Department of Jobs, Skills, Industry and Regions

Maternal Child Health Workforce Project

Final report

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WESTERN Metropolitan Partnership

VICTORIA State Government

HealthConsult Better thinking Better advice

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Abbreviations

ABS	Australian Bureau of Statistics
ANMF	Australian Nursing and Midwifery Federation
ARIA	Accessibility/Remoteness Index of Australia
CALD	Culturally and linguistically diverse
DJSIR	Department of Jobs, Skills, Industry and Regions
EMCH	Enhanced Maternal and Child Health
EPC	Early Parenting Centre
FTB	Family Tax Benefit
FTE	Full-time equivalent
GP	General Practitioners
IRSD	Index of Relative Socioeconomic Disadvantage
KAS	Key age and stages
LGA	Local Government Areas
MAV	Municipal Association of Victoria
MCH	Maternal and child health
MCHN	Maternal and Child Health Nurse
MoU	Memorandum of understanding
NWMPHN	North-Western Melbourne Primary Health Network
OT	Occupational Therapist
RM	Registered Midwife
RN	Registered Nurse
SCV	Safer Care Victoria
SEIFA	Socioeconomic Indexes for Areas
UMCH	Universal Maternal and Child Health
VMCHNS	Victorian Maternal and Child Health Nurse Student
VU	Victoria University
WMP	Western Metropolitan Partnership
WMR	Western Metropolitan Region

Executive Summary

On 27 October 2022, the Department of Jobs, Skills, Industry and Regions engaged HealthConsult under the Metropolitan Partnerships Development Fund to:

"deliver region wide research and develop a strategy to advance the Western Metropolitan Partnership (WMP) priorities and provide advice to government."

The Western Metropolitan Region (WMR) includes the six Local Government Areas (LGAs) of Brimbank, Hobsons Bay, Maribyrnong, Melton, Moonee Valley and Wyndham.

This report presents key findings from the research conducted over the course of the project, a survey of the WMR maternal and child health (MCH) workforce, and stakeholder consultations. It provides recommendations on short, medium, and long-term strategies to address key issues that are impacting the region's MCH workforce.

Key issues driving the project

MCH services, including those in metropolitan Melbourne and some regional areas, are experiencing significant workforce pressures and shortages, combined with increased service demand from a rapidly growing population in some LGAs.

There are reported high levels of some risk factors in children in the WMR, which includes the LGAs of Brimbank, Hobsons Bay, Maribyrnong, Melton, Moonee Valley and Wyndham). These risk factors include obesity, low fruit intake and low breastfeeding rates. Population growth areas generally reported a higher incidence of these factors than other areas in the North-Western Melbourne Primary Health Network.[1]

Higher proportions of children in Brimbank (15.7%), Melton (13.5%) and Wyndham (11.5%) were also identified in the Australian Early Development Census as being developmentally vulnerable in two or more of the domains of physical, educational, and emotional wellbeing in 2021.[2]

The region is also diverse. In many suburbs (particularly in the LGAs of Wyndham, Brimbank and Maribyrnong), more than 50% of the population was born overseas.

This rapid population growth, combined with cultural diversity has placed pressure on the MCH workforce, which is experiencing state wide shortages. However, these shortages are felt more acutely in some WMR LGAs than others. For example, MCH services in Wyndham and Melton are only being delivered to priority populations due to workforce shortages. A sustainable workforce with skills and capabilities aligned with local needs is required to meet these challenges.

Key findings

The nursing and midwifery workforce at a national level is experiencing changes that are impacting services at the local level. Key changes at a national level that are influencing trends and developments in the region include:[3]

- an overall contraction in the midwifery workforce since 2015. The contraction is largely attributable to nurses that were working in non-clinical roles

[1] North Western Melbourne Primary Health Network (2018). 'PHN Needs Assessment Reporting', accessed from https://nwmphn.org.au/wp-content/uploads/2020/11/NWMPHN-Health-Needs-Assessment-2018.pdf
[2] Australian Early Development Census (2021). Children vulnerable on two or more domains, by LGA, accessed from https://www.aedc.gov.au/resources/detail/public-table-by-local-government-area-(lga)-2009-2021
[3] Australian Government Department of Health and Aged Care. Nursing and Midwifery Dashboards. Available from: https://hwd.health.gov.au/nrmw-dashboards/index.html

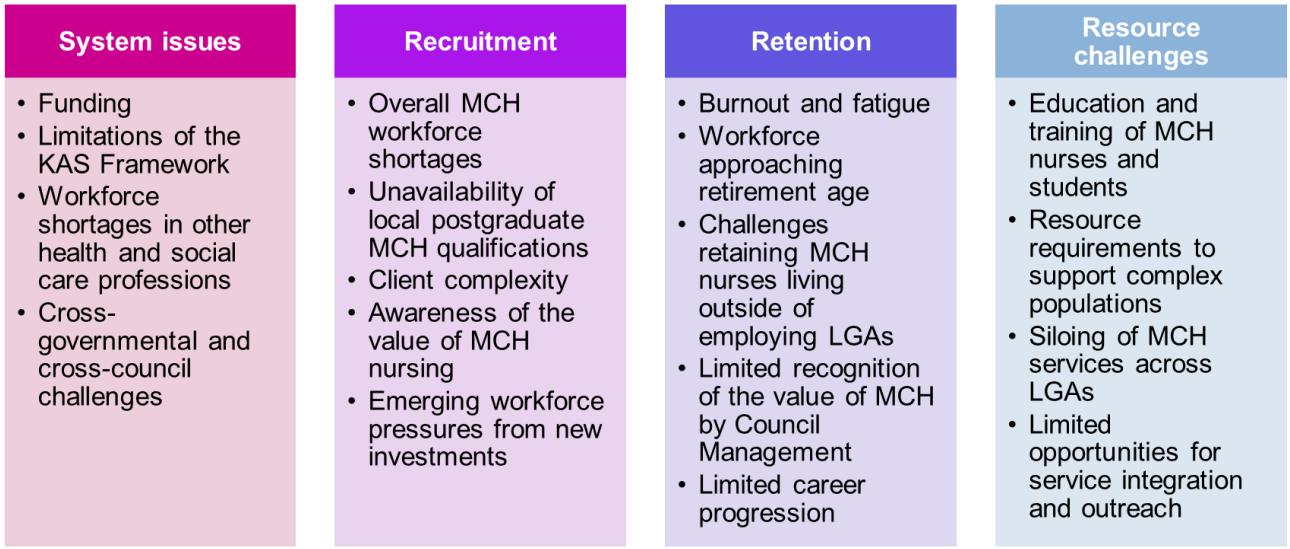
- high rates of part-time work, with 20.54 average weekly hours worked for midwives in 2021
- significant changes in the age profile of the workforce, with substantial growth in midwives aged under 40 (+37%) and a sizeable contraction in midwives aged 40 to 59 (-23%) since 2015.

MCH services in the region vary in their structure across different LGAs. Key differences include:

- Melton and Wyndham have the lowest employed number of full-time equivalent (FTE) MCH nurses per 100,000 people aged 0-4 across the region.
- overall, 17% of MCH FTE positions are currently vacant across the region, which is an increase from 13% as at 30 June 2022. This result is significantly influenced by Melton, where 59% of roles were vacant
- Maribyrnong (44%) and Hobsons Bay (26%) have higher proportions of their workforce aged 60 or above than the average across the WMR (20%). These staff may be more likely to retire in the next five to ten years
- on average, MCH nurses in Brimbank (0.86 FTE per 1.0 staff headcount), Melton (0.72) and Wyndham (0.71) work a higher fractional FTE than MCH nurses across the WMR overall (0.67)
- the region's MCH workforce is far less culturally and linguistically diverse than the region's population.

There are many challenges that are impacting the sustainability and growth of MCH services in the region. Broadly, these issues can be categorised into four groups. Specific issues within each group are summarised in Figure 1.

Figure 1: Summary of key challenges impacting WMR MCH services



Although MCH services are delivered locally, they operate within a policy framework, funding model and service delivery Framework that is set and managed by the Victorian State Government, in partnership with the Municipal Association of Victoria (MAV) on behalf of local governments. This includes Universal and Enhanced MCH Programs and activities therein, including the Key Ages and Stages (KAS) Framework. The delivery of MCH services across Victoria is thus inextricably linked to the policy and frameworks set at the system (state) level. These system level factors are difficult for LGAs to influence.

Several system level factors were consistently highlighted throughout stakeholder consultations as being significant challenges to the effective delivery of MCH services.

Challenges related to funding for MCH services and the KAS Framework were consistently reported as system level factors that are placing pressure on MCH services in the region.

Challenges recruiting MCH nurses impact the available resources in the region and hence the ability to meet the needs of its growing population. Overall MCH workforce shortages represent the most significant challenge to recruitment, but are also influenced by issues such as:

- unavailability of universities offering postgraduate MCH qualifications within or near to the WMR, and limited opportunity to undertake postgraduate MCH qualifications remotely
- complexity of the population in some areas of the region
- low awareness of the value of MCH nurses in the community, and within Councils.

Even where MCH nurses can be recruited to work in the region, there are significant challenges in retaining them. The MCH workforce survey conducted during this project revealed a wide range of challenges that are impacting retention of MCH nurses. Over 40% of survey respondents intend to exit the workforce in the next five years in Hobsons Bay and Moonee Valley. Key issues impacting MCH workforce retention include:

- high levels of burnout and fatigue, which are influenced by both workforce shortages and the rigidity of the KAS Framework
- approximately 20% of MCH nurses across the region at, or approaching retirement age (aged 60+). An ageing MCH workforce is most prevalent in Maribyrnong (44%) and Hobsons Bay (26%). This is a likely contributor to the reported high intention to exit rates
- challenges retaining MCH nurses that live outside of the LGA they work in. 60% of respondents to the MCH survey indicated that they travel from outside their employment LGA to work. Travel requirements are particularly significant for Melton and Brimbank, where only 23% and 25% of the workforce live locally. MCH nurses in Melton and Wyndham also travel substantially further to work on average (52km and 49km) than those working in other LGAs across the region. This impacts retention because where MCH positions become available closer to home, nurses usually take them
- limited recognition of the value of MCH nursing among the community and local Councils. The workforce expressed a widespread view that their skills are not valued by Councils, are not well-supported by management and that they do not feel like they have a ‘voice’
- limited career progression opportunities.

Financial and recruitment constraints were consistently highlighted during consultations as creating resourcing challenges for Councils and MCH services. Resourcing challenges may impact the ability to implement the improvements to MCH services that are recommended in this report if they are not addressed. Key resourcing constraints relate to:

- provision of education and training for new MCH students, graduates and early career workers entering the profession. Educator and preceptor roles are funded by Councils, which can create challenges in achieving the required expansion of MCH positions to meet demand. Provision of education and training may be further impacted by retirement of more experienced MCH nurses
- population complexity, which was cited as a driver of increased time and resource needs where there are a higher proportion of culturally and linguistically diverse (CALD) communities and families that are experiencing social issues such as domestic and family violence. Both the available data and stakeholder consultations confirmed that these issues are more pronounced in LGAs such as Brimbank, Melton, Wyndham, and Maribyrnong
- challenges sharing resources across LGAs to alleviate workforce pressures as a result of high levels of industrial and administrative requirements
- limited opportunities to provide integrated care and outreach services.

Opportunities to improve MCH services in the western metropolitan region

The findings set out in this report highlight a range of issues that are relevant to the development and evaluation of opportunities to improve the sustainability of MCH services across the catchment. Key issues included that:

- **there are substantial challenges facing the MCH workforce in the region**. Broadly, these issues relate to the system in which MCH services operate and challenges to MCH workforce recruitment, retention and resourcing
- **significant work has previously been undertaken** to explore potential solutions at the state and local levels
- **many initiatives have been trialled, but few have been successful** in making a significant impact on MCH services
- **meaningful changes are most likely to be made if there is a commitment by both state and local governments to addressing the key challenges** across both the system level and local levels
- **a mix of region-wide and place-based approaches are likely to be required**. The challenges facing the MCH workforce vary across the region. The impacts of issues are more challenging for some LGAs than others.

For these reasons, the process to develop new (i.e., not been previously trialled) opportunities that can positively impact MCH services was challenging.

11 opportunities were identified as being potentially feasible based on the research and consultations undertaken over the course of the project. The feasibility and impact of these opportunities were rated to identify recommendations that are likely to be implementable and effective in improving MCH services in the region.

Recommendations

This report provides three directions (and within them, seven recommendations) to guide planning and action to improve the sustainability of MCH services in the region (Figure 2).

Figure 2: Proposed directions and recommendations (bullet points) to improve MCH services in the western metropolitan region

High impact recommendations that should be pursued as a priority include:

- **establishing a new postgraduate MCH qualification in a university located in the west** to increase the supply of MCH nurses. Discussions with Victoria University (VU) identified an appetite and capacity to establish a new MCH qualification in the region, subject to a successful business case
- **formalising two WMR-wide MCH networks to deliver workforce planning, networking, and advocacy for MCH services in the region**. Once established, these networks could act as a key enabler for implementation of several recommendations made in this report, and ongoing planning, advocacy, and oversight of workforce development initiatives
- **developing a region-wide position and evidence base to advocate for change** in the MCH funding model and review of the KAS Framework, which were both highlighted as being significant constraints on the capacity of both MCH services and MCH nurses.

Many of the recommendations made in this report will require coordinated planning and involvement across WMR Councils. However, their implementation has the potential to address the significant challenges that are facing MCH services across the region.

Additionally, it is possible that the findings and recommendations set out in this report could apply to other regions across Victoria**. The WMP could play a role in assisting other partners to trial/pilot successful initiatives for broader application in other, comparable LGAs.**

1. Introduction

This section presents the context underpinning the project including relevant policies, characteristics of the WMR and key issues. This section also sets out the structure and contents of this report.

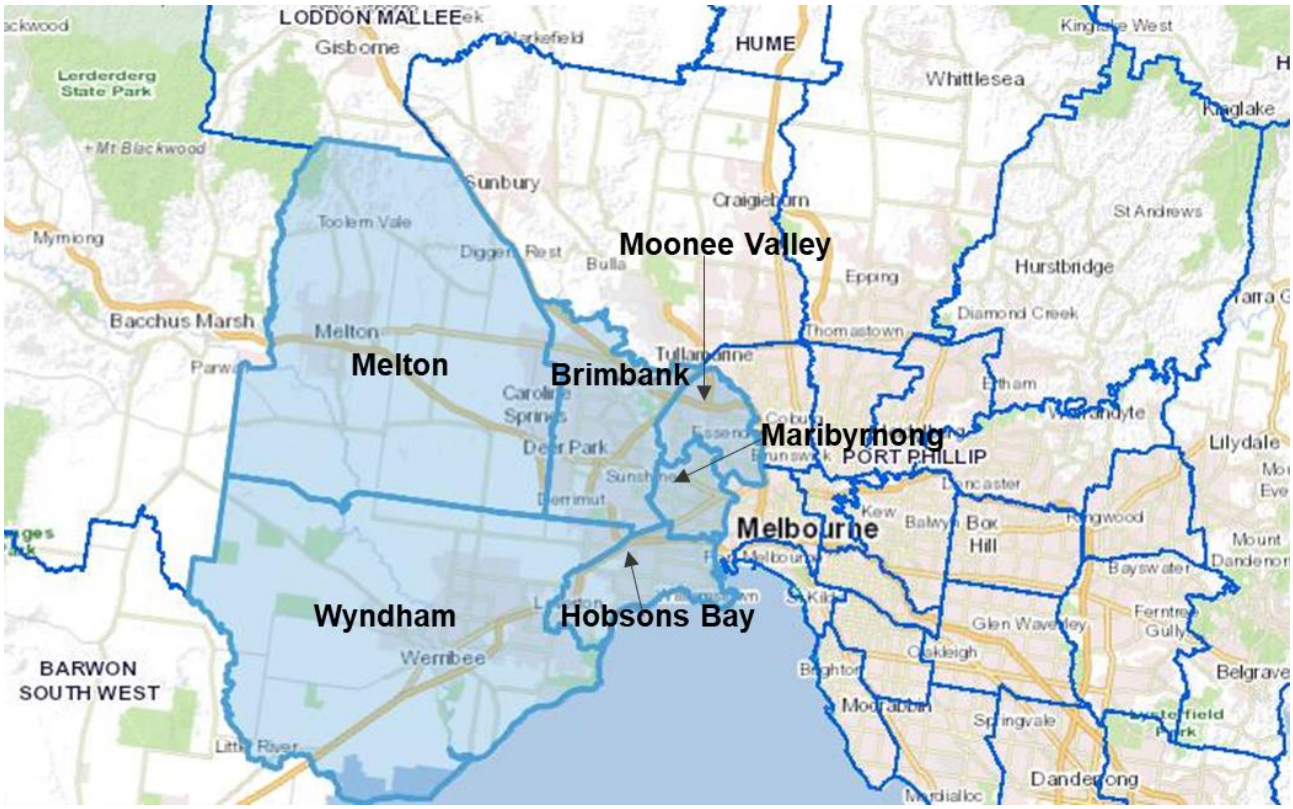
1.1. Context

The Metropolitan Partnerships are the Victorian State Government's preeminent platform for community engagement. Six Metropolitan Partnerships were established in 2017 to engage their communities, advise government on community regional and local priorities and drive local action.

The WMR includes the Brimbank, Hobsons Bay, Maribyrnong, Melton, Moonee Valley and Wyndham LGAs (which are shaded light blue in Figure 1).

MCH services, including those in metropolitan Melbourne and some regional areas, are experiencing significant workforce pressures and shortages, combined with increased service demand. These issues are exacerbated in the WMR, where many LGAs have experienced substantial population growth in recent years, which is expected to continue.

Figure 3: Map of the WMR (shaded blue)



Source: Adapted from Mapshare Victoria

Analysis of population health data and reports demonstrates that:

- **there are reported high levels of some risk factors in children in the WMR,** including obesity, low fruit intake and low breastfeeding rates. Growth areas generally reported a higher incidence of these factors [4]
- **higher proportions of children in Brimbank (15.7%), Melton (13.5%) and Wyndham (11.5%) were developmentally vulnerable** in two or more of the domains of physical, educational, and emotional wellbeing in 2021[5]

Additionally, the WMR is highly diverse. In many suburbs (particularly in the LGAs of Wyndham, Brimbank and Maribyrnong), more than 50% of the population was born overseas. A sustainable MCH workforce with the skills and capabilities aligned with local needs is required to meet these challenges.

1.2. Why MCH services are important

MCH is an important public health issue, because:

- **optimising child, maternal and family health, wellbeing, safety, development and learning has lifelong benefits** to children's health, educational and social outcomes. This is particularly so for children with additional needs.[6]
- **MCH services can help to ensure the ongoing health and wellbeing of infants, children and families**, including giving information, support and advice on parenting, sleeping, feeding, behavioural problems, safety, immunisation and nutrition.[7] They also monitor child growth and development in a child's early years through a series of scheduled one-on-one appointments. This investment in preventative health care during the early years can last a lifetime.
- **MCH nurses can organise additional activities** such as home visits if required, based on family needs.
- **MCH nurses can organise parent groups** to ensure community engagement and support, as well as assist with contacting other local support services and specialist services if required.

MCH nurses play a key role in both the prevention, early intervention and referral to appropriate services to support early childhood health and development. In doing so, they play a key role in the broader health and social service system by providing linkages with other professionals such as (but not limited to) General Practitioners (GPs), medical specialists, allied health professionals, family violence support services, Indigenous organisations, early childhood services and child protection services.

1.3. How MCH services operate in Victoria

In Victoria, MCH is a free universal primary health service for all Victorian families with children from birth to school age. MCH services are provided as a partnership between state and local governments (represented by the MAV),to promote and optimise health, wellbeing, safety, development and learning outcomes for children and their families.

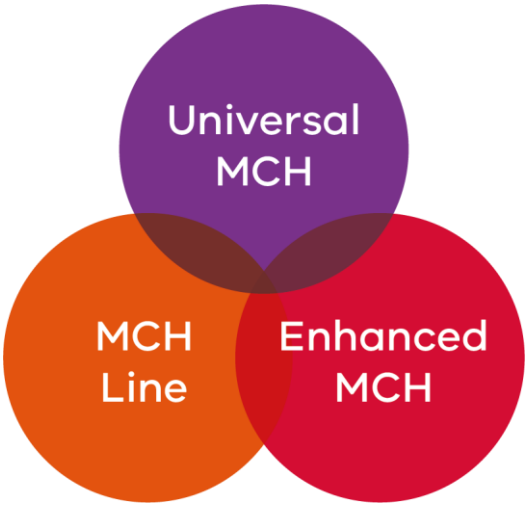
Although MCH services are delivered under the governance of the State Government in partnership with MAV, local Councils are responsible for the delivery and monitoring of the Universal Maternal Child Health (UMCH) and Enhanced Maternal Child Health (EMCH) programs.

[4] North Western Melbourne Primary Health Network (2018). 'PHN Needs Assessment Reporting', accessed from https://nwmphn.org.au/wp-content/uploads/2020/11/NWMPHN-Health-Needs-Assessment-2018.pdf
[5] Australian Early Development Census (2021). Children vulnerable on two or more domains, by LGA, accessed from https://www.aedc.gov.au/resources/detail/public-table-by-local-government-area-(lga)-2009-2021
[6] ibid.
[7] Better Health Channel. Maternal and Child Health Services. Available from: https://www.betterhealth.vic.gov.au/health/HealthyLiving/maternal-and-child-health-services#maternal-and-child-health-centres-throughout-victoria

Councils directly employ the MCH workforce, including nurses and other health and early years professionals. The workforce operates under the control of the Council or contracted provider.

There are three components to the Victorian MCH service, which are conceptualised in Figure 4.[8]

Figure 4: Components of the Victorian MCH service



Source: Victorian MCH Service guidelines

UMCH supports children, mothers, fathers, carers and families with an emphasis on health promotion, prevention, parenting, developmental assessment, early detection and referral and social support. It also provides a platform for identifying children and families who require further assessment, intervention, referral and support and brings families together to foster social networks and strengthens community connections though the flexible service capacity. The program has contact with all Victorian children from birth to school age, through ten key age and stages (KAS) consultations as well as a flexible service capacity.

EMCH responds assertively to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. This service is provided in addition to the components offered through the UMCH program. It provides a more intensive level of support, including short-term case coordination or management in some circumstances.

The MCH Line is a 24-hour telephone service supporting Victorian families with health and parenting concerns for children from birth to school age, staffed by MCH nurses. The MCH Line links families to the UMCH and EMCH programs and offers assisted referrals to a range of health and family support services, including emergency services. The MCH Line responds to the immediate concerns of callers using evidence-informed practice by providing quality guidance, information, support and counselling. The MCH Line is staffed by MCH nurses employed by the department.

1.3.1. Key Ages and Stages Framework

The KAS Framework was revised in 2009 and outlines evidence-based activities for each of the ten age and stage visits to MCH nurses. The KAS consultations are a schedule of contacts for all children and their families from birth to school age. They include an initial home visit, and consultations at two, four and eight weeks, and four, eight, 12 and 18 months, and at two and three and a half years of age. The ten KAS visits and key topics covered during each visit are outlined in Table 1.

[8] Victorian Department of Health (2021). 'Maternal and Child Health Service guidelines', Melbourne.

Table 1: KAS visits

KAS visit	Health and development monitoring	Intervention	Promotion of health and development
Home visit	Family health and wellbeing Pregnancy, birth, family history of smoking	QUIT intervention and referral Respond to assessments	Breastfeeding Immunisation SIDS: view infant sleep arrangements Safe Sleeping Checklist
Two weeks	Family health and wellbeing Full physical assessment (includes a developmental review of hearing risk factors)	Respond to assessments	Car restraints Communication, language and play Injury prevention - Kidsafe
Four weeks	Family health and wellbeing maternal health and wellbeing check hips Weight, length, head circumference	Family violence safety plan respond to Assessments Post natal depression	Breastfeeding Immunisation Women's health
Eight weeks	Family health and wellbeing Full physical assessment (includes developmental review)	Respond to assessments	Immunisation SIDS risk factors
Four months	Family health and wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight	Respond to assessments	Communication, language and play Food in first year of life Playgroup Young Readers
Eight months	Family health and wellbeing Full physical assessment Oral health Developmental assessment (PEDS/Brigance) Hearing risk factors Infant sleeping	Sleep intervention Respond to assessments	Communication, language and play Injury prevention – Kidsafe Poison information Sunsmart Tooth tips
12 months	Family health and wellbeing Developmental assessment (PEDS/Brigance) Weight and height, gait	Promote a healthy weight Respond to assessments	Communication, language and play Healthy eating for young toddlers Immunisation
18 months	Family health and wellbeing Developmental assessment (PEDS/Brigance) Oral health Weight, height, gait	Teeth cleaning Respond to assessments	Communication, language and play Injury prevention – Kidsafe Tooth tips

KAS visit	Health and development monitoring	Intervention	Promotion of health and development
Two years	Family health and wellbeing Developmental assessment (PEDS/Brigance) Weight, height, gait	Promote a healthy weight Respond to assessments	Communication, language and play Kindergarten enrolment Young readers
Three – five years	Family Health and Wellbeing Developmental Assessment (PEDS/Brigance) Vision (MIST) Oral health Weight and height, gait	Promote a Healthy BMI Respond to assessments	Communication, language and play Healthy eating and play for Kindergarten Immunisation Injury prevention – Kidsafe

Source: Victorian MCH Service Guidelines

1.3.2. Funding arrangements for MCH

Different funding arrangements apply to different components of the MCH Program:

- **the UMCH program is funded jointly by the department and local government** via a Memorandum of understanding (MoU), which provides for program costs to be shared equally between state and local governments.[9] UMCH funding includes:
  - funding for KAS consultations, which is determined based on the total number of children that are eligible to receive these services (i.e. children aged 0 to - both enrolled and not enrolled).[10] KAS consultations have agreed time allocations for funding purposes.
  - A flexible funding component, which is based on three hours of service for 40 per cent of children 0-1 year of age and three hours of service for 40 per cent of the average number of children in each age in the 0–6 year age group. The flexible component equates to approximately 25–30 per cent of service activity
    - an additional weighting formula to the UMCH program funding using the Accessibility/Remoteness Index of Australia (ARIA) and the number of maximum Family Tax Benefit (FTB) recipients with a child aged 0–6 years. This additional weighting reflects the increased cost of service delivery in rural settings and the additional resources required in areas of socioeconomic disadvantage and high need.
- **the EMCH program is fully funded by the department**. Funding for this service is population-based, and calculated on the number of Family Tax Benefit recipients in the local government area and rurality using the ARIA.[11] The EMCH program has been expanded over a three-year period from 2018–19 to provide an average of 20 hours of direct or indirect service delivery per family in metropolitan areas. In regional and rural areas the program is funded for an average 22.67 hours per family in recognition that delivery of services in rural areas takes longer.
- **The MCH Line** is fully funded by the Department.

Since 2017-18 and 2018-19 the department have fully funded additional family violence consultations for approximately 15% based on enrolment numbers of 0-12 month olds and the

[9] Victorian Department of Health. (2021). Maternal and Child Health Service guidelines

[11] Victorian Department of Health. (2021). Maternal and Child Health Service guidelines

sleep and settling initiative, which provides additional information sessions and outreach consultations to support the Sleep and Settling Model of Care.

1.3.3. Legislated educational requirements for MCH nurses

There are different educational requirements to become a MCH nurse in different jurisdictions across Australia. **Victoria is the only jurisdiction to legislate a requirement for MCH nurses to be registered as both a nurse (Division 1) and midwife, and to hold a postgraduate qualification in MCH nursing**.[12] This 'triple qualification' requirement has recently been enshrined as a requirement in legislation through an amendment to the *Child Wellbeing and Safety Act 2005.*

The legislated education and training requirements for Victorian MCH nurses aim to ensure a rich understanding of the risk factors for mothers, child health, wellbeing and development. Enshrining high levels of MCH qualification requirements in legislation supports MCH nurses to know how to intervene early when families are experiencing vulnerability and how to engage with the multiple services of support for these families.[13] It also means that **only triple qualified MCH nurses can be employed as nurses in the MCH service**.

1.4. National context

It is important to note that **significant changes to both the nursing midwifery workforces have occurred in recent years at a national level, and these changes are at least in part reflected in the challenges faced by the region's MCH workforce today**. These include that:[14]

- **there is a national shortage of nurses, which is expected to continue**.[15] The shortage is creating other downstream impacts such as burnout, fatigue and difficulties managing workload. A National Nursing Workforce Strategy[16] is currently under development by the Australian Government to better support the nursing workforce.
- **significant challenges retaining nurses in the profession**. The McKinsey 2021 Future of Work in Nursing Survey found that one-fifth of Australia's registered nurses say they intend to leave their current role in the next 12 months.[17] Given that MCH nurses need to be dual-qualified, this, along with the existing shortages described above, are also likely to impact the 'pipeline' of potential MCH nurse candidates
- **there has been an overall contraction in the Australian midwifery** workforce of approximately 3% between 2015 and 2021.
  - this contraction appears to be driven by a 40% decline in midwives in non-clinical roles, from 4,525 in 2015 to 2,708 in 2021; this decline is apparent across all age ranges
  - the number of midwives employed in clinical roles has increased by around 3.3% since 2015 compared to the overall population growth of almost 8% in the same period.
- **most midwives work part-time**. In 2019-20, 55% worked less than 35 hours per week. Average weekly hours worked in 2021 were 20.54, which represents a small increase since 2015 (19.14 hours)

[12] On the record. Health Minister supports triple MCH qualification. 2019 July. Available from: https://otr.anmfvic.asn.au/articles/health-minister-supports-triple-mch-qualification
[13] On the record. MCH qualifications protected in law. 2020 November. Available from: https://otr.anmfvic.asn.au/articles/mch-qualifications-protected-in-law
[14] Australian Government Department of Health and Aged Care. Nursing and Midwifery Dashboards. Available from: https://hwd.health.gov.au/nrmw-dashboards/index.html
[15] Victoria University (2022). 'Understanding the nursing shortage in Australia', accessed from https://online.vu.edu.au/blog/understanding-nursing-shortage-australia
[16] Australian Government Department of Health (2023). 'A national nursing workforce strategy for Australia', accessed from https://www.health.gov.au/news/a-national-nursing-workforce-strategy-for-australia
[17] McKinsey and Company (2022). 'Should I stay, or should I go? Australia's nurse retention dilemma', accessed from https://www.mckinsey.com/industries/healthcare/our-insights/should-i-stay-or-should-i-go-australias-nurse-retention-dilemma

- **most midwives (81%) are dual qualified** (in both nursing and midwifery), which increases flexibility and potential for mobility across the health sector
- **the age profile of the midwifery workforce has changed significantly since 2015.** There has been significant growth in midwives aged under 40 (+37%), but a significant contraction in midwives aged between 40 to 59 (-23%). This change is likely to create future challenges in recruiting and retaining the workforce and supporting professional education and training.

Recent publications and reports suggest that the nursing and midwifery workforces in Australia is facing multiple challenges to their future sustainability, which are summarised in Figure 5. These challenges include inadequate data for workforce planning, a predominantly part-time workforce and adverse impacts associated with factors such as burnout, mental health issues, the effects of the COVID-19 pandemic, job dissatisfaction, and poor workforce culture. All these factors are likely to impact retention of experienced nurses and midwives, which will have a flow-on impact for MCH nurses.

Figure 5: Key challenges influencing the Australian midwifery workforce

There is increasing evidence that there are inadequate numbers of midwives to support the maternity care sector in Australia, with significant problems with retention and equitable distribution of midwives across rural, regional, and metropolitan areas.[18,19]

Recent data suggests a shortfall of nurses and midwives across Australia, relative to demand. In 2021, a Victorian state wide survey of midwives and midwifery managers was conducted to investigate midwifery workforce challenges (the FUCHSIA study, conducted by La Trobe University). Three-quarters of managers reported their maternity service was inadequately staffed with midwives, with a combined deficit of 135 FTE positions among respondents[20], therefore it is likely the actual deficit is much higher.

Further complicating workforce planning is the predominately part-time nature of the midwifery workforce. In 2019, nationally collected data showed that midwives worked on average 20 hours per week.[21]

[18] Harvie K, Sidebotham M, Fenwick J. Australian midwives' intentions to leave the profession and the reasons why. *Women Birth* 2019; **32**(6): e584-e93
[19] Department of Health. Australia's Future Health Workforce Report - Midwives, Appendix B. 2019.
[20] Matthews RF, D.; Hyde, R.; McLachlan, H.; Newton, M.; Mumford, S.; Shafiei, T Llewellyn, F.; Cullinane, M.; Cooklin, A. FUCHSIA Future proofing the midwifery workforce in Victoria: A state-wide cross-sectional study exploring health, well-being and sustainability. Melbourne: La Trobe University, 2022.
[21] Department of Health. 2019, Midwives. 2019.

In Australia, until recently, midwifery has been an ageing workforce, with the average age of a midwife being 47 years.[22] As a result, a significant decline of midwives was predicted in Australia between 2018 and 2023 due to the imminent retirement of older workers.[23] A significant decline in midwives aged between 40 to 59 occurred from 2015 to 2021, where this component of the workforce reduced by 23%. However, over the same period there was a 37% increase in the number of midwives aged under 40. Given that the MCH workforce is almost entirely female – and given that women predominately assume primary care roles for young children, it may be more economical for some MCH Nurses to work less hours than to pay for childcare. This is particularly relevant for MCH Nurses aged under 40.

This **recent data suggests the midwifery workforce is unevenly distributed across age ranges and is skewed towards more of midwives who are in an early phase of their career**. Victorian data[24] reports that 51% of midwives are 10 years or less post qualification, which can translate to concerns about skill mix (i.e., balance of experienced and non-experienced midwives) for both midwifery managers and midwives and subsequently, concerns about quality of care.[25]

There is growing evidence on nurse and midwife intentions to leave the profession. A national study of midwives published in 2019 found 43% were considering leaving the profession in the next six months,[26] while a longitudinal cohort study found that one in five had left the profession within five years of graduating.[27] As mentioned above, one-fifth of Australia's registered nurses say they intend to leave their current role in the next 12 months. **Dissatisfaction with nursing and midwifery roles is reported to be a major factor in intention to leave the profession**.[28,29]

1.5. Project aims and objectives

The purpose of this project is to support the WMR to act on local priorities and inform their advice to government.

The key objectives of the project are to:

(1) **Start the conversation with Western local Councils and other relevant stakeholders** about the issues facing the MCH workforce in Melbourne's west

(2) **Articulate what the MCH workforce profile can look like in the west** to meet local needs

(3) **Provide a basis for planning and coordination** by identifying how MCH workforce capacity can be better supported in the west to meet these needs

(4) **Focus action on targeted initiatives that will make a positive impact** on the level and mix of the MCH workforce in the WMR, and potentially, the operating model for MCH services across the catchment.

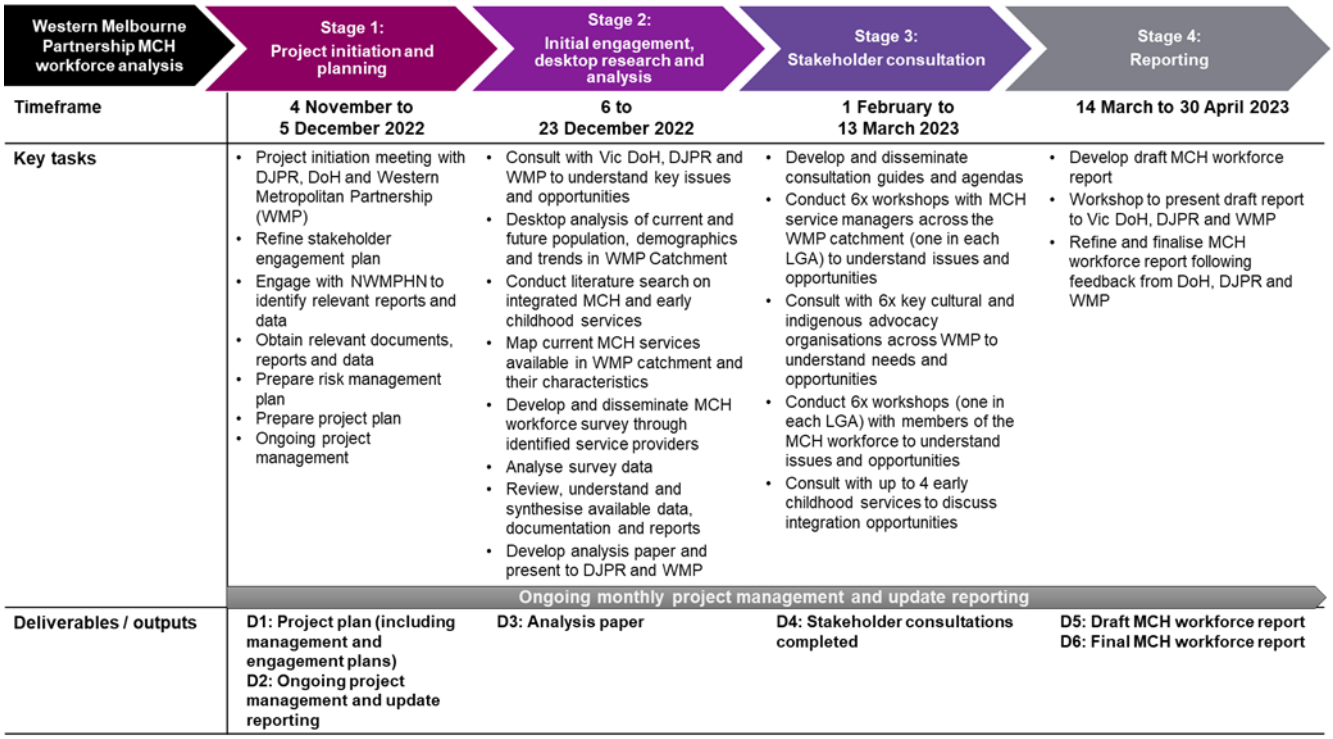
1.6. Project methodology

Figure 6 shows that the project occurred over four stages and was completed in April 2023.

The development of this report has been informed by desktop research, the development of an analysis paper, the workforce survey, stakeholder consultations and various Working Group meetings.

[22] Department of Health and Aged Care. National Health Workforce Dataset (NHWDS) Nurses and Midwives 2016-2021. 2021.
[23] Callander E, Sidebotham M, Lindsay D, Gamble J. The future of the Australian midwifery workforce - impacts of ageing and workforce exit on the number of registered midwives. *Women Birth* 2021; **34**(1): 56-60
[24] Department of Health and Aged Care. National Health Workforce Dataset (NHWDS) Nurses and Midwives 2016-2021. 2021.
[25] Births, Australia, 2021 | Australian Bureau of Statistics (abs.gov.au)
[26] Harvie K, Sidebotham M, Fenwick J. Australian midwives' intentions to leave the profession and the reasons why. *Women Birth* 2019; **32**(6): e584-e93
[27] Sheehy A, Smith RM, Gray JE, Homer CSE. Midwifery pre-registration education and mid-career workforce participation and experiences. Women Birth 2019; 32(2): e182-e8.
[28] ibid.
[29] Harvie K, Sidebotham M, Fenwick J. Australian midwives' intentions to leave the profession and the reasons why. *Women Birth* 2019; **32**(6): e584-e93

Figure 6: Project methodology



1.6.1. Stakeholder consultations

HealthConsult consulted with all six LGAs across the WMR, MCH managers and coordinators, three cultural and advocacy groups, MAV, the Victorian Department of Health, the Australian Nursing and Midwifery Federation (ANMF), one operator of an Early Parenting Centre (EPC) and conducted three workshops with the Project Working Group. All stakeholders that were consulted as a part of the project are outlined in Appendix A:x B.

1.6.2. Survey

An online survey of MCH nurses was undertaken for four weeks from 7 – 28 February 2023 to collect information about opportunities to improve MCH services across the WMR.

The survey was distributed by the MAV via all six WMR Councils. Two follow-up rounds were conducted to collect complete responses from survey participants. 86 complete survey responses were received, which represents 41% of the total MCH headcount reported in Section 3.1.

Table 2: Distribution of survey responses by LGA

LGA	Total number of MCH nurses in each LGA*	Number of survey responses	% of total MCH headcount
Maribyrnong	24	8	33%
Wyndham	72	27	38%
Hobsons Bay	19	12	63%
Moonee Valley	25	6	24%
Brimbank	30	8	27%
Melton	42	25	60%
Region total	**212**	**86**	**41%**

Source: HealthConsult 2023 MCH workforce survey. Total number of MCH nurses in each LGA is the headcount of nurses in each LGA.

1.7. Purpose and structure of this document

This final report describes the key themes to emerge from the stakeholder consultations, the workforce survey, the analysis paper and Working Group meetings with respect to the issues facing the region's MCH workforce.

This report also outlines proposed options that were considered to address these issues, and recommendations for initiatives that can make a positive impact on the level and mix of MCH nurses across the region. The structure of this final report is:

- **Section 2:** Provides an overview of key demographic characteristics of the WMR population as background information
- **Section 3:** outlines what MCH services in the region currently look like
- **Section 4:** summarises the key issues that are impacting the MCH workforce
- **Section 5:** presents opportunities to improve MCH workforce capacity in the region to meet local needs and recommendations for targeted action
- **Section 6:** outlines a vision for how MCH services can look in the region to meet local needs
- **Appendix A:** provides information about stakeholder consultations that were conducted to develop this report
- **Appendix B:** provides a breakdown of MCH nurse salaries from all six LGAs, where data was available in the public domain.
- **Appendix C:** presents MCH workforce data from WMR Councils as at 30 June 2022.

2. Characteristics of the WMR population

This section presents an analysis of key demographics and characteristics of the WMR population that will influence demand for MCH services.

2.1. Total population

The WMR consists of 963,971 people living across six LGAs. 30.3% of the WMR population lives in Wyndham (Table 3)[30].

Table 3 : People and population of each LGA

LGA	Population
Brimbank	194,618
Hobsons Bay	91,322
Maribyrnong	85,209
Melton	178,960
Moonee Valley	121,851
Wyndham	292,011

Source: Australian Bureau of Statistics 2021 Census data. Available from: https://www.abs.gov.au/census/find-census-data/search-by-area

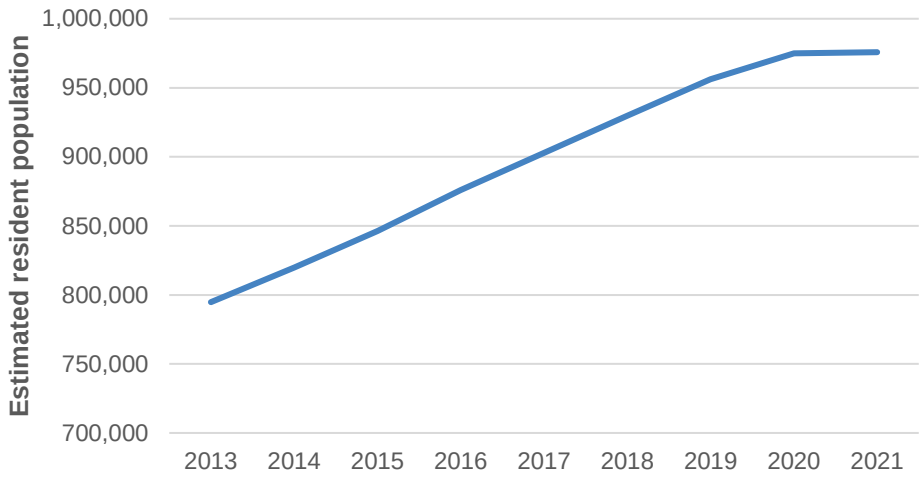
2.2. Population growth

From 2013 to 2019, the total population in the WMR increased by approximately 27,000 new residents per year.[31] By 2021 however, this growth had plateaued (Figure 7). **Most of the growth since 2013 has been located within the LGAs of Wyndham (59% of all new residents in the region) and Melton (32% of all new residents in the region). Wyndham and Melton have both been listed as among Australia's fastest-growing LGAs since 2017.**

Much of the growth across the region has been driven by immigration, with the proportion of residents born overseas increasing between the 2016 and 2021 censuses by 5.9 percentage points[32] in Wyndham and four percentage points in Melton. This compared to a 0.1 percentage point increase in the population proportion born overseas across Victoria overall.[33]

[30] : Australian Bureau of Statistics 2021 census data [cited 2023 Apr 14]. Available from: https://www.abs.gov.au/census/find-census-data/search-by-area
[31] Population estimates by LGA and Electoral Division (ASGS2021), 2001 to 2021 [Internet]. Australian Bureau of Statistics [cited 2022 Nov 24]. Available from: https://www.abs.gov.au/statistics/people/population/regional-population/2021#data-download.
[32] Percentage points represent differences between percentages. For example, a change from 30% to 45% could be described as an increase of 15 percentage points (as opposed to an increase of 50% in the original quantity).
[33] Australian Bureau of Statistics [Internet]. 2016/2021 Census All persons QuickStats [cited 2022 Nov 29]. Available from: https://www.abs.gov.au/census/find-census-data/search-by-area

Figure 7: Total population in the WMR

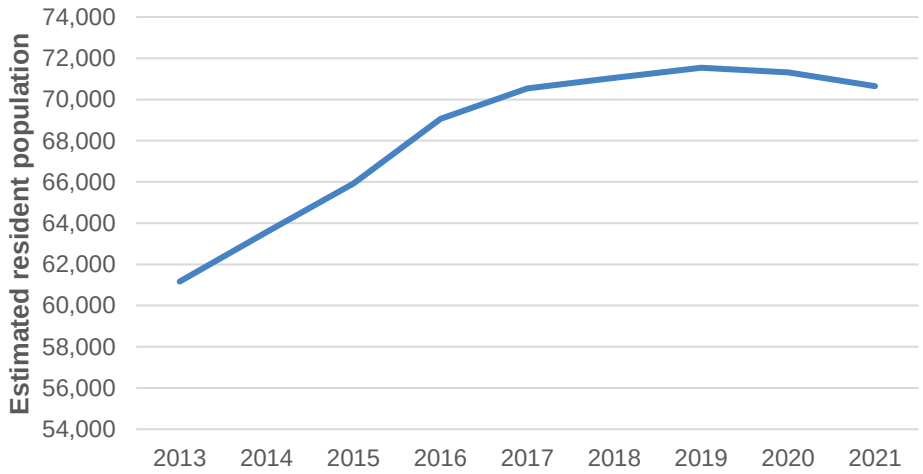


Source: Australian Bureau of Statistics (ABS) estimated resident population by LGA (Ref. 31). Note that the vertical axis scale does not begin at 0.

The population of 0–4-year-olds in the WMRhas also increased substantially, with an overall increase of 16% from 2013 to 2021, compared to 4% across Victoria.[34] Most of this growth occurred between 2013 and 2017 and has slowed substantially since then, including an overall decrease since 2020 (Figure 8). Consultations suggested that this change may be driven by population shifts (particularly from interface LGAs such as Wyndham and Melton) to regional areas because of the COVID-19 pandemic.

However, like the total population, **the increase in 0-4 year olds has not been evenly spread across all LGAs.** Highest rates of growth have occurred within Wyndham (47% more 0–4-year-olds) and Melton (33% more 0–4-year-olds), with all other LGAs showing a modest overall decrease in 0–4-year-olds.

Figure 8: Population of 0–4-year-olds in the WMR



Source: ABS estimated resident population by age and LGA (ref. 34). Note that the vertical axis does not begin at 0.

[34] Australian Bureau of Statistics [Internet]. .Stat Data Explorer (BETA) [2022 Dec 5]. Available from: https://explore.data.abs.gov.au/

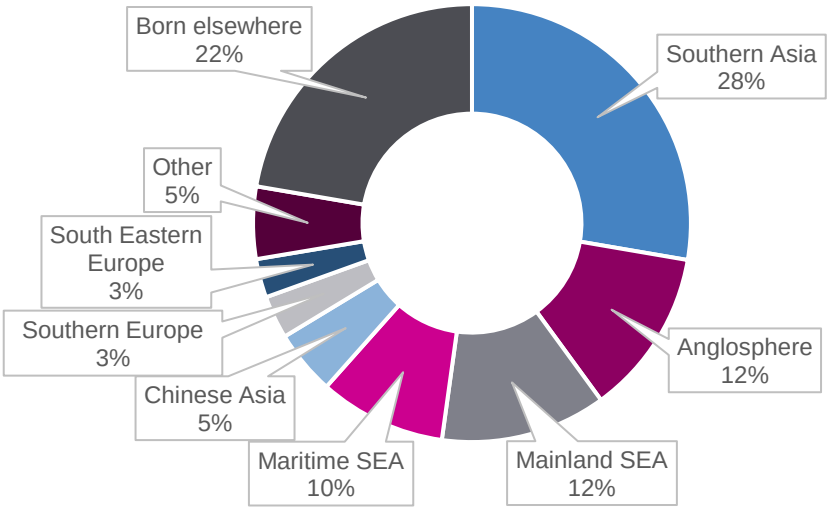
2.3. Cultural profile

The WMR has been an especially culturally diverse region for some time. **In 2021, there were large numbers of people in the catchment born in India, Vietnam, the Philippines, New Zealand, the United Kingdom, China and Italy**. People born in just these seven countries make up over 23% of the population,[35] although distributions are not always even across different LGAs. Notable communities include:

- Vietnamese people in Maribyrnong (9.5%, 7,669 people) and Brimbank (13.9%, 25,391)
- Indian people in Melton (8.4%, 14,314 people) and Wyndham (18.2%, 50,435 people).

Figure 9 shows the region of origin and percentages for those residents born overseas. In total, **those born overseas make up 44.4% of the WMR population, with 46.0% speaking a language other than English at home**. Those languages are most commonly Vietnamese, Punjabi and Hindi, although there are also relatively high numbers of Mandarin-, Arabic-, Italian-, Greek- and Urdu-speakers.

Figure 9: Population in the WMR born overseas, by region



Source: ABS 2021 Census. 'SEA' means 'Southeast Asia'. "Anglosphere" refers to the United Kingdom, New Zealand, Ireland, the USA and Canada. 'Born elsewhere' is a Census category referring to countries not identified individually, inadequately described, or those born at sea. All other categories follow the ABS Standard Australian Classification of Countries, with 'Other' covering the collected countries/categories not otherwise listed.

The WMR has been experiencing significant recent growth due to immigration, especially in the LGAs of Melton and Wyndham, with the proportion of residents in the region who were born overseas increasing from 37.5% in 2011 to 42.7% in 2021, a change in absolute numbers of over 138,000.

Immigration has been driven primarily by those born in India. The proportion of people born in India across the region has risen from 3.9% in 2011 to 8.9% in 2021, an increase of almost 55,000 people. **This is especially pronounced in Wyndham**, where the Indian-born population has increased by 42,344 people from 2011 to 2021 and, as previously noted, now makes up almost one-fifth of the LGA's population. By contrast, excepting the Indian- and Australian-born populations in the region (which changed by +5.0 and -5.2 percentage points respectively), the largest shifts from 2011 to 2021 in either direction are +0.6 percentage points (those born in

[35] Census Community Profiles (Time Series Profiles) [Internet]. 2022 [2022 Dec 15]. Australian Bureau of Statistics. Available from: https://www.abs.gov.au/census/find-census-data/search-by-area. Roughly 6% of respondents to each census did not state their country of birth; these responses have been excluded from the analysis.

Pakistan) and -0.8 percentage points (those born in the United Kingdom), which are remarkably static in comparison.

2.4. Socioeconomic profile

The degree of disadvantage in an area can be measured by the Index of Relative Socioeconomic Disadvantage (IRSD),[36] an ABS Socioeconomic Index for Areas (SEIFA) data product, which is produced using a variety of measures based on Census data. The 2021 SEIFA indices have not yet been released,[37] but the 2011[38] and 2016[39] IRSD scores for the WMR LGAs are shown in Table 4.

Table 4: IRSD scores and percentiles for the WMR, 2011 and 2016

LGA	2011 IRSD score	2011 IRSD percentile	2016 IRSD score	2016 IRSD percentile	2021 IRSD score	2021 IRSD percentile
Brimbank	926	18	921	19	916	16
Hobsons Bay	1,002	70	1,015	78	1,021	78
Maribyrnong	974	48	995	65	1,010	74
Melton	1,002	70	994	64	985	55
Moonee Valley	1,027	82	1,035	86	1,041	87
Wyndham	1,013	75	1,009	74	1,006	71

Source: Australian Bureau of Statistics.

In 2011, **Brimbank and Maribyrnong both had IRSD scores in the bottom half of LGAs across Australia**, which suggests they were more disadvantaged than average. While by 2016 Maribyrnong had risen to the 65th percentile and 74th percentile in 2021, which reflects higher levels of relative advantage than across Australia overall. However, by Brimbank's IRSD score remained very low in only the 16th percentile in 2021. This means that **Brimbank was in 2021 in the top 16% most disadvantaged LGAs in the country**.

The relative level of disadvantage also increased in Melton, which dropped from the 70th percentile in 2011 to the 64th percentile in 2016 and 55th percentile in 2021. Likewise, 2021 SEIFA data shows that disadvantage grew in Wyndham compared to 2016. The relative level of disadvantage in the other LGAs could be considered reasonably low and stable or decreasing. On the whole, the population-weighted average score across the catchment was 986 in 2011, increasing to 989 in 2016, which suggests **the relative disadvantage of the WMR is decreasing but still above the national average**.

2.5. Domestic and family violence

Domestic and family violence was noted as a key driver of client complexity and workload for MCH services during consultations. Table 5 shows that **Melton and Brimbank are the LGAs within the region with the highest rates of family incidents per 100,000 population**. Rates of domestic and family violence in these areas are almost 50% higher than in LGAs such as Moonee Valley

[36] The IRSD is a measure of relative disadvantage, with a higher score indicating a lower level of disadvantage. Signifiers of relative advantage are not taken into account. Scores are scaled so that the national mean is 1,000 and the national standard deviation is 100.
[37] Updated SEIFA data for the 2021 Census is expected to be released on 27 April 2023
[38] Local Government Area, Indexes, SEIFA 2011 [Internet]. 2013 Mar 28 [2022 Dec 19]. Australian Bureau of Statistics. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/DetailsPage/2033.0.55.0012011?OpenDocument
[39] Local Government Area, Indexes, SEIFA 2016 [Internet]. 2018 Mar 27 [2022 Dec 19]. Australian Bureau of Statistics. Available from: https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2033.0.55.0012016?OpenDocument

and Hobsons Bay, which recorded the lowest rates of domestic and family violence across the region.

Table 5: Domestic and family violence incidence per 100,000 population in the WMR

LGA	2018	2019	2020	2021	2022
Melton	1,335.0	1,482.2	1,739.3	1,654.9	1,535.6
Brimbank	1,295.6	1,382.3	1,445.6	1,495.1	1,442.2
Wyndham	1,094.8	1,213.1	1,245.1	1,357.6	1,352.4
Maribyrnong	939.1	1,038.3	986.5	1,189.8	1,223.6
Hobsons Bay	1,087.5	1,114.6	1,177.0	1,145.5	1,155.5
Moonee Valley	872.4	909.8	938.2	981.6	1,020.5

Source: Victorian Crime Statistics Agency

2.6. Education

Table 6 highlights the variation in levels of educational attainment across WMR LGAs. This table highlights that:

- **educational levels in Brimbank are far lower than in all other areas of the region**. Brimbank residents reported the highest levels of secondary school educational attainment than all other LGAs, and the lowest rates of diploma or qualifications or greater. Rates of secondary school attainment in Brimbank were substantially higher than the average for the WMR and Victoria overall, and rates of university attainment or above were lower than across Victoria overall
- **education levels in Melton are also typically lower than the Victorian average although not as pronounced as in Brimbank.** Melton recorded higher rates of Certificate level qualifications and below, and lower rates of university qualifications than the WMR and Victorian averages
- **education levels in Maribyrnong and Moonee Valley are the highest in the region,** and are generally much higher than the average across the WMR and Victoria overall
- **there is a higher propensity for postgraduate qualifications in Wyndham than the Victorian and region's average**.

Table 6: Highest level of education attained: WMR LGAs compared to Victoria

Location	Unknown / not stated	Secondary school	Certificate level (I to IV)	Diploma / Adv Diploma	Undergraduate degree(s)	Postgraduate qualification(s)
Brimbank	29%	37%	10%	7%	12%	5%
Maribyrnong	25%	25%	8%	7%	22%	13%
Melton	33%	31%	12%	8%	11%	5%
Moonee Valley	24%	28%	9%	8%	20%	11%
Hobsons Bay	27%	29%	11%	8%	17%	9%
Wyndham	34%	25%	9%	8%	14%	10%
Region total	**30%**	**29%**	**10%**	**8%**	**15%**	**8%**
Victoria	**27%**	**29%**	**12%**	**8%**	**15%**	**9%**

Source: Australian Bureau of Statistics 2021 Census Data

3. What do MCH services in the region currently look like?

This section summarises key characteristics of the WMR's MCH workforce and how it has changed over time.

3.1. Number and FTE of MCH staff

There were 215 headcount of MCH staff across the region on 30 June 2022 (Table 7). There are significant differences in the headcount across LGAs, with the total number of MCH staff ranging from 19 in Hobsons Bay to 72 in Wyndham.

Table 7: MCH headcount across the WMR, by MCH program and LGA

LGA	Universal MCH only	Enhanced MCH only	Both Universal and Enhanced	MCH Coordinator /Team Leader	Total Headcount
Brimbank	24	3	1	4	**31**
Hobsons Bay	19	1	1	3	**23**
Moonee Valley	22	2	0	2	**26**
Maribyrnong	20	3	0	2	**25**
Melton	27	5	0	8	**38**
Wyndham	54	8	0	10	**72**
WMR Total	**166**	**22**	**2**	**27**	**215**

Source: Consolidated WMR Council annual workforce planning report (2023).

The number and FTE of MCH nurses per 10,000 population aged 0-4 is lowest across the region in Brimbank, Melton and Wyndham. Differences across LGAs are most pronounced when comparing MCH FTE in Melton, which is less than 60% of the per capita MCH FTE in Maribyrnong and over 17% lower than the MCH FTE average across the region overall. When considering population only, shortages of MCH nurses are likely to be felt more acutely in these three LGAs, which is consistent with reports from stakeholder consultations.

Additional complexities associated with cultural and linguistic diversity, socioeconomic disadvantage and family violence were reported to add further challenges for the MCH workforce in these locations.

Table 8: WMR MCH headcount per 10,000 population aged 0-4 years, by LGA

LGA	Population aged 0-4	Headcount	Headcount per 100,000 people aged 0-4	FTE	FTE per 100,000 people aged 0-4
Brimbank	11,399	31	27.20	26.64	23.37
Hobsons Bay	5,953	23	38.64	14.24	23.92
Moonee Valley	6,322	26	41.13	14.19	22.45
Maribyrnong	5,099	25	49.03	11.50	22.55
Melton	14,923	38	25.46	27.28	18.28
Wyndham	26,951	72	26.72	50.80	18.85
Region total	**70,647**	**215**	**30.43**	**144.65**	**20.48**

Source: Consolidated WMR Council annual workforce planning report (2023).
Note: Headcount and FTE per capita columns are shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest

3.2. Vacancies

On average, 17% of current MCH FTE were vacant across the WMR as at May 2023, however, this result was influenced heavily by Melton and Wyndham, where 59% and 30%of current FTE were vacant, respectively. Higher rates of MCH vacancies broadly reflect where the most acute challenges were reported in MCH recruitment during stakeholder consultations. **Compared to the June 2022 data (shown at Appendix C.1), 2023 vacancies were:**

- substantially higher in Wyndham (30% in 2023 versus to 13% in 2022)
- higher in Maribyrnong (18% in 2023 versus 4% in 2022)
- lower in Brimbank (6% in 2023 versus 16% in 2022)
- stable across all other LGAs.

Table 9: Vacancies (FTE) by MCH program and LGA

LGA	Universal MCH	Enhanced MCH	Coordinator/ MCH Team Leader	Total vacancies	Total FTE	Vacancies as % of total FTE
Brimbank	1.58	0	0	1.58	28.22	**6%**
Hobsons Bay	0.6	0.3	0	0.9	15.14	**6%**
Moonee Valley	0.13	0.6	0	0.73	14.92	**5%**
Maribyrnong	1.9	0.2	0	2.1	13.6	**18%**
Melton	10.4	4	1.6	16	43.28	**59%**
Wyndham	9.55	2.27	3.6	15.42	66.22	**30%**
Region total	**24.16**	**7.37**	**5.2**	**36.73**	**181.38**	**17%**

Source: Consolidated WMR Council annual workforce planning report (2022)
Note: Vacancies as % of total column is shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest

3.3. Age

The age profile of the region's MCH workforce is substantially different across LGAs (Table 10). Key points include that:

- Maribyrnong has a substantial portion of its workforce aged over 60 and are likely to be approaching retirement. Planning for replenishment of the MCH workforce will be needed to avoid future challenges in MCH resourcing
- Melton has a very young workforce overall, with no current MCHNs aged over 60
- Brimbank has a very high proportion of younger MCH Nurses aged 40 or less (61%)
- Wyndham's MCH workforce is the most balanced of all WMR LGAs across the age range overall.

With the change in demographics towards a younger MCH workforce overall, consultations suggested that it will be important that more experienced MCHNs are available to provide mentorship, preceptorship and support to more recently graduated MCHNs that are entering the workforce. This will be particularly important in locations such as Melton and Brimbank, where a high proportion of the workforce is aged under 40, and there is a lower proportion of more experienced MCH nurses (aged 56 and over).

Table 10: Age profile of the WMR's MCH workforce, by LGA

LGA	<=40	41-45	46-50	51-55	56-60	61-65	66-70	71 +	Total aged 60+
Brimbank	61%	6%	0%	6%	10%	3%	10%	3%	**16%**
Hobsons Bay	26%	13%	13%	0%	22%	26%	0%	0%	**26%**
Moonee Valley	31%	12%	8%	8%	23%	15%	0%	4%	**19%**
Maribyrnong	32%	0%	8%	8%	8%	32%	8%	4%	**44%**
Melton	37%	8%	11%	16%	29%	0%	0%	0%	**0%**
Wyndham	22%	6%	18%	17%	17%	15%	6%	0%	**21%**
Region average	**33%**	**7%**	**11%**	**11%**	**18%**	**14%**	**4%**	**1%**	**20%**

Source: Consolidated WMP Council annual workforce planning report (2022)
Note: Darker green shading represents highest values. White shading indicates lowest values. Total aged 60+ column is shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest

3.4. Employment basis

On average, 72% of MCHNs across the region work part-time (Table 11), which is slightly higher than the 68.5% of all part-time employees that women account for across Australia. There are substantial variations in full-time[40] and part time work practices for MCH nurses across WMR LGAs, particularly in:

- Wyndham and Brimbank, where almost one-third of the workforce work full-time
- Melton, Hobsons Bay and Maribyrnong where approximately 80% of MCHNs work part-time.

Table 11: Employment status of the WMR MCH workforce, by LGA

LGA	Full-time	Part-time	Permanent relieving
Brimbank	29%	65%	6%
Hobsons Bay	22%	78%	0%
Moonee Valley	4%	73%	23%
Maribyrnong	8%	76%	16%
Melton	16%	84%	0%
Wyndham	35%	65%	0%
Region average	**22%**	**72%**	**6%**

Source: Consolidated WMR Council annual workforce planning report (2022)
Note: Darker green shading represents highest values. White shading indicates lowest values. Data does not include casual staff

The high proportion of MCH nurses working part-time is consistent with trends in the nursing and midwifery workforce observed at the national level (see Section 1.4). This is also consistent with consultation feedback that suggested MCH nurses are increasingly looking for flexibility and part-time work. The desire for flexibility is typically a result of either family commitments (for MCH nurses with young families) or older MCH nurses that are seeking to work less towards the end of their careers or have other family or community-related commitments.

However, some MCH nurses choose to work more hours on average in some Councils than others. Table 12 shows that on average, each member of the MCH workforce in Brimbank, Melton and Wyndham work more hours per week than MCH nurses in Maribyrnong, Moonee Valley and Hobsons Bay.

[40] Australian Bureau of Statistics (2022), Labour Force, Australia, January 2022, cat. no. 6202.0, Table 1. Labour force status by Sex, Australia - Trend, Seasonally adjusted and Original, viewed 22 February 2022, https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/jan-2022#data-downloads

Table 12: MCH FTE across the WMR, by MCH stream and LGA

LGA	Universal MCH	Enhanced MCH	Coordinator/ Team Leader	Total FTE	Average FTE per headcount
Brimbank	20.35	2.29	4	26.64	**0.86**
Hobsons Bay	10.64	0.8	2.8	14.24	**0.62**
Moonee Valley	11.25	1.34	1.6	14.19	**0.55**
Maribyrnong	8.1	1.4	2	11.5	**0.46**
Melton	18.08	3.8	5.4	27.28	**0.72**
Wyndham	37.5	6.9	6.4	50.8	**0.71**
Region total	**105.92**	**16.53**	**22.2**	**144.65**	**0.67**

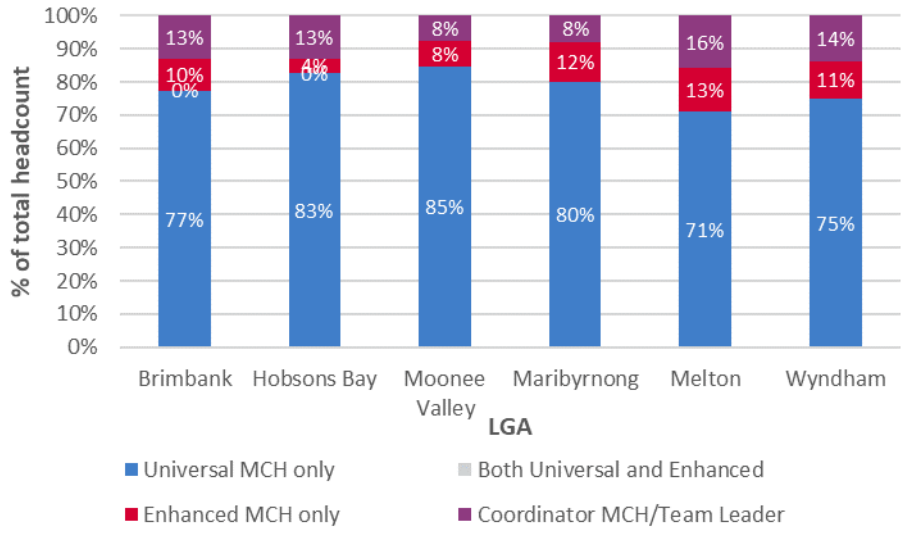
Source: Consolidated WMR Council annual workforce planning report (2022)
Note: Average FTE per headcount column is shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest

3.5. MCH staffing structure

The number of MCH headcount allocated to each program differs slightly across LGAs (Figure 10), with:

- a higher proportion of staff working within the universal program in Moonee Valley and Hobsons Bay (85% and 83% respectively)
- a higher proportion of staff working in the Enhanced MCH program in Melton (13%), Wyndham (11%) and Maribyrnong (12%)
- lower proportions of coordinators and team leaders in Moonee Valley and Maribyrnong compared to other Councils.

Figure 10: MCH staffing structure (headcount) by program and LGA



Source: Consolidated WMR Council annual workforce planning report (2022)

The differences in workforce structure and profile across LGAs may reflect differences in the client cohort in certain locations. For instance, the higher proportion of staff in the EMCH program for Melton, Wyndham and Brimbank may be related to the higher levels of domestic and family violence disadvantage that have been reported in these Councils compared to others across the WMR. This would likely result in additional funding for these positions in these Councils.

3.6. Cultural and linguistic diversity

Although the WMR population is highly culturally and linguistically diverse, the MCH workforce in the region is not representative of this diversity.

A much lower proportion of MCH nurses that responded to the workforce survey conducted for this project speak a language other than English, compared to the population overall (Table 13). This is true for all LGAs across the region. There are also a much lower proportion of MCH nurses compared to the population born overseas. These results should be interpreted with caution given the low number of responses in Brimbank, Moonee Valley and Maribyrnong.

Table 13: Comparison of WMR population and MCH workforce that reported speaking a language other than English, by LGA

LGA	Total survey respondents	% of MCH survey respondents who speak a language other than English	% of population born overseas	% of population that speaks a language other than English
Brimbank	8	0%	54%	64%
Hobsons Bay	12	0%	35%	32%
Maribyrnong	8	0%	43%	43%
Melton	25	16%	40%	46%
Moonee Valley	6	17%	32%	32%
Wyndham	27	15%	53%	56%
Region total	**86**	**8%**	**46%**	**49%**

Source: HealthConsult 2023 MCH workforce survey and Australian Bureau of Statistics Census Data

3.7. MCH nursing pipeline

Table 14 shows that **there is currently a limited 'pipeline' of potential MCH nurses in most areas of the WMR**. Rates of nurses and midwives living in most WMR Councils - and in the WMR overall – are much lower than the Victorian average (except Maribyrnong). Melton has a significantly lower rate of nurses and midwives per 10,000 population (99.24) than all other WMR LGAs, which may be contributing to the significant challenges attracting MCHNs to work in Melton. Per-capita rates of MCHN candidates (i.e. dual-qualified RNs and RMs) are roughly half of the Victorian average across the WMR overall (6.22 per 10,000 population compared to 10.52 across Victoria). Rates of MCHN candidates are around one-quarter of the Victorian average in Melton and Moonee Valley, but are above the Victorian average in Brimbank (12.38).

Table 14: Profile of nursing staff across the WMR

LGA	Total nurses and midwives	Total Nurses and Midwives per 10,000 population	Potential MCHNs (Combined RN + RM)	Dual-qualified RN+RM per 10,000 population
Brimbank	5,535	284.40	241	12.38
Hobsons Bay	1,545	169.18	36	3.94
Maribyrnong	3,358	394.09	44	5.16
Moonee Valley	2,474	203.03	34	2.79
Melton	1,776	99.24	44	2.46
Wyndham	4,537	155.37	201	6.88
Region total	**19,225**	**199.44**	**600**	**6.22**
Victoria	**206,669**	**317.78**	**6,842**	**10.52**

Source: National Health Workforce Data set (2022)
Note: Total nurses and midwives include Registered Nurses (RNs) only, Enrolled Nurses (ENs) only, Dual-qualified RNs and ENs, Registered Midwives (RMs) only, Combined RNs and RMs, Registered and Enrolled Nurses and Midwives and 'Not stated'.
Darker green shading represents highest values. White shading indicates lowest values

4. Issues in MCH services and workforce capacity across the region

This section describes the range of issues impacting the MCH workforce in the region based on the data analysis, workforce survey, desktop research and consultations undertaken. These issues have been categorised into four key groups, including system issues, challenges in recruitment, challenges in retention and resource challenges (Figure 11).

Figure 11: Summary of key issues in MCH services and workforce capacity across the WMR

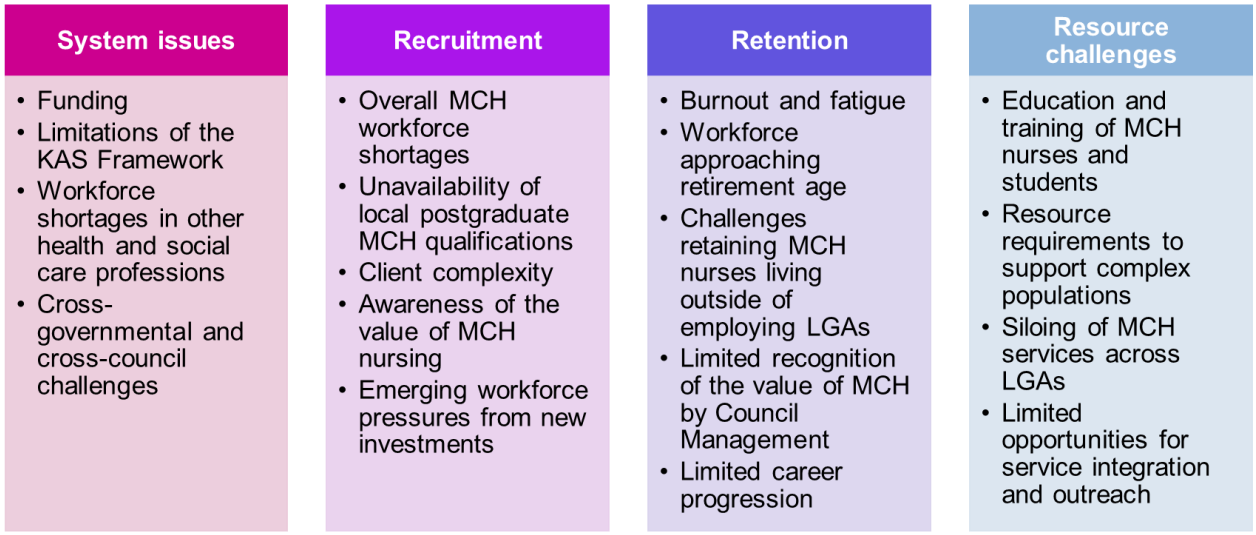


Table 15 summarises the key issues to emerge from the workforce survey regarding how to increase the MCH workforce in the region. It reflects a wide range of perceived impacts across all the categories shown in Figure 11; principally issues related to workload, staff shortages and mobility of entitlements. These issues are explored in more detail in this section.

Table 15: MCH survey responses to the question 'what are the main challenges to increasing the MCH workforce in the WMR?

Response	Number of responses	% of overall responses
High workload/ burnout	55	69%
Not enough available MCH qualified staff in Victoria	55	69%
Enabling MCH continuity of service and entitlements moving from the hospital to local government employment	52	65%
Pay/conditions compared to comparable nursing/midwifery positions elsewhere	39	49%
Perceived value of MCH nursing	34	43%
Challenges engaging with vulnerable/disadvantaged clients	25	31%
Poor organisational support/mentoring	23	29%
Extra qualification requirements needed for MCH staff in Victoria	16	20%
Challenges engaging with culturally and linguistically diverse clients	16	20%
Limited professional development opportunities	16	20%
Other (please describe)	16	20%
Low job satisfaction	11	14%

Source: HealthConsult 2023 MCH workforce survey

4.1. System issues

Although MCH services are delivered locally, they operate within a policy framework, funding model and service delivery (KAS) framework that is set and managed by the State Government. The delivery of MCH services across Victoria are thus inextricably linked to the policy and frameworks set by at the system (state) level.

Several system level factors were consistently highlighted throughout stakeholder consultations as being significant challenges to the effective delivery of MCH services. These included councils assuming a greater share of funding for Universal MCH services than the 50/50 split with the State Government, limitations of the KAS Framework and shortages of other health and social care services that create blockages in referral pathways from MCH services (Figure 12).

Figure 12: Summary of system issues impacting WMR MCH services

4.1.1. Funding

Funding was identified by almost all WMR LGAs as a major issue in the sustainability of MCH services that creates challenges in staffing and resourcing to meet community needs. For instance, MCH nursing graduates have been highlighted as great assets to local Councils, however, it is difficult for LGAs to provide the funding for recruiting educator and preceptor roles to support them.

Many WMR LGAs reported contributing a much greater share than the 50/50 funding split (between state and local governments) for Universal MCH services. This is because:

- **funding for Universal MCH services are population based, but is not set with reference to service delivery costs**. Several LGAs reported that funding has been indexed over time, but costs have increased more, which has contributed to significant service delivery pressures. One survey respondent outlined that "Funding is an issue. Department of Health funding has not been maintained to cover 50% of costs and it is worked out on a much lower unit cost than is needed to maintain the service."
- **weightings applied to funding to reflect client complexity are based on ARIA and the number of maximum FTB recipients.** The additional weightings aim to reflect the increased

cost of service delivery in rural settings and the additional resources required in areas of socioeconomic disadvantage and high need. However, some WMR LGAs believed this approach does not reflect the additional costs associated with levels of disadvantage and cultural diversity that require additional MCH time and effort. This was a particular issue noted by 'interface Councils' such as Melton and Wyndham, which sit on the boundary of metropolitan Melbourne and outlying rural areas. These areas have experienced the most significant growth in population, and are highly culturally diverse.

- **government funding does not capture infrastructure costs** associated with building or maintaining facilities that are used to deliver MCH services. All capital and infrastructure costs must be met by local Councils.

Stakeholders across the region expressed a widespread view that the funding model for MCH should be reviewed and updated to support the sector's future sustainability and to align the funding approach with the current costs required to deliver MCH services. Strong advocacy by WMR Councils to the State Government would be required to achieve this. A strong evidence base to support an argument that current funding is inadequate will be required for such advocacy to be effective.

4.1.2. Challenges associated with the KAS Framework

The KAS Framework was identified consistently by both WMR Councils and MCH nurses (through the workforce survey) as being a significant challenge to delivering MCH services in line with community needs. The Framework was last reviewed in 2009 and has not been updated since. It was consistently described as being 'rigid', 'a tick box exercise' and 'out of date'. Comments received from the MCH workforce survey included that:

"KAS visits are out of date and need review"

"I find it very worrying that families in certain municipalities cannot access a MCH for their routine KAS visit. It also worries that in some of these municipalities parent educators are providing workshops/education session on these KAS visits."

[what is needed to improve retention of MCH nurses?]- *"Respect and adequate time to complete tick boxes and KAS expectations for more complex client's needs."*

"No increase in KAS time for over 10 years yet more assessments have been added"

"Increased KAS times for more complex clients that have traumatic backgrounds in culturally and linguistically diverse (CALD) clients and also birth trauma."

"increase in KAS time allocated so that this actually reflects the time taken to perform the KAS consults- Woefully inadequate at present. Also more control over my diary"

"I would have more job satisfaction if we had enough nurses to be able to provide the entire KAS to all families. Student paid clinical placement is key for this to occur in my opinion"

"It is difficult to employ more MCHN when there are not any to employ, better pay and more admin time plus increased time for KAS consults would reduce MCHN pressure"

"Lack of staff = get more staff"

Not having access to other professionals = need more Occupational Therapy (OT), speech, psychology, peads that are free and available

"Time: increases KAS times as we do more and more in same short time and families' higher needs"

The limitations in the KAS Framework were reflected as being a clear and consistent frustration for many MCH nurses that responded to the workforce survey. These frustrations are impacting on the ability of MCH nurses to provide the level of service that is needed for many children and families; particularly those that are socioeconomically disadvantaged, CALD or have other complex needs.

Several MCH nurses who have been working for many years noted that they were previously able to develop a relationship with children and families that supported high levels of care, and job satisfaction. However, **many MCH nurses reflected that they currently have limited capacity to deliver the level and type of care that they believe is needed, which is impacting their job satisfaction**.

Many MCH nurses and local Councils considered that the duration of KAS appointments is not long enough to complete a thorough MCH consultation. The duration of appointments set out in the Framework at two weeks, eight weeks, four months, 12 months and two years is for 30 minutes. Several MCH nurses expressed a need for 45-minute appointments in the consultations and workforce survey. Some councils have implemented this change at their own expense. Comments received in the workforce survey included that:

> *" there is not enough time to complete all components of KAS AND meet client needs in current framework" "Increased time for KAS consults from 30 minutes to 45 minutes"*
>
> *"45 minute KAS appts"*
>
> *"Increasing time for ALL KAS consults to 45 mins. 30 mins are nowhere near enough time to provide adequate assessments."*
>
> *[To feel better supported I need] "less tick boxes and more time with clients who are vulnerable – to rigid appointment system – need more flexibility with appointments."*
>
> *"Please increase time of KAS consults that are currently 30 minutes to 45 minutes, I always work through my lunch break and tea breaks to get administration and notes done."*
>
> *"MCH provides complex consultations with ever increasing demands on our time. All KAS appointments need to be 45 minutes to allow enough time to complete all practice requirements."*
>
> *"The current time frames for KAS consults are totally unrealistic and woefully inadequate and DO NOT reflect the time taken to deliver the care required for these vulnerable clients."*

While there was a common view that an increase in the duration of some KAS appointments is required, doing so would mean that fewer families can be seen by MCH nurses within the existing workforce profile. Significant growth in the MCH workforce would be needed to support increases in the duration of KAS appointments.

Given the length of time since it was reviewed, **several stakeholders identified that the KAS Framework does not account well for the diversity and complexity of the population in many parts of the region.** MCH services noted that client diversity and complexity is often a substantial driver of time and resource requirements for MCH nurses. In particular, complexities and additional time associated with addressing issues such as family and domestic violence, and diversity (via need for interpreters) is not factored into the time allowed for in the existing KAS Framework. Family violence funding is recorded via a separate consultation, and is not incorporated into KAS consultations (except at four weeks). These highly complex appointments require more time and often referral to external services, which may require additional research and effort from the MCH nurses.

4.1.3. Workforce shortages in other health and social care professions

Blockages in referral pathways from MCH services caused by limited medical, allied health and social services have meant that MCH services are required to 'hold' clients for longer to maintain their safety and wellbeing. This is an issue that is impacting early childhood services more broadly.

Challenges accessing allied health professionals and paediatricians were consistently cited throughout the MCH workforce survey as a key issue. **'Not having access to other professionals' (e.g., allied health) to meet population needs' was cited by 75% of MCH survey respondents as a key barrier** to communities in the region accessing MCH services. This was the second highest ranked barrier behind MCH workforce shortages.

These shortages often require that MCH services to spend more time and effort supporting children and families, which compounds MCH workforce shortages and challenges in access for other members of the community. However, workforce shortages in the broader health and social care sectors are likely to be outside of the sphere of influence for LGAs.

4.1.4. Cross-governmental and cross-Council challenges

(e.g., state versus local government), or differences in employment arrangements for MCH nurses across LGAs. These issues mostly related to alignment of entitlements across different organisations and sectors, which contributes to challenges issues such as:

- **an inability to transfer entitlements from the hospital to the local government sector, and between councils**, which potentially limits recruitment of MCH nurses working in the hospital sector**.** Portability of leave entitlements was raised as a key benefit that could improve recruitment of MCH nurses, but is currently not possible due to industrial arrangements. This is typically impactful for nurses who have worked in the hospital setting for several years and may want to change their position to work in the community. While the hours of community nursing are desirable, many hospital-based nurses are not willing to lose their entitlements. Establishment of a single, state-wide award for professions such as kindergarten staff has been achieved and could help improve recruitment and retention if implemented for MCHNs, but would need to be managed at a state-wide level.
- **different MCH pay rates across LGAs can contribute to issues in recruiting MCH nurses for some Councils.** Appendix A: shows that Moonee Valley typically pays the highest salary for MCH nurses at all levels (years 1 – 5). Hobsons Bay is notably the lowest-paying LGA. Variations in pay rates were noted as impacting recruitment in specific areas, particularly those that do not pay comparably to other LGAs like Moonee Valley. This means that it is difficult for some LGAs to recruit MCH nurses due to low pay conditions.
- **issues in sharing MCH resources across LGAs.** Arrangements with 'loaning' staff during COVID-19 were challenging as a result of having staff move into hospital settings due to the Code Brown that was declared in Victoria. Inter-Council support reportedly worked well as part of the surge response to the COVID-19 pandemic, and in response to recent floods. However, WMR Councils highlighted that agreements to share MCHNs have been challenging due to insurance and delineation of responsibilities if an issue arose.

All these challenges are issues that are tightly embedded into the structure of the health and local government sectors and are unlikely to be influenced by action from Councils. If this could be addressed it has the potential to improve MCH staffing, but would require leadership from the State Government, and a commitment to work collaboratively with MAV and Councils.

Opportunities to address system issues impacting MCH services:

Although system issues were, identified as the most common challenges to sustainable MCH services, local Councils reported limited opportunities to influence the policy, funding and governance framework they operate within.

Illuminating the impacts of system level challenges on MCH services could be an important input to **collective advocacy efforts** (ideally involving all WMR LGAs) that aim to improve the sustainability of MCH services across the region. Such advocacy efforts could potentially be expanded further to address system challenges impacting MCH services across Victoria. Such advocacy efforts could include

- Conducting a detailed study to capture and quantify the costs associated with delivering MCH services in different locations, and to different community cohorts (including families that are Indigenous, CALD and socioeconomically disadvantaged) could be undertaken / commissioned jointly by WMR Councils. The results of such a study could be used to support advocacy efforts for a revised funding model if they show that the actual cost of

MCH services is significantly greater than the unit costs provided under the current funding model.

- Compiling the extensive feedback received in relation to the KAS Framework to advocate for the Framework to be reviewed and revised.

Refining the operation of existing 'networking' arrangements between WMR LGAs based on learnings from other LGAs elsewhere across Victoria could also be explored to improve collaboration, resource sharing and standardised MCH support structures. Consultations revealed that partnership approaches across Councils have been trialled by several WMR LGAs to address specific issues in MCH staffing, but were reportedly administratively challenging. One stakeholder described that efforts to share resources have been 'a big fail'. Although consultations revealed much goodwill and an appetite to explore cross-LGA (and cross-government) collaborations, future opportunities would need to be designed and selected carefully. Anecdotally, some LGAs in Melbourne's south-east have been able to establish collaboration and resource sharing arrangements effectively, and could be approached (potentially via MAV) to learn from how such successful arrangements were implemented elsewhere. MAV could also work to help 'broker' more consistent resource sharing arrangements across councils.

4.2. Recruitment

The stakeholder consultations and workforce survey highlighted that there are several issues relating to the recruitment of MCH nurses (Figure 13). These issues impact the available resources in the region and the ability to meet the complex needs of the growing population.

Figure 13: Summary of key issues impacting MCH recruitment in the WMR

4.2.1. Overall MCH workforce shortages

The most significant factor constraining MCH recruitment in the region is the overall shortage of MCH nurses (and nurses more broadly) across the system. However, pressure on the MCH workforce has been a longstanding issue that also reported skills shortages and a lack of MCH nurses across the system in a 2018 Victorian Parliamentary Committee.[41] Many LGAs are reportedly struggling to keep up with the demand for MCH services across Victoria. This was reflected in the MCH workforce survey, which showed that:

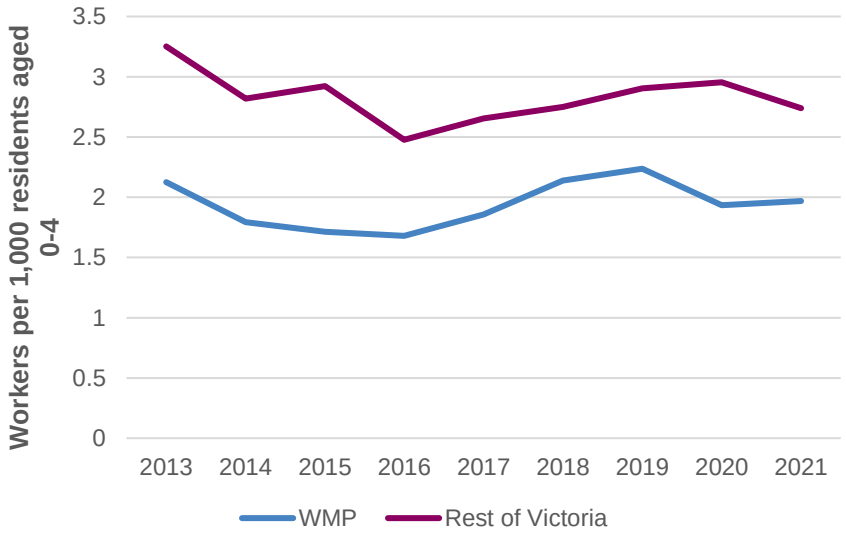
- 90% of respondents cited 'not having enough MCH nurses to meet population needs' as the biggest barrier to community members accessing MCH services in the region
- 69% of respondents cited 'not having enough MCH qualified staff in Victoria' as the main challenge to increasing the MCH workforce in the catchment.

Analysis of data from the National Health Workforce Data Set suggests that shortages of MCH nurses are more pronounced in the WMR than across Victoria overall. When compared

[41] Parliament of Victoria Family and Community Development Committee (2018). Inquiry into Perinatal Services: Final Report, accessed from https://apo.org.au/sites/default/files/resource-files/2018-06/apo-nid182201.pdf

to the rest of Victoria, the MCH workforce in the WMR is significantly smaller even when adjusting for population (Figure 14). **An additional 55 MCH nurses would be needed across the region immediately to bring its ratio of MCH nurses to population aged 0-4 in line with the rate across Victoria overall**.

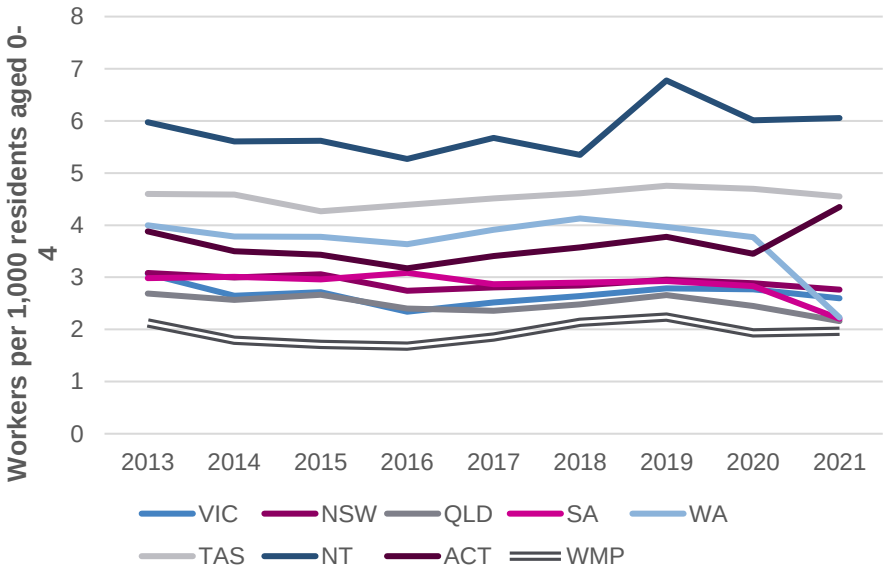
Figure 14: MCH workforce headcount (adjusted for population of 0–4-year-olds), WMR compared to the rest of Victoria



Source: National Health Workforce Dataset; ABS estimated resident population by age and LGA.

When adjusted for population aged zero to four, **the MCH workforce in the region is also substantially lower than in all other jurisdictions across Australia on a per capita basis** (Figure 15). This has been the case since 2013. The longstanding shortage of MCH nurses shown in this figure is consistent with the long-term challenges that were expressed by the City of Wyndham during consultations, which highlighted that they “have not delivered the full [staffing] requirements of the MCH service for the past ten years”, despite significant efforts to do so.

Figure 15: MCH workforce (adjusted for population of 0–4-year-olds), all states and territories and WMR



Source: National Health Workforce Dataset; ABS estimated resident population by age and LGA

The challenges staffing MCH services is felt more acutely in some WMR LGAs than others. This is illustrated by service prioritisation measures being in place within Wyndham and Melton. [42] In these LGAs, the access to the Universal MCH services is being prioritised for specific population groups. Melton prioritises children (and their mothers) from 0-8 weeks of age and provides Aboriginal and Torres Strait Islander infants and their families, children and families zero to school age , vulnerable children and families, and children with additional needs with enrolment to the Enhanced MCH program.[43] MCH appointments for children aged four months and older (that do not fit within these groups) have been paused. However, Melton council have increased their parent education team to provide more groups and education for parents in the older age groups. Brimbank Council is also encouraging families to access other supports[44] to mitigate pressures on their MCH workforce, such as the MCH Line, GPs or local SuperCare pharmacies.

Outside of the region, the City of Whittlesea has noted that that "the deficit of locally based services within growth Councils impacts on MCH as they are 'holding' clients until they can access services and are competing with other jurisdictions for services."[45] Holding clients was also noted as being common in WMR Councils, and is discussed in Section 4.1.3.

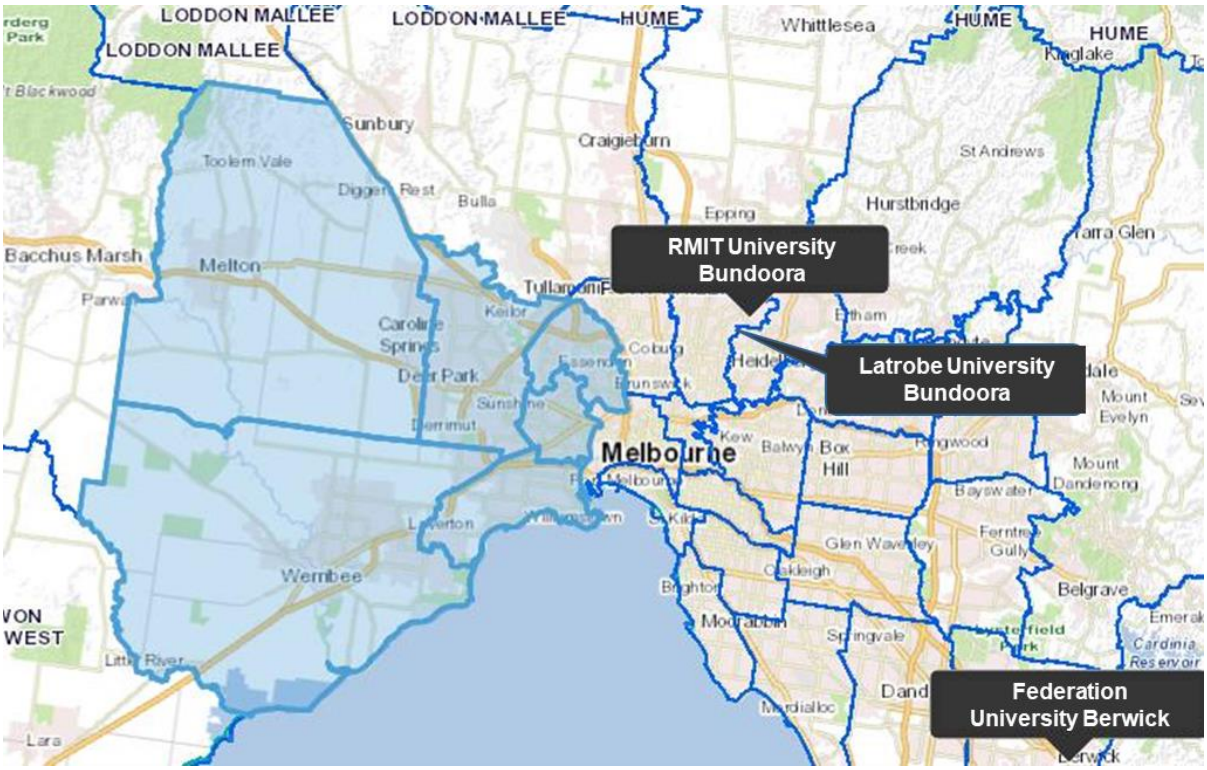
4.2.2. Unavailability of local postgraduate MCH qualifications

There are limited universities that offer MCH postgraduate qualifications across Victoria, and none of these universities are located nearby the WMR. Universities that currently offer postgraduate MCH qualifications are La Trobe, RMIT and Federation University; all of which are based in South-Eastern Melbourne (Berwick or Bundoora) (Figure 16). While some universities include partial course delivery online, requirements for face-to-face learning remain as a key part of the curriculum at all providers of postgraduate MCH qualifications. Unavailability of local postgraduate qualifications for MCH nurses can impact on recruitment to the region, because:

- it is difficult to recruit MCH nurses to the region if they are required to relocate from the other side of Melbourne after completing their postgraduate qualification
- unavailability of MCH qualifications near to the WMR can create a barrier for nurses based in the west to complete the required postgraduate MCH qualification if they need to travel long distances to study in areas that are not close to home. This could limit the extent to which a 'local' workforce can be developed in the west that aligns with its culturally diverse population profile.

[42] The Guardian (13 April 2022). 'Babies missing out on health checks in Melbourne due to Covid-related workforce shortages'. Available from https://www.theguardian.com/australia-news/2022/apr/13/babies-missing-out-on-health-checks-in-melbourne-due-to-covid-related-workforce-shortages
[43] City of Melton. (2023). Maternal & child health
[44] Brimbank City Council (2022). 'Maternal and Child Health'. Available from https://www.brimbank.vic.gov.au/health-family-and-support/maternal-and-child-health
[45] City of Whittlesea. Maternal and Child Health. 2022. Available from: https://www.whittlesea.vic.gov.au/media/8345/connected-community-maternal-and-child-health-2022-1.pdf

Figure 16: Map of Victorian universities offering MCH postgraduate qualifications



Source: Adapted from Mapshare Victoria

The unavailability of postgraduate MCH qualifications near to the region is particularly significant because stakeholder consultations and the workforce survey indicated that **MCH nurses typically want to work in or nearby the same LGA that they live in**. The high proportion of MCH nurse candidates with family commitments mean that it is undesirable for a nurse to complete a qualification in a location that located a long way from where they live.

It is noted that the unavailability of local postgraduate qualifications is also likely to be an issue in other areas of Victoria, such as rural and regional areas. **MCH services across Victoria may therefore benefit from engagement with universities (via MAV and the State Government) to explore the potential for postgraduate MCH courses to be delivered wholly online**, to improve participation of MCH nurse candidates living outside of Melbourne's northern and eastern suburbs.

Victoria University (VU) runs undergraduate nursing and midwifery courses and has several campuses in Melbourne's west. **Discussions with VU confirmed that the university has both the interest and resources to be able to develop a postgraduate MCH qualification** to support the development of a 'local' MCH workforce in the west of Melbourne. VU is interested in pursuing opportunities to develop pathways for MCH nurses that may undertake a postgraduate qualification directly into employment within local Councils in the west. Partnerships between Councils in the south-east of Melbourne and a university were reported to be one of the main drivers behind establishment of Federation University's postgraduate MCH course. The campus that currently offers VU's Nursing and Midwifery undergraduate degrees is located in St Albans in the Brimbank LGA.

4.2.3. Client complexity

The complexity of the region's catchment population was noted by several Councils as being a deterrent for some MCH nurses to work in the west. Stakeholder consultations highlighted that there is an increasing number of families experiencing family and domestic violence, which places a significant burden on MCH nurses, particularly (though not limited to) those working in:

- the EMCH program, and
- Councils such as Brimbank and Melton, where client cohorts were identified as being 'predominantly vulnerable', with high rates of family violence and Child Protection involvement (refer to Section 2.5 for relevant detail).

Feedback from Councils suggested that many MCH nurses believe that working in the west of Melbourne is 'too hard' due to the high levels of client complexity, diversity and disadvantage. These complexities were noted in addition to existing levels of burnout that were characteristic of the sector because of high workload and existing workforce shortages. **Some MCH nurses suggested that the diversity and challenge could be turned into a selling point to improve recruitment for MCH nurses**. One survey response stated that:

> *"Working in Melbourne's West is diverse, exciting, and challenging. It is a privilege to help support these families in times of need."*

Another survey response highlighted a need to recruit MCH nurses that reflect the diversity of the community:

> *"In my opinion the difficulty in getting workforce in the Western Metropolitan catchment is mainly due to lack of awareness about the Councils and the opportunities, lack of transportation network and the lack of diverse workforce to serve the diverse community."*

Although the population characteristics that contribute to client complexity cannot be addressed in the short-term, **feedback from the MCH workforce survey highlighted that Councils could play an important role in reducing burnout and fatigue**. Wyndham City introduced wellbeing days for its MCH staff, which were well-received in the survey and recommended to mitigate burnout. However, arranging backfill when staff take wellbeing days was cited as an issue that can create resourcing and capacity challenges. Availability of other supports, such as mentors, preceptors, administrative support and lactation/sleep services was also highlighted as valuable to provide capacity for MCH nurses to focus on the areas of the MCH program that they are qualified to deliver.

4.2.4. Awareness of the value of MCH nursing

Responses to the MCH workforce survey identified a widespread perception that the role, skills and value of MCH nurses are not understood or appreciated by the community or local Councils. Some raised a view that the triple qualification requirement in Victoria "is not worth the study or money for a profession that is not well respected or rewarded". The workforce survey identified several areas for improvement, including that:

> *"This was my dream career from the age of 8 years old- I am devastated that most days I come to work wondering why I did not choose something that is more valued - community awareness is really poor - half the population do not realise the education levels or qualifications needed to become a MCHN nor does Council management or leadership outside the families and children service. MCH is an undervalued resource and it's disappointing that we work so hard to specialise to be told that we should be comparable to other lower qualified members across the Council for benefits including base wages and holiday entitlements."*
>
> *"It is more than recruitment. It is also about professional respect - internal and external.*
>
> *"The reputation of MCH is undersold".*
>
> *"There is a lack of understanding of the role of the MCHN and gender bias prevents development of the service as 'we only weigh babies'' attitude persists in Local government."*
>
> *"Most feel we are below the Midwifes at the hospital so undervalued for what we do."*

Various promotional initiatives were suggested to improve awareness of the value of MCH nursing to improve MCH recruitment. These included:

- **a "huge government promotion of what we do"** was suggested by one survey respondent as being required.
- **improving understanding of MCH nursing while patients are in hospital or in the antenatal period** because "families leave hospital not aware of our service or what we do."

Table 16 shows that key elements of the MCH role that could act as 'selling points' as part of a promotional campaign could include:

- opportunities to positively impact outcomes in a key period of child development
- supporting children and families that are vulnerable or at risk of adverse outcomes
- educating and empowering families
- lack of shift work.

Table 16: MCH workforce survey responses about 'what do you like about your current role?'

Response	Number of responses	% of overall responses
Opportunities to positively impact outcomes in a key period of child development	78	92%
Supporting children and families that are vulnerable or at risk of adverse outcomes	67	79%
Educating and empowering families	67	79%
Lack of shift work	57	67%
Having job autonomy	51	60%
Providing continuity of care	51	60%
Being part of a team of healthcare professionals	51	60%
Opportunities for professional/career development	37	44%
Flexibility	32	38%
Feeling professionally respected	31	36%
Pay and conditions	26	31%

Source HealthConsult 2023 MCH workforce survey

4.2.5. Emerging workforce pressures from new investments

The Victorian Government is upgrading and expanding existing EPCs in Footscray and Noble Park, and building eight new centres, with one located in Wyndham. EPCs aim to enhance the parent and child relationship to support parents in areas like sleep and settling, child behaviour, and parent and child health and wellbeing. The aim of EPCs is to support additional families by tripling service capacity.[46]

While these EPCs provide opportunities to better meet the needs of families in the west, they will also drive increased demand for triple qualified MCH nurses. The MCH staff at EPCs will not deliver services against the KAS Framework. This may exacerbate the existing workforce shortages in or near to local Councils where new EPCs are located unless the supply of MCH nurses can be increased to meet overall demand.

[46] Victorian Department of Health (2023). 'Early Parenting Centres expansion and upgrade', accessed from https://www.vhba.vic.gov.au/health/specialist-centres/early-parenting-centres-expansion-and-upgrade

An outcomes framework, strategic framework and model of care have been developed for the EPC expansion project.[47] While the KAS Framework provides a model of care for Universal MCH services, the strategic and outcomes frameworks represent key elements of good practice system management that are not part of the Victorian MCH service guidelines. **Inclusion of a strategic and outcomes framework could be considered if the MCH service guidelines and KAS Framework are reviewed and refreshed in future.**

Opportunities to address recruitment issues impacting MCH services:

Several promising initiatives were identified through the project to improve MCH recruitment across the region:

- **Establishment of a postgraduate MCH qualification in the region** represents the principal opportunity to improve MCH services. A local postgraduate qualification would help to develop a 'locally grown' MCH workforce that is aligned to demographic profile of the community, committed to the local community, and can provide pathways directly into local WMR Councils. VU was approached to canvass its willingness and capacity to establish a postgraduate MCH qualification in the west, and discussions so far have confirmed that both the willingness and resources are available to do so.
- **Advocating to university providers for more online course delivery of postgraduate MCH qualifications** to improve participation of prospective MCH nurses living outside of Melbourne's northern and eastern suburbs. While components of current MCH courses are currently delivered online, advocating to universities to explore expanding online delivery (or alternative delivery models that allow prospective nurses to study from any location) could improve overall MCH nurse supply. Collective advocacy between WMR Councils, MAV and the State Government is likely to maximise the impact of such advocacy.
- **Promotion of MCH nursing at a both a local and state level** could help to elevate the profile of MCH nursing and enhance the 'pipeline' of MCH nurses into the system overall. Ideally, both state and local level promotions would work in tandem to highlight the benefits and value of MCH nursing overall, while also identifying key aspects of working in the region that are valued by current staff, such as:
  - opportunities to positively impact outcomes in a key period of child development
  - supporting children and families that are vulnerable or at risk of adverse outcomes
  - educating and empowering families
  - lack of shift work.
- **Establishment of targeted scholarships for MCH nurses to work in WMR LGAs** was suggested by several MCH nurses in the workforce survey. Although state wide scholarships are available through the Victorian Department of Health, these have not addressed recruitment challenges in the region. As a result, more targeted approaches are likely to be needed that support direct pathways to work in WMR LGAs. Wyndham City Council currently offers scholarships of up to $25,000 for local MCH students that agree to work at Council. It is too early to evaluate the success of this initiative, but anecdotal feedback suggests it has had an initial impact. Similar initiatives in other Councils with highly diverse populations (particularly Brimbank and Maribyrnong) could be examined to encourage broader uptake of training and education from culturally diverse MCH candidates in these locations.

Challenges related to client complexity and emerging workforce pressures from new investments are outside the scope of WMR Councils to influence. Targeted initiatives that focus on

[47] Victorian Department of Health (2023). 'Early Parenting Centres', accessed from https://www.health.vic.gov.au/maternal-child-health/early-parenting-centres.

enhancing MCH workforce capacity should be a key focus to improve MCH recruitment in the region.

4.3. Retention

Several issues relating to the retention of MCH nurses at LGAs were outlined in the stakeholder consultations and the workforce survey. Retention of MCH nurses across the region was a significant challenge. As Table 17 shows**, there are significant proportions of survey respondents in Moonee Valley and Hobsons Bay that indicated they do not intend to continue working on MCH beyond three to five years.** Table 17 also shows that **Melton and Moonee Valley also face a significant, more urgent challenge retaining their MCH workforce**, as 20% and 17% of respondents, respectively indicated that they intend on exiting their role in the next one to two years.

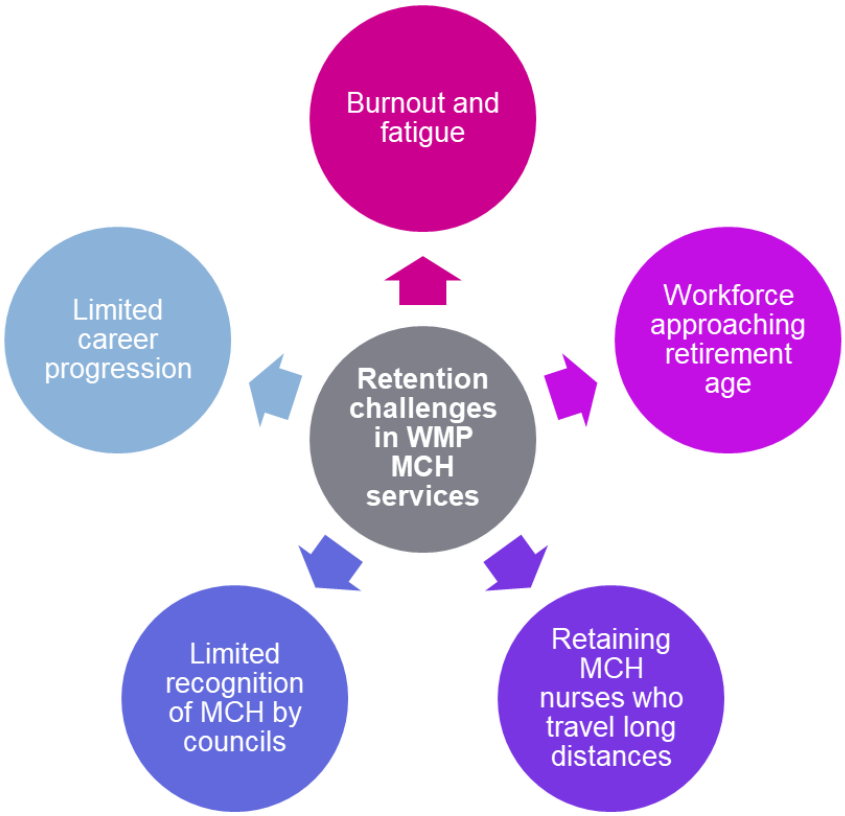
Table 17: Intentions to continue working in MCH, by WMR LGA

LGA	Survey respondents	Less than 1 year	1-2 years	3-5 years	5-10 years	10 years +
Brimbank	8	0%	0%	0%	13%	88%
Hobsons Bay	12	8%	8%	33%	25%	25%
Maribyrnong	8	0%	13%	0%	13%	75%
Melton	25	0%	20%	4%	36%	40%
Moonee Valley	6	0%	17%	33%	17%	33%
Wyndham	27	0%	19%	11%	4%	67%
Region average	**86**	**1%**	**15%**	**12%**	**19%**	**53%**

Source: HealthConsult 2023 MCH workforce survey
Note: Darker green shading represents highest values. White shading indicates lowest values

However, even those LGAs with a mostly stable workforce such as Hobsons Bay and Maribyrnong are likely to face retention challenges in the future due to ageing of the workforce and significant cohorts of older workers approaching retirement. Issues related to retention and their impacts are summarised in Figure 17.

Figure 17: Challenges retaining MCH nurses in the WMR



4.3.1. Burnout and fatigue

MCH workforce shortages are contributing to significant workload, burnout and fatigue that are impacting workforce retention across the region. In the MCH workforce survey conducted for this project, 69% of respondents cited workload/burnout as the greatest barrier to increasing the MCH workforce in the region (see Table 15, page 29).

Other factors, such as the nature of MCH work, a perceived lack of support from within Council, high administrative burden and stressors associated with the KAS Framework were also cited as sources of burnout and fatigue, which were commonly reported in the MCH workforce survey. Many nurses also reported that they rarely have time for proper breaks (including meal and in some cases, toilet breaks) due to the high levels of workload and suggested that dairies need to allow time for these base-level entitlements. Key comments included that:

"MCHNs need to be supported by employers and management to prevent burnout and fatigue"

[key barriers to improving MCH services in the region are] "Mostly lack of staffing issues. MCH nurses burning out quickly due to workloads and lack of support."

"Need to ensure structure of a MCHN diary allows MCHN's to have basic workplace entitlements and promotes well ness (i.e., proper time frames for toilet and lunch breaks). MCHN's overall need to be supported better."

"Better pay and more admin time plus increased time for KAS consults would reduce MCHN pressure"

"I always work through my lunch break and tea breaks to get administration and notes done. The current system has unrealistic expectations of nurses and takes advantage of our good will and desire to help families"

"There is no time to take proper lunch breaks and MCH nurses perform so much unpaid overtime every day because these clients are just so vulnerable, and their health needs are

often complicated often requiring huge amounts of time writing and connecting these clients (often CALD clients) to referral services. Also, large amounts of time are taken writing very detailed notes to ensure that the individual MCH nurse can do her best to be legally protected."

At <LGA> there are too many KAS consults crammed into every day, and the workload and the time frame allocated do not match, as there are just so many issues to deal with, and inadequate time frames allocated.

"As an MCHN at <LGA> we have little control over our own diaries and are controlled essential by administration staff, who I also acknowledge have a difficult role, but they actually have little understanding of how difficult and complex the MCH role is when trying to deliver care to vulnerable/CALD clients. I would like more control over my diary and if I need extra time to write referral/ notes this should not be an issue."

The most common suggestion to improve burnout and fatigue was to provide more MCH nurses into WMR Councils. Student models were highlighted as being potentially useful for this purpose, but also need to be supported by allocation of educator and preceptor resources that are already stretched in many LGAs.

Increased pay, flexibility in diaries and better working conditions were also a common theme throughout the workforce survey to address issues of burnout. Wellbeing days were highlighted as an initiative that has been implemented in Wyndham and was well-received through the survey, but which also has an impact on already limited MCH resources across Councils.

Telehealth consultations were trialled during COVID with mixed results, based on feedback obtained from WMR Councils. While telehealth holds potential to provide increased workforce capacity by allowing MCH nurses to deliver a very limited scope of work (typically initial assessment and triage), it also needs to meet the needs of parents and families. Feedback from Councils suggested that the impact of telehealth in providing additional capacity was often limited, and it is unlikely to be a viable solution for workforce capacity challenges on its own. The Victorian Department of Health has recently developed the guidelines for usage of telehealth in MCH services when usage of telehealth was required to support MCH service delivery.[48] The guidelines set out which interactions can be safely and effectively provided by telehealth for each KAS visit. They reinforce that some elements of almost all KAS consultations will require face-to-face interaction, but provide guidance on how telehealth can be used in MCH services of Councils with the interest and capacity to do so.

4.3.2. Workforce approaching retirement age

As shown in Table 10 (Section 3.3), approximately **one quarter (24%) of the region's MCH nursing workforce is aged over 60 and likely to retire soon. Based on this age profile, the impending impacts of an ageing MCH workforce are likely to be felt most acutely in Maribyrnong (38% aged over 60) and Hobsons Bay (32% aged over 60).** Maribyrnong LGA indicated during consultations that 40% of MCH nurses in their LGA are planning to retire in the years to come.

Table 18 reflects the results of the MCH workforce survey that was conducted for this project. This table reinforces the likely impacts of approaching retirement on the MCH workforce in Maribyrnong and Hobsons Bay. It also suggests that a substantial proportion of workers aged 55+ in Wyndham, Moonee Valley and Melton are likely to exit the workforce within five years.

This table should be interpreted in the context of small sample sizes that were aged 55+ for most LGAs, which could skew interpretation of the results. However, when interpreted alongside Table 10 it suggests that **retirement is likely to exacerbate current workforce shortages in most Councils across the region within the next five years**.

[48] Victorian Department of Health (2022). 'Telehealth Guidelines for Victorian Maternal and Child Health Services', accessed from https://www.health.vic.gov.au/publications/telehealth-guidelines-for-maternal-and-child-health-services

Table 18: Intention to continue working in MCH for surveys rspondents aged 55+

LGA	Survey respondents aged 55+	1-2 years	3-5 years	5-10 years	10 years +
Brimbank	2	0%	0%	0%	100%
Hobsons Bay	9	14%	57%	29%	0%
Maribyrnong	4	50%	0%	50%	0%
Melton	15	33%	0%	67%	0%
Moonee Valley	5	25%	50%	25%	0%
Wyndham	22	45%	27%	9%	18%
Region average	**57**	**32%**	**26%**	**32%**	**9%**

Source: HealthConsult 2023 MCH workforce survey
Note: Darker green shading represents highest values. White shading indicates lowest values

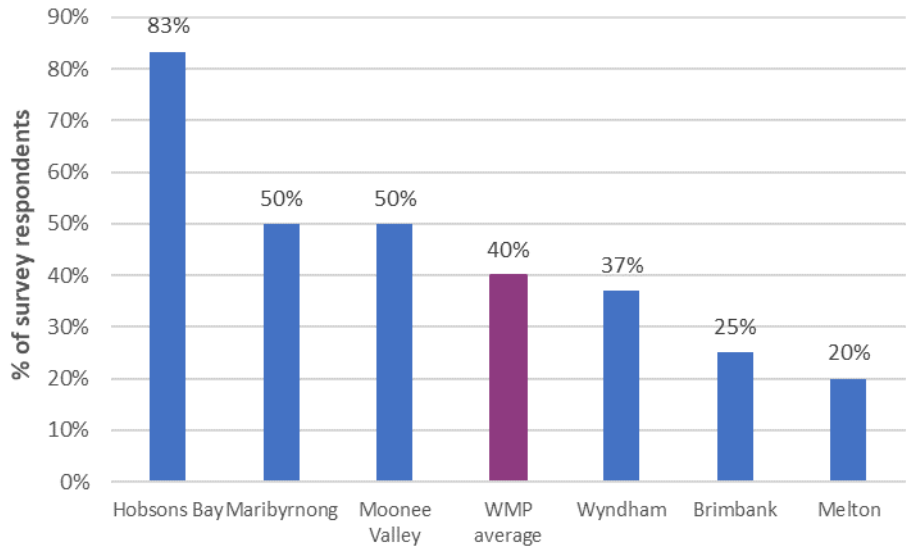
Managing the impacts of retirement in older cohorts of the workforce will require in-depth workforce planning and replenishment of the workforce to ensure there are adequate MCH nursing resources available in future. Providing pathways for younger and middle-aged MCH nurses to progress will also be important to ensure that new MCH nurses that enter the system are adequately supported. Ideally, this will require active collaboration between Councils, MAV and the State Government Departments of Health and Education, which is providing grants for workforce planning at a municipal level.

4.3.3. Challenges retaining MCH nurses living outside of employing LGAs

The MCH workforce survey showed that only 40% of respondents live within the same LGA they work in (Figure 18). Anecdotally, this creates challenges retaining MCH nurses (particularly where they need to travel long distances to work) given that many consultations identified that there is a widespread desire for MCH nurses to live close to where they work.

Several consultations with Councils included examples of where **MCH nurses that travel long distances will leave their positions in western Melbourne if they find a position closer to home.** Figure 18 suggests that this is most likely to be an issue driving challenges in workforce retention in Melton, Brimbank and Wyndham.

Figure 18: Proportion of survey respondents that live and work in the same LGA



Source: HealthConsult 2023 MCH workforce survey

The impacts of travel for MCH nurses in the region are most significant in Melton (average travel distance 52 km) and Wyndham (49 km). The stakeholder consultations highlighted that

these LGAs are those that are experiencing the most significant MCH retention challenges across the WMR. By comparison, MCH nurses working in LGAs such as Moonee Valley and Maribyrnong typically travel much shorter distances to work. Thee LGAs reported much less significant recruitment and retention challenges.

Table 19: Average distance MCH nurses travel to work

LGA that MCH nurse works in	Average distance (in km) travelled to work
Brimbank	21.5
Hobsons Bay	20.7
Maribyrnong	14.45
Melton	52.0
Moonee Valley	18.1
Wyndham	48.8

Source: HealthConsult 2023 MCH workforce survey

The challenges associated with retaining a workforce that, in many cases, travels a significant distance to work highlights the value of developing a 'local' MCH workforce that is trained in or nearby the region.

4.3.4. Limited recognition of the value of MCH by Council management

The workforce survey and stakeholder consultations highlighted a widespread view that the **MCH nursing workforce does not feel valued by Council management or executive.** Survey respondents expressed a variety of frustrations about a lack of recognition or support within Councils, including that:

> *"I feel MCH nurses would be more plentiful if they felt heard and appreciated."*
>
> *"It is my experience that MCHNs do not move to other Councils when they feel listened to and respected by the leadership team."*
>
> *"I feel MCHNs would be more plentiful if they felt heard and appreciated.*
>
> *"MCH nursing at <LGA> is an extremely difficult and unsupported role, particularly at Council and MAV Victoria level"*
>
> *"I do not feel heard or valued in this role."*
>
> *"Half the population do not realise the education levels or qualifications needed to become a MCHN nor does Council management or leadership."*
>
> *"Poor management in <LGA>"*
>
> *"Lack of respect from Local Government management"* [is the main challenge to increasing MCH workforce recruitment in the region]

Two survey respondents that indicated they were likely to exit the role within the next two years cited a lack of support from management as the key reason why this is the case.

Opportunities to elevate the role of MCH nurses within Council are likely to be required to address these issues. Establishment of forums to ensure the feedback, ideas and grievances of MCH nurses can be heard by management and executive may also improve the recognition of MCH nurses in their role to support improved retention.

Some MCH nurses also perceived that their pay and entitlements were not commensurate with others, despite their high levels of qualifications and the importance of their role. One survey respondent stated that:

"MCH is an undervalued resource and it's really disappointing that we work so hard to specialise to be told that we should be comparable to other lower qualified members across Council for benefits including base wages and holiday entitlements."

4.3.5. Limited career progression

Along with not feeling valued, **there is a lack of career progression for MCH nurses.** Many nurses from LGAs advised in the stakeholder consultations that it is easier to form a career pathway in the public hospital system. In the community setting, it is harder to progress their carer due to the unavailability of positions other than a team leader or manager role. The stakeholder consultations highlighted that this usually results in MCH nurses choosing to pursue a career in the hospital setting rather than in the community setting due to a lack of career progression opportunities.

Opportunities to address retention issues impacting MCH services:

Issues contributing to retention challenges in the region's MCH workforce are multifactorial and intersect with broader system-related issues such as limitations of the KAS Framework and overall workforce shortages. The impact of some of these challenges can be mitigated by developing a 'local' MCH workforce in the region, by increasing capacity to meet demand, reducing burnout and reducing reliance on MCH nurses living outside of the region, which often take positions closer to home when they are available.

Workforce planning (both at an individual Council level and across the region) will be important to address challenges associated with the ageing MCH workforce and impending retirement across the region, but particularly in areas such as Hobsons Bay and Maribyrnong. Formalisation of a region-wide MCH 'network' or 'community pf practice' could be considered to promote regular collaboration, information sharing, planning and advocacy on issues relevant to the MCH workforce. Such a forum could also enhance professional networks and supports for the MCH workforce overall, to improve retention.

Promoting the value of MCH, and MCH leadership within Councils should be pursued to address the widespread feeling that MCH nurses are not valued by LGA management and executive. Feedback provided through the workforce survey highlighted that MCH nurses often do not feel heard or listened to, so providing forums for MCH nurses to provide feedback and suggestions (and then executive and management acting on this feedback), could help to address this. Collecting and reporting positive feedback from families that interact with MCH services could also be used to improve job satisfaction and ensure that MCH nurses know they are making a difference to the lives of children and families.

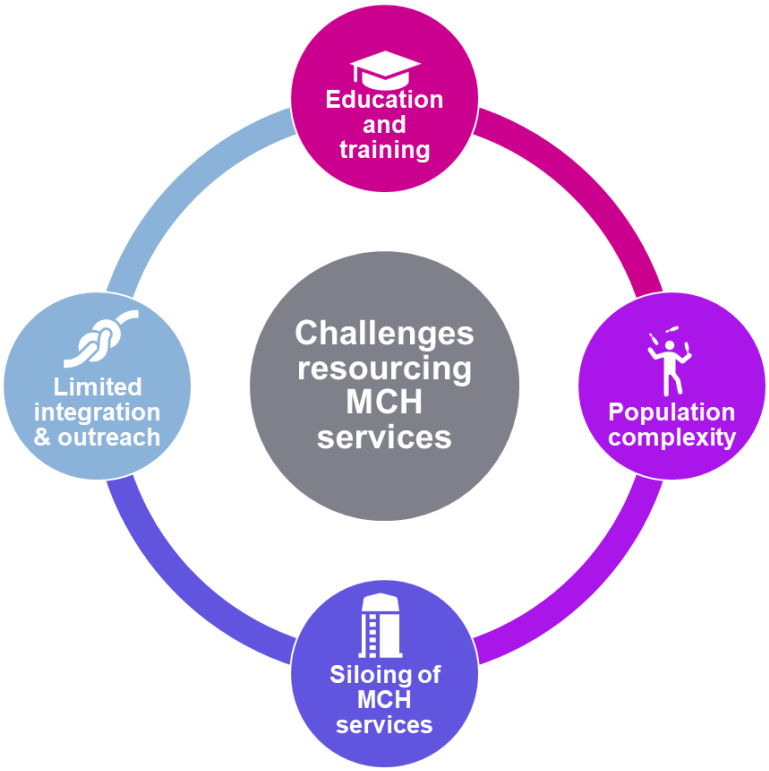
A **travel stipend** was suggested by one stakeholder to improve retention of MCH nurses that travel from outside the region. However, this is not likely to be a long-term solution to MCH retention challenges and could exacerbate existing funding and resourcing challenges across Councils and MCH services. This initiative has reportedly been trialled in Wyndham and was not effective in retaining staff.

Given that many MCH nurses also have young families, **incentives such as subsidised childcare for MCH nurses at Council-operated childcare centres** could also be explored to retain MCH nurses in their roles. This could also potentially be explored as an opportunity to integrate MCH and early childhood services if arrangements can be made for MCH nurses to work in these settings.

4.4. Resourcing challenges

Financial and recruitment constraints were consistently highlighted during consultations as creating resourcing challenges for Councils and MCH services. Resourcing challenges for MCH services across the region manifest in several ways, as summarised in Figure 19.

Figure 19: MCH resourcing challenges in the WMR



4.4.1. Education and training of MCH nurses and students

Although education and training opportunities are fundamental to the development of the MCH workforce and replenishment of older workers with new graduates, stakeholder consultations highlighted the **time and resource requirements associated with supporting new graduates.** This requires additional resources to support the new graduate in their role as well as an increased world of existing staff members.

Funding contributions from the State Government do not cover the provision of educator and preceptor roles within MCH services, which means that they must be wholly funded by Councils. Given the widely reported financial pressures faced by Councils and workload pressures on MCH nurses, this can create challenges to the sustainable delivery of MCH education and training supports. One stakeholder said:

> *"We simply cannot ask them (MCH nurses) to take on any more pressure in our current environment."*

Advocating for education and training roles to be captured by the MCH funding model should be pursued by WMR Councils. There are several important drivers for such advocacy, which could highlight factors such as:

- the fundamental role of education and training in workforce development
- the expected retirement of roughly one quarter of the MCH workforce in the region, which will exacerbate existing pressures on MCH services to provide MCH education and training to replace outgoing workers
- the establishment of state level programs such as the Victorian MCH Student Employment Model (which has not yet been implemented and is currently restricted to LGAs with severe workforce shortage), which will also require support for Councils to provide increased education and training support, for this initiative to succeed

- increasing requirements for education and training if a new MCH qualification(s) in the west are established, as the 'pipeline' of new graduates entering the system will be higher.

4.4.2. Resource requirements to support complex populations

Population complexity was also identified as a key driver of resourcing for MCH services in the region, with complexity associated with cultural and linguistic diversity, low socioeconomic status and family violence cited as a key driver of increased MCH workload. Resourcing requirements for complex populations are reportedly felt more in LGAs such as Melton, Wyndham and Brimbank than in most other areas across the region.

Consultations and the workforce survey often highlighted how use of interpreters for CALD populations in areas such as Wyndham, Brimbank, Melton and Maribyrnong can take more time to organise, and can "nearly double" the duration of the consultation. Comments received in relation to usage of interpreters included:

> *"Often interpreters are male, which makes it difficult to speak with a woman about her birth experience."*
>
> Another survey respondent outlined that:
>
> *"There is a need to improve interpreter services, have more localised interpreters relevant to local needs."*
>
> One survey response suggested to:
>
> *"Have interpreters attached to MCH service in the common languages in our area and advocates in the community through the Community Development model?"*

Challenges associated with high levels of family violence and low socioeconomic status were also consistently highlighted as stretching available MCH resources; particularly within a service delivery framework that many MCH nurses believe does not provide adequate time for such complexity to be considered. Challenges were also highlighted as being more significant in the west of Melbourne than in many other locations across Victoria. This was reported by multiple Councils as a key reason why many MCH nurses reportedly do not want to work in the west.

Although additional weightings to reflect population complexity are part of the MCH funding model, these are based on the Accessibility and Remoteness Area classification and number of FTB recipients with a child aged zero to six years. **Several Councils do not believe the approach to calculating and applying the weighting reflects the level of complexity of populations in some areas of the region**.

The ABS uses the Index of Relative Socioeconomic Advantage and Disadvantage as a key reference point for measuring relative disadvantage, and is derived by considering a range of different Census variables including income, education, employment, occupation and housing characteristics. As shown in Table 20, the IRSD provides a more nuanced reflection of relative socioeconomic advantage and disadvantage compared to using remoteness area, which classifies all LGAs except Wyndham as Major Cities. The IRSD is a single measure of relative disadvantage, which is simpler than drawing on both remoteness area and FTB recipients. **Using IRSD could be considered as an alternative to ARIA and FTB recipients to identify and adjust finding for relative disadvantage**.

Table 20: Comparison of remoteness area and IRSD scores, by WMR LGA

LGA	Remoteness Area (2016)	ISRD score (2016)
Brimbank	Major Cities	926
Hobsons Bay	Major Cities	1,002
Maribyrnong	Major Cities	974
Melton	Major Cities	1,002
Moonee Valley	Major Cities	1,027

LGA	Remoteness Area (2016)	ISRD score (2016)
Wyndham	Inner Regional Australia	1,013

Source: Australian Bureau of Statistics

4.4.3. Siloing of MCH services across LGAs

Consultations revealed significant variability across WMR Councils in the extent to which MCH workforce pressures exist, and the reasons underpinning them. Stakeholder consultations identified that **during COVID-19, attempts were made to share MCH nursing resources across WMR LGAs to alleviate workforce shortages**. For instance, Moonee Valley reported attempting to share workforce with Brimbank WMR Councils highlighted that **sharing of resources across LGAs was challenging in practice due to insurance and industrial requirements.** Often, these constraints meant sharing of workforce was highly restricted and required significant effort. One LGA described attempts to share MCH resources as “a massive fail”, which suggests there is unlikely to be appetite to explore sharing of resources further.

4.4.4. Limited opportunities for integrated provision of MCH and related services, and outreach

Published research identified many approaches to address similar issues to those faced in the region through:

- workforce development initiatives
- improving community access to MCH services and
- adopting integrated approaches to delivering MCH and related services.

The MCH workforce survey also highlighted a strong desire for more integrated approaches across disciplines to improve referral pathways, provide networking professional opportunities and to improve care for children and families. However, **opportunities to integrate MCH and related services are limited due to many factors such as resourcing challenges within Councils, and blockages in referral pathways to primary care, paediatric and allied health services.**

Where such support services are available within WMR Councils, they were received very positively and provide an important adjunct to UMCH services. Consultations revealed a view among some stakeholders that MCH are frustrated at the limited ability to work in a multidisciplinary capacity and that the rigidity of the KAS Framework limits their scope of practice. Given the legislated requirements for triple qualified MCH Nurses to deliver KAS consultations, **it was suggested that a review of the KAS Framework is needed to identify how (and under what circumstances) other disciplines can support MCH nurses in a more active multidisciplinary model to better manage MCH workload**.

The workforce survey also identified a strong desire among MCH Nurses to conduct more outreach to improve community access to, and awareness of MCH services. While this can be achieved through local service configuration decisions and use of the flexible MCH funding component, consultations with Councils identified that **current workforce shortages mean opportunities to conduct outreach are limited**. COVID-19 was identified as a key change point on the capacity of WMR Councils to conduct MCH outreach. Whereas MCH nurses were previously more often able to attend multicultural play groups, these were stopped due to COVID-19 and have not been reinstated in most LGAs due to resource constraints. Play groups were viewed as highly valuable by both families and Councils and there is value in exploring how MCH services could continue to work with them where capacity exists.

5. Opportunity assessment

This section outlines opportunities that were considered to improve MCH workforce capacity in the region to meet local needs, provides and assessment of the opportunities and presents recommendations for which opportunities should be pursued.

5.1. Opportunities to improve MCH services in the region

Consultations with WMR Councils highlighted a range of issues that are relevant to the development and evaluation of opportunities to improve the sustainability of MCH services across the catchment. Key issues included that:

- **there are substantial challenges facing the MCH workforce in the region**. Broadly, these issues relate to the system in which MCH services operate and challenges to MCH recruitment, retention and resourcing
- **significant work has previously been undertaken** to explore potential solutions at the state and local levels
- **many initiatives have been trialled, but few have been successful** in making a significant impact on MCH services
- **meaningful changes are most likely to be made if there is a commitment by both state and local governments to addressing the key challenges** across both the system level and local levels. There is an inextricable linkage between MCH services that are delivered at the local level and the funding, governance and service delivery framework that they operate within, which is developed at the state level.
- **a mix of region-wide and place-based approaches are likely to be required**. The challenges facing the MCH workforce vary across the WMR. The impacts of issues are more challenging for some WMR LGAs than others.

For these reasons, the process to develop opportunities that can positively impact MCH services and had not been trialled before was challenging. Table 21 outlines the key options that were suggested as being feasible by stakeholders. The table provides a high-level description of each option, an indicative rating of its feasibility and impact, and a rationale for these ratings. Section 5.2 then presents recommendations for which options should be pursued, and a plan for how.

Table 21: Opportunities to improve MCH workforce sustainability

Opportunity	Description	Expected impact on MCH services	Feasibility assessment
Establish a new postgraduate MCH qualification in a university located in the west to increase the supply of MCH nurses. *Key issue(s) to be addressed:* • *Workforce recruitment/supply*	**How:** Western metropolitan region Councils would approach a university/ies in or near Western Melbourne (e.g., VU or the Australian Catholic University) to establish a new accredited provider in the west for the postgraduate degree/diploma in MCH nursing. **What:** Ideally, this would involve the establishment of a pathway for students at this university to gain employment within Councils across the region. This would provide a clear pathway for nurses and midwives living in or around the region to obtain qualifications (and then, employment) in a MCH role in a Council near where they live. **Why:** Currently, providers of postgraduate MCH qualifications are located a long way away from the WMR in South-Eastern Melbourne (Berwick or Bundoora). This option would help to address the current shortages in MCH nurses across the region and support ongoing workforce sustainability by providing a local pathway for aspiring MCH nurses to live, study and work locally. Initial discussions with VU have confirmed they have the willingness and resources to pursue this option A precedent exists to establish new postgraduate MCH courses through approaches by local Councils. Federation University's postgraduate MCH course was established through an initial approach from Councils in South-Eastern Melbourne.	**High** Additional workforce supply is urgently required. Establishing a local workforce is likely to positively impact recruitment and retention	**Medium - High** Interest exists but additional resourcing for educator positions needed to avoid placing more pressure on existing MCH services / workforce
Formalise two WMR-wide MCH networks for: • **MCH managers and coordinators (network already in existence), to lead workforce planning, resource sharing and advocacy efforts** • **MCH nurses (proposed new network), to establish a region-wide community of practice and collegiate support structure.**	**What:** WMR Councils could formalise existing networks across the region to collaborate more actively on workforce planning, identify opportunities to share workforce/resources/learnings and advocate for change on key system level issues that are impacting MCH services. **How:** Existing network structures operating across councils should be formalised to establish two separate networks focused on: • Workforce planning and advocacy. This network would be comprised of MCH managers and coordinators from across the WMR • Peer support and information sharing (i.e. a Community of Practice). This network would be comprised of non-managerial MCH nurses, with oversight / involvement by MCH managers. To avoid additional workload / burnout impacts on MCHNs, this could be established as an online community of practice, with access via username and password to online discussion forums and resources that could be accessed around work commitments. This would need to be discussed among WMR Councils. Both networks would establish more regular (monthly) meetings, led by one WMR Council (with rotations every quarter or half year). A Terms of Reference and standing agenda could be developed, along with an allowance for new or 'ad-hoc' issues to be discussed.	**Medium** Impact achieved will depend on strength of evidence base and ability to influence Additional funding and system level change are significant issues – impacting these would produce great benefits for MCH services	**Medium – High** Collective / networking arrangements can be established without significant resource and time requirements Not all Councils are facing the same level of issues – which may impact the engagement of some Councils

Opportunity	Description	Expected impact on MCH services	Feasibility assessment
Key issue(s) to be addressed: • *Resource challenges* • *Workforce recruitment* • *Workforce retention*	**Why:** Current networking arrangements for managers and coordinators exist, but have had limited impact on achieving coordinated workforce planning, resource sharing and advocacy to address issues impacting MCH services across the WMR. Following from the information presented in this report, more regular discussion and information sharing could provide a platform to engage with other services across Victoria to identify collaboration opportunities and achieve stronger advocacy on key issues.		
Establish targeted scholarships for MCH nurses living in the region to undertake postgraduate MCH study with 'return of service obligations' to work at WMR Councils. Scholarships would be targeted to attract nurses to the profession in specific Councils and with specific cultural backgrounds (e.g. Indian, Vietnamese) *Key issue(s) to be addressed:* • *Workforce recruitment*	**What:** This option proposes that targeted scholarships are established by WMR Councils to attract new MCH nurses to the profession. **How:** Wyndham City Council currently offers scholarships of up to $25,000 for local MCH students that agree to work at Council. This program could be extended to other Councils (and ideally part-funded by the State Government) to support targeted recruitment of MCH nurses that live in each Council, or who are from a cultural background that is under-represented in the MCH workforce (relative to the population). A 'return of service' obligation could be included as a condition of the scholarship that requires MCH nurses to work for a period of 2-3 years in the employing Council as a condition of receiving the full scholarship. **Why:** Scholarships have proven to be successful to increase the number of MCH nurses undertaking postgraduate study, but need to be targeted to ensure nurses with specific characteristics (e.g., that live/work locally or have culturally diverse backgrounds) can take up scholarships.	**Medium – High** Research suggests MCH scholarships are widespread and likely to have a positive impact Extent of impact should be assessed based on new scholarship approach in Wyndham.	**Medium** Would be difficult for some Councils to secure funding for scholarships Could require lobbying to State Government to alter existing scholarships to make them more targeted. Would also need to consider equity impacts for other areas experiencing challenges across the state.
Enhance support to the MCH workforce to reduce burnout and fatigue. *Key issue(s) to be addressed:* • *Workforce retention*	**What:** This option would aim to improve workforce retention among the region's MCH workforce by establishing personal and professional support structures within Councils to minimise MCH burnout and fatigue. **How:** Several initiatives were identified in the MCH workforce survey as potential themes that could better support the workforce. This included the establishment of 'wellbeing days' as entitlements for MCH nurses and improving flexibility of scheduling to ensure MCH staff can take regular breaks. **Why:** Burnout and fatigue associated with the shortage of MCH nurses and the complexity of MCH work (particularly in some Councils where the client cohort is more complex) were identified as key issues impacting the retention of nurses in the profession.	**Medium** Reducing workload and burnout/fatigue were identified as key priorities to improve retention	**Medium** Changing entitlements likely to be complex and time-consuming Wellbeing days have placed pressure on existing MCH services – other approaches may

Opportunity	Description	Expected impact on MCH services	Feasibility assessment
	Wellbeing days were highly valued by MCH staff in Wyndham and could be considered in other Councils, although impacts on resourcing for MCH services would need to be considered. Limited flexibility in scheduling and an inability to take regular breaks were consistently highlighted as frustrations of the MCH workforce that are contributing to fatigue, frustration and burnout. Providing more flexibility for MCH nurses to ensure these breaks can be taken may help to alleviate these issues.		need to be considered
Improve recognition of the MCH nurse role within WMR Councils and in the community by: • **establishing forums for MCH staff to communicate with executive management and mechanisms to recognise and reward the work of MCH nurses.** • **establishing a region wide MCH campaign to promote the value of the MCHN role, including to specific cultural groups that are under-represented in the WMR MCH workforce.** *Key issue(s) to be addressed:* • *Workforce retention* • *Workforce recruitment*	**What:** This option would seek to improve retention of existing MCH nurses across the WMR by establishing mechanisms for them to be heard and recognised for the valuable role they provide within Councils. This option would also seek to improve recruitment of MCH Nurse candidates by establishing a promotional campaign to elevate community understanding of the role and value of MCH nurses. Specific promotion would be targeted to MCH nurses with a cultural background that is under-represented in the MCH workforce (compared to the community; particularly Indian and Vietnamese people. **How:** Individual Councils would establish regular forums for MCH staff to communicate issues, feedback and concerns to executive management. Separately, councils from across the WMR would collectively (ideally), or individually develop campaigns to improve understanding of the MCH role and promote MCH nursing as a career option. This would include specific, targeted promotion to Nursing and Midwifery qualified Indian and Vietnamese people, to improve the cultural alignment of the workforce to the Region's population. **Why:** Stakeholder consultations and the MCH workforce survey highlighted that MCH nurses feel that the value of their work is not acknowledged or understood by Council management and executive, which impacts job satisfaction. The profession would like more recognition for the value that they provide to the community, which was reflected by several comments in the MCH survey, including that: *"It is my experience that MCHNs do not move to other Councils when they feel listened to and respected by the leadership team"* *"The reputation of MCH is undersold and there needs to be a huge government promotion of what we do".* Additionally, analysis shows that the cultural and linguistic diversity in the WMR community is not reflected in the Region's MCH workforce.	**Medium** A combination of a region wide MCH promotion and specific initiatives within Councils could improve both recruitment and retention.	**Medium** Appetite for region-wide promotion and establishment of forums and recognition mechanisms for MCH within Councils has not yet been tested

Opportunity	Description	Expected impact on MCH services	Feasibility assessment
Increase usage of MCH students to enhance MCH workforce capacity. *Key issue(s) to be addressed:* • *Workforce recruitment* • *Workforce capacity*	**How:** This option would involve LGAs across the region working with SCV, the Department of Health, MAV, universities and the ANMF to expand their intake of student MCH nurses under the Victorian MCH Nurse Student (VMCHNS) employment model. **What:** Partnerships between WMR Councils and universities could also be explored to enhance MCH student pathways into WMR Councils, but this would require further discussion with the organisations identified above. **Why:** LGAs across the region that have been involved in the rollout of the model expressed that MCH student nurses are assets to their services and have provided a key pathway to ongoing employment.	**Medium** Establishment of pathways for student nurses could have a meaningful impact on workforce capacity if implemented well. Could be most beneficial if additional MCH qualification is developed in the WMR	**Medium** Current student model not yet implemented and is therefore untested Requires support from Educator and preceptor roles that some Councils may not be resourced to deliver. Additional funding required to avoid additional pressure on MCH workforce
Establish partnership approaches between LGAs to share workforce and resources. *Key issue(s) to be addressed:* • *System issues* • *Resource challenges*	**What:** This option proposes that the operation of existing networks between coordinators and managers across the WMR are formalised and focus on identifying opportunities to collaborate and share resources, advocate for change and conduct region-wide workforce planning to better support the MCH workforce and improve workforce capacity. **How:** Ideally, the existing MCH manager and coordinator network operating across WMR Councils would collaborate internally (and with other Councils / networks, such as those with interface councils in the north or south-east of Melbourne). The aim of these discussions would be to establish information and resource sharing agreements or memoranda of understanding to allow the MCH workforce to operate across Council boundaries. Such agreements would need to address issues in insurance, indemnity, onboarding requirements, pre-employment checks and pay. **Why:** Some WMR Councils have greater capacity in their MCH workforce than others and could thus be able to share members of their workforce if an agreement can be reached to do so.	**Medium** One LGA described contracting arrangements with other Councils as a 'big fail' so there may be a limited appetite to pursue this option. LGA to LGA agreements via MAV could be explored.	**Low - Medium** Partnering between WMR Councils was attempted during the COVID-19 pandemic, but with significant challenges and mixed results.
Embed telehealth consultations as a component of MCH services for initial assessment, triage and referrals.	**What:** Additional capacity to conduct KAS visits could be created within MCH services by enhancing the ability of MCH nurses across Victoria to provide telehealth consultations, triage and assessment services for WMR Councils. **How:** Qualified MCH nurses from across Victoria could conduct initial triage, assessment and consultation/liaison services for families at key points in the KAS Framework where face-to-face interaction may not be required. Families could then be directed to services for shorter face-to-face appointments where measurements or in-person assessments need to be conducted.	**Low – Medium** Telehealth could provide a flexible way to increase MCH capacity and reduce travel requirements.	**Low – Medium** The perceived value of telehealth was reportedly mixed among WMR Councils. While it has worked well for

Opportunity	Description	Expected impact on MCH services	Feasibility assessment
Key issue(s) to be addressed: • *Workforce capacity* • *Workforce recruitment*	Opportunities may also exist for Councils to purchase services from another municipality to deliver part of the KAS framework for older children with 15 minutes or less physical assessment within the municipality in the short-term, to alleviate demand pressures. **Why:** Telehealth was reported by some Councils as being a suitable (though not ideal) approach to engage with families that can provide flexibility for the workforce and additional capacity for MCH services if MCH nurses from across Victoria can provide telehealth consultations.	There are significant limitations to what KAS visits can be provided by telehealth Vic MCH telehealth guidelines could support clarity on when telehealth is appropriate	some, others reported significant challenges and limitations
Provide incentives for integrated MCH service provision at early childhood centres across the region. *Key issue(s) to be addressed:* • *Workforce retention*	**What:** WMR Councils could explore integrating MCH services with early parenting or childcare centres they operate. Incentives could be offered to MCH nurses working in these settings to attract and retain MCH nurses into these positions, while also better-supporting access to MCH services in the community. **How:** Subsidised childcare at Council-operated early childhood facilities could be offered to incentivise MCH nurses with children to operate from these centres. Having a MCH nurse(s) on-site at a childcare centre could also attract more potential clients (families) into these services, so potential could exist to realise a mutual benefit. **Why:** Embedding MCH nurses with early childhood services could help to meet the needs of the community and provide additional opportunities for families to access MCH services.	**Low – medium** Has been trialled in Melton and Wyndham but achieved limited impact	**Low** Space constraints for MCH nurses to conduct consultations in a childcare environment may restrict the suitability of this option.
Establish a travel stipend to improve the retention of MCH nurses that travel long distances to work. *Key issue(s) to be addressed:* • *Workforce retention*	**What:** This option proposes that WMR Councils consider introducing a travel stipend for MCH nurses that travel from outside of their LGA to assist with the costs of travel and transport to help retain these staff for longer. **How:** Councils could include a travel stipend as part of MCH entitlements to recognise additional time and costs associated with travelling from another LGA to work in a particular Council. Consideration could be given to providing a greater allowance for travelling to key areas of MCH workforce need, such as Melton or Wyndham. State government assistance could be sought to assist in funding this initiative. **Why:** 60% of respondents to the MCH workforce survey conducted for this project reported travelling from another LGA to work in their MCH role. Councils also reported challenges retaining MCH nurses that travel from outside the LGA because they typically take another position closer to home as soon as one becomes available.	**Low** A travel stipend was trialled in Wyndham with little to no impact on retention. Unlikely to be a long-term solution to improve retention for MCH nurses that travel long distances to work.	**Low – Medium** Funding constraints may restrict the attractiveness of this option for some Councils. Considered as unlikely to be sustainable under the current funding agreement.
Promote standardised support structures for	**What:** This option would seek to ensure that MCH capacity to deliver the KAS Framework is optimised by establishing key support structures/services (in all Councils) that were reportedly valued highly.	**Low**	**Low** Would be difficult to achieve due to the

Opportunity	Description	Expected impact on MCH services	Feasibility assessment
MCH services in all WMR LGAs. *Key issue(s) to be addressed:* • System issues • *Resource challenges*	**How:** A standardised support structure would consider the optimal would consider the mix of MCH nurses, Managerial/Coordinator staff, MCH nurse educators and other support staff (e.g. lactation, sleep and settling staff) based on projected activity and the mix of Universal and Enhanced services in each Council. Discussion and promotion of these roles across all WMR MCH services could support improvements in MCH workforce capacity. **Why:** WMR Councils were strongly supportive of educator roles, lactation support, administrative support, sleep/settling support and bi-cultural workers being available to support MCH services and to ensure that new MCH nurses are provided with a range of professional development opportunities.		separate arrangements across each Council. Funding constraints in some LGAs may limit extent to which this can be implemented.

5.2. Recommended directions

Seven recommendations have been identified as feasible and likely to have a positive impact on MCH services in the region (Table 22). These recommendations have formed the basis for development of strategic directions to improve MCH workforce sustainability in the WMR, which are presented in Section 6.

Table 22: Summary of recommended actions to improve MCH workforce sustainability in the WMR

Recommendation	Rationale	Priority	Implementation timeframe	Key considerations
1. Establish a new postgraduate MCH qualification in a university located in the west to increase the supply of MCH nurses.	• There is a serious shortage of MCH nurses across the region, particularly in Melton, Brimbank and Wyndham • Approximately 24% of MCH nurses in the region are aged over 60 and are likely to retire soon • There are currently no providers of postgraduate MCH qualifications in the west of Melbourne • MCH nurses prefer to work close to where they live, however, the region experiences substantia difficulties retaining MCH nurses because 60% travel from outside the catchment • VU has expressed an interest and capacity to establish a postgraduate MCH qualification in the WMR.	**High**	**Medium-term** December 2025	• Need to scope pathways between VU and WMR Councils to ensure graduates obtain employment in the WMR • Capacity constraints in current MCH services (and for individual MCH nurses) need to be considered • Implementation needs to be supported by expanded nurse educator capacity and additional funding – advocacy required.

Recommendation	Rationale	Priority	Implementation timeframe	Key considerations
2. Formalise two WMR-wide MCH networks for: • **MCH managers and coordinators (already in existence), to lead workforce planning and advocacy efforts** • **MCH nurses (proposed new network), to establish a region-wide community of practice and support structure**	• Focusing existing networks on providing a strong, unified, region-wide 'voice' for MCH services will optimise the effectiveness of the advocacy in recommendation 3. • Establishment of a dedicated WMR MCH Community of Practice for MCH nurses would provide opportunities for better professional networking and inter-professional support across the region, which may improve retention.	**High**	**Short-term** by July 2023	• Terms of Reference, scope of activities, leadership and roles/responsibilities need to be defined. • Potential to use the MCHN network as a 'community of practice' to provide support and development opportunities. • To mitigate impacts on existing work pressures, the MCHN network could be established as an online community of practice that can be accessed when convenient for MCH nurses, rather than as a formalised structure with regular meetings.
3. Develop a collective (region-wide) position and evidence base and advocate for change on: • **the MCH funding model** • **review of the KAS framework** • **expanded online learning in postgrad MCH courses** • **state-wide consistency in MCH salaries and conditions**	• Issues related to funding and the KAS Framework were commonly reported as being constraints on MCH service capacity and the flexibility of MCH nurses. • While some parts of postgrad MCH courses are delivered online, requirements for face-to-face delivery present barriers for some prospective MCH nurses that live a long way from universities that offer these courses • Other similar professions with significant Council involvement (e.g. kindergarten staff) have demonstrated the potential to achieve a state-wide consistent award that support consistent pay and conditions across the sector. A similar ward could be developed for MCH nurses, but would require state-level management and advocacy by Councils. • Advocating for change on these key system level challenges would produce significant improvements in service and workforce capacity if changes can be achieved. • Several recommendations associated with expanding workforce capacity will require additional funding that is not likely to be available within existing Council resources.	**High**	**Short-term** by December 2023	• Strong evidence base will be required on issues associated with these challenges and their impacts • WMR Councils should explore joint advocacy with MAV and the State Government to pursue alignment OF MCH pay and conditions, and to explore increased availability of online MCH courses • Look to augment evidence presented in this report with additional data and MCH nurse / community perspectives.

Recommendation	Rationale	Priority	Implementation timeframe	Key considerations
4. Enhance support to the MCH workforce to reduce burnout and fatigue	• Burnout and fatigue are significant issues impacting MCH nurse retention and need to be acted upon • Wellbeing days were well-received by staff at Wyndham and could be considered by other Councils (but may create workload management challenges) • Many nurses in the MCH survey were dissatisfied with limited flexibility in their diaries and an inability to take breaks they are entitled to – methods to increase flexibility are required (while also balancing high community demand for MCH services).	**Medium - High**	**Medium to long-term** 2024-25	• Suggestions on approaches to improve flexibility were not widespread and would need to be considered by MCH services – potential discussion point for MCH network (recommendation 2)? • Wyndham reflected that wellbeing days have created challenges in managing workload and backfill given existing workforce shortages – increased workforce supply needed (Recommendation 1) to better manage this.
5. Improve recognition of the MCH nurse role within Councils, and across the region by: • **establishing a region wide MCH promotional campaign** • **establishing forums for MCH staff to communicate with executive management** • **mechanisms to recognise and reward the work of MCH nurses.**	• MCH nurses feel the value of their work is not acknowledged or understood, which impacts on job satisfaction and retention. • Recruitment of people with specific cultural backgrounds will help to improve the alignment of the MCH workforce in the WMR to population characteristics. • Providing mechanisms for MCH nurses to have a 'voice' may generate ideas to improve workforce retention. • Mechanisms to reward MCH nurses for the work they do could possibly take the form of collecting and providing feedback from families on the valuable work they perform, which may improve job satisfaction.	**Medium**	**Short-term** December 2023	• Approaches may vary from Council to Council – ideally discussion at the region-wide manager and coordinator network (Recommendation 2) will support an approach that is consistent across the region. • Will also require a commitment to capture and act upon suggestions / feedback.
6. Establish targeted scholarships for MCH nurses to undertake postgraduate study with 'return of service	• Scholarships have been implemented widely to support increased uptake of MCH qualifications and have reportedly had some positive impact. However, they need to be targeted to specific geographic areas recruit nurses into the region.	**Medium** (subject to evaluation of current	**Medium-term** June 2024	• Should only be considered if scholarships recently established in Wyndham are proven to be effective • Value of scholarships to incentivise workforce will need to be balanced

Recommendation	Rationale	Priority	Implementation timeframe	Key considerations
obligations' to work at WMR Councils.	• Wyndham has recently implemented a $25,000 scholarship to attract MCH nurses to work in the region.	initiative by Wyndham)		against existing Council funding constraints • Funding constraints within some Councils may require value of scholarships to be adapted
7. Pilot the Victorian MCH Nurse Student Employment Model in eligible councils across the region to improve workforce capacity.	• A Victorian MCH Nurse Student Employment model has been developed but has not yet been implemented. • The model provides an opportunity to expand workforce capacity and provide pathways into specific Councils.	**Medium**	**Medium-term** December 2024	• VMCHNS model was developed to assist services with workforce deficits of > 30% (e.g. Melton) – not suitable for all Councils • May require an expansion of educator positions to avoid placing further pressure on existing MCH services / workforce • VMCHNS student employment model not yet implemented across Victoria – may need to trial initially in selected LGAs before broader rollout

6. What can MCH services look like in the region to meet local needs?

This section proposes three key directions to guide planning and action to improve the sustainability of MCH services in the region (Figure 20). These directions seek to address the challenges that are impacting MCH services and articulate what the MCH workforce can look like in the region to meet local needs. Each of the three directions captures the recommendations made in Section 5.2.

Figure 20: Proposed directions for MCH services in the WMR

6.1. A sustainable workforce, trained and employed locally, aligned to population characteristics

Providing pathways to increase the supply of MCH nurses is required urgently to address existing workforce shortages, which is the main issue impacting MCH services in the region. While the MCH workforce shortage is currently impacting LGAs such as Melton, Wyndham and Brimbank more than other LGAs, increased supply will be required to address the impending retirement of approximately 24% of MCH nurses across the catchment in the next five years. Training a workforce that is based in the region will support better recruitment, retention and alignment of the characteristics of the MCH workforce to the characteristics of the population that are living in the region.

Ideally, 'growing' a local workforce within the region will ensure that:

- future MCH services are better equipped to meet demand
- the workforce is more likely to be retained (because it is local), and
- the workforce will be better aligned to the characteristics and needs of the population.

Three recommendations are proposed to provide a sustainable, trained and employed locally, and aligned to population needs.

Recommendation 1: Establish a new postgraduate MCH qualification in a university located in the west to increase the supply of MCH nurses.

Discussions with VU have confirmed that the **willingness and capability exists to establish a postgraduate MCH qualification within the region**. These discussions have suggested that it may be possible that **student intakes could begin as early as 2025 or 2026 if discussions with WMR Councils progress constructively**.

Key matters to be addressed to implement this recommendation include:

- establishing a working group drawn from MCH services across the region (and potentially other stakeholders) to ensure discussions keep progressing
- developing a pathway with VU for local MCH students that graduate from the course to obtain employment with MCH Councils
- VU developing a business case to seek funding and resources to establish the course
- co-designing the course content (between VU, WMR Councils and other stakeholders, such as the State Government and MAV)
- advertising / communicating establishment of the new course prior to its commencement to support recruitment of local MCH nurse candidates.

Although this option was generally received with enthusiasm, **some WMR Councils were concerned that this option would not be viable unless it was accompanied by enhanced funding and resources for educator positions**. These Councils expressed that both MCH services, and the MCH workforce are under significant pressure and that measures to alleviate these pressures (such as those outlined in recommendations 2 and 4) will be required to give this recommendation the best chance of success.

Recommendation 6: Establish targeted scholarships for MCH nurses to undertake postgraduate study with 'return of service obligations' to work at WMR Councils.

Scholarships for MCH nurses have been implemented at a state wide level to the value of $5,000,[49] but have not had a significant impact on increasing recruitment of MCH nurses into some areas of the region. More targeted scholarships were suggested by several respondents to the MCH workforce survey and by Councils to target recruitment of MCH nurses to specific locations.

Wyndham City Council has recently introduced three scholarships of up to $25,000 for dual qualified RNs and RMs to complete postgraduate study in MCH nursing. Preference is given to Wyndham residents and those, who after gaining MCH qualifications, agree to work (subject to vacancies) at Wyndham City Council.

Although applications are fully subscribed, Wyndham reported that it is too early to determine whether the scholarships have been successful in recruiting and retaining high-quality MCH nurses. **Subject to the success of this initiative being proven, other Councils across the region could implement similar initiatives if they have the available budget and supporting educational resources**.

Key matters to be addressed to implement this recommendation include:

[49] Victorian Department of Health (2021). 'Maternal and Child Health Workforce professional development', accessed from https://www.health.vic.gov.au/maternal-child-health/maternal-and-child-health-workforce-professional-development#victorian-maternal-and-child-health-scholarships

- proof that the scholarships in Wyndham have been successful in improving MCH recruitment and retention
- Wyndham sharing learnings from implementation of the scholarships with other WMR Councils, possibly via the network or community of practice suggested in recommendation 2
- consideration by other Councils of their capacity to fund similar scholarships, and the value of those scholarships.
- how best to communicate the availability of the scholarships to aspiring MCH nurses
- ensuring sufficient nurse educator and preceptor resources are available to support scholarship recipients.

Recommendation 7: Pilot the VMCHNS model to improve MCH workforce capacity in eligible councils (particularly Melton and Wyndham).

Student MCH nurse models were suggested as a useful way to increase workforce capacity and provide pathways to employment within specific LGAs. **This recommendation proposes that eligible WMR Councils (with a FTE deficit of more than 30%) nominate to pilot implementation of the new VMCHNS model**. Subject to the success of this initiative, other Councils across the region could nominate to be involved in the future.

Key matters to be addressed to implement this recommendation include:

- identifying a WMR Council(s) with the interest and workforce capacity to pilot the model. Based on current staff vacancy rates (see Table 9), Melton and Wyndham would be eligible as pilot locations because MCH vacancies are 30% or more of total FTE
- governance of the model involves an MoU between the Department of Health, MAV and ANMF. Employment is operationalised through a further MoU between the employing Council and ANMF. Draft MoUs and student position description have been developed for interested Councils
- learnings from implementation of the model could be shared via the network/community of practice suggested in recommendation 2.

6.2. The MCH profession is in demand because its value is recognised and celebrated

Although they are highly skilled and qualified, **the MCH workforce survey highlighted a widespread feeling among MCHNs in the region that their role, skills and value are not understood or appreciated** by members of the community, other healthcare professionals or management and executives of Council. This lack of recognition is contributing to frustration and challenges retaining MCH nurses, who work within a workforce that is already stretched, to meet high levels of community demand.

Improving awareness of the value of MCH nursing is required at multiple levels to improve recruitment and retention of MCH nurses. With action across both state, regional and Council levels, it may be possible to elevate the profile of MCH nursing as a profession to improve the MCHN 'pipeline' and help retain MCH nurses for longer.

Ideally, the recommendations made in this direction will contribute to improving the profile of MCH nursing across Councils, the region (and ideally, state wide) to:

- ensure the skills and important role played by MCH nurses are recognised by the community and by Councils that employ them
- improve recruitment of MCH nurses (particularly from within the region) by increasing awareness of the important role that they play and the positive impact they can achieve

- improve retention of existing and future MCH nurses by responding to feedback received in the MCH survey to address the significant burnout and fatigue that are being experienced.

Measures to improve recognition of MCH nurses within Councils could begin in the short-term as an interim step towards designing and establishing supports to mitigate burnout and fatigue into the medium-term. Although fatigue and burnout are significant issues that are impacting the workforce now, meaningful solutions to these issues are unlikely to be 'quick fixes' and will ideally be informed by further consultation with the workforce across the region (ideally facilitated through the network proposed in recommendation 2).

Recommendation 4: Enhance support to the MCH workforce to reduce burnout and fatigue.

The significance of burnout and fatigue being experienced by the region's MCH workforce will require action is taken as a priority to mitigate further challenges to retention. **Wellbeing days have been implemented in Wyndham, were well-received by MCH nurses and could be considered for broader roll out to other Councils**. Broader implementation may be more feasible if workforce supply challenges can be addressed (per recommendation 1).

Further discussion and feedback from the workforce will be needed to design approaches to provide more flexibility in MCH nurse diaries to ensure they are able to take breaks and write notes, without needing to undertake significant work outside of hours. Although this was identified as a significant issue through the workforce survey, there were no clear suggestions on how to implement changes that can achieve this without further impacting community access to MCH services. This is because lengthening all KAS consultations to 45 minutes would mean fewer children and families could be seen within available workforce capacity. However, Some Councils have moved to implement 45 minute KAS consultations at their own expense to address issues associated with workload and burnout for MCH nurses. Discussion with MCH services across the region, and with the workforce, will be useful to design a workable solution. Ideally, this would be considered in conjunction with measures to increase workforce supply if KAS consultation times are increased.

Key matters to be addressed in implementation of this recommendation include:

- detailed consideration of workforce and service impacts associated with implementation of wellbeing days in Wyndham City Council. Although these were reportedly well-received by the workforce they have created challenges managing workload and backfill, so would need to be carefully considered before rolling out more broadly
- further engagement between MCH services and with the workforce will be beneficial to develop solutions to improve flexibility of scheduling and to ensure MCHNs are able to take breaks they are entitled to.

Recommendation 5: Improve recognition of the MCH nursing role within Councils, and across the region by:

- **establishing a region wide promotional campaign to improve awareness and interest in MCH nursing as a profession**
- **establishing forums for MCH staff to communicate with executive management**
- **mechanisms to recognise and reward the work of MCH nurses.**

Recommendation 5 proposes to improve understanding and recognition of the MCH nurse role at various levels (region, within Councils, and in the community) through three key initiatives; all of which could be further designed and developed through the region-wide MCH network proposed in recommendation 2. **This would include**:

- **developing a campaign(s) aimed at educating health professionals, dual qualified nurses and the community on the skills and value MCH nurses** provide for families and

communities. The important role played in relation to supporting early childhood development would be highlighted as a part of this campaign, along with the high level of skills and expertise. Ideally, examples of impact MCHNs have achieved for families would be highlighted to add weight to their value. The campaign would ideally be developed collaboratively by WMR Councils and rolled out across the region

- **establishing forums for MCH staff to communicate with executive and management in Councils** to provide feedback and suggestions. Ideally, the design and operation of any forums would be developed within each Council based on their specific needs and circumstances
- **implementing mechanisms to recognise and reward the work of MCH nurses**. Again, these would be developed on a Council-by-Council basis (although there may be value in agreeing what could work on a region wide basis). Mechanisms to reward MCH nurses for the work they do could possibly take the form of collecting and providing feedback from families on the valuable work they perform, which may improve job satisfaction.

6.3. A region that actively partners, collaborates and advocates for change

As separate organisations, the Councils that comprise the WMR operate within separate governance structures and deliver MCH services differently. While there have been attempts at collaborating across Councils, these have produced mixed results. Although some of the issues impacting the MCH workforce are Council-specific, others are being felt across the region.

Consultations with WMR Councils have shown that there has been an appetite to collaborate in the past, but that collaboration has not been as effective as Councils had hoped. Formalising the structure and process to underpin collaboration across the region could provide a platform for better alignment of services and support structures, professional networking, support and collective advocacy on issues that are impacting MCH services across the region.

Recommendation 2: Formalise two WMR-wide MCH networks for:

- **MCH managers and coordinators (already in existence), to lead workforce planning and advocacy efforts**
- **MCH nurses (proposed new network), to establish a region-wide community of practice and support structure.**

Establishment of a system and process for MCH services across the region to collaborate, share information, provide peer support and advocate for change to key issues is recommended as a core tenet of more sustainable MCH services in the future. Establishment of a region-wide MCH 'network' and/or community of practice could underpin the successful implementation of several other recommendations made in this report. Ideally, the frequency of these meetings would be updated to monthly and would include standing agenda items related to resource sharing, workforce planning and advocacy. Discussions about advocacy would seek to develop a shared evidence base and 'louder voice' to advocate strongly for change on key issues and enablers needed to improve the sustainability of MCH services across the region.

Ideally, the region-wide MCH network would:

- have a defined scope and structure, including a Terms of Reference, membership, details of Chairs (ideally rotating across LGAs), objectives and an annual plan
- focus on information, sharing, advocacy opportunities, collective workforce planning, and develop and monitor cross-region workforce improvement projects
- be comprised of managers and coordinators of MCH services from each WMR LGA

- meet regularly (suggest monthly) with a standing agenda could be developed, along with an allowance for new or 'ad-hoc' issues to be discussed
- liaise with executive management in WMR Councils and other external stakeholders as required where opportunities for advocacy or influence are identified.

Key matters to be addressed in implementation of this recommendation would include:

- responsibilities for developing and agreeing the structure and processes the group would work within
- identifying initial leadership of the network and arrangements for the chairperson to rotate periodically
- managing involvement and operation of the network around existing commitments.

Recommendation 3: Develop a collective (region-wide) position and evidence base to support advocacy for change in relation to the following system level issues that are impacting MCH services:

- **advocating to the State Government regarding the MCH funding model, to:**
  - **understand the costs associated with MCH service delivery and how they vary across locations, and for different client cohorts**
  - **review the approach used to allocate weights to reflect population complexity**
  - **share costs associated with employment of MCH nurse educators within the MCH funding model.**
- **advocating to the State Government to request a review of the KAS Framework to:**
  - **ensure it aligns with contemporary evidence and the issues currently facing the MCH workforce**
  - **provide more flexibility for MCH nurses**
  - **identify how KAS consultations can be conducted more efficiently within current time allocations, and whether opportunities exist to lengthen some consultations without creating challenges in service access**
  - **opportunities for multidisciplinary involvement within the context of the legislated qualification requirements for MCH nurses.**
- **advocating to the State Government and MAV to establish state-wide consistency in pay and conditions for MCH nurses across Councils**
- **advocating to universities for greater availability of online course content for postgraduate MCH qualifications**.

Aside from overall workforce shortages, funding for MCH services and challenges for MCH nurses associated with the KAS Framework were the factors most often cited as impacting the MCH workforce. Since both the funding model and KAS Framework are developed outside of local government, evidence-based advocacy will be required to achieve change on these issues.

Additionally, there was appetite among many stakeholders to explore **alignment of pay and conditions for MCH nurses across Victoria**. Advocacy to universities was also suggested to **explore whether a greater component of postgraduate MCH courses can be delivered online**, to improve participation of MCH nurse candidates living outside of Melbourne's northern and eastern suburbs.

As a region with some of Australia's fastest-growing LGAs, **the region has the potential to influence how services are designed and delivered to meet the needs of growing, highly diverse populations**. The region-wide MCH network could coordinate advocacy across the region

to pursue the changes that were consistently highlighted by Councils and MCH services as being key impacts on MCH sustainability. The network could also advocate for funding and other changes required to implement other recommendations made in this report.

Key considerations required to implement this recommendation include:

- establishing a robust evidence base for advocacy efforts. The research and analysis presented in this report could provide a starting point, but may need to be augmented with more specific analysis and feedback from the MCH workforce or community members, to illustrate the impacts of limitations in funding and the KAS Framework
- whether, and how to involve key executives across WMR Councils, and external stakeholders such as unions, peak bodies and other organisations
- determining the best advocacy approach, including whether written submissions, interpersonal advocacy or formal mechanisms are likely to achieve the greatest advocacy impact.

Given the high impact of system-related issues on MCH services, this recommendation is suggested as the 3rd-highest priority in this report. Ideally, advocacy should form an initial priority for the region-wide MCH manager and coordinator network (Recommendation 2). Advocacy could be pursued for other issues as well, however, these immediate priorities reflect the key issues that have been identified during this project.

Appendix A: Stakeholder consultations

Table 23 details key stakeholders that were consulted as part of the review and when these meetings occurred.

Table 23: Stakeholder consultations

Category	Stakeholder	Date
Membership association	Municipal Association of Victoria	13 December 2022
Managers and coordinators	MCH Managers and Coordinators	3 February 2023
Universities	Universities (Federation and RMIT)	7 February 2023
Universities	Victoria University	30 March 2023
Department of Health	Victorian Department of Health	14 February 2023
Department of Health	Victorian Department of Health	28 February 2023
Cultural and advocacy group	Victorian Cooperative on Children's Services for Ethnic Groups (VICSEG)	21 February 2023
Cultural and advocacy group	Australian Vietnamese Women's Association	14 March 2023
Cultural and advocacy group	Co Health	2 March 2023
Advocacy Group	Australian Nursing and Midwives Federation and Victorian Association of MCH nurses (VAMCHN)	9 February 2023
EPC	Tweddle	24 February 2023
Best Start Facilitator	Wyndham LGA Best Start Facilitator	16 March 2023
LGA	Moonee Valley LGA	9 February 2023
LGA	Maribyrnong LGA	13 February 2023
LGA	Melton LGA	13 February 2023
LGA	Brimbank LGA	15 February 2023
LGA	Hobsons Bay LGA	21 February 2023
LGA	Wyndham LGA	23 February 2023

Appendix B: MCH nurse salaries across the WMR

The following tables show the available annual wage rates for non-managerial MCH roles across the WMR using information sourced from Fair Work Australia.

Table 24: MCH nurse year 1

LGA	2015	2016	2017	2018	2019	2020	2021	2022	2023
Brimbank	$95,909	$99,074	$101,451	$98,915	$101,042	$103,265	$109,193	$111,049	$111,048
Hobsons Bay	$94,034	$96,384	$98,312	$100,278	$102,922	$104,157	$105,719	$107,305	$108,914
Maribyrnong	N/A	$96,868	$99,289	$101,771	$104,316	$106,663	$109,063	N/A	N/A
Melton (annual)	N/A	$90,803	$93,073	$95,400	$97,785	$100,229	$102,735	N/A	N/A
Moonee Valley	$98,276	$101,814	$105,683	$106,016	$108,486	$111,013	$113,594	$113,594	$114,924
Wyndham	$95,539	$98,788	$102,048	$105,415	$107,839	$110,320	$112,857	$115,115	$115,115

Table 25: MCH nurse year 2

LGA	2015	2016	2017	2018	2019	2020	2021	2022	2023
Brimbank	$98,139	$101,378	$103,811	$101,451	$103,632	$105,912	$111,840	$113,742	$113,741
Hobsons Bay	$96,487	$98,899	$100,877	$102,895	$105,577	$106,844	$108,447	$110,074	$111,725
Maribyrnong	N/A	$99,265	$101,747	$104,291	$106,898	$109,303	$111,763	N/A	N/A
Melton (annual)	N/A	$99,793	$102,288	$104,844	$107,466	$110,152	$112,906	N/A	N/A
Moonee Valley	$100,890	$104,522	$108,494	$108,145	$110,665	$113,243	$115,849	$115,849	$117,179
Wyndham	$98,086	$101,421	$104,768	$108,225	$110,714	$113,261	$115,866	$118,183	$121,166

Table 26: MCH nurse year 3

LGA	2015	2016	2017	2018	2019	2020	2021	2022	2023
Brimbank	$95,909	$99,074	$101,451	$103,632	$105,861	$108,189	$114,117	$116,057	$116,057
Hobsons Bay	$98,898	$101,371	$103,398	$105,466	$108,188	$109,486	$111,128	$112,795	$114,487
Maribyrnong	N/A	$101,251	$103,782	$106,377	$109,036	$111,489	$113,998	N/A	N/A
Melton (annual)	N/A	N/A	$103,822	$106,417	$109,077	$111,804	$114,600	N/A	N/A
Moonee Valley	$102,908	$106,613	$110,664	$111,022	$113,609	$116,256	$118,897	$118,897	$120,227
Wyndham	$100,538	$103,957	$107,387	$110,931	$113,482	$116,092	$118,762	$121,138	$123,560

Table 27: MCH nurse year 4

LGA	2015	2016	2017	2018	2019	2020	2021	2022	2023
Brimbank	$98,139	$101,378	$103,811	$106,043	$108,322	$110,706	$116,634	$118,616	$118,616
Hobsons Bay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maribyrnong	N/A	N/A	N/A	N/A	$111,217	$113,719	$116,278	N/A	N/A
Melton	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Moonee Valley	N/A	N/A	$113,243	$113,243	$115,881	$118,581	$121,248	$121,248	$122,579
Wyndham	N/A	N/A	N/A	N/A	$116,319	$118,994	$121,731	$124,166	N/A

Table 28: MCH nurse year 5

LGA	2015	2016	2017	2018	2019	2020	2021	2022	2023
Brimbank	N/A	N/A	$103,811	$106,043	$108,322	$110,706	$116,634	$118,616	N/A
Hobsons Bay	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maribyrnong	N/A	N/A	N/A	N/A	$111,217	$113,719	$116,278	N/A	N/A
Melton	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Moonee Valley	N/A	N/A	$115,499	$115,499	$118,190	$120,944	$123,638	$123,638	$124,969
Wyndham	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix C: WMR MCH data at 30 June 2022

This appendix shows MCH workforce data for WMR Councils as at 30 June 2022. This is presented for comparative purposes to the May 2023 workforce data shown in Section 3.

C.1. Number and FTE of MCH staff

Table 29: MCH headcount across the WMR, by MCH stream and LGA (30 June 2022)

LGA	Universal MCH only	Enhanced MCH only	Both Universal and Enhanced	MCH Coordinator /Team Leader	TOTAL Headcount
Brimbank	22	3	1	4	**30**
Hobsons Bay	14	1	1	3	**19**
Moonee Valley	21	2	0	2	**25**
Maribyrnong	20	2	0	2	**24**
Melton	28	6	0	8	**42**
Wyndham	54	9	0	9	**72**
Region total	**159**	**23**	**2**	**28**	**212**

Source: Consolidated WMR Councils annual workforce planning report (2022).

Table 30: WMR MCH headcount per 10,000 population aged 0-4 years, by LGA (30 June 2022)

LGA	Total population	Total Headcount	MCH headcount per capita	Total FTE	MCH FTE per capita
Brimbank	11,399.	**30**	26.32	**23.91**	20.98
Hobsons Bay	5,953	**19**	31.92	**14.64**	24.59
Moonee Valley	6,322	**25**	39.54	**14.89**	23.55
Maribyrnong	5,099	**24**	47.07	**14.90**	29.22
Melton	14,923	**42**	28.14	**26.08**	17.48
Wyndham	26,951	**72**	26.72	**54.49**	20.22
Region Total	**70,647**	**212**	**30.01**	**148.91**	**21.08**

Source: Consolidated WMR Council annual workforce planning report (2022).
Note: Headcount and FTE per capita columns are shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest

C.2. Vacancies

Table 31: Vacancies (FTE) by MCH stream and LGA (30 June 2022)

LGA	Universal MCH	Enhanced MCH	Coordinator/ MCH Team Leader	TOTAL vacancies	TOTAL FTE	Vacancies as % of total FTE
Brimbank	2.9	1	0	**3.9**	**23.91**	**16%**
Hobsons Bay	0.6	0	0	**0.6**	**14.64**	**4%**
Moonee Valley	0.13	0.6	0	**0.73**	**14.89**	**5%**
Maribyrnong	0.6	0	0	**0.6**	**14.9**	**4%**
Melton	13.98	0.6	0	**14.58**	**26.08**	**56%**
Wyndham	4.93	1	1	**6.93**	**54.49**	**13%**
Region total	**23.14**	**3.2**	**1**	**27.34**	**148.91**	**13%**

Source: Consolidated WMR Council annual workforce planning report (2022)
Note: Vacancies as % of total column is shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest

C.3. Age

Table 32: Age profile of the WMR's MCH workforce, by LGA (30 June 2022)

LGA	<=40	41-45	46-50	51-55	56-60	61-65	66-70	71 +	Total aged 60+
Brimbank	53%	3%	7%	13%	3%	7%	10%	3%	**20%**
Hobsons Bay	16%	11%	16%	0%	26%	32%	0%	0%	**32%**
Moonee Valley	28%	12%	8%	12%	20%	16%	0%	4%	**20%**
Maribyrnong	33%	13%	0%	8%	8%	25%	8%	4%	**38%**
Melton	26%	5%	7%	19%	14%	17%	10%	2%	**29%**
Wyndham	19%	3%	21%	22%	17%	13%	6%	0%	**18%**
Region average	**28%**	**6%**	**12%**	**16%**	**15%**	**16%**	**6%**	**2%**	**24%**

Source: Consolidated WMR Council annual workforce planning report (2022)
Note: Darker green shading represents highest values. White shading indicates lowest values. Total aged 60+ column is shaded using a 'traffic light' schema where red = highest; orange = middle and green = lowest