Submission No 41

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

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Response to

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- **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.**

- Increase flexibility of service provision (i.e. Go to the family – not family come to you). Providing home visits, preschools visits, playgroup attendance to assess children is much easier for many parents. Expectations of families to come to health does not always work if the family has multiple children, no car, live in remote/isolated area or simply cannot organise the appointment/visit. In these non-health settings, the clinicians can see the interaction of family members in their home or play environment. There is also the likelihood of other family members being present who can reinforce any advice given and assist in implementing any programs/exercises that are prescribed. Virtual or telehealth models rarely work for remote and disadvantaged families who may have no internet/data or device. The Northern Territory uses these models successfully.

- Develop and implement dedicated expert staffing and teams for paediatrics focusing on outpatients/milestone assessments and follow ups. This expert team needs to consist of occupational therapists, physiotherapists, speech pathologists, child and family health nurses, Aboriginal health staff, social worker and psychologist. Currently hours that are designated for paediatrics are regularly redirected to prop up inpatient services when shortages occur, and staff are utilised to provide adult services. This means paediatric services are reduced and wait lists grow. Additionally in rural areas staff allocations are often deemed generalists and are expected to provide adult acute services this means that less priority is given to paediatric community services when staffing is limited

- Dedicated paediatric Allied Health teams would increase the capacity for skill building in regional centres and allow this same expert team would have capacity to visit smaller facilities on a regular basis eg monthly to Tingha. Smaller towns struggle even more than larger facilities to attract experienced staff. An outreach model that assists these towns would help.

- Appropriate and adequate office and clinic facilities. Co-location of disciplines in an appropriate building with enough space for clinicians to work from (i.e. Child family health nurses, speech pathology, physiotherapy, occupational therapy, Aboriginal Health worker, social worker and psychologist) would enhance networking and ease of case conferencing. The Space also will need to accommodate multiple clinic facilities for multiple appointments by different disciplines as well as waiting and play space for families. For families that can come in, visiting one space for consults with multiple team members rather than multiple appointments is appealing. Ideally this building could be central in town (not on health campus). The advantage of this is it is more welcoming for Aboriginal families who in the past have had poor experiences with health. Parking and ease of access is likely to be improved having a site away from hospital campus knowing most hospitals do not have enough parking.

- Dedicated Aboriginal/community liaison worker to support other paediatric team members. Currently Aboriginal Health Workers only work for aboriginal services and are not formally

linked with allied health. Often local knowledge is required to find families and convince them that an appointment is a necessary thing to do. Aboriginal families are more comfortable with visits when an Aboriginal health worker is there offering cultural support. They can also help engage elders and other community members to relay the importance of monitoring milestones and addressing any delays. Many other vulnerable populations also exist in regional areas who require support to access services. Currently most support workers are located in external organisations which can lead to increased breakdown in communication rather than enhancing participation

- Overwhelmingly, all disciplines need more staffing hours. Waiting lists for children to access services are 12 months on average. This is absolutely not early intervention. Vulnerable families should be followed up regularly to ensure good outcomes for the first 2000 days. Unfortunately, as these are the hardest and most time-consuming families to maintain contact with, they tend to be missed. Sustained home visits up to 2 years is required for level 3 clients but there is not the staffing to do this.
- The NSW (New South Wales) Department of Education allocate staffing to be present in preschools and early years of school. Occupational therapists and speech pathologists have a key role in the early identification of children with delays and the expertise to continue/commence programs and therapy to build capacity for teachers and educators to implement strategies.

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

A) Staffing limitations is the single biggest factor. Child and Family Nurses are the usual service for routine checks to be undertaken. The current staffing levels rarely allow for checks beyond the initial 8 weeks. Even if children are identified with delays, waiting lists are so long that it is over a year before a child can access a service.

B) TRANSPORT – In the Tablelands Sector, except for in Armidale there are no buses/public transport. Often families have multiple children and no car. It is much easier for staff to travel to the family. There are also situations where it is best if families can come to the clinic and transport is required to assist those without support.

C) GP (general practitioner) access. In the past some parents have chosen to have their child reviewed with their GP. There is an ongoing lack of GPs (general practitioners) in the rural setting, and this is rarely a viable option. A lack of GP's makes it difficult for families to seek a referral to a Paediatrician.

D) In the Tablelands Sector access to day care and preschool is severely limited with up to a 2 year wait list. Educators are well placed to identify children with delayed milestones and will refer on to appropriate services. If the child has not gained a place in any preschool/childcare facility they won't be identified. Unfortunately, the most vulnerable children are the most likely to not attend preschool anyway.

E) Parental capacity and awareness. Apart from the CFHN (child and family health nurses) education, there is no further education around the importance of having routine checks. Many parents would not be aware that regular milestone monitoring is beneficial to catch any delays early. Navigating the system to access services can also be too hard for the parent.

F) Isolation – many families are in remote towns with no services locally. Telehealth not an option for these families as internet connectivity is poor and socioeconomic barriers mean they do not always have a device or data.

G) Families moving frequently and phone numbers changing. Some of the most vulnerable families move a lot. They are difficult to contact.

H) Complex families with drug and alcohol problems. The capacity for these families to engage with health for routine appointments is limited. They often need a case co-ordinator to assist them which we do not have.

I) Limited services. Occupational Therapy, Physiotherapy and Speech pathology have very few hours dedicated to paediatric services for early intervention. The move to the NDIS (National Disability Insurance Scheme) meant many paediatric clinicians left the service with the expectation from health that only "acute" services would need to be provided. These hours were deemed to be dispensable by health and rediverted, as all non-acute/non health related cases would end up in NDIS. This has not transpired as many patients do not meet threshold to access NDIS and fall back to health. There are no longer the staff to deal with these children. The NDIS has increasingly not accepted lower to moderate level children and now that burden is returning even more so to health. Children that are eligible for NDIS (or potentially so) require a thorough paediatric workup to assist in accessing the NDIS. This can take 8-16 hours to perform assessments and write reports. More time taken from children who are on the waiting list. Many families lack the capacity to navigate the NDIS system increasing the burden for NSW Health staff to assist with transfer to the NDIS.

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

A) NDIS has depleted the pool of applicants within allied health. Better salaries are often available within the NDIS. Many staff left the health system to take jobs with private providers. These private providers head hunt new graduates leaving health with fewer recruitment options.

B) We need senior/qualified staff to mentor and plan for the future. These are the hardest staff to attract and retain in NSW Health. Rural services are across the board less staffed (even when population ratios are used) and due to the structure of services, cannot compete with city positions especially when positions are lower grades (level 1/2) with limited career progression options in rural centres. Rural clinicians end up doing complex higher duties without the remuneration.

C) Enhancements come in lesser amounts (often 8 hours) and are often temporary. Recruitment trends indicate that people will not move to a rural area for a part time role with only temporary hours.

D) NSW has the lowest allied health salary in the country. Eg 5.9% lower than Queensland.

E) Housing for staff can be problematic

F) Day care for staff is limited and difficult to access. Most staff can only work on the days they have managed to get childcare.

G) All states are desperately short staffed and there are many incentives offered with all employers competing for the same limited pool of staff. Encouragements for school leavers to undertake these professions from local area is required with enticements to enter health at graduation.

H) Current staff are so stretched that staff are now retiring early/leaving. The job has become dissatisfying for many knowing they have extensive waiting lists and are not meeting the needs of their

community. There are also limited growth opportunities in the rural sector making roles less appealing.

I) Most viable option is to encourage local students to go into health. Offers of no HECS debt if come into rural health. (eg Cerebral Palsy Alliance is offering 27 week post graduate training program). Promotion of health professions at school forums

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

A) Dedicated paediatric teams with senior clinicians in cental "hub" areas (eg Armidale). This team can outreach to smaller facilities and conduct regular follow up appointments for vulnerable families but also conduct routine milestone checks and then implement follow up care if required. All team members currently are part time and part of a broader generalist team. The hours allocated are not enough to provide the services required. There is no point in assessing if there is no capacity to implement follow up. The team would build the capacity of junior staff to ensure sustainability and succession planning. This team would work best if co-located and preferably in an "off campus" situation that is more readily accessed by parents/families. Absolutely more hours are needed for this team to function properly. Babies are first identified at birth and then on referred to other services as required by Child and Family Health nurses/Aboriginal health services. If a family is lost to the service (eg move) the time taken to find them to re-engage is too great to be done routinely. These are the families we need to find.

B) Telehealth is not an option for the most vulnerable unless lead by a clinician (usually at the client end) and support with IT or brought to local facility. Although this model of care can be used by some – face to face is often necessary to conduct various tests (eg reflex testing, feeling fontanelles). There are many internet "black spots" in rural areas and the more remote the worse this gets.

C) Screening (Brighter Beginnings) will lead to identification. These will be stressful to families if there are no viable options to follow up. Currently this is the case if more screening is added to the already stretched caseload capacities of existing clinicians.

D) Private companies being employed by preschools, and schools to run screening clinics to identify problems in rural areas. Unfortunately, most of these companies only provide screening which leads to increased referrals back to Health for treatment where capacity is limited at current staffing levels.

5. Any other related matters.

Projects often are metro centric eg complex care co-ordinator based in JHH (John Hunter Hospital)

Department of Education does not have any in house speech pathology or Occupational Therapy

Private providers are selective in who they will offer a service to. Some won't take certain cohorts. They will leave the harder customers and will not "chase" vulnerable families.

Lack of housing - overcrowded with family and friends.

Drug use and alcohol addiction of parents leads to difficulty engaging and getting good outcomes.