our partners in this space. We recognise that there is more to do, and that is why quite considerable work has gone into the development of the workforce strategy, which will then be supported with very specific actions, but also into staff wellbeing. We committed well over $8 million to a wellbeing initiative to be guided, co-designed and co-delivered with staff. Some of you may have seen some of the announcements and commentary on that from one of the fantastic CHS staff over the last couple of days about rolling out some of those evidence-based initiatives that have been developed with staff.

We are committed to ensuring that our nurses and midwives are amongst the highest paid in the country. Our understanding is that they are about the second best paid nurses in the country, after Queensland. We know that we need to continue to keep up with that. The current common core offer in the ACT public service enterprise agreement negotiations goes a considerable way to ensuring that that is the case, but those enterprise agreement negotiations continue for nurses and midwives. Part of the key element of that negotiation is in relation to the delivery of phase 2 of ratios. We have delivered phase 1 of ratios, in partnership with the Australian Nursing and Midwifery Federation and with our staff, and we have fully funded the 90 full-time equivalent positions to deliver those. We have just gone live with compliance reporting online in relation to that.

The working group that supports the implementation of ratios has more detailed data in relation to compliance than there is on our current website. We will continue to provide more detailed information, as we can do that, particularly on developing measures for through-shift reporting, because we know that at the moment that public reporting is point-in-time and there is a bit more work to do on that.

In relation to—

THE CHAIR: We might go to questions.

Ms Stephen-Smith: Can I just do one more thing before I go to you?

THE CHAIR: No worries.

Ms Stephen-Smith: There were some questions asked specifically in relation to the north-side hospital transition. I want to table some responses that were provided to the ANMF on 31 May by the transition team to some of the questions that they and their members had been asking. It might short-circuit the process if I can table the responses so that we do not have to repeat that information in relation to some of the questions that have been asked.

THE CHAIR: Please. You are welcome to table it, but I cannot imagine we will have an opportunity to read it before asking you questions.

Ms Stephen-Smith: I know how this process works.

THE CHAIR: So you may hear us ask some of those questions. Speaking of which, we will go to questions now. I will start. My first question is based on the evidence we just heard from the ANMF, in our previous session, and it goes to the Health Workforce Strategy 2022-2032.

Ms Stephen-Smith: The 10-year strategy.

THE CHAIR: I do not want to verbal our union friends, but the appraisal the committee appeared to get from the evidence was that it was a good document, with a lot of good statements, but that it had limited accountability or lacked accountability. Would you be able to explain to the committee how CHS will hold itself accountable to meeting the ambitions of that strategy?

Mr Peffer: Yes. I might start off and then I will hand over to Ms Lang to provide some of the detail. It is an important strategy for us. We are an expanding health service, so it has formed a critical part of our planning for the expanding of services but also how we construct those services. It is something that engages the workforce as part of that process. I think that, even though the strategy is only one year old, we are already starting to see some of the impacts through that strategy. One of the things we might do, as part of this response, is to share with the committee some of the numbers for some of the changes that we are starting to see.

Ms Lang: Canberra Hospital nursing and midwifery introduced the Nursing and Midwifery Workforce Plan 2022-23 in May 2022. That is in alignment with strategies related to our ACT Health Workforce Strategy, but it is more around increments: smaller chunks of work developed to look at that broader strength in relation to nursing and midwifery. From a CHS perspective, we have done quite a lot of work in relation to the nursing and midwifery plan, particularly over the last 12 months. You can probably see that it is multi-pronged, because, as we have heard during the day, a lot of work needs to be done in relation to that.

Part of that was about ascertaining exactly what our baseline nursing is per ward, particularly looking at the inpatient wards at the moment. We have done a lot of work on looking at exactly what our skill mix is—our RNs, ENs and years of experience et cetera—for every single ward that we have at the hospital. That gives us the opportunity to roll it up. We can work closely now, and it is all stored centrally so that all the managers, the directors of nursing—everybody—can see that information and it is updated live each time the manager changes anything within their roster or their staffing establishment. So it is really their establishment report, baseline. We can see where there are gaps in their workforce, such as whether they are identifying people who are working towards going on maternity leave—planning in relation to that. This enables us to help the managers then fill their workforce shortfalls.

In support of that, we have also established a central nursing and midwifery workforce unit, which was part of the Nursing and Midwifery Workforce Plan, and that is aimed at developing this piece of work. We have started that with the inpatients; we will roll that our to our community and walk-in centres. We have centralised nursing and midwifery recruitment and we are looking at more targeted

advertising, more targeted talent acquisition, for particular areas.

Another piece of that work is about developing our workforce and the capability of our workforce. We have identified particular areas from our nursing leadership, our managers, who have raised concerns in relation to their ability to support their staff. We have provided certain opportunities through the Australian College of Nursing this year. We will be able to have about 60 staff attend a leaders mindset program this year. That can be done over six months or six weeks. We have got spaces for 60 staff to attend that particular program, at the level 3 clinical nurse manager role. We will support that.

We are in the process of developing a community of practice for our managers, which is a forum for all our managers, nurse managers, CNCs, to meet on a regular basis and share knowledge, share information. It will also give us the opportunity to supplement what these guys are learning through the leaders mindset program and provide other learning opportunities.

We have established a community of practice for our educators. We are four workshops in, and they have identified a particular plan of work that they as a group would like to develop and areas of work that they would like to standardise, from an education perspective, so that we are all teaching in the same fashion. We have educators and clinical development nurses all involved in that particular workshop.

The management community of practice will work in the same manner but will also provide support to staff that we are sending off for training and education so that we give them the opportunity to continue with their learning.

In addition to that, in relation to developing our workforce, we currently have about 140 staff who are accessing scholarships through the Office of the Chief Nurse. That is for postgraduate training in specialty areas—for example, critical care, maternity, midwifery and mental health—so that we can develop specialised skills in those particular areas as well.

We have a number of activities to look at the expanse of practice. We are looking at introducing a trial for the RUSON, and that is due to commence in July this year. We have sent out, today, the consultation documentation. That is around clarifying exactly what the roles, responsibilities and duty statement of the undergraduate nurses will look like within CHS. Then, after feedback from the ANMF in relation to the AINs' roles and responsibilities, we will be able to clearly articulate the difference—

THE CHAIR: Forgive me for saying this, but I just have to go back to my original question. That is useful, and I am sure everyone on the committee appreciates knowing that, but my question was about accountability. I can add some more context to why I asked that. Let's go to pages 15 and 16, which talk about the strategic priorities and early actions. It would appear to me that there is a third column missing, which is, basically, who will do it and by when. I can give you an example. Point 2, subpoint 4, says:

> Identify, collect and analyse reliable, recent and applicable baseline workforce planning data.

Then subpoint 6 says:

> Commit to improving publicly available health workforce data.

Those two things appear to be things that stakeholders regularly tell me they want. The ANMF just told us that they want that. I am trying to get to the third column that is not in the strategy: when will it happen and who will deliver those things?

Ms Stephen-Smith: Maybe the best way of approaching that, for all of the actions, is to take that on notice and we can provide you with a table about who is responsible and what the time frame on those actions is going to be. I will pass to Ms Cross, particularly in relation to the data issues.

Ms Cross: By way of context, the strategy is for the whole health system. It will be underpinned by a three-year action plan, and within the action plan is when you will start to get into the specifics of who does what by when. So this—

THE CHAIR: Just so that I am really clear: the action plan will be the—

Ms Cross: Ten-year strategy.

THE CHAIR: This workforce plan is for everyone who works everywhere, whether or not they necessarily work for us?

Ms Cross: Yes.

THE CHAIR: The plan that you are talking about, the three-year one, will be for people who work for the government.

Ms Cross: No. Again, it will be for the health system, but within that there will be specific actions. When we gather data, it will not be just about people employed in the hospitals; it will be broad workforce data and we will be saying what we will be doing, by when and by whom. That is in the three-year action plan. The strategy is quite high level; it is covering a 10-year time frame. Then you have the action plan, and then underneath that you will have the very specific CHS workforce plan. We might have a specific data project for allied health. That is the next level down from the strategy, which was always meant to be a 10-year, high level work plan.

THE CHAIR: When do you expect the three-year workforce plan and then the subsequent CHS workforce plan to be released?

Ms Cross: From memory, the first workforce plan will be 2024 to 2026, which is three years. So we will be developing that this year and then it will cover that three-year period.

Ms Stephen-Smith: In terms of your question, we can still take on notice, looking at the fact that we have already identified early actions within the strategy, who is working on those actions and what activity is currently underway. Certainly, in relation to those data issues, there is already work underway. Obviously, we cannot

pre-empt budget outcomes. Some of this may become a little bit clearer after budget in terms of who is doing that work and in what way and how it is funded. Some of these things will be being done within the existing resources.

So I think we can still take on notice for each of the early actions that are specifically identified whether further detail is needed as part of the action plan, whether there is already work underway, who is responsible for doing that work and the time line that we are looking to complete that work in. I think that is information we will be able to provide to the committee.

MS CASTLEY: I want to refer to a comment in the workforce strategy, where it says:

> Current health workforce data in the ACT is inconsistent and insufficient for health planners to have a clear understanding of the current workforce, support anecdotal reports of service gaps or deliver holistic, robust workforce plans.

I am wondering if you can tell me specifically what areas we have insufficient and incomplete data to deliver a 'holistic' and 'robust' workforce plan.

Ms Cross: The area we would particularly point to would be people employed in the private sector in nonregulated professions. If it is a regulated profession, we have quite good data. If it is not, then we just do not have access to a database that easily provides that. That is probably the biggest area. When it is a publicly funded part of the health system it is much easier to access data because there is normal reporting on that.

Ms Stephen-Smith: The other thing I would add to that, by way of example, is that we can tell you that in the 1 January to 31 March reporting period there were 7,984 nurses and midwives with general registration in the ACT. That points to the fact that, where we have a regulated profession, we can actually pretty easily understand those numbers.

But one of things that the ANMF has raised with us in the context of workforce planning at a more granular level, at an organisational level, is that you might know that you have X-thousand nurses but do you know how many of those nurses are due to retire in the next five years? Do you know how many of those nurses are about to take maternity leave? It is that level of granular detail around the workforce that CHS has been doing that workforce planning around to get much clearer data at an organisational level of not just the numbers but also what that succession planning or what that workforce planning at a divisional level, ward level and team level looks like.

Mr Peffer: I might just add to that a little bit. Frequently it is the case that we have got the data but our ability to pull and report on that in a live environment is somewhat constrained. We have done a lot of work on this over the last six to 12 months. Ms Lang has led this work, and it has given us a much richer picture now in terms of skill mix—because we know it is not just about the raw numbers of who is on what shift but also skill mix and levels of experience that matter in terms of how

safe the care is and the environment that people experience when they work day to day.

So we have made some significant headway in the last 12 months in terms of our ability to be able to pull this data and report. We have still got some way to go, particularly in our community settings. But, in our inpatient wards and settings, we now have quite good data that we can pull and report on.

MS CASTLEY: It is my understanding that there is a more of a hospital huddle. Is that the right term? Is that where you are able to work out on any given day what the percentage is and how your staffing levels are going? Can you get the data for today, for instance?

Mr Peffer: That is correct. We do have what we call a hospital huddle. It covers our two inpatient facilities in the University of Canberra Hospital as well as the Canberra Hospital. As part of the huddle, we have our professional leads report on our medical, nursing and midwifery, and allied health workforces for the day as it relates to an inpatient setting. As part of that reporting we look at what our shortfalls are on the day, if we have had sick calls, and what we have not been able to cover.

MR PETTERSON: Dealing with the workforce mapping, does that start once someone enters employment? Do you have some type of, I guess, gauge of the pipeline of students and graduates that we can expect CHS to employ?

Mr Peffer: We do have a reasonable handle on that—and Ms Lang might want to expand on this a bit. We have some very active relationships with our feeder universities. That is the future pipeline of talent that we are working to capture and retain here in the ACT. We have a range of avenues that people can pursue in terms of entering the health service. Kellie, do you want to expand on that?

Ms Lang: We do have various avenues, but we do work with the universities as well to identify what the possible number of graduates we could be expecting next year and where we need to work on that. We also need to look at the number of graduates that we can expect, what our turnover rates are and what our maternity leave is looking like at this particular point in time. For example, there are approximately 340 FTEs currently on maternity leave. That is a significant number.

We know that, predominantly, most of them will come back part-time on reduced hours. They may well have gone on leave as a full-time FTE but they will come back part time so that they can manage their family and do all of those sorts of things-which we totally support. That then creates another vacancy. So it is rounding foreseeing that, being able to identify that and then be able to ensure that, from our turnover rate, we are able to recruit into those spaces.

Plus we have building five and we have phase 2 ratios, which we have not finalised negotiations around yet. So there is still quite a number of staff that we do need to recruit over the next—

THE CHAIR: I am particularly interested in the midwifery workforce. We heard from a professor from the University of Canberra earlier today—and I trust someone,

Meg, has been watching the proceedings today. They were expecting 18 graduates in midwifery. I think the committee was broadly surprised to learn about the attrition rate they are seeing. A lot of people enrol in midwifery and not complete their qualifications as a result of the cost-of-living burden during studying due to the fact that they are not paid during placement. There were few different examples given.

Has the ACT government heard that feedback before? What strategies are we putting in place to mitigate that? We have a graduate program and we have a certain number of full-time jobs, so we obviously want to fill them, and it appears we are not, according to the University of Canberra.

Ms Stephen-Smith: We have certainly heard that feedback, and we have been talking to the University of Canberra about that as well. You are absolutely right, of course, that the cost of living is a real challenge for students. My understanding is that, for midwifery students, because they do actually need to follow a certain number of pregnancies right through in, effectively, a continuity model, that is quite challenging because they might be at work and then they get a call and they have to go. That makes it quite difficult to sustain what is, kind of, a normal job.

Ms Lang talked about the undergraduate student of nursing program. We still have some thinking and planning to do around an undergraduate student midwifery program. But, potentially, we have an opportunity—and now I am speaking completely out of school—to think about how offer employment opportunities to undergraduate student midwives that will enable them to have the flexibility to then do what they need to do to complete their studies.

That is something that I have been thinking about as a response to the feedback that I have had from the roundtable that we had as part of the workforce strategy. We had a roundtable with undergraduate students, nurses, midwives, paramedics and medical students, and that was one of the pieces of feedback that I had directly from a student after that session. But we have also heard it from the University of Canberra.

So those are the kinds of things where we are hearing that feedback and then starting to think about how we can actually support the universities and the students to be able to complete their studies in this very difficult environment.

Mr Peffer: One of the other things that we are working on in partnership with the university is the curriculum and the course as it is currently designs. The course is designed to set people up for a certain experience in the midwifery workforce.

We know that the Canberra Hospital handles the high-risk births, not just of the territory but also of the region. Where at times we might have people entering their career expecting a certain type of work environment, what they are then experiencing on the ground is more of almost an emergency department type front door situation, which is perhaps not what they were looking for and not what they had been trained to expect.

We have had some really productive conversations with the University of Canberra around the construction of their curriculum, just to make sure that we are setting

people up for success and that they are stepping into an environment that they are expecting and prepared for.

MR MILLIGAN: The Australian Nursing and Midwifery Federation in their submission said that in 2021 the ACT government only offered a small number of positions for graduate students who had finished their nursing and midwifery degrees. The figure that they put in their report was 27 per cent of graduates were offered a position. I am wondering why that number is so low, considering we have a desperate need for more nurses and midwives here in the ACT.

Ms Stephen-Smith: That number is obviously a couple of years old. This year we had a record number in nursing and midwifery, but particularly around nursing graduates, employed. It is also important to remember that the University of Canberra, in particular, is a catchment university for a wider region and there is some expectation that students at UC will then go back to the area that they came from and will go and work in the wider region, and that is good for the whole health system. It is good for us if southern New South Wales is able to recruit nurses, particularly nurses that were trained here, and people are moving backwards and forwards.

But Kellie may want to speak to more recent graduate recruitment numbers and that 2021 figure. I do not know if we will be able to comment on the proportion of UC graduates, but Kellie may be able to give some numbers.

Ms Lang: I cannot comment on the 2021 but, for this year, we actually offered 170 positions to various graduates, and we were able to take 122. We had 170 suitable applicants to whom we offered positions. However, new graduates generally apply to a number of areas—as we all did at that particular point in time—and then they have their choice. So we did take 122 this year between February and May.

MR MILLIGAN: Did you know the percentage in terms of the total number of students graduating and how many had taken the positions?

Ms Lang: No, I do not, sorry, but we can take that on notice.

MR MILLIGAN: We have heard today and in a lot of submissions that there seems to be a shortfall in nurses and midwives in the ACT. Obviously, this inquiry is about a recovery plan. In the last few years it has been hard on nurses and midwives right across the board and we have heard that there has been a lot of burnout as well.

Given the acquisition of Calvary, which is due to take place shortly, there may be potential losses in nurses and midwives. Does that government have a contingency plan ready to go in case there is a drop in the number of midwives and nurses due to that acquisition?

Ms Stephen-Smith: I will hand over to Mr Peffer to talk about that in a moment. I think it is a good opportunity, though, to clarify that there has been some misreporting in the media in relation to the target of at least 85 per cent of staff coming across for us to be able to ensure that we can provide continuity of service at the northside hospital.

We want all of the nurses and midwives to transition across to Canberra Health Services. If only 85 per cent, or a bit more, transition, that can still be a safe transition and delivered safely.

There has been some misreporting that indicated that 15 per cent of staff would not have a job. That is absolutely not the case. One hundred per cent of the staff at Calvary Public Hospital Bruce who are eligible to work for CHS—and there are only a tiny handful that are not—will have a job on 3 July if they want one with Canberra Health Services. So I think it is really important to correct some of what has been misreported in relation to that 85 per cent. I will hand over to Mr Peffer to talk about the continuity of services.

Mr Peffer: Thanks, Minister. Our objective through the transition is to maximise the number of healthcare workers who come across as part of the transition. To do that, what is important to us and what is important to the workforce, as they have conveyed that to us, is clear and consistent communication; certainty about their own employment arrangements and whether they can keep their existing shift structure, remain at the same hospital and those sorts of things—all of which we have given written commitments about; and consistency in terms of how the organisation is going to work. We have given some commitments about that as well.

We are working very hard to preserve in place the existing leadership within the institution, so that people's day-to-day experience of 2 July to 3 July, ideally, should be minimal disruption and minimal change. We are moving as quickly as we can to give people certainty. So today we have started issuing offers of employment. In the region of 100 will go out today and there will be more that go out tomorrow.

We will keep moving forward so that, as soon as people indicate their willingness to transition as part of the announced acquisition, we will give them certainty as quickly as we can, and they will know, from that letter of offer that goes back, that all of their existing entitlements and arrangements will be preserved through that process.

In the event that some workforce—to a number—does not transition as part of the plan and that begins to impact service delivery, we will assess what that looks like on a case-by-case basis. It could be individual services that are impacted. But we do have the ability with CHS to provide a level of safety net for services right across the territory.

That is something that we have had to activate and bring into being in the past. It is something that we have done as a result of the well-reported, fires that took out seven of the territory's 20 public operating theatres. We had to move very quickly to be able to backstop the service there.

Right now we are in winter—and it certainly feels like winter, I can tell you, in the hospital—and we see the pressures of what that looks like. There are patients that are moved between the facilities regularly to manage that demand as it might present on the day.

MR MILLIGAN: You mentioned that, if it is only 85 per cent that goes across, it will be safe. Can you explain what you mean by "it will be safe"? Will it be safe for

patients and staff? How have you measured this? How can you guarantee that it will be safe? What sort of tool have you used to measure that?

Ms Stephen-Smith: Again, a lot of the public commentary about this draws some kind of equivalence between the size of Calvary Public Hospital and the size of Canberra Hospital. Canberra Hospital is a 670-bed hospital and Canberra Health Services is a $1.6 billion organisation. Calvary Public Hospital is a 250-bed hospital and runs on a $270 million contract.

We do not want to lose anybody. We want everyone to transition across—and the more that do the better. We have heard, including from the College of Nursing and the AMA last week, that the figure is expected to far exceed 85 per cent. But it is not like we are talking about 15 per cent of the entire health workforce. I think it is really important to keep that relativity in mind. When Mr Peffer talks about the capacity of Canberra Health Services to be the backstop for the regional health system, it already is. So, in that context, I might hand over to Dave.

Mr Peffer: Thank you, Minister. In terms of running the health system, every single day we are making decisions about demand and supply, we are activating and de-activating, we are surging and we are closing capacity where we do not need it. So we do not have a fixed supply and that is it and, if something happens, we are in disaster territory; that is just not the reality of how these things work.

To give you a bit of sense, in recent days, we have had some very heavy admissions, particularly on the paediatric front—admissions at the rate of three times what we would expect at this time of year. Pleasingly, in the last two weeks, we have seen our COVID admissions roughly halve, which is good news, but we have actually seen RSVs—another respiratory illness—take off and it is now outstripping COVID.

So there are all these factors that, on a day-to-day basis we make decisions on about what supply we bring to bear. We have, I guess, two streams that we manage. One is unplanned activities. These are people turning up to the emergency department each and every day. These are acute admissions, and we need to deal with them. Then we have got elective or planned activity, and that is the variable that from day to day we will have to adjust to make sure that we are carrying the load.

But to expect that this is not something that would be unusual in the health context is just not the case. We see service impacts each and every day right throughout the year in terms of workforce not being available, infrastructure outage and theatre fires and the system is able to respond—and this transition will be no different.

Ms Stephens-Smith: **A**nother example of that is the implementation of the Digital Health Record last year. Every single staff member on the front line who is going to use the Digital Health Record had to come offline and undertake training for the Digital Health Record. Every single one of those thousands of people had to undertake training, and we managed through it with additional resources. And we are putting additional resources into this transition. In some ways, this transition is not as big a change as the implementation of the Digital Health Record.

Mr Peffer: If I might just add one more thing. We spend a phenomenal amount with

the secondary employment market that we have created here in the territory by having parallel health services. We poach from each other on a daily basis. Today we will be recruiting people from Calvary and today they will be recruiting people from our team.

It is not in the territory's interest to do that. We are spending money on it and it is not growing the health service. It is just disadvantaging and generating activity that, to some extent, is just wasted effort. Being able to remove that from people's day-to-day activities and focus on actually growing the healthcare workforce here is one our objectives through this. It will be a long-term gain for the health service but ultimately for the patients as well.

THE CHAIR: Thank you, Mr Peffer.

Ms Castley: We heard from the ANMF that the loss of one nurse or midwife could affect an entire ward or unit. I understand that Calvary is much smaller than Canberra. What do you say about that—that one senior nurse missing will make a significant difference?

Mr Peffer: Our intention is not to lose any healthcare workers on the way through, but we understand that people will make their own decisions. Every day, there are people who are sick or their kids are sick or things happen, and we have to respond to that. I do not think it is desirable in any way to have experience drained from the system. That is not what we want.

Over the last 12 months we have worked on some of the initiatives that Ms Lang spoke about earlier, and we are starting to see the results of that work. If I can take us back 12 months, in May of last year, in terms of our relief staff numbers in CHS in our nursing workforce, we had 44 registered nurses and 10 enrolled nurses. We are now at a point of 74 RNs and 26 Ens.

Now that actually makes a big difference when day to day you are managing shortfalls and you need to plug unexpected gaps. That is just a steady trend upwards because of the work that we have been doing. We can see that in terms of agency use and overtime. All the indicators are headed in the right direction.

MR PETTERSSON: Culture in the public health services has come up fairly frequently throughout the inquiry. I was wondering what evidence you have that there have been improvements in culture?

Ms Stephens-Smith: We have had a number of annual reviews of the Culture Review Implementation, and I think all of those have found that there has been some really great work done at a system-wide level and within each of the three organisations, the Health Directorate, Calvary Public Hospital and CHS.

Obviously, every time we do one of these annual reviews, there are also opportunities to continue to improve, and the improvement of culture is an ongoing journey. At Canberra Health Services, I think a lot of work started off with working with the workforce to identify the values that they share and the behaviours that are associated with that. Mr Peffer has done a lot of work to reinforce that, and that is coming through in the surveys.

I know that Ms Castley has made a big thing around the response rate in the culture survey last year—which I think Mr Peffer can speak to—but we were assured by the independent provider of that survey that that response rate was sufficient for us to be able to look at that and say that is a robust result.

When you compare it some of the other surveys that people draw on, it is a very large number of staff who respond. When I talk to my colleagues interstate and say, "For us, 35 per cent was not the best response rate we have had," they say that they would be jumping up and down with joy if they got a 35 per cent response rate in one of their local health networks or hospitals. So for us, it was not where we wanted to be but for health service, it is pretty good. I might hand over to Mr Peffer to talk about what that trend is showing.

THE CHAIR: Before we go to Mr Peffer, if you do not mind, Minister, I feel compelled to say in Ms Castley's defence that the ANMF were here recently and they were scathing of the 35 per cent rate. So taking on board what you have said about these numbers from your colleagues—

Ms Stephens-Smith: And I am sure that you took the opportunity to ask them how many people complete their surveys.

THE CHAIR: Good point.

Mr Peffer: I think it is a fair point. I guess we can kind of sit here and talk about the statistical relevance of things but, at the end of the day, what we had was more than 2,900 people fill out a survey and tell us how they felt—and, a lot of them, frontline healthcare workers. More than 860 were our nurses and midwives as well.

Actually, the timing of the survey, I think, is relevant as well. We had just gone through the Digital Health Record, which had been such a significant transformational reform project—the last I thought I would be involved in the health context until recent months. It took an entire workforce offline, some people for three weeks at a time, to re-train however many thousands of people and then to—big bang—go live, and to run more or less emergency structures for 24 hours a day for weeks on end to haul this thing into existence and then operate the health service.

That is when we pulled the trigger and went live with the survey. We could only keep it open for two weeks because, any longer than that, we were heading into school holidays. It was less than an ideal time. It would have been entirely reasonable not to run the survey and to say "We are too short on time; we cannot extend it as we have with prior surveys which we have run for four weeks—that is how we get the higher response rate". But we thought, "No, if ever there is a time where we do need to get a sense of how the workforce is going and check in and make sure we are focused on the right things, now is the time."

So that produced the lower response rate, which has been the focus, I think, for some time. Pleasingly, it reinforced some of the progress that we had been making in terms of people's experience or witnessing of bullying, of harassment and of discrimination of various forms in the workforce. These are all things that we had been working

towards improving.

Even if we were not to focus on just the 22 results, because of the engagement rate, if you look at the trajectory we are on, it is the right one. It is a hard thing to turn around the culture in a 9,000 person organisation. It is very, very hard and it takes a decade. But we are on the right track, and we are making that incremental progress year after year.

We are seeing that come through in the results. I think, from memory, it was the best result we had seen in culture since we started doing the surveys back in 2005. So we have not come close to being where we are today. Despite what people might feel existed in the health service or their sort of memory of the golden era, it was not a golden era for our workforce. But we have seen that steady progress over the last five or so years, where there has been a really concerted focus on culture.

Ms Cross: Can I add to Mr Peffer's response?

THE CHAIR: Please.

Ms Cross: Mr Peffer pointed to the fact that we had just been through the Digital Health Record rollout. I think it is important to remember the whole year, because we started with the Delta-Omicron lockdown and the big impact on the health workforce with everyone being furloughed. CHS then went through accreditation, which is always a huge workload and huge process. Then we had the winter second wave, which again had the huge impact, and then we rolled into the Digital Health Record.

So, if you understand the cumulative impact in that year and look at the survey results in that context, I think they are extraordinarily good.

Ms Stephens-Smith: We also know that there is a lot more work to do. Some of the things that have been talked about in relation to Canberra Health Services have been in areas where there has been disruption precisely because the leadership of the organisation has taken some really difficult decisions to address longstanding areas of cultural challenge. That in itself is disruptive but, ultimately, it is to the benefit of the staff in those areas and those organisations as a whole.

Those decisions are difficult, and that is why they have not been made over long, extended of periods of time. Those hard decisions are now being made with the full knowledge that there are going to be repercussions from that but that they in the best interests of the staff in those teams and the organisational culture as a whole.

It reflects the feedback that we certainly saw in the cultural review in 2018 and in probably some of the culture surveys at that time and subsequent was, "We keep telling you these things and we keep giving you the same feedback and we do not see action." I really want to give Mr Peffer the credit, as he has been willing to take the action that people have been feeding back through those messages in a bottle to the CEO and through the surveys more broadly.

MR PETTERSSON: Thank you for that response. It was quite a high-level response. I was hoping someone could speak to some of the more specific cultural challenges

that nurses and midwives have faced and what work is underway to improve things for nurses and midwives specifically.

Mr Peffer: Perhaps a good example is the clinical supervision, which we might talk through.

Ms Lang: Yes. That is a program that is supported by and presented by the Chief Nurse and Midwifery Office. It is a program around being able to provide support and a mentoring type of process and opportunities for staff to provide feedback and talk through their challenges. It can be a one-on-one or it can be a group session.

We have approximately 130 people trained, with more to be trained later this year within that program. That is creating a network within the organisation, to be able to provide that support for various staff within our areas, and it is cross-border—"I might work on this ward but I am going to develop some clinical supervision programs with some staff from another particular area."

The Chief Nurse and Midwifery Office present a symposium at the end of every year. The first one was last year and we have another planned for this year. Staff who are involved in clinical supervision come together and share their experiences and their programs. Last year we saw some really good programs from Calvary Hospital and we saw some great programs from Canberra Hospital, where staff are using clinical supervision to provide that support and encourage staff to share. That part is around changing the culture and providing some more leadership within the organisation as well.

Mr Peffer: In terms of the feedback, I have spoken to a number of nurses who have sat on both sides of this program. I was talking to one of our senior renal nurses just the other day, and the signal it sends to the workforce in terms of taking them out of the clinical area and saying, "We are just going to sit down and invest this time in you and your development and to hear about your challenges and where, as an organisation, we can support your development," is a signal of valuing the workforce.

Our junior nurses or those participating in the program, having that level of supervision, are getting a lot of it. It has been very, very well received. I think it is a credit to everyone who has put that program together.

Mr Stephens-Smith: I would just add that the clinical supervision framework sits within this broader remit from the Chief Nursing and Midwifery Officer around the Towards a Safer Culture program. We invested almost $4.7 million in the second stage—or the next steps—of the Towards a Safer Culture program in the last budget, which is something that we do in partnership with ANMF.

One of the things that will be done under that is expanding the Safewards model of care implementation to an additional 12 wards. That is about creating a safe environment for both patients and staff within those wards and really changing the ways that people respond to each other, reducing the use of sort of restrictive practices within that ward and creating a more respectful environment overall. We are also looking to refresh the awareness campaign, 'Be kind and respectful to our nurses and midwives'.

All of that goes to improving the psychological safety and wellbeing of nurses and midwives in their workplace, which then more broadly contributes to a positive culture. We know that people who are stressed out or who are not feeling safe are not going to feel as good about their workplace from that culture perspective but also are probably not going to behave as well towards each other either.

MS CASTLEY: Mr Peffer, I understand you said that the golden years were not the golden years and that it looks like it could take 10 years to turn around and ensure a culture change. I acknowledge it takes a long time. Mr Davis pushed one of our people on the panel earlier today to say, "Basically, there is not change; it is not getting any better," and Mr Davis said, "Really; no better at all?" and the response was "Minute", or something like that.

THE CHAIR: "Miniscule".

MS CASTLEY: Miniscule. There seems to be a real gap. If you read the ANMF submission and the quotes from nurses, you see, for example, "Bottom line, it is just too dangerous to go to work." Another one says, "I am sick to death of being told to make do, to keep up or it will get better. It has not gotten better; it has gotten worse." Another one says, "I'd like actual breaks".

What's happening with these people? How are they not seeing any change? Is it possibly that you might not be seeing what is actually happening on the ground? We hear constantly from nurses and midwives that it is really not getting any better. Ten years is a long time for them to keep saying these things.

Mr Peffer: Look, I agree; 10 years is a long time. At any point in time, people's experience of the workplace will vary quite widely within the organisation. If we break down our cultural results, we will see that some teams are absolutely flying and, if you step onto the floor or you walk that ward and listen to what the team says, they will be loving life. Then there will be other teams that are genuinely struggling and they might have even gone backwards in the last year. There are some teams that have taken a step backwards in the last couple of years, but there are many more teams that have taken a step forward.

It will take us a long time. It is that concept of "a rising tide floats all boats", but it takes a long time to get there. There are particular units that the minister alluded to that have had a concerted intensity of focus, where we have had to bring in some external help, do deep-dive reviews and then make some difficult decisions. Sometimes that impacts people's employment. We cannot do that for hundreds of teams at the one time.

After we go through a process like that, which is traumatic for everyone involved, there is never a situation where one side thinks, "This is all fantastic," and the other side thinks it's horrible. Everyone takes a hit when you go through a process like that in a team. It then takes time to rebuild, for the team to settle, and to recruit, if there are shortages in the team. It is an involved process to go through. It is in the long-term interest. You cannot just say, "Let's not do anything because what if a team goes backwards?" It is in the long-term interest of the health service and, ultimately, of the

patients that we are caring for.

But I accept those views. I spend a lot of time out walking through our wards, through our facilities, and out in community facilities. I hear firsthand about how people are feeling on the day, what the pressures are. We hear it every morning with our huddles: who is struggling that day, where we are short, what we are going to do about the patients and how we support those teams. All of that is real, so I do not question any of that. But what I can say is that we are headed in the right direction. We heard about some of the initiatives earlier. If I bring it more specifically back to nursing and midwifery, I mentioned that the indicators are headed in the right direction. Having a relief pool of workforce that can be readily deployed to address some of those shortfalls is a big part of it.

I will share with the committee some other indicators which might be of interest. In terms of casual hours worked per month within our nursing workforce, in May 2022 we averaged about 10,000 per month. Today we are at about 7,000. That is a marked improvement. It might still sound very, very high, but it is a marked improvement. In terms of acute overtime shifts worked by permanent and temporary staff—this is a direct measure of: "We've got shortfalls. Can you stay for an extra shift or can you come in on your weekend or on your time off?"—there were 792 in May of last year and 391 in May of this year. So we have seen a steady progression down.

All of these indicators are what shapes people's day-to-day experience of the work the health services call on them personally to do and the contribution we are asking them to make. We have still got a long way to go. We know where we have recruitment shortfalls. I heard Mr Daniel speak earlier about rostering shortfalls. We completely accept that, but we are in a better situation today than we were 12 months ago, and certainly than we were 24 months ago, and we want to keep driving in the right direction.

THE CHAIR: I would like to talk about the $8.75 million Health Workforce Wellbeing and Recovery Fund. Does that need a switchover of witnesses? I saw a nod, and a wink and a smile.

Ms Stephen-Smith: But you can ask your question, I think.

THE CHAIR: I can. I think the committee would benefit from broader information about the genesis of that fund and how you intended on rolling it out. Admittedly, that was in October last year. I would also like a bit of specificity about the recent announcement for wellbeing peer support officers.

I really want to stress that what I am about to say is not a criticism, even though it might sound like it, because I do not want to look a gift horse in the mouth. I am sure it came from the workforce. They all sound very excited about it. I just could not help being struck, driving into work listening to it on the radio, by the thought that nurses and midwives are burnt out, stressed and overworked and doing 7,000 hours of casual work in a month. Where are they going to find the time to support their peers, in addition to their already overwhelming jobs? I would like a little bit more understanding about that particular program, because if I was a nurse right now I do no know if I would be putting my hand up for extra work.

Mr Peffer: I might respond directly to that question and then we can expand on the broader program and what that looks like, and the process that we are going through in terms of training and equipping people. By virtue of the environment that a lot of our nurses and midwives work in, there is a level of trauma and emergency care and unexpected things that happen each and every day. They will be happening right now across our facilities.

Whether or not we train people to be able to respond and support their peers in their situations, those situations are going to happen. I do not think it is a suggestion that all of a sudden these people will have new work to do and they will be responding to situations or environments that they did not in the past. It is happening right now. It has happened in the health service forever. What we want is to have a well-equipped workforce that feel supported that they can respond and support people. Because right now, they will be doing it but they will not be equipped or trained to do it.

THE CHAIR: That makes sense. Ms Coulton.

Ms Coulton: I acknowledge the privilege statement.

THE CHAIR: Thank you.

Ms Coulton: I am here in a capacity to talk to the wellness initiatives. The peer support officer program is obviously a relatively new initiative, so we are monitoring that really closely and carefully to make sure that it is effectively delivering what we need it to deliver. We have 17 officers at the moment who have been predominantly self-nominated, or perhaps their manager has put them forward and they have accepted that nomination. They have been trained at a professional level. We have partnered with our EAP provider to give them specialist training.

Their role is to be that first point of call for team members who are experiencing difficulties in the workplace or at home and then to refer them to the relevant internal or external provider. It is not about creating a new FTE role. It is about a point of reference, appropriately qualified and trained in relevant areas so that they can then refer their colleagues to the right place.

THE CHAIR: Can I ask a quick clarifying question, if you would not mind, Ms Coulton? I do want to hear the rest. Just to confirm: for those 17, the government paid for the external provider?

Ms Coulton: Yes. That is government provided. Converge International is our EAP in the ACT.

THE CHAIR: And these 17 people were all trained on work time?

Ms Coulton: Yes.

THE CHAIR: Okay.

Ms Coulton: Yes.

THE CHAIR: Sorry; go on.

Ms Coulton: Twelve of those are nurses and one is a midwife, out of that 17. We have a further 20 being trained on 22 June, which we are taking as a positive outcome that we have additional people stepping forward to take on that role. Of that additional 20, we have nine nurses in addition to the 12 already, plus an additional midwife to the one already. The types of things that they are being trained in are building rapport and trust; maintaining confidentiality, which you anticipate is obviously already a part of their role, but it is a different type of confidentiality; managing boundaries; and self-care.

To the point that you are making about taking on additional workload, it is very important that those people who are performing this type of role are also looking after themselves. So they are also being trained in self-care. Part of that program is obviously closely monitored: "Raise your hand if this is something that you're not able to continue to provide support in, or something that perhaps you may not have been anticipating as an impact for you." It is something that we will obviously monitor and adjust as we go forward.

THE CHAIR: Thank you. So this program is paid for out of the $8.75 million in the fund?

Ms Coulton: Yes.

THE CHAIR: How much is this program in particular?

Ms Coulton: I will have to take that on notice; sorry.

THE CHAIR: That is all right.

Ms Coulton: I do not have each of the initiatives broken down into the individual amounts with me.

THE CHAIR: That is okay. It would be good to go into some of the other initiatives then. Is the $8.75 million, at this point, spent?

Ms Coulton: No. We have got the remainder of this year; we have programs and we have the additional training coming up in the next couple of weeks. So, yes, there is funding that will be expended by the end of this financial year.

THE CHAIR: Actually, I am going to take my last question back because I have got a better one. You watch. This announcement was made in October of last year.

Ms Coulton: Yes.

THE CHAIR: By the government's own admission, the decision to acquire Calvary was not made in October of last year, but that is when we decided we needed to start spending some money on the health and wellbeing of our workforce. We are now expanding the size of our workforce, because, as Mr Peffer says, we would like 100

per cent of those Calvary employees to come and work for CHS. Are we going to need to top this up, do we think?

Ms Stephen-Smith: I will take that one, Chair. We are not expanding the size of our workforce immediately. Obviously, we will continue to expand the size of our workforce. With every budget, we will have funding to employ more healthcare workers. But this initiative covered all three arms of the ACT public health service—CHS, the Health Directorate and Calvary Public Hospital Bruce—and that was allocated on a pro-rata basis.

THE CHAIR: Wonderful. So there are already programs funded out of this fund that are running at Calvary?

Ms Stephen-Smith: There is funding available to Calvary to determine programs to run under this fund.

THE CHAIR: Wonderful. Is there any work happening at the moment with Calvary's current workforce—with the hope and expectation that they all choose to come and work for CHS—to access this fund for what I assume will be some very real and timely psychosocial challenges through the transition?

Mr Peffer: No, not immediately. There are certain aspects where we will be investing, where the minister has asked us to have a look at whether we can cover the entire clinical workforce when we become one team. I think it is important, though, to take a step back and outline that the process we went through to land the initiative. It is very much health service specific. This was an initiative which the government funded, but it was workforce driven.

Your earlier question was: "Do people really want to be a part of this?" This is a proposal that actually came from our nurses, midwives and doctors when we took 150 people off site and said, "Clearly, we have to have a workload-workforce focus in the health service, in terms of recruiting to our profile and being able to deliver the services. But, alongside that, we need to focus on people's personal and professional wellbeing. What does that look like?" That was very well attended. It was a really engaging afternoon. What is in the fund has not been driven from the top or anything like that. It has genuinely come from the workforce saying, "These are the priorities."

I have had a number of midwives and team members from our Women, Youth and Children division talk to me about these sorts of programs. They recognise that a traumatic birth is a very challenging situation for everyone who is in that room and everyone who has come into contact with that family—and even those who then support the workforce who have been a part of that. So it is about having the capability within the team to immediately respond and say, "I know what to do in this situation. I am equipped, and I can make sure that we look after people." These are concepts and proposals that have come from the workforce.

Ms Stephen-Smith: In terms of Mr Peffer's point, what we have asked is to identify if there is unspent money for Calvary Public Hospital that we can then use to engage with the workforce on what initiatives they are interested in. We can also explore whether to engage with them on things like the Mayo Clinic Well-Being Index app

that has been rolled out across Canberra Health Services as a pilot at the moment. That conversation can be held with the Calvary Public Hospital Bruce staff, following the acquisition date and once we are in that longer transition period, to say, "Would people here be interested in participating in that project or do people want to come up with their own initiatives, using the funding that is available?"

We have also talked separately about, and have separately funded, the recognition that this process of acquisition and transition will have an impact for people and that we need to support their wellbeing quite specifically through that. We have talked about things like grief workshops, for want of a better term, again to be driven by what the staff think is going to support them and their responses to this situation, not something that is determined from the top down.

Ms Castley: I would like to talk about the scope of practice. It is something that the ANMF and other nurses have raised as well. There have been reports and FOI documents that we have seen, stating that there are recommendations to increase the scope of practice. I believe that it has been talked about for a while now. I am wondering what the hold-up is and why we are still calling for the scope of practice increase?

Ms Stephen-Smith: There has been ongoing work in relation to the scope of practice for nurse practitioners. There is quite a specific piece of work that the Chief Nursing and Midwifery Officer has done in relation to that. We have made some changes around the scope of practice recently in walk-in centres, taking the minimum age for treatment at a walk-in centre down from two to one. We have also indicated that we want to look at further expansions to the scope of practice in the walk-in centres. That is something we are really keen to do.

As I think one of the witnesses from the ANMF indicated, there are additional things that our advanced practice nurses and nurse practitioners can do. We have just opened the Weston imaging service, the community-based imaging service at Weston Creek. That will help people who are attending walk-in centres. They can go and get an X-ray and come back to the walk-in centre for treatment of their sprains, minor fractures and those sorts of things that our nurses and nurse practitioners can treat, and already do.

There is also work going on that maybe Mr Peffer can talk about in Canberra Hospital's emergency department to implement more nurse-led care in the emergency department. That was something we did in response to demand last year. It changed some of the mindset in relation to the role of nurse practitioners in the emergency department in Canberra Hospital. Historically, that has not been a particularly well accepted model of care in the emergency department, unlike at Calvary Public Hospital. We are looking to ensure that we are recognising the role that nurse practitioners can play in that environment. I might ask Mr Peffer to talk about that and then throw to Mr Dombkins to talk about the nurse practitioner work more broadly.

Mr Peffer: Thank you, Minister. This is an initiative that we kicked off last year as a bit of a pilot, and we have seen some good results from it. Part of the benefit of the trial has been the upskilling that some of our nurse practitioners and advanced practice nurses have provided to emergency department colleagues when they have stepped in.

The team members who came in came primarily from our walk-in centres. They are used to a level of autonomy and operating independently because they do not have the safety net of having a big, acute hospital attached to the service. They are out in the community. It is very much a nurse-led service.

The confidence that those team members brought into the department showed the strength of a nurse-led model in terms of accessibility of care and timeliness of that care. I think it reinforced for our emergency department—and, I am sure our clinical director would not mind me saying, for him and his medical colleagues as well—the benefits of the walk-in centre model and what that can really contribute to the broader care system.

Moving forward, I think there is a greater willingness from our emergency department to rely on our walk-in centres in terms of the care that they can provide, but also a real willingness to now explore that as an ongoing model that we can embed. We have had some great conversations with some of the Calvary team members in recent weeks about that being quite a strength in their emergency department. It is quite advanced, compared to where we are at in Canberra Hospital, and that is something that I think the two leadership teams within the emergency department will be working on in the months ahead.

Ms Stephen-Smith: Mr Dombkins can give you a brief rundown of the nurse practitioner project.

Mr Dombkins: Good afternoon. I have read and acknowledge the privilege statement. A body of work was undertaken within the CNMO. We did a forensic analysis and a deep dive, which is evidence based, in relation to the full scope of practice for the nurse practitioner. It is different in every state and territory. We were able to formalise the documentation required for the legislative change, which is at the forefront compared to other states and territories. That is awaiting review, within the minister's office, for us to proceed. So there is the potential for the full scope of practice for nurse practitioners to be implemented within the ACT, compared to other states and territories.

Ms Stephen-Smith: I have, rather belatedly finished, reading that documentation. That is a very comprehensive piece of work, so some legislative change is required and some practice changes are required. There is also work going on at the commonwealth level now, which was not the case when I became health minister. All of my colleagues around the table at health ministers' meetings are now saying that everyone needs to be working to their full scope of practice. We know that that creates challenges between professions sometimes, but I think all health ministers are now united in saying, "You know what? We have to get through some of those barriers to ensure that we are using the skills of our whole health workforce the best we can."

I know there have been some comments about walk-in centres and the use of additional staff, different types of practitioners, in relation to those, and how they relate to the urgent care centres. We are absolutely committed to our walk-in centres continuing to be nurse led. One of the things that came out of having the pilot in the emergency department last year was a recognition by the medical staff both of what

nurse practitioners could do but also that a little bit of extra advice, support and an indication that, "Yes, this is within your scope," from one of the doctors actually enabled the nurse practitioners to work to a bigger scope.

In terms of being able to support that broader scope of practice within our current arrangements, having someone that you can speak to, to get authority to do something that is a little bit more than you are currently able to do, will enable our nursing workforce to do more within the walk-in centres. That is the approach we are taking to thinking about how we supplement our nurse-led walk-in centres: keeping nurses at the forefront, keeping them nurse led, but finding ways to enable them to do more.

Ms Castley: As a government, you have proved that you can move very quickly when you have made up your mind to do something. Mr Dombkins has got this body of work ready to go. How quickly are you prepared to get this off the ground, if we know that this helps with the attraction and retention of staff?

Ms Stephen-Smith: We are going to work on doing this. I cannot give you a time line on this; a lot of practice changes and scope of practice things are incremental. I gave you an example earlier of reducing the age in the walk-in centres. We will be working both incrementally but also with our commonwealth colleagues on some of the legislative issues because there are some interactions between commonwealth rules and ACT rules that we need to work through.

THE CHAIR: My supplementary may lead to a misunderstanding about commonwealth policy, but I am sure that, as you are across it, Minister, you will put me on the straight and narrow. It is about the difference between the urgent care clinics proposed by the commonwealth and our nurse-led walk-in clinics. You have just proposed, if I understand correctly, a model where there would be a doctor in a nurse-led walk-in clinic, to enable the change and to broaden the scope of practice. It would appear to me, based on information from nurses who have contacted me and this committee, that there is a lot of resistance and a lot of scepticism that doctors in nurse-led walk-in centres would lead them to no longer being nurse led.

Ms Stephen-Smith: Yes. We very clearly heard that message, and we have also very clearly heard the message from general practice that the original announcement from the commonwealth was that they would be GP led. We are trying to work through both of those issues to come up with a model that does not confuse people by establishing a completely separate GP urgent care clinic and then having our walk-in centres that have a slightly different scope of practice—and who do you go to for what?

We do want to create integration, but we have very clearly heard the message from nurses and nurse practitioners about retaining nurse-led clinics. We are working with the commonwealth on a model that will enable that to happen and the integration to occur, while addressing the feedback that we have heard. I think there is an example of where this worked during COVID. I do not know if, Mr Peffer, you are in a position to talk about how GP support was provided through the COVID response.

Mr Peffer: I do not think I would do it justice today.

Ms Stephen-Smith: It is probably a bit detailed.

THE CHAIR: That is fine because that is not really the point of my question. Broadly, the commonwealth seems to have a position that states and territories can get access to this big bucket of money to open urgent care clinics. It appears to me—stop me if at any point I am wrong—that that works better in other states and territories that do not already have a tried, tested and trusted nurse-led walk-in clinic. How are those conversations going with the commonwealth to still get the territory's share of funding for our nurse-led walk-in clinics if an urgent care clinic, such as they propose, does not quite suit us?

Ms Stephen-Smith: Those are exactly the conversations that officials have been having. I will hand over to Ms Cross to talk about the progress on those conversations.

Ms Cross: I think it would be fair to say that the commonwealth recognises the unique situation in the ACT. We would be hoping that sometime this financial year we would reach an agreement with them. We are very close to reaching an agreement. They certainly understand that we have the walk-in centres and do not want to do anything that impacts on that. I should not say it in this forum, but they are sympathetic to the idea that we might need more funding as well.

Ms Stephen-Smith: You just did.

Ms Cross: I said I should not, not I would not!

Ms Stephen-Smith: Both Minister Kearney, obviously a former nurse herself, and Minister Butler are very interested in our walk-in centre models. They are keen to see them thrive.

THE CHAIR: Tremendous.

MR PETTERSON: The health workforce issues are not just local; they are in all jurisdictions and they are also international. I am curious what work and what conversations are underway at a national cabinet level across the Australian jurisdictions to try to solve this issue at a national level.

Ms Stephen-Smith: A lot of work. There is a health chief executives forum that has a workforce taskforce. So there is a lot of work here. There are a lot of conversations around how we should all collaborate and cooperate and not seek to poach from one another. There is also a lot of competition, because as soon as someone announces something to incentivise their workforce, other people copy that. There is collaborative competition; that might be the best way of putting it. Do you want to talk about the workforce taskforce?

Ms Cross: I think the key project that national cabinet has commissioned is a review by Robyn Kruk, who is looking particularly at recognition of overseas qualifications and how we can streamline our processes without impacting on safety or the quality of the people who work here. That review has been looking at a number of measures and has presented an interim report to national cabinet. That goes through health ministers and then through the national cabinet.

As the minister said, within the health ministers forum the National Workforce Taskforce has been very focused on this and has a number of what they describe as tiger teams looking at specific issues around visa, locums and the particular workforce issues. All of that involves all of the states and territories. Some of it will be progressed by health ministers and some by national cabinet.

MR MILLIGAN: We heard briefly about the positive practice environment standards that have been implemented in Queensland, and that they have good results. Is that something the government has considered implementing here?

Ms Stephen-Smith: I briefly heard that evidence and I have seen the AMNF submission on that. I think that seems like a very positive contribution. I am aware that the ANMF were saying that in Queensland they are now talking about embedding it in enterprise agreements. Our enterprise agreement negotiations, in addition to pay and conditions, have been very much focused on phase 2 of ratios, but this does seem like something that could potentially be taken forward, as part of the Towards a Safer Culture considerations into the future. I am speaking completely out of turn here, but that is a collaborative process with the ANMF, so I would certainly say that if they want to raise that through that process, or through enterprise agreement negotiations, we would be very willing to have that conversation.

This culture change in complex healthcare organisations is not something that governments or senior executives can do alone. There are a lot of professional bodies that also have an influence over the different areas of the workforce. Some of those colleges and professional bodies have done really incredible work in terms of culture and addressing things like bullying and harassment within their workforce. The Royal Australasian College of Surgeons did a lot of work in this space after having some very poor outcomes.

We do seek and really want to work with both unions and professional organisations on addressing some of these challenges, as well as, of course, with our academic partners. As we are training students coming through, UC and ANU are now doing a lot of collaborative work to bring different multidisciplinary teams together while they are at university, which is building that respect between different professions. We need respect within professions and we need respect between professions if we are going to build a positive workforce culture. While some of it comes from the top, not all of it comes from the top, and we really need everyone working together to achieve that.

THE CHAIR: That would have been a great place to leave it, had I not had one quick question that I insist you will need to take on notice. I would like to get some data on nurses and midwives asking for leave and subsequently getting leave approved in order to take part in professional development. How many requests have been made over the last year by nurses and midwives to take part in professional development, and, of those requests, how many have been approved? I am trying to get my head around some evidence we heard earlier about some staff completing their compulsory professional development on personal time. Some of those data points would be useful. Who would like to take that on notice?

Mr Peffer: I will take that on notice.

Ms Stephen-Smith: Take it on notice for CHS?

Mr Peffer: I will just caution, Chair, that I am not sure how good the data is that we will be able to find for you on that. I do not think our business systems will capture the reason why someone has taken annual or personal leave.

THE CHAIR: But it will capture if they are not in the workplace because they are completing PD?

Mr Peffer: I do not know.

THE CHAIR: There is not a separate category of leave for that?

Ms Lang: They can apply for professional development leave.

THE CHAIR: Yes.

Ms Lang: So we can definitely demonstrate that.

THE CHAIR: Great.

Ms Lang: But I cannot demonstrate—

THE CHAIR: I would like to know who has applied and then who has been approved for that leave.

Mr Peffer: As in numbers?

THE CHAIR: As in numbers.

Mr Peffer: Okay.

Ms Lang: We can definitely say who has been approved, but I am not sure about the numbers for applications. But we will follow up and see.

Mr Peffer: We will see what we can pull up.

THE CHAIR Okay. Thank you. I would like to thank everyone who appeared before the committee today, and for their submissions. Everybody will be provided with a copy of the proof transcript in the coming days, to verify for accuracy. A number of questions were taken on notice, so please liaise with the committee secretary to get those answers in, and also let us know if there are any mistakes in the proof transcript. Other members of the Assembly who may wish to ask questions need to lodge them on the parliamentary portal as soon as practical, and no later than five business days after this hearing. Today's hearing is now adjourned.

The committee adjourned at 5.02 pm.