Submission No 11

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

Name: Name suppressed

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21st February 2024

Thank you for the opportunity to respond with a submission into improving access to early childhood health and development checks enquiry. As a Child & Family Health nurse, I am interested achieving the best outcomes for young children. I want to stress however, that although I am employed by NSW Health, I am responding to this submission in a personal capacity rather than my professional one and have deliberately not referenced the LHD where I work as I do not represent the LHD.

1. Changes needed to address gaps in outcomes for vulnerable children, including those in rural and remote communities, Aboriginal communities, and culturally and linguistically diverse communities.

- The Building Strong Foundations (BSF) and Aboriginal Maternal Infant Health Service (AMIHS) models provide targeted Aboriginal maternity and Child & Family Health services in culturally safe spaces, however there are variances in resourcing and individual models of care. Wrap-around multidisciplinary services – allied health, nursing, paediatricians, oral health, and vaccinations, with familiar and trusted clinicians are more likely to engage families, with a one stop, holistic approach. These models improve access to earlier preventative care, health promotion and intervention pathways as required. Services offer not only healthcare, but health promotion activities such as swimming classes, walking and art groups, cooking skills and Yarning circles which promote child, family and community wellbeing. Funding for these programs has not kept pace with population growth.
- Creating an Aboriginal & Torres Strait Islander Personal Health Record (Blue) book with culturally appropriate artwork, language and referencing the unique screening tools or interventions i.e. ASQTRAK, Plums & Hats and targeted vaccinations would increase health literacy and participation around early childhood development and checks.
- CALD communities experience challenges engaging with C&FH services despite free of charge access, given their limited experience of nursing focused services or awareness of what is offered. Many experience financial barriers to accessing GPs and fear visa implications if developmental concerns are identified. Both parents are often engaged in low paying, long hours or shiftwork, where children are minimally supervised, or by grandparents. CALD grandparents have reported fears of taking children outside the home, are unaware of community services and supports available and experience language barriers. Children have limited stimulation, play or exposure to socialisation experiences, which may affect their developmental outcomes, and many do not attend childcare or preschool. These children have higher than average developmental vulnerabilities on more than one domain. Development of culturally appropriate service directories, both Health and Community

agencies which includes the importance of early childhood surveillance in language, may ameliorate some of these barriers to access. Designated in language grandparents supported playgroups in safe locations will increase their social participation and may assist in accessing child health information and support services, and also create occasions for opportunistic health checks and intervention.

- Increasing capacity for sustained nurse home visiting models – the NSW Sustaining NSW Families (SNF) program will be expanded in 2024 to include SNF light and plus models of care to better meet individual requirements, such as shorter durations for planned return to work or plus models which provide additional support for more complex families who would previously have been ineligible for the service. These models are research and evidence based and meet the 'gold standard' of care for vulnerable families. Increased reach and number of these programs across NSW is desirable.

2. Barriers that affect parents' access to routine health and development checks that track their child's progress against developmental milestones.

- There is limited understanding, both by parents and other health professionals of the role of the Child & Family Health nursing service. It needs a consistent name nationally and increased promotion of its role and benefits for families. Improved recognition of the skills and expertise of Child & Family Health nurses in the child development space and promotion of the service as an affordable, non-stigmatising option for families.
- Some sort of financial benefit to families who complete the child health checks would incentivise improved compliance for routine health checks and increase health literacy. Linking checks to the Family Tax Benefit Part A, in the same way as for routine vaccinations would increase participation rates and is a way of highlighting the importance and prioritisations of health checks to parents.
- Affordability in accessing GPs for routine care is a major barrier for many families, especially since bulk billing GP practices are hard to find. Many families delay seeing a GP until the child is unwell, then the focus is on the current illness rather than child development. Many GPs are unfamiliar or uncomfortable in performing developmental surveillance and complete only a weight and general health checks but tell parents the check is completed. Families don't know the difference. GP practices are business models which rely on high turnover, so they have practice nurses (if available) complete immunisations and sometimes the child health check in part. A partnership with PHN and Child & Family Health found practice nurses did not feel comfortable with completing the checks, did not know normal parameters of development and lacked the prerequisite skills given few had completed a Graduate Certificate in Child & Family Health.
- Hospital emergency departments rarely consider discharge referral to Child & Family Health services for follow-up on routine issues and many are unaware of the service or what is offered. Improved communication and referral pathways are required between acute and community services.
- Few parents read their Blue Personal Health Record book and it is more often stored in a draw, so they miss valuable opportunities for health promotion and anticipatory guidance. Almost all parents access some sort of pregnancy, breastfeeding or sleep apps, which allow them to track their journey, get updates and information. This would be a low cost, contemporaneous solution to improving health literacy around child development and get parents actively involved in their child's development progress.

- Many parents do not access services unless they have specific concerns about their child (or themselves), so improving promotion around the importance of attending regular checks to ensure their child is 'on track' is vital and allows for improved early interventions when variances occur rather than waiting until the problem is significant and causes concern. Electronic reminder systems, similar to vaccinations can be built into the electronic Blue Book or apps which remind parents when a check is due and also advise them what is expected at the check. This way, if clinicians are shortcutting, the parent will be empowered to ask why a component of the check was not completed.
- Most Child & Family Health services in NSW operate Monday to Friday 8.30-5pm which is not inclusive of working families. Current budgets do not facilitate weekend or after hours work which would reduce the workforce to remain cost neutral.
- Most Child & Family Health buildings are Council owned, often with historical agreements (since post WW1) in place whereby NSW Health provide the skilled workforce and council provide facilities free of charge. Buildings are dated and in varying states of significant disrepair which presents an unprofessional environment and undervalues the service provided to the public. Most do not meet community expectations of Health facilities. Services are disempowered to advocate for improvements or relocation to alternate facilities as councils threaten eviction.
- There has been a significant population growth, especially in Metro areas which has not been reflected in an increased capacity of the C&FH workforce or facilities that meet current demand. Most services must prioritise families with newborn infants and breastfeeding support, so families with older children struggle to get appointments for older child checks. The drop-off rates from 6 months onwards are significant, till only about 4% of 4-year-old children attend their child health checks.
- The Brighter Beginnings funding was proposed to be utilised for 4-year-old children to receive health and development checks, ensuring they are on track before starting school. These have been implemented in different ways in LHDs, some enhancing existing C&FH services to achieve older child universal checks and others creating multidisciplinary teams to offer targeted approaches to a limited number of vulnerable children. This targeted approach will support children with known vulnerabilities, but potentially creates gaps for children with unidentified vulnerabilities.
- Many parents believe that if they are accessing early childhood services (daycare or preschool), they would be made aware of concerning issues. Childcare centres have varying capacity for childhood development assessment, given many have only one qualified educator and several childcare assistants onsite. Some private facilities fear parents will withdraw children if they alert them to issues, and so avoid having 'difficult' conversations. Parents believe that if the childcare is not concerned, then neither should they be, until school commences, and the child has missed the opportunity and benefits of early intervention. There is no National accreditation process with benchmark standards for childcare facilities in NSW which should be urgently considered, especially in the case of universal access to childcare.
- Child & Family Health nurses conduct development surveillance and secondary screening, however, have limited access to some referrals which may necessitate families having to access a GP at additional cost. Creating easier referral pathways for families will both increase the likelihood of participation and decrease duplication across multiple services. This is a barrier for vulnerable populations who struggle with affordability in accessing GPs who do not offer bulk billing.

- Referral pathways for CALD families on student visas are complex. Although C&FH services are free of charge, most allied health, counselling, child development services or paediatricians are fee for service, even in the public domain. This presents financial challenges for some families, who arrive in Australia with health insurance as part of their visa requirements, but on arrival, drop the level of cover to the cheapest option. Most funds require a 12 month wait period and do not cover pregnancy, birth, or dependents. Families then try to waive fees for maternity antenatal care, tests, and birthing in public hospitals at considerable cost to the taxpayer. Accountability is urgently required by tertiary institutions, who make considerable profits from students, to look after their welfare in Australia. A shared cost approach between Government and universities should be considered rather than NSW Health and Australian taxpayers absorbing these considerable costs for ongoing care, intervention, and therapy. Many parents will avoid checks if they are concerned about their child's development or avoid treatment or therapy fearing visa implications. Their belief is that 'schools will sort it out' once they have achieved permanent residency. Delays in accessing appropriate treatment can have major long-term implications for the child and increase the ongoing costs for health and education services. This is a significant concern and burden for those health districts who have major university campuses within their catchment and consequently a large volume of international student residents. It is also increasingly problematic for NSW Education, who are often unaware of the child until they enrol late or prior to starting school, which does not allow sufficient time to apply for specialist support staff. This creates an ongoing burden for teaching staff and other students in the classroom. Some states (ACT) with large international cohorts do charge a nominal fee (redeemable via private health insurance claims) for international students to access C&FH services, $50 per intervention, which supports employment of additional staff and resources. This might be considered in NSW.
- Limited face-to-face interpreting services create barriers for parents in accessing C&FH services and impact on the quality of interventions.
- CALD families fear discrimination around cultural child rearing practices. This is commonly seen around the practices of infant co-sleeping, a practice which is strongly discouraged by NSW Health clinicians. These discrepancies between NSW Health policy and cultural practices, undermine a family's trust in services and perception of their cultural practices. Nurses work in partnership with families to create goals and with the parent as the expert in mind but with a safety focus, however this does not always translate across cultural groups, especially for new migrants. Use of Cultural Education Officers help nurses navigate cultural versus Australian parenting practices safely and respectfully.
- Aboriginal families engage best with services which are targeted and culturally designed. Cultural support is offered by employing Aboriginal nurses or Aboriginal Health Workers. Services which promote consumer co-design and offer culturally safe and supported environments, where Aboriginal parents can engage with staff in trusted, non-judgemental ways increases participation and empowers families in their parenting journey.

3. Recruitment and retention of health professionals to address workforce shortages.

- A workforce survey conducted 7 years ago demonstrated that around 40% of the child and family workforce was over 50 years of age and likely to retire within 5-10 years. At the time there was no real succession plan in place with a considerable workforce crisis.
- Since then, substantial workforce capacity building has occurred with creation of student Child & Family Nurse positions, allowing nurses to work in temporary employment (against

workforce vacancies) while they undertake their Graduate Certificate in Child & Family Health nursing over 12 months. Previously, nurses needed to be fully trained before considered for employment. Most apply for a permanent position upon successful completion of the course and staff retention has been more than 90%.

- NSW Health offers scholarship programs for the Graduate Certificate in Child & Family Nursing and this should be commended and continued. Child & Family nurses tend to have more than 5 years post graduate experience as an RN and are more likely to have a family and mortgage, making further study sometimes unrealistic. Scholarships encourage a diverse representation of participation.
- A re-examination of the workforce capacity after 5 years demonstrated a significant improvement and a healthier balance across the age demographic.
- Opening pathways to training and employment for single registrant midwives to Child & Family Health. Midwives' skills and experience with wellness models of care aligns with the Child & Family focus and a skills gap analysis identified minimal areas of additional supports required.
- Transition to professional placements and graduate nursing pathways have supported nurse/midwives to trial the Child & Family Health environment before taking on additional post graduate training.
- Many districts are creating career advancement pathways, e.g. to CNS2 level in recognition of the skills and expertise of Child & Family Health nurses and the autonomous nature of the role. Previously, the profession had a somewhat flat structure with limited opportunity for career advancement. This should be encouraged as a long term staff retention strategy.

4. Funding for early intervention programs and screening to ensure children are given support for developmental issues, including telehealth and other models.

- Models of care which promote a universal approach are integral to identifying vulnerable children who live outside the known low socio-economic areas (vulnerability has no postcode). Universal screening identifies children from all walks of life with developmental vulnerabilities, for a variety of different reasons.
- During COVID, telehealth models of care were implemented to reach vulnerable families whose barriers to accessing services (lockdowns, health issues, transport etc) may have had long term impacts. While families appreciated the ability to be seen or connect with other families, subsequent feedback suggested an overwhelming preference for face-to-face support, as much as possible. Some services providing support for vulnerable populations, such as sustained nurse home visiting programs, offer catch up calls between face-to-face sessions to touch base and help parents remain 'on track' with their goals. This is highly valued but not a replacement for face-to-face support. Nurses work with vulnerable populations, where parents have had minimal or substandard parenting themselves and mentor parents by role modelling parenting skills which is preferable conducted face to face.
- Families with vulnerabilities are rapidly increasing in number, as is their complexity. Although a relatively small total percentage of overall clients, they take a significant proportion of time, both face to face, in case conferencing, referrals and follow-up.

5. Any other related matters

- The first baby clinic opened in Alexandria, Sydney in 1914, followed by Newtown and Darlinghurst. This was the start of community based, publicly funded child and family health

services in NSW. Today, across NSW there are over 500 Early Childhood Health Centres, staffed by qualified Child and Family Health Nurses. The early focus was on reducing infant mortality as in 1914 about one in 10 children died before they turned one. Declining birth and infant mortality rates, and a reduction in the incidence of serious childhood infectious disease, have been matched by a change in emphasis away from *survival* in childhood, to quality of life, parenting issues, prevention of illness and health promotion. These issues form the basic concepts of child and family health services and resulted in the development of the range of child health and parenting programs that Child and Family Health Service offers today, in a universal framework.

- Child and Family Health Nurses work together with each family to look at the unique situation of the family and what they can do to promote better health. Today, nurses are well educated and up-to-date, and their practice is based on the best available training, evidence, and research. A nurse not only thinks about health as an absence of disease, but as a state of complete physical, mental, and social wellbeing. Nurses strive to work with each family not just to be well, but to be as healthy as they can possibly be. Some of the services that nurses deliver include health checks, early intervention for developmental problems, or immunisations. Sometimes a nurse will identify other issues that affect a family's health, such as housing problems and employment issues, or family violence, and, in these cases, nurses need to connect families to other services to get them the help they need.

- In recent years, the increased acuity and complexity of families has created a dilemma between continued universal care models and more targeted approaches for vulnerable families. The current funding arrangements do not support both. The risk is, that with dedicated targeted approaches to care which are defined by SEIFA score, residency or cultural background, hundreds of children who are not seemingly living in disadvantaged situations (disadvantage has no postcode), may face significant vulnerability by nature of family circumstance, health issues or disability which would otherwise go undetected until they commence school.

- Child & Family Health nursing roles continue to evolve, expand and develop. Nurses absorb multiple public health initiatives which water down the core role and purpose as early childhood development experts. Nurses have absorbed universal Safe Start maternal mental health and Domestic Violence screening, are asked to conduct smoking cessation support via NRT replacement therapy and carbon monoxide (Smokelizer) monitoring, manage childhood obesity with routine weight and height measurements and will shortly also monitor dad's mental health and wellbeing. They do this in addition to the child's developmental check within an hour's appointment timeframe, including documentation. It allows little time to explore variations from the norm or offer strategies to assist parents bridging gaps in their child's development. Lengthening appointment times would reduce the number of available appointments each week when demand already exceeds capacity. These health promotion activities are important, even vital in supporting environments which promote health and wellbeing for children to grow and thrive, however prioritisation of these activities is necessary for nurses to be able to perform the core role of childhood developmental surveillance. A core set of roles and responsibilities for Child & Family Health nurses must be developed which allow the nurse to focus on the child at the centre, and with a realistic list of priority areas and 'to be done if possible', to prevent the service becoming a 'dumping ground' for every new initiative. Investing in ensuring NSW children are developmentally on

track, healthy and ready to engage in education needs to be prioritised by valuing and supporting an established expert workforce, with the capacity to do this work at the highest possible standard.

I hope the information provided is helpful and provides context into the challenges for services, parents and children accessing early childhood checks. I am happy to be contacted to answer any queries.

Yours sincerely,

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