T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Wangaratta — 25 October 2017

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Witnesses

Ms Rebecca Sacco, maternal and child health team leader, and
Ms Liz Flamsteed, head of innovation fund project in antenatal engagement, Rural City of Wangaratta.

The DEPUTY CHAIR — I welcome to these public hearings Ms Rebecca Sacco, maternal and child health team leader, and Ms Liz Flamsteed, head of innovation fund project in antenatal engagement, from the Rural City of Wangaratta. Thank you for attending today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof of the transcript. I invite you now to make a 15 to 20-minute statement, which will be followed by lots of questions from us. Thank you.

Ms SACCO — Thank you. My name is Rebecca Sacco, and I am the maternal and child health team leader at the Rural City of Wangaratta. I have been in this position since April last year, and prior to commencing at the Rural City of Wangaratta I worked in three other municipalities in our region. I worked part time in two municipalities and also have casual positions in two other councils.

At the Rural City of Wangaratta I currently have three permanent staff in my team and four maternal and child health nurse relievers, who all also work in employment outside of the Rural City of Wangaratta. We have an EFT of around three, including our enhanced home visiting service, and support approximately 300 new families every year, with a total of 1890 children currently enrolled at our service. We cover approximately 3639 square kilometres and frequently have to travel up to an hour each way to offer home visits for families in the perinatal period.

To become a maternal and child health nurse in Victoria we are required to hold qualifications in nursing, midwifery and a graduate diploma or masters in child, family and community health, and I believe that the requirements to hold all of these qualifications brings a vast wealth of knowledge and experience to the role to better support our families throughout the early years experience. However, along with these qualifications comes great expense to the nurse undergoing training, and some work has been done by the Municipal Association of Victoria and the Department of Education and Training to combat this through the provision of grants. However, it has to be acknowledged that any study requires time away from paid employment and also time away from families and is a strain on the families.

In my experience it has been very difficult to attract quality staff to north-east Victoria. I believe this may be in part due to low equivalent full-time positions, inconsistent and low rates of relief required and also our geographical location, being a large travel time from the city. I believe that attracting quality maternal and child health nurses to our region may also be hindered by the low pay rates seen in north-east maternal and child health services. There is a large discrepancy between municipalities in our region, let alone comparing rates to metropolitan-based municipalities. I believe that negotiating individual enterprise bargaining agreements is detrimental to rural maternal and child health services. Staffing at each maternal and child health service is based on birth notifications, and therefore we should all have very similar ratios and workloads, and this in a sense creates a greater sense of inequity in our pay rates. If I am unable to offer staff competitive rates, how can I attract them into my service here in the north-east?

In respect to services in north-east Victoria I believe that we have some fantastic opportunities to offer clients in the perinatal period. The early motherhood service is a vital perinatal service and it is well utilised by families in our entire region. The early motherhood service is proactive in promoting the wellbeing of families but also offers a valuable service when families are in need. The response and support my staff receive from the service is also vital. For example, a staff member recently went into a client's home for a key ages and stages home visit and found the client to have a very flat affect, which can be normal in those first few days after a birth, but the nurse felt that this was of note. The same nurse saw the client again a few days later for a key ages and stages two-week visit and, due to concerns, used a screening tool on the client, which raised more concerns about her mental wellbeing. With permission, the nurse then contacted the early motherhood service, who after discussion with the nurse and talking to the client visited that client a couple of hours later. The client was actually admitted to hospital for treatment. Once she was stabilised she was sent to a mother and baby unit in Melbourne for help with bonding and caring for her child.

Without the support of the early motherhood service this is a very complex time and consuming task for a maternal and child health nurse, who is often not equipped with specific skills to give the client the care and direction required. I believe that support from them is vital for us, but I think also we need to be looking at the

fact that our women have to go away from our region and from our support networks to spend time with their babies in a mother and baby unit, the closest being Melbourne or having to go to Canberra.

We have very limited infant mental health services in our region, and I feel that we need greater funding and service provision in this area as we know that early intervention is vital to long-term wellbeing. Our maternal child health service is lucky enough to offer 12 places per year with an infant mental health specialist; however, much more is needed. Wangaratta offers a lactation clinic to all clients in the perinatal period and beyond, and we find this is a fantastic service in supplying not only breastfeeding advice but linking clients to services and promoting self-care and attachment.

The Rural City of Wangaratta maternal and child health service leads a continuity of care meeting on a monthly basis. This meeting includes local services, such as Northeast Health domiciliary nurses, the community midwife program, antenatal booking staff, the early motherhood service, the lactation clinic, Upper Murray Family Care, Cradle to Kinder and child protection, and aims to provide a collaborative approach in the antenatal, perinatal and postnatal periods for vulnerable clients.

And in conclusion, before I hand over to Liz to discuss the antenatal project, I feel that a mechanism for equality in wages needs to be developed. We need to develop ways to attract and retain quality staff to rural areas, and we need to ensure ongoing and increased funding for mental health services such as the early motherhood service and infant mental health services, and on my wish list would be a mother and baby service in our region.

The DEPUTY CHAIR — Thank you. Liz.

Ms FLAMSTEED — Good morning. My name is Liz Flamsteed, and my role in Wangaratta is an enhanced maternal and child health nurse, so I work within our team, and I have been working as a maternal and child health nurse for 16 years in Wangaratta. I just want to talk about our innovation project funding, which we received in 2016. We implemented the innovation project to engage families antenatally in the maternal and child health service. We were successful in securing a state government grant of $40 000, which was really well utilised over the period of 12 months. The grant was used to implement a project which aimed to improve continuity of care by engaging with vulnerable women and their families in the antenatal period and by increasing collaboration and communication between agencies involved in the care of pregnant women and their families in this Rural City of Wangaratta.

The idea for the project emerged through informal observations by our team on what successful engagement looked like for maternal and child health practitioners, especially in the role that I do, which is the enhanced maternal and child health service. We observed that we had often had improved outcomes for vulnerable families when they were already familiar with the service, and that came through having seen the families previously, and then we knew that they were pregnant again and already had a good relationship developed. But our key was securing a really good relationship with the families who we had not met before.

The maternal and child health service usually engages first with families following their discharge from the birth in hospital, and we continue to see families up to six years of age. We identified that where a supportive and collaborative rapport had been established prior to the birth, families had more understanding of and confidence in our service and were more willing to engage over the longer term, which is the key.

What defines a vulnerability? You might not be familiar with how we define vulnerable families in the antenatal or postnatal period, but in our experience it might be a teenage parent, some as young as 15 years most recently. The family might have a history of or current family violence; there might be a history of or current mental health problems, in particular anxiety; a history of current drug or alcohol use, most commonly methamphetamine and marijuana; a lack of social support — they might be a single-parent family, they might have had a traumatic birth previously or have undergone a traumatic birth. They might be physically isolated — sometimes we travel up to 50 kilometres to see a parent who has got no transport — and they might also have unstable housing.

So as part of the rollout of our antenatal innovations and outreach, the Wangaratta maternal and child health service, along with the collaboration of the antenatal team at Northeast Health Wangaratta, refined an existing antenatal vulnerability tool, which still remains in draft form. We wanted to make it easier to use this tool to identify the vulnerabilities across the partner services that were involved in the project. The tools supported the early identification of vulnerabilities and appropriate referrals to specialist services before the birth of the baby.

The project involved collaboration with a number of stakeholders, as Rebecca has already outlined, leveraging relationships already established through existing continuity-of-care meetings. These are held once a month, which we attend and Northeast Health attend, along with a number of other partners such as the department of human services, child protection workers, Upper Murray Family Care, Cradle to Kinder, the social worker, lactation services and, importantly, the early motherhood service out of Northeast Health as well. Through this we were able to get their support in our project and also develop a really strong understanding of the focus of our project and what we were trying to achieve. The shared purpose really supported the smooth implementation of our trial, and really we could not have done that without the support of the hospital; it was really instrumental in the project being successful.

A number of positive outcomes were seen from the project, the most significant of which was an improved relationship with our clients, demonstrated by an increased understanding and trust in our services — maternal and child health. Historically we have had a bit of a bad rap as maternal and child health. I think there is a poor understanding in vulnerable families of what we do, and in many cases we are perceived in a slightly threatening way because we are coming to check on their wellbeing and how they are parenting. We want to remove that stigma by establishing that relationship earlier and helping them to understand that we are there to improve the outcomes for their baby and child, and that early intervention in particular is the key to a more successful outcome.

We had the ability to identify areas of risk much earlier, such as prevention of sudden and unexplained infant death — I think it is really, really crucial to have that early prevention education; promotion of breastfeeding, very importantly, to keeping our breastfeeding rates up — antenatally if we are helping to prepare the client and educate them about that, then the outcomes are going to be much greater — identifying family violence risk; offering advice about car safety; offering Quit and promoting immunisation; but also by facilitating the early referral to other services such as perinatal mental health, which is the early motherhood service, social work, family support services and, importantly, lactation services. The communication and information sharing with the local child protection officer in Wangaratta, the community worker in particular, was really enhanced as well.

Overall this translated into the completion of almost 100 per cent of key age and stage consultations within the duration of the grant itself. We only saw 30 families in the time that we administered this innovation project, so 30 out of 300 births per year — 10 per cent. Normally I would not have had the success of completing all of our key age and stage visits in those families because they disengage, they are hard to locate or they just do not want to be involved in the service, which is voluntary. So we are really happy to see that it actually was almost 100 per cent uptake of our key age and stage consultations during that 12-month period.

Our project has also demonstrated that such simple innovations as offering an antenatal engagement and a simple change to our current practice can result in much improved outcomes for vulnerable families. We hope that it can be considered as an innovation that can be embedded into statewide practice, and certainly the goal of the innovation funding was to look at practical changes that could be implemented across the state.

Most importantly our maternal and child health service provision is greatly supported and enhanced by existing perinatal services in the area, such as the antenatal and postnatal services of Northeast Health. We are really fortunate we have got a great relationship with the team antenatally and in the postnatal unit and lots of communication sharing. Really that enhances the service delivery that we provide. The early motherhood or perinatal mental health program and lactation clinic — communication is really enhanced between those services with us, and again we support one another very well I think.

With the collaboration of our partners and our unified approach to delivering a high standard of quality perinatal care to the families within the Rural City of Wangaratta, we can feel reassured that vulnerable families are getting what they need at the right time and earlier than they were. This is only possible with continued funding, so at the moment the funding for our project has ceased. It was funding me to work half a day a week in that area to try and outreach antenatal families. I have not got that time set aside now as part of our funding, but I am trying to do it over and above and on top of my normal work. So it would be great to see if we could actually, with the hours that we are funded for, allocate time for that. Also our needs need to be supported in professional development, ensuring that we have adequately trained staff who are not only recognised for our quality service provision but are paid at least at the state average, which we are not, as Rebecca has outlined.

There is one other thing in regard to professional development. Having to travel to Melbourne for anything, even particular ongoing university diplomas or certificates or postgraduate study, and wanting to research the project that we have done in Wangaratta, I looked at a postgraduate certificate in clinical research through nursing at the University of Melbourne medical school — $34 000. Not only is it time away from work, but the expense of trying to complete study like that, postgraduate, is just unachievable and unaffordable. As Rebecca outlined, on our wish list for Wangaratta is an inpatient mother and baby unit to be connected to Northeast Health and better opportunities for training closer to home.

The DEPUTY CHAIR — Thank you very much. It is really interesting to hear about your work, some of the issues and the program that you have been involved in. Can I ask just to start with: what is the earliest you go into a home with a newborn?

Ms SACCO — From day five would be the earliest.

The DEPUTY CHAIR — And with the program that you were involved in?

Ms FLAMSTEED — Well, as soon as the hospital antenatal team have the mother booking in, which could be as early as 18 weeks, they have the tools to identify that this family is vulnerable. That referral comes through to us, so as early as 18 weeks we have got a vulnerable family who have been identified as needing extra support after the baby, but in our project what we are trying to do now is make contact with them, so even as early as 18 weeks: 'Hi, this is our service. This is what we can provide. Would you like to meet us so you know what we can provide and how we can support you after the baby is born'. So as early as 18 weeks —

The DEPUTY CHAIR — And that is a stage that they are suspicious about?

Ms FLAMSTEED — No. I think there is a misconception that we are the welfare sisters. It is interesting, and it is terminology that is just so antiquated. Yes, some —

The DEPUTY CHAIR — That is different though from coming in at five days after birth?

Ms SACCO — Very different. I think post-birth there are a lot of things going on for any new mother, but I think there is so much focus on trying to look after this new baby. They have been through something of a traumatic experience. Even when it is a great experience, there is still a lot to deal with emotionally, like the hormones are crazy. But in that antenatal period they are quite receptive to a lot of education and intervention. I say that, and it sounds very hard, but, you know, light stuff, because they want the best for their baby.

Ms FLAMSTEED — And they like to develop connections. They like to develop a good relationship with their antenatal midwife. They like to develop a relationship with their doctor or GP who is supporting them as well. It is really nice. Women like to develop relationships and particularly around birthing. They feel special, they feel cared for and I think that is just part of the whole picture. The education we can assist in providing. We do not take over their antenatal care at all. That is completely separate. We are simply offering and informing them, 'This is what we can do for you after the birth, but in the meantime did you know about safe sleep?', because perhaps we will get to the home and they have got an unsafe sleep environment for their baby, they have not got an appropriate car seat, their housing is unstable, they are currently using drugs or alcohol that has not perhaps been picked up — maybe it has, maybe it has not. There are so many things that antenatally we can support and educate them in. And as we said, earlier intervention, early referral, better outcomes.

The DEPUTY CHAIR — So when you are identifying the vulnerable families — and you ideally, say, to get in there at about 18 weeks — what number are you getting in at around that time?

Ms FLAMSTEED — Well, we have only had the project run over a 12-month period, so it is not currently running as such. Many we would not see at 18 weeks because their vulnerabilities might be identified at their second or third antenatal visit at the hospital, or they might present late at 36 weeks and be identified as vulnerable. Any time in that period would be great. What we are finding is that at the very least they are being identified and flagged as a vulnerable family so that postnatally we make sure we pick them up.

The DEPUTY CHAIR — So how many, what percentage, were you able to get prenatally?

Ms FLAMSTEED — We got 30 clients out of 300 births for the year, so 10 per cent of the mothers that birth in Wangaratta — we saw 10 per cent in a 12-month period — that were identified as vulnerable and were followed up, actively followed up, and had good outcomes.

The DEPUTY CHAIR — That is excellent.

Ms FLAMSTEED — As we said, it is not a difficult thing to administer.

The DEPUTY CHAIR — One of the things that we have heard previously in our inquiry is that: 'Whilst we want to go in and offer educational programs to make things better' — a safe environment, the car seats and all this stuff that you have just talked about — 'people are just worried about not having a roof over their heads'. The authority is going in or the department is looking at trying to make this bit better, but their head is not in that space because they have got other things that are much more pressing. Do you find that?

Ms FLAMSTEED — Yes, it can be, but I think administering it at the right time and gently and slowly and not being intrusive is really important. It is a subtle approach; it is a combined approach. Even postnatally with lactation services as well and early motherhood, the information sharing that has gone on in the antenatal period, when it is not just administered by one person — it might have family services involved already, there might be a social worker involved already, the department of human services is frequently involved with the majority of my clients as well — everyone is working gently together to try and develop the relationship. I guess that is the best way to put it.

Ms SACCO — I think also housing is one of our risk factors, so if it is recognised antenatally, that is actually linked with services before the baby is born —

Ms FLAMSTEED — Yes; it takes time.

Ms SACCO — It helps take some of that pressure off, because there is a long wait for housing — a very long wait for housing.

Ms BRITNELL — I was just thinking about 20 or 30 years ago when you became a maternal and child health nurse you did not have the cost. You did it because you wanted to go into that direction. You can get paid just as much in a hospital working in maternity as you can in this area — even though you have done more study, by the sounds of what you have just articulated — so there is no driver. We are hearing in the inquiry a lot of people in their 50s and 60s are in these roles and then there is a big gap. Is there some link between that lack of incentive for higher pay, because from what you have articulated, you are not getting paid according to your qualification —

Ms SACCO — Some areas definitely are. I think there is a big disparity. For example, in one of the shires I have recently come from had an EFT of 1.1, and when you are in a staff of 70 trying to organise an EBA your two little votes do not have much weight. Our wages are negotiated separately to the rest of the municipality because we are under a nursing agreement, but it is not a state thing, so every single maternal and child health centre is negotiating their own. Unless you are an amazing negotiator — and a lot of us do not have those skills — it is very difficult to get pay parity or even pay rises. I am pulling this off the top of my head, but our union rep at the time was saying that we have a $12 000 pay difference between nursing in Benalla and nursing in Wangaratta in maternal and child health.

Ms BRITNELL — So you were not a 3B or a 4A under the system?

Ms SACCO — No, we are not ranked like that at all; it is all individually negotiated. Four of the lowest paid municipalities are in this region, so getting a nurse to come and do relief from Melbourne where they are getting paid much, much —

Ms FLAMSTEED — Why would you?

Ms SACCO — Maybe $15 an hour more. There is not the incentive to come. And having a low EFT, you cannot offer someone to relocate on two days a week.

Ms FLAMSTEED — We do the work because we love what we do.

Ms SACCO — We do love what we do.

Ms FLAMSTEED — You would not do it if you did not love it.

The DEPUTY CHAIR — I just want to ask: everyone seems to be part-time. Is there a reason? Is that lifestyle, or families? Where are the 9-to-5, Monday to Friday people?

Ms SACCO — They are not really around, to be honest. I think it comes from a number of factors. I think it is lifestyle to a degree. I know in our service three of us have children, so I think out of the four of us, two of us work 0.8. I think that we are well-paid comparatively. I think that for a lot of people it is a step down from working full-time in a midwifery ward. So there are all those sorts of factors to it. There is low EFT, and my personal belief is it is good to have a few different people working in a service because we all have such different personalities and we bring different things to our clients. I do like that diversity in the staffing, but I think there are a lot of different factors for that. We do not have the births to support full-time work most of the time too.

The DEPUTY CHAIR — You have mentioned lactation consultants, and many others have too. What specific skills do you need to have to be a lactation consultant?

Ms SACCO — It is actually another whole lot of training. I could not elaborate.

The DEPUTY CHAIR — I want to talk about sudden infant deaths or stillbirth, what services that you see that are required for the families around that sort of an event and whether they are adequate. Do you know if they are different in different areas?

Ms FLAMSTEED — We have been very fortunate not to have experienced a sudden and unexplained infant death in Wangaratta.

Ms SACCO — I have had one in my previous job. It was an appalling experience for me personally. I was the maternal and child health nurse. I was the only one who had seen this child. The child was 10-months-old. I was in a very small community. I was never advised of the incident — ever. I rang departments. I did not get a call from the mother, of course; I did not get a call from the police; I did not get a call from the hospital — nothing. I have never actually heard.

The DEPUTY CHAIR — You heard on the grapevine?

Ms SACCO — I heard on the grapevine within hours of the death happening, and I tried to follow that up. I never got any information — ever. So it was very difficult then to follow up with the client. I did find the client. She did not want to speak to me. It was a horrible experience.

The DEPUTY CHAIR — Who would you think would be the person in that situation to provide the care and the support and the referrals to organisations that might be able to help them?

Ms SACCO — I thought it would have come from the police who attended. I thought they would have let me know, so then I could offer support to the woman. To be honest, I have got no idea what the process was at all, because I could never get anywhere with following that up.

The DEPUTY CHAIR — Is that something that you deal with in training to be a maternal and child health nurse?

Ms SACCO — No

Ms FLAMSTEED — Well, grief and loss and death. But on a different note. If there is a fetal death in utero or a stillborn infant at the hospital, we are notified immediately, pretty much, as soon as the mum is being discharged or as the event happens, because we are up at the hospital three days a week collecting birth notifications. We are made aware of that fetal death in utero or stillborn baby straightaway. As a maternal and child health service, even though we will not be seeing that baby, we still offer a service to the family: 'Would you like to have us pop around and see you?'. The hospital has already linked them through to perinatal mental health services and their GP, so that service runs, we think, quite smoothly, but it is when it is a community event that the feedback or the referral services are impaired.

Ms BRITNELL — The previous speakers identified this lack of a point of contact. Is that another example of where there is no central point that is required, perhaps, in regions?

Ms SACCO — Definitely. We could have children go down to the Royal Children's Hospital in Melbourne and never hear anything about it. We might hear a report from the mum at a visit six months later, 'Oh, we were at the Children's for some sort of gastric thing'. We do not get any information —

Ms FLAMSTEED — Actually even within our local area we will refer to GPs daily in our service, if not several times a day for various things — it might be hip dysplasia, it might be a developmental issue, it might be anything.

Ms BRITNELL — What about children who are at risk? We have had incidents in Victoria over the years where children have died because there has been no link between police, protective services and social welfare. Are you linked in with children at risk so that if anything happens you do get notified?

Ms FLAMSTEED — Yes. Rebecca attends the high-risk infant meeting with the department of human services, but through our continuity of care meeting we are meeting with that child protection worker, the community worker, once a month, so families at risk are discussed, and making sure that that follow-through is attended, but —

Ms BRITNELL — If that is in Wangaratta, but what if this person comes from Southern Riverina?

Ms FLAMSTEED — No, not necessarily. Actually, on that point is the ridiculous nature of the notification process we have to go through. I call it ridiculous because I have had a situation where I made a notification, rang Box Hill. We can no longer ring our local Wangaratta child protection service to say, 'We have a notification, we've got a child at risk'. We now have to ring Box Hill. Our number gets taken and we are told we will be rung back by an intake worker. In the situation I had, 11 phone calls over 2.00 p.m. to 11.00 a.m. the following day —

The DEPUTY CHAIR — You made 11 phone calls?

Ms FLAMSTEED — Eleven phone calls it took me to make a notification, from 2.00 p.m. to 11.00 a.m. the next day. I said to them on the phone, 'This is a complete joke'. I said, 'What's happened to this baby in the last 12 hours? Do you know? Do I know?'.

The DEPUTY CHAIR — So what has brought about that change — decentralisation or something?

Ms SACCO — The state decentralised it.

Ms FLAMSTEED — We used to be able to ring through to Wangaratta. We could talk to the workers we knew — we knew most of them: 'Hi, we've got a baby here' —

The DEPUTY CHAIR — How long has that been happening?

Ms FLAMSTEED — Twelve months?

Ms SACCO — Twelve months.

Ms FLAMSTEED — Yes. So I do not know how that gets addressed, but —

Ms SACCO — I guess on that too, given they have got no idea of our geographical area. 'Could you just pop out?'. 'Well, actually, they are an hour and a half away'.

Ms FLAMSTEED — I tell you, one thing that is working well in that community referral program is that we will refer, as I said, daily in our team to GPs. We rarely hear back from a GP; rarely would there be any acknowledgement of referral. The paediatricians are fantastic about it. We meet them; I meet with them once a week at a paediatric meeting, so the feedback and referral process is really enhanced there. Personal communication feedback through to other services such as lactation, early motherhood, the antenatal team and the postnatal team at the hospital is great, but it is the tertiary referrals. For speech therapy, physiotherapy and anything like that that comes with the hospital, the referral process is always acknowledged and we get a letter back. But it is the doctors, the GPs, that do not acknowledge our referrals. So we will then have to ring them up:

'How did you go with your hip referral? Did you have the ultrasound? Has your baby got hip dysplasia? Are you going to the kids hospital? Oh, didn't the GP tell you?— No.' So that is difficult.

Ms SACCO — I think also, and I know this is something that has been worked on, the out-of-home care data situation has been a bit tricky. There are children who go in out-of-home care, and we do not know. Liz had a child recently, and when she went to do the home visit, their house had a 'for lease' sign up.

Ms FLAMSTEED — So I rang the child protection worker and said, 'This family is not here anymore. Have they relocated? I cannot contact the mum.' and she said, 'Oh, she has moved to Benalla.' A different municipality. And I said, 'So has that transfer happened? Because I cannot transfer her notes without her consent'. 'Oh, I am leaving that up to the mum', says the child protection worker, and this is someone different. I said, 'That is not going to work, because historically that mum will not engage because she is vulnerable. She will all just ignore the service'. So, anyway, she ended up being referred through by child protection, but that is an isolated incident, I guess.

The DEPUTY CHAIR — Yes, but that child had gone into out-of-home care, had it?

Ms FLAMSTEED — No, it had not.

Ms SACCO — There are ones we do not hear about who have gone into out-of-home care.

Ms FLAMSTEED — On two occasions I have had the foster carer ring me and say, 'I have got a new baby', and I have not heard about it. So a foster carer who I know well in Wangaratta will ring me: she has got a premature, eight-week-old baby in her care as of 24 hours ago, could we organise a visit? No one has rung me — 24 hours later they will — but the mum, the foster carer, has rung me first. So there is a real disparity —

Ms BRITNELL — Luckily we are so much more technologically advanced today. We are doing really well.

Ms FLAMSTEED — Yes, but that information sharing is complicated. You have got confidentiality issues and you have got consent issues. I know, like with Patchwork, which we do not use in Wangaratta, the eHealth record or whatever, all of that stuff is in its infancy or being rolled out in certain places but not all over. So some areas are doing it well and some areas are not, because it is not uniformly —

Ms BRITNELL — Sorry, the eHealth is rolled out somewhere, but not here?

Ms FLAMSTEED — I do not know.

Ms SACCO — I think it is everywhere, but I don't know the uptake here.

Ms FLAMSTEED — They are talking about that being a universal record that everyone could link in and perhaps see that, 'Oh, actually this patient has already been seen as a client of whatever service in whatever other health municipality'. But we do not do it here, but if that was to be the case, then information sharing would be much easier.

The DEPUTY CHAIR — What about the information you get from the hospital for referral?

Ms FLAMSTEED — It is great.

Ms SACCO — They have been great.

Ms FLAMSTEED — So through this part of the antenatal project, the hospital already had a vulnerability tool that they used to identify antenatal clients at risk. We are working to refine that so that it is an easier to administer, more defined tool that is based on evidence.

Ms SACCO — They have also recently begun to include their birthing obstetric summary for us post-birth, so we get a birth notification with the obstetric summary. So we can actually see that this mum has had a 2 litre haemorrhage or there has been a traumatic birth, so we are a bit more prepared for even our universal staff to go in and be more helpful with that family.

Ms BRITNELL — In the health system, you are bound by confidentiality as professionals and that has been the case for many, many years, that is correct?

Ms SACCO — Yes.

Ms BRITNELL — But I am hearing that privacy laws are what has changed in our society in the last 10 years and that is what is preventing the continuity of care through system access?

Ms SACCO — Yes.

Ms BRITNELL — Can you help me understand, when you are already professionally bound by confidentiality, the logic behind not being able to access systems where information is going to help you do your job?

Ms SACCO — I think it comes from fear of organisations and sharing information. I have only been doing this job for about five years, so I have always being bound by this 'you cannot do this without this consent and this consent'. It can be quite daunting to then have a secondary consult with someone, because you are thinking, am I overstepping the mark here?. Also, people say, ' Oh that consent is too weak, that is not enough'. So I think there is a lot of fear around are we getting informed consent and is it binding if we go and share this information even though it is all confidential. Because I think sometimes when you share something, people act on it, and are asked, 'How did you know that?'. I do not know the answer to that really.

Ms BRITNELL — So confidentiality and privacy are contentious?

Ms SACCO — Yes, I think so.

Ms FLAMSTEED — You need to be able to be 100 per cent sure that the records are going to be maintained safely and securely, and that only the right people are going to have access to those records and that you have got, as Bec said, informed consent from the client knowing that information is only going to be shared with the people that are outlined here or that are pertinent to it. You know but sometimes you think, 'Wouldn't it have been great to know that about the client before we see them? How could we have known that?' You know, if you got a client who is doctor shopping for GPs for scripts and has been in a New South Wales child protection service and then comes to Victoria, lots of that information you are not privy to it. We cannot transfer records interstate. I do not believe child protection can transfer records interstate either. I know there is a glitch in that. I know we have had conversations about this in the past, but they cannot get their records from interstate because they are under another child protection service, so there are always gaps.

The DEPUTY CHAIR — With regard to your — is it 10 key visits that you would normally have?

Ms SACCO — Yes.

The DEPUTY CHAIR — You have talked about a lot of services and calls that you want to make in between those; how does that fit within the model? Is that you guys going over and above and causing extra work?

Ms FLAMSTEED — It is part of the service.

Ms SACCO — It is part of it. We have administration time each day and we would do that in our administration time.

The DEPUTY CHAIR — So you might call some people, even though you are only seeing them for 10 visits?

Ms SACCO — That is correct.

The DEPUTY CHAIR — You have got that ongoing?

Ms SACCO — Yes, absolutely.

Ms FLAMSTEED — And if they need more than 10 visits, they get them so they will come back for an additional consultation. Or if they are deemed to need more than the 10 key age and stage visits because of

vulnerabilities or increased needs, they may be then referred to the enhanced maternal and child health service and have home outreach or be allocated another 17 hours of service.

The DEPUTY CHAIR — And if you notice — and you gave an example of a mother, I think — some mental health issues, where do you refer them? Have you got a lot of places to refer the people to or is it just the one place?

Ms SACCO — Usually straight to the early motherhood service.

Ms FLAMSTEED — That would be our first priority, and then the GP. Then in situations that I have had in the community, I have rung adult mental health services at North East Health and talked to a practitioner there who has been really helpful when there has been a mum who has had suicidal intent or presented in a bizarre fashion.

Ms SACCO — I believe that the perinatal emotional health or the early motherhood service are only available for us to refer up to 12 months after the birth, so we have to have other avenues after that time.

Ms FLAMSTEED — And we would refer to A&E — if someone presented in a really unstable mental state, then we would refer them to accident and emergency straight away or call out the —

The DEPUTY CHAIR — Are the psych beds here?

Ms SACCO — I do not know. Maybe Kerferd?

Ms FLAMSTEED — We have got Kerferd, but we cannot comment on all of that from a hospital point of view.

Ms SACCO — But not for a baby room, I don't believe.

Ms FLAMSTEED — There is a mental health facility called Kerferd that is attached to North East Health, but not a mother-and-baby unit, and that is what we desperately, desperately need to service this area. We have to send mums to Wodonga to access a day-stay-settling clinic. When they need extra support to settle their baby with sleeping issues, they go to a day-stay clinic in Wodonga and then we can possibly refer then to Melbourne to residential units — which is Queen Elizabeth, Tweddle and O'Connell — but that is not easy. The waitlist for those places is often three to six months.

Ms BRITNELL — The children's ward would not be not an option? It is not an option?

Ms FLAMSTEED — You cannot just refer a baby to the children's ward for sleep and settling issues unless there is a physiological reason for it. They do not have those beds. They would laugh if we tried to refer them. However, one of my clients most recently, a mum with a very difficult social situation, was referred to the paediatric ward for two-night stay to try to get on top of settling because there were so many other things that were contributing to this 18-month-old being so unsettled. That is unique; that would not happen with regularity at all. They do not have the beds for that kind of service.

The DEPUTY CHAIR — I have just got one final question for Rebecca. You have worked at a number of other rural health-setting councils?

Ms SACCO — Yes.

The DEPUTY CHAIR — Is it different there?

Ms SACCO — Yes. They are all different. They all are completely different. They offer the same essential service, but obviously the governance of them is all quite different. They have all got their own —

The DEPUTY CHAIR — So the challenges are —

Ms SACCO — Very much so.

The DEPUTY CHAIR — Same challenges? Different challenges?

Ms SACCO — Yes, staffing challenges at most of them.

The DEPUTY CHAIR — I was thinking that, when you say you do not have places to refer to, I live in Yea in Murrindindi shire, you know —

Ms SACCO — In this region for, say, early motherhood services, Alpine, Benalla, us, Mansfield would refer to Wangaratta. So we are all trying to take a little snap at it. So Cradle to Kinder, for example, I think they have got 25 beds. They cover this whole Hume region. Twenty-five places for mums up to 25 years of age. They are full, I think, now. They have been going —

The DEPUTY CHAIR — Where is that based, the Cradle to Kinder?

Ms SACCO — They are based here in Wangaratta, but they do all the outreach — up to Towong and back, so huge geographical areas.

The DEPUTY CHAIR — It is indeed. Thank you very much, it has been a very valuable contribution that you have made, and I think we both enjoyed that as well.

Ms FLAMSTEED — Thanks for listening.

Witnesses withdrew.