Submission to Productivity Commission : Early Childhood Development Workforce Draft Report (June 2011) Limited to Chapter 12- "Child Health Workforce ".

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This submission outlines concerns I have with draft recommendations 12.1, 12.2, 12.3 , 12.4 and aims to highlight some of the many strengths that exist in the KAS Victorian Framework, which have been overlooked in this report.

Draft recommendation 12.1. EVIDENCE BASE FOR PRACTICE

The draft recommendation, and the tenor of the text surrounding it ingnores completely the fact the recently implemented Victorian KAS framework (in line with NHRMC guidelines),has a strong evidence base, see page 8, 9 M&CH practice guidelines 2009. The report creates the impression that all areas of Australia deliver a maternal and child health service largely devoid of evidence to support its efficacy.

I will limit most of my comments to the Victorian service , as I don't have an extensive knowledge of the service in other parts of Australia. What I can advise is that the service in Victoria is universal, provides a consistent accessible service, with 35 measureable outcomes(p 5) M&CHS practice guidelines 2009. These desired outcomes all have considerable evidence to show they improve child health, family functioning, maternal health and wellbeing. Current, relevant,

empirical evidence informs every area of the framework, including the program standards 2009, and 2011 Maternal and Child Health Practice guidelines. See DEECD website: http://www.education.vic.gov.au/ecsmanagement/matchildhealth/policyreports/default.htm for more extensive information on the multitude of evidence imbedded in the current framework. The process of implementing the framework started in 2009, has involved extensive ongoing training and roll out of appropriate resources to ensure nurses have necessary skills to deliver it.

The framework is being evaluated annually over 3 years, by the Centre For Community Child Health the 2nd evaluation is currently underway, (see DEECD website for the evaluation of 2010) This process which will bring further improvements, and provide additional evidence of its effectiveness in achieving better health outcomes.

The service also appears to be unique in that it is funded by the state and local government, ensuring adequate funding to implement a quality service. I believe it is this funding base that enables Victoria to provide 10 key visits, and it may well be the case that other states offer less visits not because there is no evidence to support its efficacy, but rather that there is insufficient funding to deliver them. I believe it is inappropriate to have Child Health Service reliant on funding from the corporate sector ie New Zealand (p 358 of your report), where baby food manufacturers and disposable nappy companies, along with the government sponsor the service.

The Victorian model with the partnership between the state and local government areas gives the local community a very personal, and also a

financial stake in the service, as it is their rates and taxes that pay for it. The service is both accountable and has adequate flexability to respond to the unique needs of the local community despite being a universal service.

This structure encourages the service for form strong relationships with other health professionals, early childhood services and other nurses in each region. Participation rates in the service are high 99.8 % of families making contact with the service at the home visit, over 80 % at 2yrs, almost 70% at 3yrs and 63% at 3.5 years, and the annual customer satisfaction survey last month for the council I work for had a 93% satisfaction rate with the M&CH service, we will or course be working hard in the year ahead to improve satisfaction in the remaining 7 %. Almost all municipalities have computerized record of the consultations, and those who do not are obliged to submit detailed information about all of their activites including parent groups conducted, , breast feeding rates, referrals of both children and their families, screening tests , etc, enabling reliable data collection that can be used to measure child and family health outcomes.

Vulnerable families can access extra in home support from the enhanced home visiting service, can be referred to mother- baby units, and early parenting centres. Each municipality , has a family service manager, Maternal and Child Health Service Co ordinator, regular team meetings , staff inservice, staff supervision, DEECD conferences, and performance reviews to ensure staff have adequate training and support to provide best practice, quality, evidence based care. Many municipalities have administrative staff to make appointments, family

support workers, lactation clinics, offer specific parent groups, fathers nights, parenting sessions, and liase with maternity hospitals to ensure continuity of care

It would appear after reading your report that many other states offer more fragmented models of care, with differing levels of evidence based practice, often using practioners and nurses with less formal training. The Victorian framework is well placed to inform the National Framework for Child and Family Health Services and universal delivery model mentioned on page 57,(under the role of the Australian government in child health services), in the draft report.

Draft recommendation 12.2. SCHOLARSHIPS.

Scholarships if they are of an adequate amount to assist with the true cost of doing the course, are a valuable tool to attract nurses to the service .

The Graduate Diploma I completed in 1998, was part time over 2 years, cost $3,500, (HECS) which was paid back over about 3 years.

I had to reduce my working hours which had a huge impact on my income, could have cost me my job had my then employer not agreed to cut my hours, and affected my ability to provide for my 3 young children as a single mother. For several months I had to depend on a government pension, as my reduced wages were inadequate. I was also caring for my dependant elderly relatives who had serious health conditions, one of whom died midway through the course.

The course now costs about $ 12-13, 000, which I could not afford at all, now I have a morgage (even with HECS) without a lot of the cost being covered by a scholarship. I feel the current scholarships do not cover an adequate amount of the costs involved and this may be the true barrier to their effectiveness.

In addition to this the New Zealand system of supporting their nurses to work whilst they study (p 358 of the draft report) would attract nurses who like myself are not in a position to fully self fund their education.

In Victoria MCH nurses support M&CH students by providing them with their 120 hrs of supervised clinical practice. I believe preceptorship training for maternal and child health nurses and the provision of teaching aids would assist in providing better support for both nurses and students in this role. Mentoring and support for newly employed nurses, training for existing nurses to learn managerial skills, a formal career structure are essential components to support, recruit and retain experienced nurses.

Also in Victoria many municipalities are building multi nurse centres , which helps to combat the isolation that can occur when nurses work on their own. This can be a barrier to nurses considering M&CH as a career, especially new graduates who need support to consolidate their skills.

To attract more nurses to study M&CH courses need to be flexible, affordable, keep to one day of university attendance, to allow

nurses to keep working, and must offer adequate opportunity to develop clinical skills.

12.3 MIDWIFERY AS A REQUIREMENT TO DO M&CH NURSING/ 12.4 TRAINING REQUIREMENTS.

The Victorian M&CH framework, includes maternal health checks, interventions, and starts in the early post partum period with a home visit, and sometimes starts ante natally when mothers visit during their pregnancy with older children, or when women with complex needs are referred just prior to the birth of their babies to EHV.

Many CALD women without medicare, access the service within days of giving birth, often have complex needs, and limited family support.

My midwifery training has given me a wealth of knowledge about the impact of antenatal complications, difficult births, intra partum complications, congenital defects, continuing illness in the post partum period, prematurity, birth injury, breast feeding, and feeding problems have on the health and well being of mothers and babies. Midwifery has taught me how to help women initiate and maintain breastfeeding, to recognize maternal post partum complications such as urinary incontinence (up to 30 % incidence), the 10 % of mothers who develop post natal depression, and the ability to refer women to appropriate services. Also to effectively manage the 10 % of babies that are born, low birth weight, sick or premature, and to understand the strains this can place on families.

I draw on my experience as a midwife on a daily basis, it is an essential part of my knowledge base. I see it as a major strength, not as a barrier

or weakness as it is portrayed in the draft report. It should remain as a requirement for registration, and I strongly support the NHMRC which states that nurses undertaking child health checks should have adequate training.

I do not regard a 20 hr course that requires no clinical training (p 233, 234 of the draft report), as being adequate training to undertake work as a maternal and child health nurse (p232, 233, 234.) of the darft report. Especially if you look at it in the context of nurses and midwives needing 20 hours of relevant professional development per qualification per year to maintain their qualifications.

Also practice nurses can be div 2 nurses, or nurses with no training in child health, and would not have adequate skills to work in this area, as maternal and child health nurses(p 225 of the draft report). Their skills are better suited to being family support workers.

Surely offering scholarships, assistance with housing, flexible courses in maternal and child health, and asking nurses in remote areas what assistance they would need to commit to further study, will offer the best chance of recruiting more nurses. It is essential to ensure nurses working in the area of Child and family Health are adequately trained and supported. Nurses in Victoria despite having extra required training are not more expensive as evidenced in the table on (page 226 of the draft report).

In conclusion Maternal and Child Health nurses in Victoria, provide a great service that values the professional standards developed and recently revised. The Victorian public, Maternal and Child Health

nurses, and all those who dedicate themselves to improving the health and wellbeing of children and families, will not welcome or support a National Universal Service that is anything less than what we currently provide.

Our determination to maintain our qualifications, does not seek to denigrate nurses working in other states and territories but rather supports the belief that it is essential that Maternal and Child Health Nurses have the skills to support the health of mothers upon whom children reply for the majority of their care. Our extensive knowledge is a strength not a liability.. We are not precious but proud of our achievements !

I trust that my comments and those of my fellow nurses will be considered as you complete your report.

Sincerely Linda Teng.