LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING
Mr Johnathan Davis (Chair), Mr James Milligan MLA (Deputy Chair),
Mr Michael Petterson MLA

Submission Cover Sheet

Inquiry into Recovery Plan for Nursing and Midwifery Workers

Submission Number: 15

Date Authorised for Publication: 14 February 2023

To the Standing Committee on Health and Community Wellbeing, ACT Legislative Assembly,

Please find below a submission into the Inquiry into Recovery Plan for Nursing and Midwifery Workers developed by the Discipline of Midwifery at the University of Canberra. The Submission is divided up into the following sections:

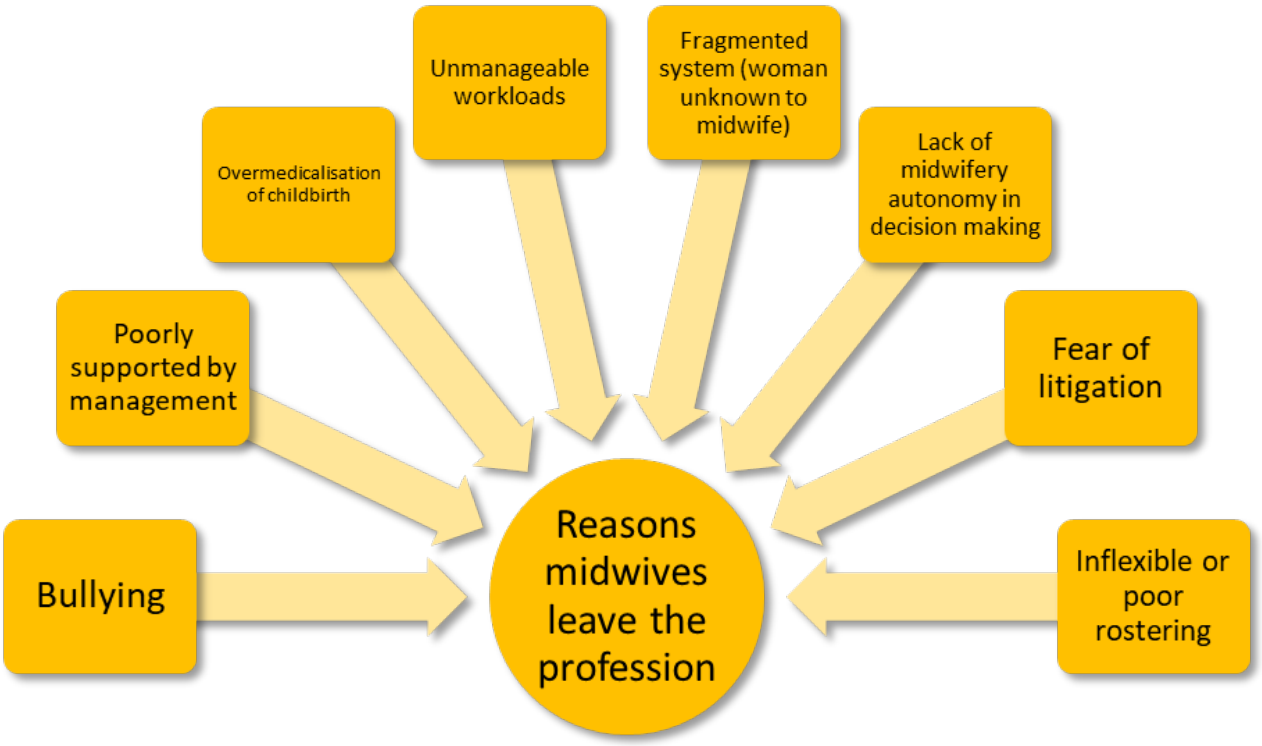
- Improving workforce culture and job satisfaction as a means to retain midwives
- A freestanding birth centre for the ACT as an alternative employment option to prevent midwives leaving the profession and
- Student support, recruitment and retention as the future midwifery workforce.

Please contact us with any questions about the below.

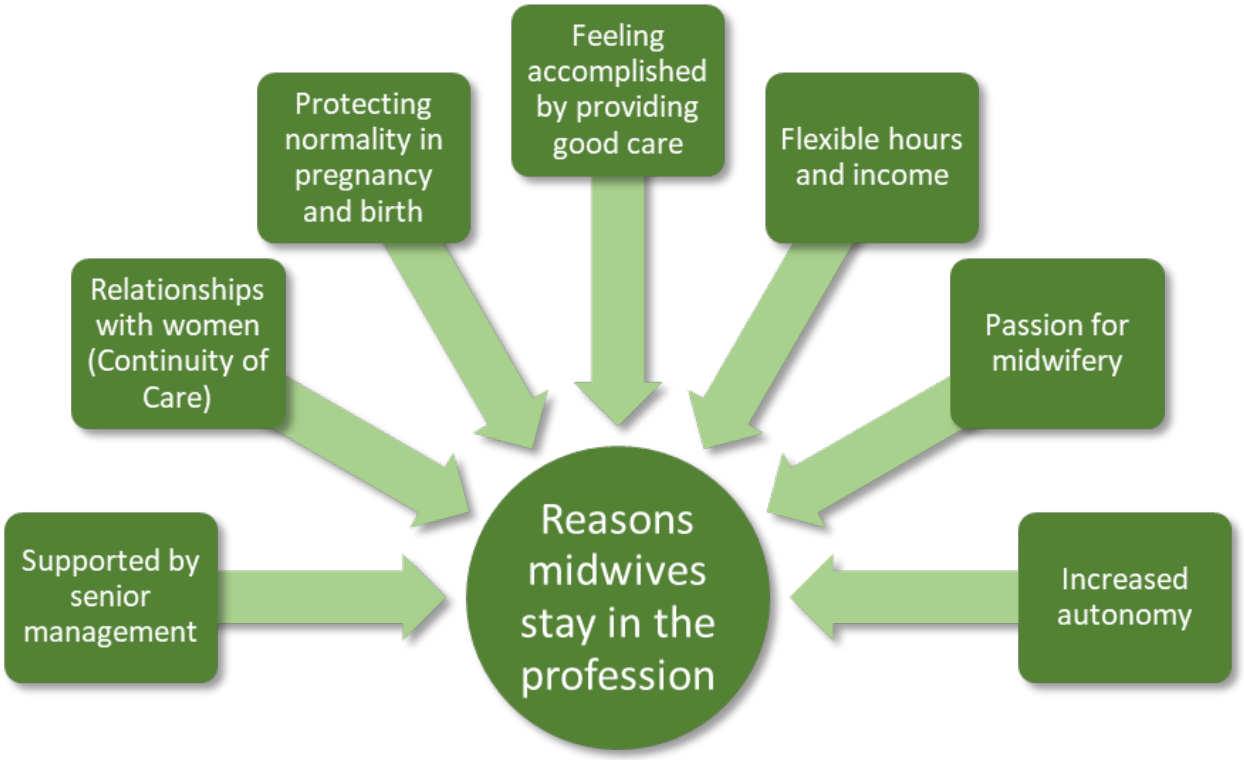
Warmly,

Kai Hodgkin, Midwifery Lecturer University of Canberra

Workforce culture and job satisfaction



(Harvie et al., 2019)



(Bloxsome et al., 2017; Fenwick et al., 2018)

Harvie et al. (2019) surveyed 1037 Australian midwives on their intention to leave the profession. 42.8% indicated they had considered leaving the profession in the preceding six months. 27.1% indicated they would unlikely still be in the profession in five years.

One of the most critical factors in the ACT is the lack of midwife-to-woman ratios. Midwives want to provide quality maternal and newborn care, which are cited as reasons for staying in the profession (Bloxsome et al., 2017). When midwives cannot provide adequate care due to unmanageable workloads, midwife dissatisfaction follows (Harvie et al., 2019). Midwives report feeling as though they are "being used as a processing factory worker in a human experience" (Harvie et al., 2019). The roll-out of ratios was promised in the 2021-22 Financial Year but has not yet materialised (ACT Government, 2022). Action on this is urgently needed.

Many midwives in the ACT still work in a fragmented system, meaning they have no continuity of care with women. One of the reasons midwives stay and are satisfied in the profession is because they build relationships with women (Bloxsome et al., 2017). ACT Health has made ground in this area by increasing the number of midwifery positions for Continuity of Midwifery Care Services. Rostered Team Midwifery is currently being implemented at Calvary Bruce and planned for Centenary Hospital. These initiatives should increase the opportunities for women to know their caregivers and thus increase midwifery satisfaction and retention, however this is yet to be seen and has not been well studied elsewhere. Supporting midwives to transition into continuity of care models should be a priority

(Fenwick et al., 2018). Retention of new graduate midwives may increase if they had these opportunities in their first year of registration.

Overmedicalisation of childbirth is having a significant impact on midwifery retention. Non-evidenced-based medical practices fuel unhappiness in midwives (Harvie et al., 2019), whilst fragmented care increases adverse outcomes for women and babies (Sandall et al., 2016). In a study by Harvie et al., (2019), midwives regarded the management level of some pregnancies and labours by obstetric staff to be unjustified. Midwives professional judgements as primary carers were sometimes overruled and midwives felt sidelined in a hierarchy system (Harvie et al., 2019). Respectful relationships with obstetric staff are crucial for improving workplace culture. The high induction and Caesarean rate in ACT public hospitals put further pressure on staff to cope with their workloads. Birthing outcomes have become increasingly more complex, yet the number of midwives allocated to postnatal areas has not increased to cope with these complexities.

The recent introduction of central fetal monitoring and computers on wheels means that midwives are spending less time in the room caring for women and more time outside managing the software. Central fetal monitoring (CFM) potentially undermines safety by impacting on relational processes in maternity care (e.g. midwives or obstetricians making judgements about a fetal heart trace without an understanding of what is happening in the room). CFM has been shown to increase birthing women's and midwive's levels of anxiety. Perinatal benefit has not been established (Brown et al., 2016; Small et al., 2021 & 2022) The over-medicalisation of childbirth seems to have received little attention in the ACT. Addressing this issue is an opportunity for ACT Health to improve midwifery satisfaction, culture and retention.

Midwives stay in the profession when they feel supported by management and can plan their work-life balance through flexible rostering (Bloxsome et al., 2017). Current Calvary staff mention the arduous task of rostering that can take an experienced Level 2 midwife off the floor for several days. Based on this feedback, ACT Health (in particular Calvary Public Hospital Bruce) may consider investing in an intelligent rostering system. Adopting such a system would liberate experienced staff, giving them more time to care for families or provide much-needed professional development for less experienced staff, which may result in higher workforce retention rates in the ACT.

Our junior midwifery workforce in the ACT must have access to clinical development midwives who can take the time out to teach and support them. Current CDMs in both hospitals are frequently redeployed to fill staffing shortfalls and cannot fulfil their education roles.

Bullying and harassment of midwifery students is a major deterrent to continuing with their studies and entering the midwifery profession in the ACT. Students anecdotally report the discordance between seeing or experiencing bullying-type behaviour in a profession that is supposed to promote women's health and well-being. Taking real action on harassment is likely to lead to staff and students feeling heard by management and aid midwife retention. Midwifery students are often viewed within ACT hospitals as an inconvenience or burden. The narrative around students must change so that they are seen as the valuable resource that they are. Midwifery students are akin to blood transfusions for the anaemic ACT midwifery workforce.

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Free standing BC UC/Industry collaboration

We propose that a freestanding birth centre in the ACT would make an outstanding improvement to workforce in the ACT. If this were to be developed in collaboration with the University of Canberra as a combined teaching and care facility (similar to the UC Hospital), this would additionally make Canberra a destination of choice for studying midwifery thus promoting growth and excellence in the future of the midwifery workforce.

In addition to Covid, under staffing and high workload demands, stress for midwives comes from not being able to work within, and to the full extent of our scope of practice and not in line with the midwifery philosophy. Midwifery is founded on a profound respect for women and their right to have their social, emotional, physical, spiritual and cultural needs and expectations met from their healthcare[1]. In the fragmented maternity care where midwives are so stretched that they can’t take bathroom breaks, midwives are unable to work within this philosophy which creates dissociation and dissatisfaction in work.

If the ACT were to develop a freestanding birth centre which affords midwives the ability to develop their careers working in a model of care which respects and supports them and the midwifery philosophy, this would not only provide career satisfaction, it would be highly desirable to midwives nationally. This would provide scope for improvement in our workforce shortage, burnout and stressors.

In a freestanding birth centre, all women would receive midwifery led continuity of care which is acknowledged as the gold standard of care [2] and is highly desirable to women in the ACT[3]. Women who receive midwifery led continuity care, when compared with any other model of care, are less likely to experience regional analgesia (such as an epidural), instrumental birth (such as forceps), premature birth, early fetal loss, episiotomy (a cut to the perineum at the time of birth) or amniotomy (having their waters broken by a health professional)[4]. Women were also more likely to be satisfied with their care despite a slightly longer labour length. These outcomes have been echoed in research from the ACT where a 2015 study found that women receiving midwifery-led continuity of care via the CHWC Birth Centre for their first baby were less likely to have a caesarean section birth or instrumental birth than women having their first baby via the non-continuity model of care[5].

A freestanding birth centre would enable supporting of midwifery students as well as opportunity for retention and development of new graduate midwives directly into a midwifery-led continuity of care model which is not currently available in the ACT. Of 2022 University of Canberra midwifery graduates, a significant portion have chosen to move to NSW or overseas to New Zealand instead of remaining in the ACT for their new graduate year and future career. Anecdotally, much of this move is because of dissatisfaction with care models and employment options in the ACT. Students are trained within the best evidence-based model of continuity of care and are unable to consolidate that training without moving interstate.

A survey of Australian graduate midwives found that nine out of ten aspired to or would find job satisfaction in working in a continuity of care model[6]. New graduate midwives feel well prepared to work in continuity based on the training they receive and feel as though this model helps them consolidate skills and knowledge, be supported and develop strong relationships with women and peers[7]

In addition to the model of care, giving birth outside of a hospital can result in lower rates of unnecessary intervention for low risk women without any compromise on safety to mother and baby. A large meta-analysis of 14 studies including approximately 50 000 women giving birth at home found that there was no difference in maternal or neonatal death between those who intended to birth at home and those who intended to birth in hospital, regardless of where they ended up giving birth[8]. A large data-linkage study of birth settings in NSW found that there was no difference in major neonatal adverse outcomes between women planning to birth in a hospital, a birth centre or at home[9]. The 2011 prospective National Birthplace in England Study looked at women intending to give birth in hospital, hospital-attached birth centres, free standing birth centres and at home[10]. They found that while women having their first baby had higher rates of transfer if they intended to birth outside of hospital, there were no difference in any other negative maternal outcomes, including death and morbidity.

Finally, it is likely that supporting women to give birth via a freestanding birth centre would be more cost effective to the public health system than hospital birth. While complicated to calculate, births outside of hospitals and in attached birth centres are cheaper than hospital-based births.

Additionally, the decrease in intervention associated with midwifery-led care and birth outside of hospital confer increased savings to the health budget.

A 2016 systematic review found that of 11 studies which analysed cost of care in different settings, 8 found a cost saving in out of hospital settings[11]. A more recent study of the care of women at low risk of needing obstetric intervention in NSW found that the cost was $4802 for homebirth, $4979 for a birth centre birth and $5463 for a hospital birth[12]. A comparison of three different models of care in the same hospital in NSW found that on average, the cost of birth for a first time mother was $3903.78 per woman in a midwife-led continuity of care program[13]. This was a saving of $1590.91 when compared to first time mothers receiving standard hospital care.

Some of these savings would be a result of decreasing rates of which research has repeatedly shown results from both midwifery led continuity of care and birth settings outside of hospitals. Intervention is the process whereby health professionals provide mechanical or medical assistance in the birthing process. This includes caesarean section, forceps or vacuum birth, induction of labour and the like. These processes are designed to prevent negative outcomes and are life-saving when used appropriately, though just like any surgery or medication, they always have side effects and are currently over-used in our maternity systems.

For example, caesarean section involves a greater risk of maternal death and illness than vaginal birth including from bleeding and hysterectomy[14]. In future pregnancies, women who have had a caesarean section are at greater risk of uterine rupture, abnormal placental implantation, ectopic pregnancy, stillbirth and preterm. Babies born by caesarean section are at greater risk of allergy, atopy, asthma and childhood obesity than babies born by vaginal birth. Additionally, caesarean sections are far more costly than vaginal births.

The optimal number of caesarean sections is not clear, though the ACT currently has a much higher rate than has been shown to provide the most benefit. Large studies have found that no country sees any further decrease in death or illness in mothers and babies, above a caesarean section rate of 9-16% of all births[15]. In the ACT, the most recent figures available show a rising caesarean section rate which was at 34% in 2019[16]. Anecdotally, hospital staff have recently spoken of monthly caesarean rates as high as 42% in 2022.

Methods to optimise the rate of caesarean section and other interventions have been well documented and include midwifery-led continuity of care and giving birth outside of hospital, if appropriate[17]. The National Birthplace in England Study found that with increasing distance from the hospital (attached birth centre, free standing birth centre, home), the risk of intervention such as caesarean section reduced[18].

There is an urgent need to reduce unnecessary intervention in the ACT and midwifery-led continuity of care in conjunction with increasing birth options outside of hospital will help achieve this. This, in turn, will result in reduced workloads and stress for existing staff. Normal vaginal births are cheaper, require less staff, time, documentation and resources than caesarean sections.

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Recruitment and Retention of Midwives and Support for Students in the ACT

Recruitment and retention of midwives has significantly changed in the past ten years. Previously midwifery staffing was at stable levels and there were fewer job opportunities locally for new graduate midwives, meaning that some had to search interstate to secure a new graduate midwifery position. In addition to this, following completion of their new graduate year, these midwives would usually stay in the same hospital and therefore retention was also stable. This provided stability with the maternity unit and an adequate skill mix, which, in turn ensured a balance of experience so new midwives were well supported by skilled and knowledgeable midwives (Tucket, Eley & Ng, 2015). However, in recent years, there is a critical shortage of midwives, not only remaining in the profession but also continuing into their new graduate year. Many hospitals struggle to recruit enough new graduate midwives to meet staffing demands which is having an additional impact on staffing numbers.

Disillusionment with the role of the midwife was a key reason for 50.8% midwives wanting to leave the profession and those midwives most likely to cite disillusionment were more likely to be aged between 18 and 29 years and have been practising for less than 5 years (Harvie et al, 2019). When New Graduate Midwives reported a lack of supportive relationships within the workplace they demonstrated feelings of stress, vulnerability, dissatisfaction and fear. The perceived lack of support received by these graduates was related to midwifery staff shortages, negative attitudes and hostile hospital culture (Hopkinson et al, 2022). Anecdotally, it is expected that 28 Bachelor of Midwifery Students will graduate from the University of Canberra in 2022, however this has not been enough to fill local new graduate positions in ACT hospitals. In addition to this, a large proportion of UC graduate students have chosen to seek graduate positions, overseas or interstate rather than remaining in the ACT to consolidate their knowledge.

Student midwives struggle financially throughout their degree with increased placements demands over the three years and the inability to maintain regular secure employment due to the uncertain nature of the on call work they must attend in first and third years of their degree (Fenwick et al., 2016). For reference, nursing students in ACT need 880 placement hours while midwifery students need 1310 hours over 3-year degree. This impacts, not only their emotional and physical wellbeing but can also impact their academic performance due to juggling work, placement and study. Students often rely on savings, budgeting or borrowing from family members to survive financially through their 3-year degree. and have increased transport expenses due to extra travel to and from women's homes for appointments and to attend on call births. In addition to this, students with young families have the additional struggles with irregular child-care options and juggling after school care (Fenwick et al., 2016; Grant-Smith & deZwaan, 2019).

To ease this financial pressure on student midwives in the ACT, the government should consider financial support for students, at least in the first and third year of the Midwifery degree, to support these students manage financially due to the irregular nature of unpaid on-call work and challenges they face to maintain secure employment and financial security. In addition to these, an incentive to recruit student

midwives would include payment of their university degree. In Victoria in 2022, the Victorian Government introduced a $9000 scholarship whilst students study their nursing or midwifery degree, but they also offer incentive to remain in the Victorian Public system by offering $7500 incentive if the graduates stay with the health service for two years (Victorian Govt, 2022). This supports attraction and retention of new staff and contributed to rebuilding the midwifery workforce in the ACT over the coming years.

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