30 AUG

My name is Anne-Marie English and I have practiced as a maternal and child health nurse in Victoria for the past 20 years. Initially I worked as a relieving nurse in the metropolitan area then in 1992 moved to the City of Casey in the growth corridor in the southern metropolitan area for eleven years. This is an area of high need with competing demands for scarce resources. These were the years of competitive tendering in local government in Victoria. I worked as the Coordinating Nurse managing the MCH business unit – the largest service in the state with 35 nurses servicing a population of in excess of 20,000 children 0-6years and their families with 3000 new births per year. For the last 9years I have worked in an inner metropolitan area in the City of Glen Eira as a clinic nurse delivering the MCH service.

I am a midwife and nurse registered with the Australian Health Practitioner Regulation Authority. I completed my General Nurse training at St John of God Hospital Ballarat in 1974 and Midwifery at Mercy Hospital for Women Melbourne in 1975. Additionally I completed a Diploma in Nurse Education from University of New England in 1981; a Bachelor of Applied Science- Advanced Nursing in 1987 from La Trobe University in which I was awarded MCH registration and finally a Graduate Diploma in Business Management from Monash University.

My submission is limited to Chapter 12 of the Early Childhood Development Draft Report and the "Child Health Workforce".

I am particularly concerned with recommendations 12.3 and 12.2 of the Draft Report regarding the removal of midwifery as a qualification prerequisite for MCH nurses, and questioning the value of scholarships for MCH programs of Study. These recommendations would reduce the quality of the Victorian MCH nursing service which is unmistakably dependant upon robust qualification requirements and educational preparation of Victorian MCH nurses.

I am strongly opposed to the removal of midwifery as a prerequisite for MCH nurses and believe my qualification in midwifery has given me a critical body of knowledge and invaluable professional skills to practice as a MCH nurse.

I can recall many instances where I have drawn upon my midwifery knowledge and experience in providing MCH nursing care where client's health would have suffered had I not had this qualification.

There are many instances where the client's delivery details report that the placenta and or membranes are not complete following delivery. As a midwife you are aware the client could develop a uterine infection or post partum hemorrhage. The uterus is not able to contract because of the presence of this material with serious consequences from haemorrhage or at best leaving the client with anaemia and issues in establishing an adequate milk supply. Therefore you make the client aware of what symptoms to look for and strategies to employ to minimise any effects.

Breast feeding problems of attachment, low supply are issues we encounter daily in our work. As a midwife you are aware of the anatomy of the breast and physiology of lactation and advice clients on strategies to facilitate the establishment of lactation.

The requirement to be a midwife has in no way hindered my practice as an MCH nurse and in fact it is an essential qualification that informs my everyday practice as an MCH nurse.

I also believe it vitally important that MCH nurses be registered nurses. The knowledge gained through my general nurse training has provided me with a strong foundation to use in my everyday MCH practice.

My first year back in clinical practice was spent in a single nurse centre and two instances stand out to highlight the importance of general nursing knowledge. A mother visited with her first baby and she had an obvious swelling in her neck. Goiter development is not unheard of during pregnancy but this was beyond normal. At my insistence she reluctantly followed up again with her GP and was subsequently diagnosed with a malignant thyroid tumor. Fortunately she was treated successfully and had a second baby 6yrs later.

In another instance a third child was brought to the clinic and gradually over 6-8months he became more emaciated and unwell with a protruding tummy and emaciated limbs. I was able to encourage the mother to have his symptoms investigated as I suspected the child could have coelic disease. Not only did this child have the disease but his two brothers and father were diagnosed as well.

Finally it is vitally important that MCH nurses complete a post graduate MCH program of study. This additional study has provided me with the necessary knowledge and understanding to provide holistic and family centred MCH nursing care in the community setting.

In the past week a former client and her 5yr old called to visit and she recounted this story to me. When she brought the baby as a newborn, on examination I noted she had uneven creases in her thighs. This can be indicative of developmental dysplasia of the hip. The woman's obstetrician was not concerned and the GP was hesitant to Ultrasound the baby's hips but did and DDH was diagnosed. The baby wore a Pavlick harness for 6-8months and continues to be monitored regularly but otherwise has normal gait.

I strongly believe the requirement to be a midwife, registered nurse and to have undertaken MCH post graduate program of study are critical to my ability to provide quality MCH nursing care. Possessing such qualifications should not be seen negatively as a barrier to MCH nursing, but rather the cornerstone of providing quality MCH nursing care.

Draft Recommendation12.2

When managing the MCH service in the fast growing City of Casey maintaining an adequate workforce was always a challenge. 85% of the workforce lived outside the municipality and their average age was 55years. With the cooperation of the stakeholders- Community Services Victoria, Nurses Board of Victoria, MCH Coordinators group, a project was undertaken to scope the workforce and develop means to recruit and retain a workforce for the future. The idea of scholarships was a product of this time as

this strategy had been successful years before when other professions were seeking to recruit i.e. teachers. Many of the more affluent proactive municipalities such as City of Kingston and Bayside initiated and successfully implemented their own scholar programs reaping the benefit of a flourishing workforce. In my currently municipality a quarter of the workforce have come from the scholarship program so to cancel it without thorough analysis of retention rate of graduates would be a very short sighted action.

I am concerned at the limited consultation undertaken by the Productivity Commission with Victorian Nurses. Our service is widely considered best in Australia if not world wide and has many strengths. It is therefore surprising to me that the Commission has not held Public Sittings with Victorian MCH nurses. To help the Commission understand the many strengths of the Victorian MCH framework, I would be grateful if the Commission would meet with me and other MCH nursing colleagues.

I thank the Commission for considering my comments above.

I hope that the far reaching strengths of the Victorian MCH nursing service can be adopted by other states and the recommendations are not imposed that reduce and diminish the quality of the Victorian MCH nursing service.

Anne Marie English
RN, RM, FRCNA.