Australian Nursing & Midwifery Federation Tasmania

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Committee Chair
House of Assembly Select Committee on Reproductive, Maternal and Paediatric Health Services in Tasmania

The Australian Nursing and Midwifery Federation (ANMF) is both the largest nursing and midwifery union and the largest professional body for the nursing and midwifery teams in Tasmania. We operate as the State Branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents around 8000 members and in total the ANMF across Australia represents over 300,000 nurses, midwives and care staff. ANMF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

The core business of the ANMF is the industrial and professional representation of nurses, midwives and the broader nursing team, through the activities of a national office and branches in every state and territory. The role of the ANMF is to provide a high standard of leadership, industrial, educational and professional representation and service to members. This includes concentrating on topics such as education, policy and practice, industrial issues such as wages and professional matters and broader issues which affect health such as policy, funding and care delivery. ANMF also actively advocates for the community where decisions and policy are perceived to be detrimental to good, safe patient care.

The ANMF's initial concerns for the Tasmanian Midwifery professions occurred in 2016 when the University of Tasmanian announced the intention to cease offering their post graduate midwifery degree in Tasmania.

The ANMF sought alternate avenues for this course to be readily available for Tasmanian RNs wishing to complete the post graduate degree and later the direct entry undergraduate degree. This was then announced as being an interstate university with students expected to travel along throughout the course for periods of time to complete their study along with the onerous clinical placements.

Similarly, around this time, discussion commenced with respect to a new service design for maternity services in the north west due to having two services for birthing with limited birthing numbers, with the proposal to have birthing handled privately at the North West Private Hospital. ANMF advocated strongly against this proposal on behalf of members, however, the decision was made to progress with this proposal.

Soon after this time we started to see the initial issues arise with the North West Integrated Maternity Service in the north west region, which under that model had a dis-jointed service with birthing occurring at the North West Private Hospital. This meant that women were cared for in the ante-natal period by Tasmanian Health Service Midwives and then by North West Private Hospital Midwives for Birthing and then were returned to the THS for post-natal care. Of course this resulted in communication difficulties, missed risk reports for women and their babies and at times serious adverse events. There were significant issues with the contract compliance between the THS and North West Private Hospitals in terms of the Governance and Safety and Quality committees with infrequent meetings and lack of commitment between the parties to appropriately address safety issues from the North West Private Hospital.

As a result, after much advocacy the ANMF supported members in raising local concerns which did not address the issues for some time. During this period the North West Maternity Service Burnie Outpatient Clinic was identified as having multiple safety issues including a doorway that a hospital trolley could not even fit through in the event of a Code Blue, consulting rooms that could only accommodate two people, again rising safety issues in the event of an emergency, lacked confidentiality and women accessing the service were required to complete internal vaginal swabs MSUs etc at the public toilets adjacent to the Hudson's Coffee Shop.

The ANMF were criticised at the time for publicly calling on the Government to address the conditions these women were receiving care after likening them to a developing country and whilst this may have been over stated, the issues remained and they were serious safety and quality matters, not to mention the lack of dignity and respect the women were being afforded at an extremely precious and vulnerable time. This did result in the Government committing funds in the next State Budget for a new Burnie Clinic, which pleasingly is now in operation.

In 2018, the ANMF supported members to launch industrial action after the ongoing issues with the NWIMS and called on the Government to launch an independent midwifery lead inquiry. In time this was agreed to, but required staff to sit in on interviews with the inquiry lead as well as the State EDONM at the time. Members felt this diminished their frankness in the interviews and felt intimidated to speak out on matters of vital importance for fear of retribution. As result the desired outcome to return birthing services to public hands did not occur until multiple serious adverse events occurred and another review was conducted in 2021 and finally it was announced birthing would return to public hands.

Now, I don't back track on history to reminisce. I provide an outline of these specific matters to highlight the parallel between women's health issues being diminished and women being silenced at times when raising their own induvial health concerns, and with Midwives, a predominately female profession and a minority group given the size of the profession within the Tasmanian Health Service.

If these highly trained, skilled and competent health professional's concerns were heard and acted upon with respect and they were provided the opportunity to discuss them in a safe and supported environment, I can only speculate as to the enormous benefit this would have had to the Midwifery workforce in terms of retention and recruitment, to women's pregnancy, birthing and ante-natal and the outcomes for these women's babies and their families.

In amongst the 2016 and 2018 issues, the ANMF were involved in discussions with respect to developing a safe staffing tool for Midwifery Services across the state. Birthrate Plus was proposed at the staffing tool to determine staffing across all maternity services. The ANMF has reservations about the model as it was in use in NSW and our NSW ANMF colleagues raised many concerns with the lack of transparency with the model and how the staffing calculation was determined along with the lack of support for babies. The ANMF raised these including the issue with the workloads for the babies not being included in the model. In an Australian first, some care tasks for babies were included in the model with a 15 minute allocation such

as giving a Nasogastric Tube Feed or doing a Blood Glucose Level. However, over time this model has proved to be ineffective to meet the diverse, ever changing and acuity of the women and babies across the State require in Maternity care. The issues with the model remain, that the re-calculation of staffing assessment is key person dependent with only one person in the Country able to complete the staffing re-assessment due to commercial in-confidence restrictions associated with the model, lack of transparency on how the calculation determines the final FTE and no way for members to check the calculation as they are not privy to the calculations and that it does not provide enough time for care of newborns in the post-natal settings.

At the RHH in July 2021 the ANMF first raised a grievance with respect to workloads and through the Tasmanian Industrial Commission received a commitment that all Associate Midwifery Unit Managers would be able to be in-direct, meaning they would not also need to carry a patient load in addition, to bed management, managing staffing, supporting early career midwives, responding to emergencies and juggling the Pregnancy Assessment phones. This outcome was also extended to the LGH who were also starting to see significant issues with their staffing due to vacancies.

The vacancy issues really commenced around 2018, with the NW having a huge reliance on agency Midwives and the LGH and RHH followed in this pattern and have continued to do so. In industrial negotiations, the ANMF secured a commitment to have existing RNs paid at their substantive rate when working in maternity units as students as the wags loss to retrain was significant and subsequently have lobbied and received Federal Government support for paid clinical placements also for midwifery students to reduce this deterrent to studying midwifery. However, the staffing challenges remain.

Recently at the RHH the ANMF called publicly for an independent review of midwifery services at the RHH after ongoing and significant clinical, cultural, workload and workforce concerns were raised. Again, many of these issues were driven by a lack of staff, with missed medications, infrequent checks of emergency trolleys, a ratio of 1:15 in the post-natal unit, ANMUMS carrying out their loads with up to 50 phone calls a shift, delayed inductions and caesarean due to lack of staff, inability to provide breastfeeding support to new mothers, bullying of staff and many midwives leaving and working elsewhere. This review has been carried out, however, there is much work to be done in order for the recommendations to be implemented and to achieve the desired outcome.

The ANMF believe that improving staffing with filling all midwifery positions (with agency staff as required) is critical to achieve the other required improvements. This includes the implementation of more lactation consultant positions to assist those women who need breastfeeding support. The benefits of supporting breastfeeding for women who are able and choose to breastfeed their baby is enormous, proven in evidence-based research and simply put has lifelong health benefits for both the baby and mother.

Rectification of these staffing issues must be the first priority as this will also improve safety for women and babies. Secondly, the leadership of maternity services must be considered with a women focussed objective so that decision making has the women's needs driving decision making and also one that reflects an open and mutually respectful leadership style such as LMZ theory and adaptive leadership to allow the Midwives to be equally involved in directing and achieving change. Lastly, supporting the existing midwives and early career midwives through skill development and support models with clinical coaches and more educators is essential. To support these aims minor adaptions can be achieved within the Midwifery Group Practice Model.

At the LGH in particular, the Midwifery Group Practice model, which is best practice continuity model where midwives follow women throughout their pregnancy care, birth and provide post-

natal care at home, is a massive support to the region in supporting pregnancy care. However, the model is run by a Grade 5 Midwife who independently manages the service, the staff and caseload and associated management matters such as rosters, performance development assessment etc and also assists clinically. The ANMF have advocated for many years for a Nurse Unit Manager to be dedicated to these programs alongside the Nurse Unit Manager for core midwifery i.e. inpatient midwifery services. This is no different to having multiple NUMs in charge of discrete medical or surgical units in the hospital, but again, midwifery services is not afforded a similar level of dedicated management and support structures.

It would be remiss not to discuss the amazing work that lactation consultants do across the State. As a very small team with minimal numbers, these amazing skilled health professionals support the preparation for, development of, early breastfeeding skills and also provide support and care for women in the post-natal period who are experiencing challenges with breastfeeding, mastitis or needing supporting with expressing breastmilk. It is true that breastfeeding support is also part of the role of a midwife, but for any women who has not breastfed before, this compassionate and understanding care and ultimately time, which, as already outlined, many midwives simply do not have the time to provide when even meeting the basic tasks at times is challenging. The benefits to the baby include higher intelligence tests, reduced risk of being overweight or obese and less prone to diabetes later in life. Women who breastfeed also have a reduced risk of breast and ovarian cancers (World Health Organisation 2025). The ANMF have heard multiple reports of women who wanted to breastfeed their child but ultimately had to revert to using formula as they were unable to access the level of support their required in hospital to continue breastfeeding. The ANMF finds this manifestly inadequate and is directly at odds with the Tasmanian Government's Long Term Plan for Health 2040, Investing in preventative health and health promotion as well as the objectives of the Healthy Tasmania Plan. Preventing diabetes, obesity and cancers starts at birth. Invest in lactation consultants so that these preventative measures can actually be taken by those who can and wish to take them. I would also like to note that the ANMF support the notion that fed is best for any newborn and their mother and these women and their babies also equally need support in the early days to set them up for healthy and safe choices for their babies and their families.

Discussing preventative healthcare leads me to the Child Health and Parenting Service. The CHAPS service is a critical lifeline for new babies, their mothers and families in the early days, 2 weeks post-partum, through to 4 years and beyond. This service provides critical support to women and their babies as they grow, learn and develop. The early checks of newborns to identify and take action on health issues from feeding challenges, weight gain, hearing, domestic violence matters, to hip dysplasia, is pivotal in setting children and their families up for a well and healthy lifestyle. These early interactions also offer a wonderful opportunity to support and guide health prevention discussions and actions from exercise to healthy eating options and encouraging smoke free environments. Unfortunately, the value of these early checks, supports and intervention and prevention is not valued adequately, with most Child and Health Services across the state struggling to fill vacancies and for many years, denying the opportunity for interstate Child Health and Parenting Nurses with Post Graduate qualifications to enter the services at as a Grade 4 Registered Nurse, or allowing those within the services to progress to a Grade.

Fortunately, through years of advocacy, this matter has now been resolved, but it should never have been an issue in the first place with all other areas of the Tasmanian Health Service allowing this option and opportunity for many years.

In addition, during COVID-19 the Child Health and Parenting Service was reduced with staff redirected to COVID-19 vaccination clinics. Whilst COVID vaccination clinics were essential and staffing challenges were dire, the effect that this had on a large cohort of women, babies and their families during this time was significant. Even when services resumed, only essential

checks were carried out with many families missing out on healthy kids check at 4 years, the last check before children commence school and the last opportunity for heath issues to be detected and acted upon.

Similarly, like maternity services, the ANMF have sought a workload model to be implemented for Child Health and Parenting Services. This service has not had uplift in nursing staff for well over 5 years and has varying levels of administrative and business support, which generally have been inadequate to support the level of service provision. Again, this is a vital service not only to ensure the lifelong health of new babies and their families, but entire communities. If we are serious about changing our health outcomes and chronic disease burden, this is where we must start, early intervention, education and health prevention for the next generations.

In instances of care requirements for women who may be experiencing mental health illness or need support with their babies, the lack of service provision in Tasmania is nothing short of horrific. The ANMF staunchly advocated for the Tasmanian Government to take over the St Helens Private Hospital site in Macquarie Street, Hobart to ensure the continuity of care for women accessing the Mother Baby Unit and the ECT and EMS, however this was not supported due to alleged cost of renovations required. One might argue that this cost was likely to akin to the cost personally and to other health services for those women who now cannot access support for settling, feeding and sleeping challenges who have had to resort in many instances to leaving the state to seek support interstate, where they have had the means to do so. Those who don't, have had the option of seeking mental health support through services which are severely understaffed and with long wait times, or secured a bed at the RHH Mother Baby Unit, which is not a suitable environment for those needing mental health support whilst caring for a baby concurrently.

The ANMF have welcomed the State Government funds for mother baby beds and implementation of the Tresillian model at the Launceston Medical Centre, yet no additional services have been supported in the South currently or in the forward estimates. Thankfully some private GPs, who are in high demand, have worked tirelessly to support these women as have the those nurses in the Child Health and Parenting Service, but this is not enough, nor is it good enough for the State Government not to immediately step in to address a dire gap for women and their babies who are in need of specialised support. The risk is that the women who are struggling with the care needs of their child is that, without the right support, they will too go on to develop mental health issues impacting, them, their babies, their families and broader communities. To ignore this critical health need is at best a serious oversight and bordering on negligent.

Lastly, I would like to mention School Nurses and the important role that they too play in supporting the early intervention and health prevention of our next generations. Whether it is promoting good oral hygiene with demonstrating appropriate teeth brushing techniques as good oral health is linked to overall health to teaching body awareness and safety to support with epi-pens and nasogastric feeds for those children who need it in schools, the roles actively are supporting children, their health and preventing chronic disease and healthy lifestyle choices. Every school should have at a minimum a full time School Nurse and more for larger public schools or schools in lower socioeconomic areas that demonstrate highest needs.

In summary:

- The cultural phenomenon of minimising women, their health needs and diminishing those voices, concerns and advocacy of those midwives, lactation consultants, child health and parenting nurses and school nurses by the Tasmanian Government must end.

- Exploration of the delivery of Midwifery in Tasmania with the University of Tasmania must be undertaken.

- The budgetary, structural and industrial provisions, including safe staffing and resources, must be aligned with all other clinical areas within the Tasmanian Health services. This must include:
    - Developing a working group to develop a ratio model to replace the current Birthrate Plus Maternity Service Model.
    - Immediately fill all midwifery positions, implement an additional 4 FTE lactation consultants at the RHH, 3 FTE at the LGH and 2 FTE at the NWMS.
    - Implement clinical coaches and additional clinical midwifery educators.
    - Implement Grade 7b Nurse Unit Managers in the Midwifery Group Practice Model.
    - Continue the development of the CHAPS workload model, fill all vacant FTE and implement permanent support roles for each region.
    - Fund implementation of the Tresillian model for the North West and Southern Regions and open 4 dedicated mother beds in the South and North West outside of the RHH or NWRH/MCH with a broader admission criteria that allows for mother seeking settling, sleeping and feeding assistance.
    - Increase the School Nurse FTE to allow at a minimum 1 FTE of School Nurse in each region.

Thank you for the opportunity to contribute to the Select Committee inquiry.

Yours sincerely,

[redacted]

Emily Shepherd
Branch Secretary