

1990 - 2002

Reflections of the NSW Chief Nursing Officer

by

*Judith Meppem PSM
NSW Chief Nursing Officer 1990 - 2002*

INTRODUCTION

My 12 year tenure as Chief Nursing Officer (CNO) for NSW from 1990 - 2002 was the pinnacle of my nursing and midwifery career as well as the most challenging.

Leaving the known and therefore somewhat 'safe' operational context in an area Health Service and moving into an unknown departmental bureaucracy and the political context was an incredible experience and one that I would not have missed. However, at the same time, resigning from the position in August 2002 after 12 as CNO was also a difficult decision.

The opportunity to re-create a 'nursing and midwifery presence' in the NSW Department of Health (Department) and to establish the position of CNO as a meaningful one; representing nurses and midwives from the public, private and academic sectors as the interface between the Minister, the Director-General of Health and the nursing and midwifery profession were experiences that I will always value.

One of the many highlights of my tenure was to work with five very different Ministers from two sides of politics and five very different Director-Generals.

Ministers

Liberal Government

Mr Peter Collins	1988-1991
Mr John Hannaford	1991-1992
Mr Ron Phillips	1992-1995

Labor Government

Dr Andrew Refshauge	1995-1999
Mr Craig Knowles	1999-2003

Director-Generals

Dr Bernie Amos AM	1989-1994
Mr John Wyn-Owen	1994-1997
Mr Michael Reid	1997-2001
Mr Robert McGregor AM	2001-2002
Ms Robyn Kruk	2002-current

In this document (commissioned by the Director-General of Health) it has not been possible to include everything that occurred over the 12 years and so as a personal ¹ reflection of my tenure as CNO, it will provide an overview and highlights of:-

- the context at the time the position was created;
- how the position was developed within the Department and the system;
- organisational framework;
- some of the nursing and midwifery workforce challenges that emerged together with some of the strategies that were put in place; and
- a number of the key challenges for the future.

¹ Personal opinions of Judith Meppem

CONTEXT

The position of CNO was created in 1989 and following advertising and interview processes I commenced in June 1990. Prior to 1989 there had been a nursing presence in the Department in a variety of models. Ms Maureen McGrath had headed up the last iteration (the Nursing Unit) and I wish to acknowledge the work of Maureen and her staff.

It had appeared to the profession at the time that one of the biggest challenges facing a number of the previous nursing teams in the Department was that they had to work through three to four levels in the organisation before they got access to either the Director-General or the Minister. The Nursing Unit had been disbanded for approximately 12 months prior to me taking up the position. During that period with no 'defined' nursing presence in the Department, other departmental officers (non nursing) had dealt with professional nursing and midwifery issues as they arose and a situation where policy was being determined without nursing and midwifery input had arisen. This was unsatisfactory to the profession as so much of health policy has a direct or indirect impact on nursing and midwifery practice.

There had been a great deal of lobbying over a number of years prior to 1989 for nursing to have a greater presence at each level of the health system and particularly for the creation of the position of Chief Nursing Officer at a more senior level in the Department. The lobbying was spear headed by Judith Cornell, the then Executive Director of the NSW College of Nursing (NSWCN) and Patricia Staunton, the then General Secretary of the NSW Nurses Association (NSWNA). At that same time there was also a significant issue with nursing vacancies and the workload of nurses and as such '*nursing*' was a significant issue for the Government of the day.

In the mid 1980's we had finally seen the creation of the positions of Area Directors of Nursing (ADON) in the Area Health Service (AHS) structures finally, as the result of the direct lobbying of the then Minister for Health the Hon Peter Collins by Patricia Staunton. Whilst it is understood that a number of previous departmental officers had supported the creation of the positions their ultimate implementation was not fully supported by a number of the bureaucrats and administrators at the time.

In 1989 the then NSW College of Nursing's Orator was Mrs Yvonne Moores who was the Chief Nursing Officer of Scotland just prior to becoming the Chief Nursing Officer for the United Kingdom. As part of her visit to NSW, Mrs Moores had a meeting with Minister Collins and was able to outline her role and how it assisted her Minister as well as Departmental Officers and processes. It was not long after that visit that Minister Collins announced the creation of the position of CNO for NSW as a member of the newly formed Senior Executive Service (SES).

There was a lengthy period of advertising and interviews and as a result an appointment was not made until June 1990. One of the challenges at the time was that the position had been structured at a level in the SES that was the same as the ADON positions of the larger AHS. There was a need for some negotiation to take the CNO position to a higher level in the SES to more fully reflect the level of activity and breadth of coverage of the position.

The response of some of the profession to the result of those negotiations was fascinating. I well remember the day that one of the daily newspapers ran the story about my appointment and included details of the salary in the information. I was attending a National nursing conference in Sydney that day and there were a number of Interstate delegates. A number of them expressed concern about the salary package being too high! As this was the first nursing position to be structured at that level in the SES, I believe their concerns reflected a lack of understanding of how SES salary packages were structured, together with the tax and superannuation implications. It took some months for the matter to settle down.

DEVELOPMENT OF THE POSITION

Moving into the Department after nearly 12 months where there had not been a nursing presence presented unique challenges. Fortunately Ms Julie Williams who had worked in the previous Nursing Unit was one of my Western Sydney Area Health Service (WSAHS) staff that had returned to the Area after the closure of the Nursing Unit. I was therefore able to release her for two days a week to go back into the Department and start to re-establish a nursing presence and to collect the intelligence on 'who was looking after what' as far as nursing and midwifery went.

Establishing internal systems and communication processes within the Department, the health and education sectors and the profession were a priority. Having a high profile in the health system was an advantage as was my management background at both a hospital and Area Health Service level. I would also acknowledge Ms Deborah Hyland who as my first Associate Director was instrumental in helping me set up the systems especially as at that time I was well known for my absolute computer illiteracy. In addition my secretary Jo Ann Cuneo (nee Stafford) came with me from Western Sydney Area Health Service and as she knew my thought processes was an invaluable asset to Deborah, Julie and I as we went about creating the Nursing Branch.

Despite the fact that some of the then senior officers of the Department were not enamored with the creation of the CNO position, I was personally made to feel welcome. Many people assisted me where possible to re-establish the nursing and midwifery presence. To this day I do not know if that was because they were pleased to hand it over because it was a headache or whether my 'reputation' had preceded me!

In the very early days I made the decision to set up a process of 'secondment' for nurses in the system to come into the Department and work with us as it:-

- Allowed them an opportunity to experience how the Department and Minister's Office functions, whilst at the same time allowed them to participate in policy development at a State/strategic level;
- Provided an opportunity for them to bring their ideas, expertise and networking into the activities of the Nursing Branch and to the position of CNO; and
- Resulted in them taking an appreciation of the wider issues and functions of the Department back to the system.

This was a very successful strategy and as they returned to the system they did so with a good understanding of the Departmental and Ministers Office processes. Over the 12 years I had 41 staff work with me in various capacities; 34 who were registered nurses/midwives who were seconded in from all around the State.

Appendix One highlights the staff, including their seconding hospital and where they initially moved to after they left the Branch.

Orientation to the Department was an area that suffered from a few problems in those days. Moving into a departmental bureaucracy from the operational aspects of the health/hospital system, with no public service experience is a little challenging including discovering how systems and processes function; what you can and cannot do and say; while at the same time getting on with the day-to-day activity.

My staff and I called on all the 'resources' learnt from our nursing and midwifery days to get on top of the challenges we faced, to make things happen. The realities of both the health system and the Department are very different. I therefore strongly believe that having departmental staff who have worked in the system and therefore understand how hospitals and other health services function is one important element of the staffing profile of the Department. It is also valuable for them to take that departmental experience back to the system.

I acknowledge that a great deal of effort has gone into the orientation program for SES staff over the years and that it is now a very relevant program. This needs to be continuously monitored to ensure that transitions are smooth and supported.

Organisational Framework

Over the 12 years the position of CNO and supporting infrastructure was affected by several organisational restructures in the Department; however at no stage was the CNO position downgraded or compromised in any way.

From the establishment of the position I always had direct access to the Minister and Director-General on professional nursing and midwifery issues. Administratively we were part of a Divisional Structure and as part of that structure, for day-to-day issues, I worked through a Deputy Director-General.

This was an issue for some of the profession, as they believed (and some still believe) that the CNO position should report directly to the Director-General. While I acknowledge that with different people in the various positions it could have been a real issue, it was never an issue in the time that I was in the position.

With the volume of work that the Executive deal with on a day-to-day basis it was and still is not practical for the Director-General to have large numbers of direct reports. In addition I believe that the SES level of the CNO position, requires that the incumbent is able to manage those potentially challenging situations.

What it did mean was that you had to research your issue well, have all your evidence and arguments ready and be prepared to discuss and if necessary debate the issue. It

also meant that if the decision was not what you might have preferred, you had to be able to accept the decision and promulgate it to the relevant people in a positive, supportive and constructive way.

Another variable in the structure was that although I worked through the Deputy Director-General of the various iterations of an 'Operations Division' (however named) for the majority of my portfolio responsibilities, I also worked through both the Chief Health Officer and the Deputy Director-General Policy for a number of my responsibilities. This meant I had to ensure that the communication channels were open and used well so that all the players were well informed as to what was in place and the results of all the strategies implemented.

One of the successful strategies was that I was able to negotiate and maintain membership of the Senior Executive Forum, which is where all the Chief Executive Officers (CEO) met on a regular basis with the Director-General and Senior Department staff. This enabled me to raise nursing and midwifery issues and also to respond to issues raised by the CEOs.

One of the primary roles of the position of CNO was as the professional interface between the Minister, Director-General, Department and the public, private and academic sectors of the nursing and midwifery profession. While the day-to-day activities focused mainly on the public sector, in all briefings and advisory processes the impact on the private and academic sectors was always included.

One of the early decisions that was made was that the CNO and staff would not be directly involved in any "industrial relations" negotiations as this activity was the province of the Industrial/Workforce Relations Branch (WRB) of the Department and the NSW Nurses' Association. This allowed the CNO to remain impartial and to provide advice to WRB when requested. At times there was the need for debate where the advice was not always valued. At times it also meant that I had to offer my advice when it was not requested! This division of activity was (and still is) a little confusing to some of the profession and needed to be explained on a regular basis.

I believe that the strategy was the correct one and one that needs to be maintained.

Relationships with the Ministers and the Departmental Executive

I enjoyed good working relationships with all five Ministers and their staff. They were all different and it was certainly interesting when there was a change and we had to orientate them to the different issues facing nurses and midwives and the different nursing and midwifery practice and educational contexts.

Working with Ministers from two sides of politics was also a great experience as you saw the different approaches and responses to issues of the day. Over the 12 years it was obvious that the nursing and midwifery issues were the same no matter what party was in Government. The only differences were in the way some of the issues were managed.

I also enjoyed good working relationships with five different Director-Generals as well as a number of very different Deputy Director-Generals. This brought with it its own challenges as you had to learn their modus operandi as well as keeping them up-to-date with the different issues facing nursing and midwifery.

In addition it was important to ensure that you were consulted appropriately when decisions were being made that impacted on nursing and midwifery practice.

Working with Government and the Public Service both in the development of policy and the operational issues was challenging and interesting and an experience that I will always value.

Ministerial and Departmental Media Staff

These relationships were also important as they dealt with the multitude of media enquiries and critical incidents etc. They relied heavily on getting accurate and timely information. Again it was interesting when there was a change and we had to orientate them to the different issues facing nurses and midwives and the different nursing and midwifery practice and educational contexts.

I enjoyed good relationships with all the media staff as they responded to nursing and midwifery issues. The departmental media staff was particularly supportive and helpful especially when I had to be interviewed by the various media.

Relationships with the Media

Over the years this was *mostly* a positive experience, however at times it was not a pleasant experience as a number of journalists took my comments out of context. On a few occasions a story ran with an unfortunate misquote that I then had to spend time explaining to the profession.

One of the disappointments was that despite how hard the Department's Media Unit and I tried to get the good news stories about nursing and midwifery into the media – all the media were really interested in were the sensational and negative stories. They could never balance those stories with the many great things that were happening in nursing and midwifery practice, education, management and research.

Relationships with other Divisions and Branches

This is a particularly important element of functioning successfully within the Department as no Branch can or should work in isolation.

At various times throughout my term, this was a challenge that the Department faced particularly related to communication through such a large organisation. Given the nature of health service provision it was inevitable that there were a number of Branches working on similar or related issues and it was important that each knew what the others were doing. It was an important responsibility of the Directors to ensure that briefs were not forwarded to the Executive without input from all the relevant Branches.

Once established, the working relationships between Nursing and the other Branches was always interesting, challenging and productive. Vigorous debates were necessary at times. However, that was an important element of the business of the day and while it sometimes created headaches it was not insurmountable.

The Branches I wish to particularly acknowledge for their support and input to Nursing Branch/Office of Chief Nursing Officer (OCNO) are Ken Barker and Finance and Administration; Karen Crawshaw and the Legal Branch; the Media/Communications Branch and the Executive Support Unit (ESU). I also want to acknowledge the secretarial staff of the Senior Departmental Executive.

The systems that are in place to manage the many briefs and ministerials that are required; and responses to parliamentary question time are to be commended.

One of the most successful strategies implemented by the Department over recent years has been the Clinical Information Access Program (CIAP), which has given nursing and medical clinicians point of care access to a vast amount of information that assists their practice. Diane Ayres and her team are to be commended on this initiative and on its continued growth.

Relationships with the System

An important element of the success of the role of CNO were the networks (**Appendix Two**) and the relationships we established with the system.

Nursing and Midwifery communication channels were set up and maintained through a variety of mechanisms. They *included*: -

- Second monthly meetings with all the Area DONs;
- Regular meetings with the NSWNA, NSWCN, Institute of Nursing Executives (INE), NSW Midwives Association (NSWMA), Australian & New Zealand College of Mental Health Nurses (A&NZCMHN) Enrolled Nurse Professional Association (ENPA) and Technical and Further Education Commission (TAFE);
- Meetings with the Executive of Specialty Nursing and Midwifery Organisations;
- Regular meetings with the Deans of Nursing and the Academic Sector;
- Meetings with the Private Sector;
- The Peak Nursing Council and then the Peak Nursing Forum;
- Rural and Remote Nursing Council; and
- Ongoing communication with other groups and organisations.

We also exhibited at conferences, established a website, issued a regular newsletter and I took every possible opportunity to speak at Conferences etc to disseminate information and receive feedback.

I also spent a great deal of time visiting health services across the State, talking to staff and seeing first hand what they were doing and what their issues were.

Our nursing and midwifery network was particularly strong and my 'underground' (as it was referred to by some) always alerted me to what was happening and we often

knew well before it became an issue. This meant that we were often able to have a briefing note completed before it was requested!

One of the challenges that were evident throughout the 12 years despite the many strategies in place, was the ongoing difficulties with communication and getting the messages out to the bedside nurses and midwives and members of the various organisations.

Working through the AHSs and the nursing and midwifery organisations meant that you had to rely on them disseminating the information. Unfortunately this was not successful in some situations. The very size and mobility of the public, private and academic nursing and midwifery workforce meant that it was and will always be a key issue.

Systems and Processes

The establishment of comprehensive processes and systems is critical to the efficient functioning of any Branch, as is meeting the deadlines and responding to changing priorities. Seven examples of what we established that underpinned our operation are:

- Management of our ministerial and briefing processes:
These were a priority and we usually always met the deadlines. We consulted widely on the issues raised and cross-referenced to other related issues.
- Communication processes, committees and forums etc. These were very comprehensive and inclusive.
- Comprehensive and accessible database on all nursing and midwifery organisations.
- Internal filing systems. These were very comprehensive and accessible.
- A reference (catalogue) cupboard including all the valuable resource material on nursing and midwifery, which we accessed frequently.
- Nurse Strategy Reserve
Comprehensive processes were developed to ensure that this money was expended effectively, including AHS reporting systems. To ensure that the money was spent across the financial year we established an agreement with Finance that we could give AHS preliminary advice on what they could expect, pending formal budget notification so that they could start at the beginning of the year.
- Nursing Department of Health Reporting System (DOHRS)
This is an information system that we developed with the first report issued in October 1992 to collect some aspects of workforce data. Area Health Services enter information into the system each month at a local level and access the reporting function within the system. The Nursing DOHRS Report provides nurse managers/program managers with information to assist in the monitoring of human resources.
- The information includes headcount (RN, EN, AIN, TEN numbers, resignation numbers), measurement of FTEs on Casual (Pool and Agency), Maternity Leave, Overtime (calculation based on overtime hours paid); and Positions Actively being Recruited (PAR).
We used the Nursing DOHRS information:
 - to monitor the nursing and midwifery workforce;

- to brief the Minister and Director-General;
- to respond to enquiry from both within and outside the Department;
- to inform the allocation of funding for nursing and midwifery initiatives; and
- to inform the development of Statewide recruitment and retention strategies.

In 2000 the name of the Nursing Branch was changed to the Office of the Chief Nursing Officer (OCNO) to more appropriately reflect all the functions and activities which covered nursing and midwifery and nurses and midwives.

My Ministerial appointments to the Board of The NSW College of Nursing and also to the NSW Nurses Registration Board were valuable in that they provided an opportunity to convey the Ministerial and the Departmental interests in the activities of both organisations.

I also found it valuable to have:-

- a three year term on the NH&MRC Health Care Committee as the nominee of the Royal College of Nursing Australia;
- a term on the Commonwealth Committee on Nursing in General Practice as a representative of Australian Health Ministers Advisory Committee (AHMAC); and
- a term on Australian Health Workforce Officials Committee (AHWOC) as a NSW Health Department nominee

as it afforded me additional opportunities to contribute at a National level.

A related highlight was Nursing Branch's involvement in the development of the health care section of the official bid for the Sydney 2000 Olympic and Paralympic Games and the fact that I am a signatory to that document. I also contributed as a member of the Health Care Committee for the preparation for the Games.

CHALLENGES OF THE ROLE

A major aspect of the role of the CNO is as the professional interface between the Minister and the Director-General and the nursing and midwifery profession. There were a number of operational realities that impacted (and continue to impact) on the provision of nursing and midwifery services and therefore it was necessary for the CNO to be aware of these realities and also to be ready to investigate and assist in the resolution of issues that emerged. The realities included:-

Operational Context

Key day-to-day challenges for nursing and midwifery managers *include*

- Meeting patient/consumer expectations;
- Competing demands from full-time, part-time and casual nursing and midwifery staff; administrators, doctors; and everyone else
- Keeping the whole ship afloat 24 hours a day, 365 days a year;
- Balancing nursing and midwifery workload, staffing requests, skill mix, models of care and quality care;
- Staying within allocated budget;
'Establishment' v Budget issues
- Legislative Frameworks/Departmental and Local Policies

- Circulars/Mandatory Reporting and Education etc
- Codes of Conduct etc
and
- Dealing with external forces *eg media, critical incidents etc.*

Workplace Reality

- Increasing patient acuity and activity;
- Increasing day of surgery admissions;
- Increasing day only admissions;
- Increasing length of stay and productivity;
- Lack of good information systems;
- Increasing consumer expectation; and
- Tension between hospital and community about activity and budget allocation.

These all had an impact on workload and on nursing and midwifery practice and led to many of the professional and industrial issues that emerged about workload, skill mix and nursing and midwifery retention.

Other Issues and Challenges included:-

- Some decisions were not always what 'an individual' or 'a group' may want;
- Time lag with some decisions;
- Each person gives their advice up the line – for many decisions it is someone else who decides;
- The role of CNO is not easy as you walk a very fine line between the different elements of what you believe is the way forward, what the Department wants, what the Minister wants and what the profession wants. Somewhere among all of that is what the patients need;
- Implementing and positively promoting decisions that you may not have been completely happy with;
- Professional and industrial differences; and
- Other agendas – eg medical, administrative etc.

Nursing and Midwifery Workforce Challenges

The New South Wales (NSW) health system provides high quality service. I agree that our public system is one of the strongest in the world, built on the foundations of universal entitlement and access and that it is the result of the outstanding commitment of all who work in it and have built it over the generations.²

A comprehensive issues paper³ outlines a number of the issues that were impacting on the nursing and midwifery workforce. Approximately 40,000 nurses were employed in the NSW public health system. Together with nurses employed in the private, community services and aged care sectors nurses they make up the largest section of the health and community services workforce. A significant number of nurses now

² NSW Government. (2000) *Our Commitment, NSW Nursing Workforce Strategy*. NSW Health Sydney

³ NSW Health. (2001) *Nursing in New South Wales Workforce Issues*, Issues Paper. Unpublished Sydney

work outside the traditional hospital setting and there is a growing need for all nurses and midwives to remain abreast of current issues and to proactively participate in health planning and decision making processes.

Nurses generally feel undervalued and believe that they are hearing two messages. One that says we need nurses and the other, at a more operational level, where they are continually being asked to do more. They also perceive a lack of recognition for the high level of clinical judgement and decision making of highly skilled and experienced specialty nurses.

Recruitment and retention of nurses continued to be a high priority of NSW Health. However, it was also recognised that a number of the issues were 'societal' issues and not 'nursing and midwifery workforce' specific. As such they continued to present major challenges for the health system.

Examples included:-

1. Nurses and midwives like all other workers are now strongly influenced by lifestyle choices and are demanding much more access to part-time and casual employment to enable them to balance family, study, and the social elements of their lives. This presents significant challenges for nurse managers, who are required to staff health services over a 24-hour day, seven days per week.
2. The majority of nurses and midwives are women, many who leave the workforce for varying periods, to have and raise children and manage other family responsibilities.
3. The mobility of nursing and midwifery qualifications (both Interstate and Internationally), which is a central attraction of the career, facilitates travel and the movement in and out of the workforce.

The health system, in some sections, continues to respond slowly to the recognition of the multiple roles of spouse, parent, student, nurse and individual, which describes many nurses across NSW. Skilled nurses and midwives leave the system in order to access the flexibility they require.

Casualisation of the workforce is a factor in that more nurses (like other occupations) want to work part-time and casual shifts to enable them to do other things (eg. study, parenting, spouse's business etc). This creates tension with full-time staff who are then required to work the more "undesirable" shifts.

Other issues included:-

- The nature of nursing and midwifery work itself. While nursing and midwifery is a very rewarding career, it is physically, mentally and emotionally demanding;
- Nursing and midwifery care is essential yet it is still relatively invisible;
- Access to and financial support for education. Nurses believe that they are disadvantaged (as compared with medical officers) with access to leave and financial support for educational activities;
- 24-hour nature of nursing and midwifery services and the requirement for shift work, including 'unsociable hours';

- Ageing nursing and midwifery workforce;
- Seasonal fluctuations in the availability of nursing and midwifery staff;
- Impact of the reduced availability of support staff;
- Workplace culture. Bullying is a 'system wide' issue between staff categories as well as within professional streams. This is exacerbated by 'hostility' and aggressive behaviour by patients and their relatives;
- Safety and security of both persons and possessions;
- Violence in the workplace and telecommunication black spots;
- Power structures - within nursing and midwifery and between medicine/nursing and nursing/administration;
- Access to affordable child care and before and after school care;
- Access to affordable accommodation including availability for undergraduate students on clinical placement;
- School leavers and society have very different expectations of how they will be treated; and
- Nurses and midwives find their qualifications are an excellent stepping-stone to other work and career opportunities.

There were a number of other challenges that emerged over the years including:-

Education of Nurses and Midwives

This was very frustrating over the 12 years as there were a range of issues that related to undergraduate and postgraduate nursing and midwifery education. A comprehensive issues paper was prepared in regard to these issues.⁴ In particular, we had significant difficulty accessing accurate and timely data on undergraduate nursing enrolments and graduations including both preliminary data on enrolments and projected graduations early in each year, together with the final formal advice later in each year, to inform our ongoing workforce planning.

Difficulties with the timing and interpretation of data, together with policy shifts at Commonwealth level exacerbated the problem. The concerns were raised by NSW Health through NSW Education to the Commonwealth and directly from the Minister for Health and Director-General to both Commonwealth Health and Education on numerous occasions.

In 1983 NSW transferred undergraduate nursing education from hospital certificate courses to the tertiary sector commencing in 1985. A 'Commonwealth/State agreement' provided for financial assistance for the nine years from January 1985 to 30 December 1993. One of the States responsibilities under the Commonwealth/State agreement was to provide the Commonwealth with workforce planning data and projections.

At a macro level nursing intake numbers were set to meet Statewide nursing workforce needs, given estimations of the different attrition rates that would apply and initial workforce participation.

⁴ NSW Health. (2001) *Tertiary Nursing Education*, Issues Paper. Unpublished Sydney

In 1991, NSW Health and Education supported the move to a three year undergraduate 'degree' program in NSW with a number of provisos:-

- i. maintenance of intake numbers appropriate to meet the State's workforce needs;
- ii. graduate study funding not being compromised;
- iii. the Commonwealth meeting any additional costs of a capital and/or recurrent nature associated with the transfer to degree programs in 1992, 1993 and 1994 onwards; and
- iv. the Commonwealth being in a position to successfully negotiate with the higher education institutions the introduction of a three year program, with no reduction in numbers (subject to i.) and the maintenance of clinical experience that is acceptable to the Registering Authorities.

The Commonwealth assumed full responsibility for nursing education programs in the tertiary sector, from January 1994 and all the funds were transferred from NSW to the Commonwealth. Based on workforce requirements, NSW Health continued to advise that we required a steady state of 2,490 EFTSU undergraduate first year enrolments per annum as identified in the following table . The Commonwealth had not approached NSW Health to renegotiate this number.

University	Commonwealth/State Agreed 1 st Yr Intake EFTSU
ACU	168
CSU	159
UNE	100
SCU	100
Sydney Uni.	485
UTS	392
UWS	662
Uni. Wollongong	131
Newcastle	293
TOTAL	2,490

Universities had consistently not been able to meet the continuing target (2490) intake numbers. It was considered that this was due to a number of factors, including:-

1. The competing career options for school students – despite improved salaries and conditions for nurses;
2. Reduction in the pool of school leavers;
3. Variances in the University Admission Index (UAI) and the impact that this has on recruitment into nursing programs;
4. HECS charges;
5. The additional cost associated with potential rural students living away from home; and

6. Education sector reforms including budgetary impact and the subsequent reduction of available places by universities.

In addition, informal advice from some nursing faculties indicates that available places continued to be reduced in some nursing programs. We continued to raise the issues with NSW Education. The Higher Education Directorate also continued to raise them with individual Universities, the NSW & ACT VCC and with the Commonwealth Department of Education Training and Youth Affairs (DETYA).

The situation was exacerbated by:-

1. The increasing casualisation of the nursing and midwifery workforce;
2. Ageing of the current nursing and midwifery workforce;
3. Environmental/retention issues;
4. Issues of access – geographical, Aboriginal and Torres Strait Islander (ATSI) and Non English Speaking Background (NESB);
5. The mobility of nurses between the Public and Private Sector; and
6. The mobility of nurses Interstate and Internationally.

The then Director-General and I attended a meeting of the NSW and ACT Vice Chancellor's Conference (VCC) on 15th December 1998. The meeting was most unsatisfactory as a number of the Vice Chancellors at that time made it clear that they would not be "bound by any numbers", despite what agreements Government believed existed. They stated that as autonomous organisations they would determine numbers from year-to-year, and that former agreements were no longer relevant.

These statements coupled with a shift at Commonwealth level to 'student demand' as the basis for funding university places, was a concern for NSW Health as this continued to impact on the nursing and midwifery workforce. The Vice Chancellors had stated that we needed to "negotiate individually with universities". This was not acceptable to NSW Health, as we needed to look at the State as a whole.

Prior to and immediately following the transfer, nursing places and funding were quarantined. As the Commonwealth continued to decentralise the tertiary sector activities to universities the issues were compounded. Following the transfer of undergraduate programs we had also seen the progressive transfer of many of the hospital-based postbasic certificate programs to the tertiary sector.

Enrolments in the programs varied across the State and this was impacting on the preparation for specialty practice. It has had a significant impact on the midwifery workforce.

Nursing and Midwifery Workload and Skill Mix

There are longstanding (and ongoing) issues around nursing and midwifery workload measurement; increasing nursing and midwifery productivity and appropriate skill mix for the different practice contexts versus what was available both in nursing and midwifery workforce numbers and budget allocation.

One challenge was the issue of the transition of the new graduate and the mindset that still exists in some places that the new graduate needs to do a series of clinical rotations before they can move into a specialty area. Fortunately we are (at long last) slowly starting to see that turn around with some specialty areas taking the new graduate in and providing them with an individualised and supported transition.

It was of real concern to me when I was told by some nurses and midwives that they would rather work short than have new graduates nurses and enrolled nurses on their shift – something I could neither understand nor accept.

There is also the ongoing debate of whether you need nurses/midwives in some contexts. This was promulgated (in the main) by non-nurses who believe that you can introduce other categories of staff to undertake nursing and midwifery work. The lack of Australian research in this area compounded the issue. There were many forums on the issue that ultimately led to the development of the Management of Nursing Resources Reference Manual⁵.

Following much discussion and debate on the issue the Department announced in 2002 a major research project⁶, which will examine nursing workload, skill mix and patient outcomes. This will provide important information (in an Australian context) for the future, on which to base decisions on staffing levels and skill mix.

At the time of finalizing this document, the research is in its early stages and is being undertaken by the University of Technology, Sydney.

Information Systems and Data

Another challenge was obtaining accurate and timely information particularly on the nursing and midwifery workforce numbers and changes over time.

Despite a great deal of effort and work by a number of people to address this issue it was still not fully resolved when I left and I understand that work continues in this regard. Our issues *included* access to:-

- data on numbers of nurses employed in the different categories and specialties;
- completeness and reliability of data;
- agency nurse utilisation by specialty and category;
- casual pool utilisation by specialty and category; and
- accurate turnover data.

Influence and Power

I have always believed that good health care is about a multidisciplinary and collegiate approach to all aspects of the health system and that it includes doctors, nurses, midwives and allied health professionals as integral members of the team. Unfortunately in some aspects, over my 12 years this was not always the case.

Nurses and midwives are challenged (some would say overshadowed) by the power and might of some elements of the medical profession. This was evident on a number of occasions as we continued to have to lobby strongly for appropriate nursing and midwifery representation on some Departmental and Area Health Service committees and nursing and midwifery input into policy determination.

⁵ NSW Health. (1998) *Management of Nursing Resources Reference Manual- A Business Planning Model*. Sydney

⁶ Nursing Workload Research. Announced by the NSW Minister for Health in 2003.

It was also evident in some of the organisational restructuring or what I refer to as the 'you beaut ideas from overseas'. I was often a little outspoken about this as there was a continued push to implement a range of new structures despite the fact that it would appear that a number of overseas countries were moving back to some of the earlier models.

I am fully supportive of nursing, medical and allied health clinicians being more involved in the management of health services. However, I also believe that there needs to be an infrastructure that manages the 'whole' of the health service so that we do not see little empires springing up with their moats and drawbridges.

I believe that at times the nursing and midwifery professions are prevented from moving forward or doing things differently by some very powerful elements in the system. A number of very good senior nurse managers were lost to the system because their positions were disenfranchised by these new structures and many of them had seen the implications for nursing and midwifery practice. Another concern is that we have seen a loss of all that expertise and corporate knowledge.

I am dismayed that the value of good nursing and midwifery management goes largely unrecognised in some situations and at times is both overtly and covertly obstructed. I think that this is in part due to the fact that in some situations nurses have allowed the word nurse to be removed from their title. I also think another factor is that nurses and midwives have not used the right terminology.

Some have argued their concerns from nursing and midwifery's point of view and not perhaps in relation to better patient outcomes. We then get the phenomenon of 'there they go again – whinging nurses' etc. There is no doubt about it the argument needs to be couched in a way that gets people attention and support and 'quality of care' and 'improved patient outcomes' are winners in this regard.

NURSING AND MIDWIFERY STRATEGIES

There were a significant number of strategies implemented over my tenure to address the nursing and midwifery workforce and clinical practice issues. They are highlighted in my last Recruitment and Retention Report (July 2002) at Appendix Three.

A number of key strategies included: -

Enrolled Nurse Review⁷

Chaired by Deborah Hyland a Taskforce examined factors surrounding the education, role and function of the enrolled nurse in NSW. It was as a result of the review that the education of enrolled nurses was extended to the Advanced Certificate level (now Certificate IV) and also that a State target ratio of one enrolled nurse to four registered nurses was set to be achieved across NSW. There were also a significant number of other recommendations made to enhance the role of the enrolled nurse.

⁷ NSW Health. (1991) *Review of the Education, Role and Function of the Enrolled Nurse in New South Wales*, Final Report. Sydney

It is of concern that despite great effort an enhanced role for the enrolled nurse has not been fully embraced by some elements of the nursing and midwifery service and academic sectors. We still see resistance to the inclusion of enrolled nurses in the team and to the extension of the role. There are also inconsistencies across health services and in some instances within health services as to what enrolled nurses are allowed to do.

This has resulted in an ongoing push by politicians, bureaucrats, administrators and doctors for an increase to enrolled nurse and trainee enrolled nurse numbers as well as the introduction of other levels of worker to address the 'nursing and midwifery shortage'.

While I have always fully supported the role of enrolled nurse in the health care team; the ratio or balance of registered nurses to enrolled nurses, trainee enrolled nurses, assistants in nursing and other levels of worker must be managed. Supervision issues in a busy workplace are critical in this regard to ensure that appropriate nursing and midwifery care is able to be provided.

Peak Nursing Forum

This was established in 1992 (known then as the Peak Nursing Council) to discuss broad professional issues that were impacting on the service (public and private) and academic sectors. It brought together representatives of the major nursing and midwifery organisations at the time and was an invaluable communication channel and consultative process.

Around 1998 the Council was widened to include representatives of all the nursing and midwifery organisations (100+ total members). This provided the opportunity to discuss and debate the issues on a much broader front, appreciating the diversity of opinion and at the same time finding a common way forward. Issues that were discussed included transition of the new graduate; scope of nursing and midwifery practice; nursing and midwifery competency; work of the NSW Health Council; nursing and midwifery's future; Government Plan of Action Implementation Groups; impact of the changes in health on Community Health and realistic and sustainable models of nursing and midwifery care.

The forums were challenging given the many different perspectives but at the same time informed the debate and provided valuable information for the work of OCNO.

Marketing and Media Campaigns

A number of 'marketing' campaigns and material were developed over the years - 'Nurses. We can't live without them'; 'Dare to Care'; 'Nurses are the Heart of NSW Health'; 'Nursing for Life'; and 'Nursing: You can make a difference'; are some of the themes that were used. These campaigns were successful in the short-term however there are ongoing challenges to address, to improve the image of nursing and midwifery in some sections of the community.

Overseas Recruitment

Over the years 'overseas recruitment campaigns' were undertaken to address cyclical nursing and midwifery shortages and in later years as part of the winter bed strategy. A number of Area Health Services had programs in place and the Health Department also undertook a number of programs. Each of the initiatives resulted in a significant number of nurses being recruited however there were also substantial associated costs and the benefit to the system was mainly short-term because of immigration rules and the fact that the nurses wanted to travel.

1990: This was in progress prior to my appointment and we took over the management of the initiative when I took up office.

2001/2002: This program was coordinated for OCNO by Ms Kerry Russell, Director of Nursing Services at Concord Hospital and was very successful⁸. Planning was well in train for the 2002/03 initiative again coordinated by Ms Russell.

NSW Ministerial Recruitment and Retention Taskforce 1995⁹ and NSW Rural & Remote Nursing Summit 1998¹⁰

These activities both produced a number of recommendations that were designed to address the issues that emerged in the discussions. These recommendations are all still relevant today.

The *NSW Rural and Remote Nursing Council* was established in March 1999 as a result of the R&R Summit and also reflected the growth of 'Nursing Councils' across NSW. Unfortunately these Councils have not been as successful as we hoped in some AHS. With appropriate support and infrastructure they could be a perfect vehicle to enhance communication and effect change.

NSW Midwifery Taskforce¹¹

In 1993, a Taskforce, chaired by Diana Tricket considered the implications of changing models of midwifery practice on maternity service provision, undertaking a comprehensive review of all aspects of midwifery practice in NSW.

The need for midwifery services to work within a collaborative framework was seen as essential to maintaining positive health outcomes while meeting the expectations of the consumer. Consultation between women and service providers was also raised as an issue that is critical to the planning and provision of a maternity service that ensures choice, control and continuity of care for women in all phases of childbirth.

⁸ Russell, K. (2002) *NSW Health Overseas Recruitment 2002*, Final Report. Sydney

⁹ NSW Health. (1996) *NSW Ministerial Taskforce on Nursing Recruitment and Retention*, Final Report. Sydney

¹⁰ NSW Health. (1998) *Rural and Remote Nursing Summit*, Final Report. Sydney

¹¹ NSW Health. (1996) *Midwifery Taskforce Report*. Sydney

The report made a significant number of recommendations that reflected the need for changes to occur in the provision of maternity services in a positive and systematic way that values both the providers of maternity services as well as the consumers.

Emergency Midwifery Guidelines

These were developed by the NSW Midwives Association with funding from OCNO to provide a reference point for rural and remote registered nurses (not authorised to practise midwifery) who were faced with women in labour turning up at the hospital where there were no maternity services.

The Branch also serviced a Departmental Maternity Services Advisory Committee that was established and produced a five-year strategic plan for NSW Maternity Services.¹² A sub-committee was then established to revise the Department's Homebirth Policy. Ms Pat Brodie was instrumental in both of these activities. In addition the Department funded the development of an Options Paper regarding the development of publicly funded homebirth services on a Statewide basis. Unfortunately the recommendations from this report have still not been progressed.

Midwifery Models of Care and Homebirth

A very difficult process as we watched the continued medical opposition to some midwifery led models of care including homebirth options. Midwifery practice has been at the cutting edge for many years with their models of care, yet there are still people who are unwilling to allow change to occur to allow this progress in a measured way. Women have a right to choose their model of childbirth and the health system needs to facilitate these options with appropriately skilled health professionals providing the primary care.

Review of the NSW Nurses Act

The review of the NSW Nurses Act under the leadership of Karen Crawshaw¹³ was a challenging experience. Debate within the nursing profession around the terminology of nursing and midwifery and the recognition of midwifery as a separate profession was heated.

I have always believed that midwifery is at the cutting edge of our health continuum, a primary health care philosophy within a wellness model at its best, notwithstanding the potential for 'obstetric risk' to complicate what is essentially a 'normal' life event.

No where is the challenge of midwifery more apparent than in the rural setting where you are often isolated and unable to call on the vast resources that are available in a teaching hospital environment. It is this isolation factor that makes rural nurses and midwives the most multi skilled of all. This is more so at this particular time as they are at the crossroads or 'edge' of major changes with the pending changes to the NSW Nurses Act that will result in a first for Australia with the NSW Nurses and Midwives Act.

¹² NSW Health. (2000) *NSW Framework for Maternity Services*. Sydney

¹³ Karen Crawshaw. Director of Legal and Legislative Services. NSW Health Department. Sydney

While it was a long and sometimes difficult debate, the changes are ones that I fully endorse. Whether you see yourself as a midwife, both a nurse and midwife, a nurse in the specialty of midwifery, an obstetric nurse or whatever else – one thing is certain – the review of the Nurses Act has been a very significant activity, particularly in regard to Midwifery practice, as will see:

- a formal change of the nomenclature to nursing and midwifery;
- a specific Midwifery Standing Committee that will report directly to the Board;
- much tighter regulations for midwifery practice; and
- direct entry undergraduate programs for midwives.

I believe that the changes will provide the basis for the next phase of growth in midwifery practice, education, research and management.

NSW Nursing Scholarship Fund

The NSW Nursing Scholarship Fund (formally the NSW Rural and Remote Nursing Scholarship Fund) was established in May 1998. It complemented other 1996 Rural Health Workforce Strategy initiatives to aid in the recruitment and retention of nurses in rural and remote NSW. The Rural Health Support Unit, located in Grafton within the Northern Rivers Area Health Service, initially managed the Fund for the CNO. This was transferred to the Nursing Branch in September 1999 due to the closure of the Unit.

A steering committee and reference group, comprising representatives from across the health, tertiary and education sectors was established in July 1998 to develop guidelines and criteria for undergraduate scholarships and rural placement grants. In 1999 the first scholarships and rural placement grants were allocated to undergraduate nursing students. 2001 saw the introduction of postgraduate scholarships for registered nurses working in the public health system in NSW.

To reflect the addition of a postgraduate scholarship stream, the name of the Fund changed to the NSW Nursing Scholarship Fund, however a rural focus continues with the rural undergraduate scholarships.

As at July 2002 there were five scholarship streams:-

1. Grants for undergraduate nursing students undertaking a clinical placement in a rural area.
2. Grants for undergraduates from a rural university (Charles Sturt, New England and Southern Cross) undertaking a clinical placement in a metropolitan area.
3. First year undergraduate nursing students from a rural area.
4. Aboriginal scholarships for undergraduate nursing students.
5. Postgraduate nursing scholarships for nurses employed in the NSW public health sector.

There were two scholarship selection panels with representatives from NSW Health, the NSW Nurses' Association, NSW Universities Nursing Faculties, Area Directors of Nursing, and Aboriginal Health Branch. These panels also provided recommendations for changes to the scholarship criteria and improvements to the application process.

Indigenous Nursing Project

The NSW Rural and Remote Aboriginal Nursing Strategy was established to increase the number of Aboriginal nurses in NSW, and to improve career development opportunities.

The initiative began in June 2001 and the initial objectives were the: -

- Development of the overall strategy;
- Development of an Aboriginal and Torres Strait Islander nursing promotional video and a CD – ROM with information for school students and community members on nursing careers;
- Provision of advice to hospitals, Area Health Services and universities on ways to recruit Aboriginal and Torres Strait Islander people to identified nursing education and nursing positions; and
- Provision of Scholarships. In 2001 two undergraduate scholarships were awarded to indigenous people studying a Bachelor of Nursing and in 2002 this number grew to 24.

Nursing Careers Advice and Work Experience

Positive work experience opportunities for school children are highlighted as one of the significant factors in the ultimate choice of career. To enhance the opportunities provided by NSW Health Services a Careers Advisers Network was established. In addition new marketing material was developed in 1994 by OCNO and circulated. This was evaluated in 1998/99 including a comprehensive survey of School Career Advisers. Revised marketing material was developed and then under the chairmanship of Ms Anne Butler, 'Dare to Care'- a workbook and work experience guidelines were developed and circulated widely.

Funding for External Research included

'Who wants to be a Nurse?' ¹⁴

'Perceptions of Nursing as a Career Choice' ¹⁵

NSW Nursing Workforce Research ¹⁶

Nursing (and Midwifery) Re Connect

In 2002, Nursing *Re Connect* was launched as the new model of re-entry to the nursing and midwifery workforce in the public sector; re connecting nurses 'not working in nursing' with paid nursing employment opportunities and individualised, tailored support to their re-entry to the workforce.

¹⁴ Lawler, J., et al (1997) *Who wants to be a Nurse?* A report on applicants selecting nursing as a university course in New South Wales in 1997, The Sydney Nursing Research Centre, The University of Sydney.

¹⁵ Tang, K.C., et al (1996) *Perceptions of Nursing as a Career Choice*, Multicultural Health Unit, South Eastern Sydney Area Health Service. Sydney

¹⁶ NSW Health. (2000) *NSW Nursing Workforce Research Project*, Nursing and Health Services Research Consortium, Sydney

This was a significant change to the previous model of re-entry where nurses had been required to undertake an unpaid refresher course and then seek employment after they had completed the program.

NSW College of Nursing Contract

The Department has had an arrangement with the College to provide clinically focused educational programs (under agreement) since 1977. A formal contract has been negotiated for many years and the arrangements are reviewed every year and performance indicators and financial reports are embedded within the contract. There are a significant number of advantages with the arrangement that would not be possible through universities. In addition The College is a 'Schedule 3 Affiliated Organisation' under the Health Services Act 1997 and as such the Department is able to direct its influence on the educational programs and also to change the priority areas, as industry needs change.

NSW Ministerial Standing Committee on the Nursing and Midwifery Workforce

This was established in 2000 to provide advice to the Minister for Health and to the Director-General of Health.

Terms of Reference included:-

- developing, monitoring and reviewing strategies to ensure the provision of appropriate nursing care to meet the service delivery needs of the public health system;
- the education and ongoing development of nurses employed in the public health system;
- evaluating and reporting upon specific nurse recruitment and retention strategies;
- promoting research into nursing workforce needs and models of nursing care;

An action plan was developed and is currently being progressed across NSW.

Website/Newsletter/Customer Surveys

The development of the Branch's website (initially by Michelle Wensley) and our regular newsletters greatly enhanced our communication processes.

They were both very well received by the profession and we received very positive and valuable feedback from both the initiatives and also from our regular customer surveys.

Nurse Practitioner Project¹⁷

A very tortuous process! As the only person who was part of the whole 12 years from 1990 to 2002, I still vividly remember some of the experiences that I lived through as we continued to push the Project forward.

¹⁷ NSW Health.(1991-1998) *Nurse Practitioner Project*, Reports of Stages One, Two and Three and the Nurse Practitioner Framework.

My main concern was around the ongoing opposition and misinformation that continued to be promulgated by the powerful 'opponents' despite the accurate information that they were given over and over again by the Director-General, myself as well as the Department's Legal Branch.

The media always focussed on the medical professions concerns and that meant we were always on the defensive having to 'provide evidence' that these nurses would not do something terrible to their patients. This was despite the successful pilot projects that had been undertaken.

The committee meetings and working parties were very challenging as we worked very hard to encourage all the different stakeholders to support a consensus position that took into account their concerns but at the same time provided a framework to move forward. An independent facilitator had to be commissioned to manage the steering committees for the different stages of the Project as there were so many different agendas and debates. At times the hoops we went through to keep the Project moving were unbelievable.

As highlighted earlier, nurses and midwives are challenged (overshadowed) by the power and might of the medical profession. While there are many medical colleagues who individually support the concepts 'the party line' prevails in any media coverage. We are however now starting to see the tide change at long last and way overdue. As more and more nurses and midwives are authorised and are practising across NSW the community will see what we have always said, that this is about advanced expert nursing and midwifery practice where nurses and midwives work in collaboration with their medical colleagues to provide a safe and effective health care option.

There were many other strategies, which are outlined in **Appendix Three**.

NATIONAL ISSUES

On a National level I remain concerned that despite the many efforts by a number of people we still do not have a National Chief Nursing Officer.

In the nursing and midwifery world, Australia is way behind other countries, as we are never represented by a senior nurse in Government at the Federal level and do not participate at a National level in British Commonwealth and International meetings. It also means that Nationally consistent nursing and midwifery education, practice, management and research is that much more difficult to achieve across the States and Territories.

It was reassuring that my concerns about this were supported by the then Ministers and Director-Generals. A number of letters went back and forwards to Canberra over a number of years – but to no avail.

In addressing the nursing and midwifery issues that impact at a National level there needs to be a collaborative approach by many people and organisations and this must include the State and Territory Chief Nursing Officers however titled. However there

needs to be a focal point at a senior level at the Commonwealth, supported and funded appropriately.

While I wish the National Nursing Taskforce, (that as at September 2003 we are still waiting for) well in its deliberations, I believe that it is a political substitute for what we really need which is a Federal Chief Nursing Officer.

WAS IT ALL WORK?

I have never worked as hard or as long as I did on a day-to-day basis as CNO, however there was also another side of the Department that very few people got to see. Over the 12 years I met and had the privilege of working with some very dedicated people; dedicated and committed to their job and to making a difference in the health system. I was always incensed at the media when they said negative things about public servants and bureaucrats. Long hours, evenings and weekends were the 'norm' for so many people.

On a lighter note there were also some 'social' times. For example, Department of Health Christmas parties were a fascinating experience, as we saw the hidden talent of the staff emerge including the performances of some of the SES staff. In our case it was Lord of the Dance in River Branch, the Wiggles and O.C.N.O - a take off of the Village People and the song YMCA. I will never forget the look on the Ministers' faces when I came out in successive years as Lord of the Dance, Dorothy the Dinosaur and the Chief!

ONGOING CHALLENGES

There are many ongoing challenges that face the health system and its workforce. I am unable to cover all of them in this document. The broader system challenges are outlined in a range of publications including Department of Health documents. The nursing and midwifery challenges are all outlined in the publications referenced in this document as well as many other publications.

These are just a few examples in relation to nursing and midwifery.

Communication

This is one of the biggest ongoing challenges that the whole health system faces. Keeping a high profile out in the system and understanding workplace issues is critical to the position of CNO. This will enable the provision of proactive and relevant advice.

Workload

The NSW Nursing Workload Research Project is a vital piece of research that will provide valuable information to inform decisions about staffing levels, skill mix and models of care. Strategies to enhance ownership of the results of the research by both the Department and the Profession will be necessary.

Recognition

Consistent and tangible recognition of the important role of nurses and midwives at every level in the health system is required to change the current perception by nurses and midwives that their input is not valued.

Environment

There are many environmental issues that must be resolved to improve the workplace, to enhance recruitment and retention.

Involvement

It will be important that nurses and midwives continue to be involved in the decision making at every level in the health system. This would include appropriate representation and participation on the proposed Health Care Advisory Council and the Clinical Senate.

Education

Issues around access to and affordability of undergraduate and formal postgraduate education; transition support for new graduates; ongoing skill development and re-entry programs will be critical to ensuring a sustainable nursing and midwifery workforce.

Leadership

Succession planning and ongoing support will need to be a high priority as the nursing and midwifery workforce continues to age. Strong mentors will also be critical to the ongoing support of nursing and midwifery leaders.

We have lost a number of very good 'senior nurse managers' from the system because their positions have been disenfranchised with the emerging organisational structures.

NSW CNO Position

The position of CNO is much broader than workforce. It also encompasses significant elements of leadership together with clinical practice, education, research, management and professional matters. It is important the position of CNO continues at a senior level in the Department with appropriate status and recognition. It is interesting to note that over the years a number of NSW Area DON positions have moved up the SES bands to be on the same level as the CNO. The SES level of the CNO position needs to be reviewed.

Strong relationships with other Branches and Divisions are also important elements of the position as is the 'independent' status and nature of the CNO role.

Direct access to the Minister and Director-General are also important elements that need to be maintained.

Commonwealth CNO

NSW Health needs to continue to lobby strongly for the Commonwealth to establish a position of Federal Chief Nursing and Midwifery Officer, suitably resourced and at an appropriate organisational level.

CONCLUSION

As highlighted in the introduction, it is just not possible to include everything that was experienced and/or implemented over the 12 years. As a personal reflection of my tenure as CNO I have provided an overview and highlights of:-

- the context at the time the position was created;
- how the position was developed within the department and the system;
- organisational framework;
- some of the nursing and midwifery workforce challenges that emerged and the strategies that were put in place; and
- a number of challenges for the future.

Working with Government, Health Ministers and the Department of Health are experiences that I will always value.

I was often asked by nurses and midwives when I was out and about –“well why don't you just go into the Ministers or Director-Generals office and demand” that this or that be done! The other great line was “well what are you (that was me) doing about it”, relating to whatever issue we might have been discussing at the time.

My answers were always (and still are) that: -

- Nursing and midwifery is but one part of a very complex system albeit a very important part; and
- It is not a one-person show. It is about everyone working together to address the issues.

Let me assure you that the position of CNO is very challenging as you walk a very fine line between the different elements of what you believe is the way forward, what the Department wants, what the Minister wants and what the profession wants. Somewhere among all of that is what the patients need and at all times the decisions I made within my delegation; together with my advice to the Director-Generals and Ministers were based in the first instance on that very important fact.

I left the position of CNO knowing that a great deal had been achieved, many strategies had been funded, implemented and were continuing across the State, many issues had been resolved and that nurses and midwives were much more involved in the decision-making processes of the Department.

I believe that my staff and I contributed significantly to the ongoing development of nursing and midwifery as key elements of the health system.

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ACKNOWLEDGEMENT

Meppem, J.L. (2003) *Getting to the Heart of the Matter*, 51st Annual Oration, The College of Nursing, Sydney

APPENDIX ONE

Nursing Branch/ OCNO Nursing Staff Profile 1990 – 2002 as at 30 August 2002

	Seconded to NB/OCNO from	Position following NB/OCNO
Associate Directors		
Deborah Hyland	NM, Prince of Wales Hospital	Executive Director, Health Public Affairs - NSW Health
Bronwyn Wilkinson (nee Fisher)	Area Nursing Executive NSAHS	Manager, Community and Extended Care Services – NSAHS
Kerry Russell	NM, Concord Hospital	DON, Concord Hospital
Anne O'Donoghue	ADON GMAHS	Area DON, Northern Rivers AHS
Marianne Goodwin	NM, St Vincent's Hospital	Current
Rural Nursing Advisors		
Jean Shelley	RNO Southern Regional Office	Area DON & Quality Management, Southern AHS
Mary Scott	DON Grafton Hospital	Manager of Clinical Quality and Nursing – Royal Newcastle Hospital
Heather Burrell	HSM, Deniliquin HS	Policy Division NSWDOH
Policy Analysts		
Julie Williams	NM, Westmead Hospital	Permanent OCNO
Amanda Adrian	NM, CSAHS	Now Commissioner, Health Care Complaints Commission
Amber Brittain-White	Clinician, RNSH	Clinician RNSH
Anne Butler	Careers Adviser POWH	Co-ordinator, Nursing Career Development – SESAHS
Annette Walters	NM (Midwifery) Royal Hospital for Women	NM Royal Hospital for Women
Jan Potapof	Clinician, POWH	Private Enterprise (eg AWA, ORTA , State Rail)
Kate Rawlings	Clinician, Sydney Children's Hospital	Director/Nursing Director of the Child and Youth Health Network – Hunter AHS
Lisa Wagg	Clinician, Sydney Children's Hospital	Home Duties/New Mother
Michelle Wensley	Clinician, St Vincent's Hospital	Clinical Information Unit (CIAP) NSW Health
Pat Brodie	Clinician (Midwifery) St George Hospital	Clinician/Researcher UTS/St George Hospital
Patsy Trethowan	Clinician, Liverpool Hospital	SOCO - Health Care Now Consultant to Greek Olympics 2004

Peter Avery	ADN Prince Henry Hospital	DON Rachel Foster Hospital
Gerry Murphy	NM (After Hours) Wyong Hospital	Divisional Nurse Manager, Anaesthesia and Surgery – CCAHS
Dianne Saunders	Clinician, POWH	NSW College of Nursing
Maria Fenn	NUM (Midwifery) Royal Hospital for Women	Nurse Manager – Maternity, St George Private Hospital
Anna Treloar	Clinician, CHS – Kempsey	Clinician, Kempsey Hospital
Suzanne Schacht	Clinician, St Vincent’s Hospital	Home Duties/New Mother
Rosemary Cullen	NUM RPAH	Nurse Manager (after Hours) RNSH
Michelle Hill	NUM, Royal Hospital for Women	Bed Manager, Royal Hospital for Women
Mary Rose	NM, Operating Rooms - John Hunter Hospital	NM, Operating Rooms - John Hunter Hospital
Cecilia Lau (Dr)	NM, Children’s Hospital at Westmead	Current OCNO
Susie Lang	DON Poplars Private Hospital	Current OCNO
Raymond Lovett	Clinician New England AHS	Current OCNO
Suellen Allen	NM, Royal North Shore Hospital	Current OCNO
Ainslie Burne	Clinician, St George Hospital	Current OCNO

Support Staff

CNO Secretaries

Jo Ann Cuneo
Elizabeth Harrison
Joanne McFarlane

Clerical Assistant

Margaret Rout

Administration Officers

Debbie Tanner
Jo Ann Cuneo
Jim Ellis

Scholarship Officer

Amber Long
Jo Ann Cuneo

APPENDIX TWO

NETWORKS



- Ministerial Standing Committee on the Nursing and Midwifery Workforce

Judith Meppem July 2002

NSW HEALTH

RECRUITMENT AND RETENTION OF NURSES

PROGRESS REPORT

NSW Health

PREPARED BY

Judith Meppem
Chief Nursing Officer
New South Wales

Updated July 2002

INTRODUCTION

The recruitment and retention of nurses continues to have a high priority with the New South Wales (NSW) Government and Department of Health (DOH). This paper provides a summary of the situation to date and an overview/update of the current strategies and activities including some additional information from Area Health Services (AHSs).

An overview of current NSW Key Nursing Recruitment and Retention Initiatives:-

Direct include

- **Nurses Pay Rates**
MOU for salary increases of 4% from 1 January 2003 and 5% from 1 July 2003. In addition to this, the IRC is currently hearing a 'special case' lodged by the NSWNA.
- **Nursing *Re-Connect* strategy**
re connecting nurses 'not working in nursing' with paid nursing employment opportunities and individualised, tailored support.
- **NSW Nursing Scholarships**
 - Postgraduate courses for Registered Nurses
 - First year undergraduate (rural) nursing students
 - Undergraduate "rural clinical placement" grants
 - Aboriginal and Torres Strait Islander u/g and p/g courses
- **Education**
Annual funding of approx \$20m for a range of education initiatives, *including:-*
 - Orientation programs for specialty clinical areas (OPSCA), mental health education and post enrolment programs
 - Funding for NSW College of Nursing education programs
 - Transitional support funding for new graduate nurses and midwives.
- **Mental Health Nursing Initiatives**
\$5m over two years to develop new mental health courses, enhance existing ones and provide scholarships.
- **Nursing Workload, Skill Mix, Staffing Levels & Models of Care Research Ministerial Standing Committee on the Nursing Workforce**
Developing additional strategies to create an environment that is supportive, adaptable and sustainable:
 - Streamlining human resources processes;
 - Investigating clinical coordination roles;
 - Reviewing non clinical work performed by nurses;
 - Transforming workplace culture and;
 - Showcasing nurses with leadership and management skills.
- **Marketing and Promotional Activities**
- **Overseas Recruitment**
- **Aboriginal Nursing Project**
- **Nurse Practitioner Project**

Indirect include

- **Child Care Initiatives**
- **Violence in the Workplace Initiatives**
- **Accommodation Initiatives**

BACKGROUND

Based on the advice from the NSW Nurses Registration Board as at 30th June 2001 there were 92,177 nurses currently registered or enrolled with the Board.

Approximately 40,000 (32,000 full-time equivalents [FTE]) nurses are employed in the NSW Public Health system. Together with nurses employed in the private, community services and aged care sectors nurses are the largest occupational group of the health and community services workforce. We estimate that there may be approximately 15,000 FTE nurses working in the private hospital and nursing homes sector.

Recruitment and retention of nurses continues to be a high priority of the NSW Government as evidenced by the recruitment, retention, educational and promotional strategies currently in place. However, it is also recognised that a number of the current issues impacting on recruitment and retention are 'societal' issues and are not 'nursing workforce' specific. These pressures and the choices nurses make present major challenges for the health system in maintaining a work environment that supports the needs of nurses in today's world.

Examples include:-

4. Nurses like all other workers are now strongly influenced by lifestyle choices and are demanding much more access to part-time shifts to enable them to balance family, study, and the social elements of their lives. This presents significant challenges for the managers of the health system who are required to staff health services over a 24 hour day, seven days per week;
5. The majority of nurses are women, many who leave the workforce for varying periods, to raise children and manage other family responsibilities;
6. The mobility of nursing qualifications (both Interstate and Internationally) which is a central attraction of the career, facilitates travel and the movement in and out of the workforce;
7. The average age of the current nursing workforce is increasing; There is increased 'competition' between many occupations in recruiting school leavers; and
8. Graduates with nursing degrees find their qualifications an excellent stepping-stone to other work opportunities.

All other Australian States are facing similar issues relating to their nursing workforce, as are many international health systems.

Our ongoing challenge is to realistically address the issues so that we can continue to support nurses in their fundamental professional contribution to the health system.

The Department of Health Reporting System (DOHRS) nursing figures for June 2002 highlight that in the public sector, AHSs were "actively recruiting" 1811 FTE positions. At the same time they were using 1911 FTE casual pool staff and 1023 FTE supplementary nursing staff including 643 FTE Agency nurses and 380 overtime FTEs.

This situation fluctuates from time-to-time related to seasonal fluctuations in the availability of staff. The use of casual pool staff also reflects in part, a strategy of managing peaks and troughs of activity, together with meeting the lifestyle needs and individual choices of nurses.

It is important to acknowledge that a significant number of nursing recruitment and retention strategies have been implemented over recent years by the health system. Had these strategies not been progressed, the nursing workforce situation would be even more challenging.

These initiatives have included:-

1. On a broad front, in partnership with the NSW Nurses' Association, there have been a range of initiatives, including but not limited to:-
 - New Nurses Award
 - 10 Hour Night Duty – Phased re-introduction
 - Employer sponsored child care centres
 - Clinical Nurse Specialist (CNS) Review
 - Development of a Safety and Security Policy and Manual
 - Grievance Procedures, Harassment Free Workplace Procedures and Codes of Conduct
 - Enhanced Clinical Nurse Consultant (CNC) Structure
 - Enrolled Nurse (EN) Career Pathway
 - Study Leave Reporting Requirements
 - Nurse Practitioner Salary Classification

2. Through the Office of the Chief Nursing Officer (OCNO), in partnership with the NSW Nurses' Association, nursing organisations, health services and the nursing education sector, a range of activities and strategies have been progressed over the last 10 years. They include but are not limited to:-
 - Nursing *ReConnect* from January 2002
 - Establishment of the NSW Ministerial Standing Committee on Nursing Workforce (MSC). The report of the MSC was released and is available on www.health.nsw.gov.au/nursing. The action plan has been developed to assist other current strategies to create an environment that is supportive, adaptable and sustainable.
 - Research Project to identify the potential pool of registered and enrolled nurses currently not working or working, but not in nursing whom may be interested in returning to nursing.
The report of the research was released by the Minister in December 2000. It was accompanied by the announcement of additional funding for a range of strategies across the State.
 - The development of a range of initiatives to increase the number of indigenous nurses.
 - Research into nursing workload, models of care and skill mix and the impact on patient outcomes is currently being progressed in a range of specialty areas and metropolitan and rural contexts.
 - Mental Health Nursing Initiatives
 - Nurse Practitioner Project

- Enrolled Nurse Review
- Midwifery Taskforce
- Skills Audit and Needs Analysis
- Ministerial Nursing Recruitment and Retention Taskforce (1996)
- NSW Rural and Remote Nursing Summit (1998)
- Specialty Vacancy Research
- New Marketing Material and Theme (Brochures, Videos, etc)
- Ongoing marketing and promotional activities
- Media Campaign and Ministerial tour of NSW
- Establishment of the Peak Nursing Forum
- Consultative Nursing Forums
- Establishment of the Rural and Remote Nursing Council
- Funding for the transitional support of new general and midwifery graduates and for mentor/preceptor programs
- General and Midwifery Refresher Programs (prior to Nursing *ReConnect*) and Skill Updates through the NSW College of Nursing (NSWCN) and NSW Midwives Association (NSWMA)
- Overseas Qualified Nurses (OQN) Assessment Programs
- Distance Education Program Development
- Block Grants to AHSs for local initiatives for registered and enrolled nurses – eg OPSCA, Mental Health and Enrolled Nurse Programs
- NSWCN Contract - for courses in specialty areas for registered and enrolled nurses
- Salary supplementation to AHSs for NSWCN and TAFE courses offered under contract to the DOH
- Review of Mental Health Education
- Management of Nursing Resources Guidelines
- Development of Work Experience Guidelines
- Specialty Workforce Modelling Projects
- Midwifery Think Tank
- Survey of New Midwifery Graduates
- Review of Midwifery Education
- OCNO website
- Support for 'individual nominations' for Overseas Qualified Nurses with appropriate visas, wishing to work in NSW
- Two Professorial Nursing Chairs – Rural and Remote Nursing
- NSW Nursing Scholarship Fund
 - Undergraduate Scholarships for rural students
 - Rural clinical placement grants for undergraduate students
 - Postgraduate Scholarships
 - Aboriginal Scholarships
- Mental Health Think Tank
- Increased nursing representation on departmental committees
- Survey of 670 schools (Career Advisers) to evaluate the impact of the new nursing Marketing and Promotional Material
- Establishment of the NSW Health Nursing Career Advisers Network
- Additional funding for a range of targeted mental health nursing initiatives
- Additional funding for the postgraduate scholarship fund

- The development of new 'nursing work experience' frameworks and student workbooks.

More detailed information on nursing education is attached.**(Attachment One)**

CURRENT SITUATION

Implementation and review of recommendations arising from all of the strategies identified above continues on an ongoing basis. Other initiatives and developments *include*: -

- NSW Health continues to raise with the Commonwealth issues surrounding the nursing workforce, particularly in relation to undergraduate and postgraduate education and national coordination. This lack of coordination has exacerbated the situation, notwithstanding individual 'State' responsibilities in relation to nursing practice, regulation, service delivery contexts and industrial frameworks.

National Coordination is required for all professional and related activities given that there are many stakeholders at both Commonwealth and State levels. For example:- Commonwealth Department of Health Divisions, State Health Departments, Australian Institute of Health and Welfare (AIHW), Department of Education, Training and Youth Affairs (DETYA), Universities, Commonwealth Aged Care, Veteran Affairs and the Private Sector, together with professional organisations (*ANF, RCNA, ANCI, ACCDNS*) and other specialty nursing groups.

NSW strongly supported all of the recommendations of the National Nursing Forum held in September 1999.

- NSW Health contributed to both the Senate Inquiry into Nursing and the National Review of Nursing Education.
- AHSs all continue to facilitate a range of strategies at a local level to increase nursing recruitment and retention. They include:-
 - Local marketing and promotional activities;
 - Establishment of nursing career adviser positions;
 - Work Experience programs for school students;
 - Attendance at Nursing Expos;
 - Local hospital open days;
 - Ongoing education activities for registered and enrolled nurses;
 - Partnerships with the tertiary sector;
 - Establishment of clinical chairs and adjunct appointments with the tertiary sector to enhance nursing;
 - Support of enrolled nurses undertaking the Bachelor of Nursing program;
 - Local scholarships;
 - Support for nurses 're entering' the nursing workforce;
 - Mentoring programs;
 - Website development and internet job advertising;
 - Business sponsorships;

Special winter recruitment strategy;
Innovative rostering systems to maximise flexibility;
A move in many health services toward managing similar clinical areas in clinical streams, resulting in a flatter management structure which enables increased clinical participation in management decisions;
Nursing publications;
New models of clinical care;
Clinical networks and clinical supervision initiatives;
Nursing research; and
New models of education.

- Nurses are integrally involved in the implementation groups associated with the NSW Governments Action Plan for Health.

- Other Divisions in the Department are managing a range of initiatives including:-
 - Access to accommodation for staff and students;
 - Increased Child Care Places;
 - Expanded models of maternity care;
 - Working Relationships:
A joint statement from the Health Department, Labour Council and Unions has been issued to Area Health Services on the need for harmonious working environments and relationships; and
 - The NSW Ministerial Taskforce on Security and Violence in the Workplace has been established and is addressing the areas of concern in the health system.

NURSING EDUCATION

ATTACHMENT ONE

Nursing education in NSW is funded through a number of channels.

Overview of Funding Sources

Exclusions:-

Undergraduate Nursing Education.

On the transfer to the tertiary sector, total funding was transferred from NSW Health to Commonwealth Education. All activities related to undergraduate nursing education should therefore be funded by the universities.

Course costs associated with external continuing education providers other than by contract with the DOH or an AHS.

Formal postgraduate education programs in the tertiary sector are a Commonwealth responsibility.

1. Office of the Chief Nursing Officer (OCNO) Funding

These are over and above AHS recurrent budgets.

1. NSWCN course costs
2. TAFE contract costs
3. AHS – including 14 week TAFE block salaries for Trainee Enrolled Nurses (TEN) and associated TEN program funding, OPSCA, New Graduate Transitional Support Funding, RN/EN/Mental Health grants and salary supplementation for NSWCN courses
4. Nursing *ReConnect*
5. Special Initiatives Grants.

2. Area Health Service Recurrent Budgets

1. TEN salaries
2. Post-registration and enrolment specialty courses funded by AHSs
3. Post-registration and enrolment continuing education funded by AHSs
4. Education staff
5. Study leave
6. Additional costs (by agreement), associated with undergraduate and postgraduate university programs
7. Other programs, including mandatory programs eg. CPR, Fire, Child Protection, etc.

Analysis of some of the educational pathways includes:-

A. FORMAL REFRESHER PROGRAMS

ON HOLD PROTEM - DUE TO NURSING *RECONNECT*

Evaluation of the Nursing *RECONNECT* model will be progressed shortly.

General Registered Nurse Refresher Course

Registered nurse refresher courses, which are funded by the Health Department, are conducted by the NSWCN.

The course is designed to facilitate the re-entry into the nursing workforce of registered nurses who have not worked in nursing for several years. There is no mandatory time limit on when a refresher course must be undertaken.

The format is under continual review to meet the changing needs of the students and the system and also to maximise access and ensure cost-effective use of funds.

There are no course costs for refresher students. Funding from the Department meets the NSWCN course costs and the College's support of the students whilst on clinical placement.

The current format of the registered nurse refresher course has been designed to suit metropolitan and rural students:

Metropolitan format is eight weeks and includes 150 classroom hours over six weeks and 60 hours of clinical experience over two weeks.

Rural format is eight weeks and includes 150 classroom hours over four weeks and 60 hours of clinical experience over four weeks.

The flexibility of the format takes into consideration the distance rural students will travel to undertake the course and the limited clinical facilities available for the clinical experience component.

From July 2000 a new format was introduced which includes a distance education package of three weeks, two x one-week theoretical components and a 60 hour clinical component.

Each year the location of refresher courses is negotiated to ensure a reasonable geographical spread, equity of access and a focus on rural locations where required.

One-off special initiative refresher courses can be negotiated where funds exist and a demand is demonstrated.

A number of AHSs also fund and conduct their own refresher programs as an additional strategy.

Midwifery Refresher Course

The Midwifery Refresher Course conducted by the NSWCN on behalf of the Health Department involves completion of a distance education package, a theoretical component of two weeks and a clinical component of three weeks. The course duration is 12 weeks in total.

The NSW Midwives Association is also funded by NSW Health to run refresher programs and skill updates for registered nurses who are authorised to practice midwifery. The program content varies according to the needs of the student and context of care.

The locations of these courses are negotiated to address the areas of need and to maximise access. In addition, the Commonwealth has provided funding of \$900,000 over a three year period, to provide midwifery skill updates for midwives working in rural and remote NSW.

Enrolled Nurse Refresher Course

Enrolled Nurse Refresher Courses, which are funded by the Department, are conducted by TAFE. This does not preclude AHSs conducting their own programs.

The current format has been in place since January 2001 and is under continual review. It involves completion of a distance education package and a three day face-to-face component.

The course is designed to facilitate the re-entry into the nursing workforce of enrolled nurses who have not worked in nursing for several years. There is no mandatory time limit on when a refresher course must be undertaken. There are no course costs for refresher students. Funding from the Department meets TAFE costs for the face-to-face component and the costs for the distance education package.

The Enrolled Nurse Refresher course is also available in combination with an Enrolled Nurse Conversion Course. This involves completion of a distance education package and an eight day face-to-face component.

Enrolled Nurse Conversion Course

The Enrolled Nurse Conversion Course is designed to upgrade the qualifications of hospital trained enrolled nurses to a Certificate IV qualification.

There are no course costs for employees of the public health sector. Enrolled nurse employed in the private sector wishing to undertake the Conversion Course may do so as 'user pay' students.

B. OVERSEAS QUALIFIED NURSES (OQN) ASSESSMENT PROGRAMS

Pre-registration assessment of OQN is conducted by the NSWCN on behalf of the NSW Health Department to facilitate registration/enrolment of OQN and their entry into the NSW nursing workforce. The format is under constant review to meet the changing needs of both the applicants and the health system.

The OQN program for registered nurses requires completion of a six-week theoretical component and a four-week clinical assessment component. Registered nurses can fast track through the program if they are successful at a challenge assessment. The fast track program then requires a two-week theoretical component and a four-week clinical assessment.

Prior to the current model, OQN could only seek assessment by hospitals, which involved a three-month period of employment. The format was revised to address the difficulty nurses were having in accessing periods of employment for assessment.

The OQN program for enrolled nurses requires completion of a four-week theoretical component and a four-week clinical assessment component.

The OQN program for midwives requires completion of a two-week independent learning package and a four-week clinical assessment component.

C. POSTGRADUATE EDUCATION

To meet the differing needs of both the workforce and the system, there are four primary postgraduate education pathways.

1. Transitional Support for New General and Midwifery Graduates (TSF)

The Department provides funds through the OCNO to facilitate the employment and support of new graduates.

The funding is used by AHSs in a variety of ways ranging from:-
structured programs;
employment of clinical support staff;
use of self-directed learning packages.

This funding has also been provided to the private sector for some years.

2. Orientation Programs for Specialty Clinical Areas (OPSCA)

The Department provides funds through the OCNO to facilitate short skill development programs, as an introduction to a range of specialty areas. AHSs determine their local priorities from year to year.

Mental health and post-enrolment grants are also provided to AHSs for local initiatives.

3. NSW College of Nursing Contract

The Chief Nursing Officer negotiates an annual contract with the NSWCN for the provision of a range of postgraduate certificate courses for registered nurses and specialty continuing education programs for enrolled nurses.

This is based on a formal needs analysis conducted by the College, feedback from their students and staff and input from professional nursing organisations as well as from OCNO.

Salary supplementation for student's attendance is automatically provided to AHSs, on receipt of attendance lists from the College. The College also provides for additional private sector participation in these courses on a 'user pays' basis.

The course format, modes of delivery and geographical spread are under constant review. More and more courses are being provided in a combination of distance education and face-to-face modes, to take account of rural needs. Increasing numbers of courses are also being moved 'off campus' into country NSW. The College is also planning to move to 'video conferencing' delivery mode to improve access for rural and remote nurses.

The College has also made significant progress in having their programs recognised for articulation to the tertiary sector, by the process of recognition of prior learning.

The latest advice from the College indicates that they have written agreements with 15 universities (currently 6 in NSW) relating to credit transfer policies. Students undertaking courses through the College can gain credit points ranging from 'by individual assessment' to 'credit of one year' into a Masters program. Negotiations continue with the remaining NSW universities.

4. University (Specialty) Postgraduate Programs

The move of undergraduate nursing education into the tertiary sector has also seen the parallel move of postgraduate nursing education into the tertiary sector. There has been a growth of programs at graduate diploma, masters and more recently doctoral level.

AHSs continue to develop a range of different partnerships with universities to address specific local issues. One example of this is the programs that provide a graduate certificate exit point at the end of one year with the potential for students to continue on to graduate diploma and masters programs.

The increasing number of 'joint appointments' for nursing staff between AHSs and universities and recognition of prior learning (RPL) are enhancing postgraduate education opportunities for nurses.

Access to clinically relevant specialty programs continues to be a significant challenge for registered nurses. This is due to many factors including fees, release

from work whilst ensuring maintenance of the service, length of some of the programs and the quantum numbers wishing to access the different programs.

NSW Health has particular concerns in relation to midwifery programs. A midwifery qualification is a pre-requisite for an authority to practice midwifery under legislation in all States of Australia. In that context it is not an 'add on' qualification.

All of our midwifery programs have been transferred to the tertiary sector and it is critical that DETYA sponsored places for midwifery programs are maintained in order to meet our workforce needs. Universities are having some difficulties in recruiting and retaining sufficient students in the midwifery programs. Advice from the nursing faculties is that this is in part related to fees payable for the programs, given they are classified as postgraduate study.

It would appear that universities are moving to 'full fee paying' status for midwifery and other specialty courses.

Recognition and action by the Commonwealth is required to maintain HECS places in specialty nursing programs. The State Government continues to raise with the Commonwealth, issues surrounding both undergraduate and postgraduate education.

A report to the Australian Health Ministers Advisory Committee (AHMAC) in February 1996 identified a number of recommendations of the National Nursing Education Review (1994 and beyond) that had not been implemented.

NSW Health welcomes both the Senate Inquiry into Nursing and the National Review of Nursing Education.

5. Area Health Service Initiatives

There are also a multitude of educational strategies in place at local AHS level.

Examples include:-

- Preceptor and mentoring programs;
- Registered nurse and enrolled nurse specialty skill development programs;
- Mental health programs;
- Local refresher programs both structured and individually tailored;
- Continuing education programs;
- Programs in partnership with the tertiary sector; and
- Programs in partnership with the NSWCN.