Australian® Nursing & Midwifery Federation
VICTORIAN BRANCH

535 Elizabeth Street
Melbourne Victoria 3000
ABN 80 571 091 192

Box 12600 A'Beckett Street PO
Melbourne Victoria 8006

anmfvic.asn.au
t 03 9275 9333
f 03 9275 9344
e records@anmfvic.asn.au

MH:mg

24 September 2026

Jill Butty
Director, Women's, Maternal and Child Health
Community and Women's Health Community and Public Health Division
Department of Health

Via email *jill.butty@health.vic.gov.au*

Dear Jill

Re: ANMF (Vic Branch) Submission regarding MCH Service Key Ages and Stages [KAS] Refresh

As foreshadowed in the recent Murdoch Children's Research Institute [MCRI] ANMF (Vic Branch) Key Ages and Stages [KAS] Refresh Focus Group, we are pleased to provide a written submission to the MCH Service KAS Refresh.

By way of context, the Victorian MCH Service is widely recognised as the 'Gold Standard' of maternal and child health services or as observed by Emeritus Professor, Dorothy Scott, OAM:

> *the envy of the rest of the country and well beyond the shores of this country, as some of us have long known…* (and) *the cornerstone of Governments' universal, early intervention and prevention program covering all children and are particularly important in the early care of vulnerable children* [1]

ANMF submits that review of the KAS Framework must be anchored on an understanding that the MCH Service is fundamental to Victoria's primary prevention, early identification and interventions strategies for mothers, parents, children and families, and be purposed towards building on strengths of the MCH Service and removing barriers or obstacles which restrain or limit full realisation of these strengths.

The KAS Refresh must also recognise the interconnectedness and interdependent nature of each component of the MCH Service. The MCH Service has three components: the Universal MCH Service (comprising the KAS Framework and Flexible Service Capacity and the Enhanced MCH Program) and the MCH Line. Each component serves a critical function and cannot be viewed in isolation from the other.

To help inform our submission to the KAS Refresh, ANMF conducted an online survey of approximately 1500 MCH nurses within the MCH Service [**Survey**]. Their contributions are referenced throughout this submission, together with the input of ANMF delegates and the wisdom and experience shared with ANMF by MCH nurse members through industrial and professional advocacy across Victoria.

Our submission is aligned directly to questions continued within the **MRCI** '*MCH KAS Refresh Focus Group Guide'*.

[1] Philip Cummins, Dorothy Scott and Bill Scales Report of the Protecting Victoria's Vulnerable Children Inquiry Department of Premier and Cabinet, Victoria, 2012.

We would be pleased to discuss any elements of our submission with you and ask that it be provided to the MCRI as part of consultation.

Yours sincerely

Madeleine Harradence
Branch Secretary
ANMF (Vic Branch)

c.c. *ANMF Records Department*
Nicole Allan, Assistant Secretary, ANMF Victorian Branch
Belinda Clark ANMF Victorian Branch
Anthony Stafford, ANMF Victorian Branch
MCH Expert Advisory Group members

Australian® Nursing & Midwifery Federation
VICTORIAN BRANCH

535 Elizabeth Street
Melbourne Victoria 3000
ABN 80 571 091 192

Box 12600 A'Beckett Street PO
Melbourne Victoria 8006

anmfvic.asn.au
t 03 9275 9333
f 03 9275 9344
e records@anmfvic.asn.au

ANMF (VIC BRANCH) SUBMISSION – MATERNAL AND CHILD HEALTH [MCH] SERVICE KEY AGES AND STAGES [KAS] REFRESH

1 What's working well?

a.Thinking about KAS as it currently operates, what's working well — for you, for families, for the system? (Prompt if needed: specific visits/components, timing, materials, relationships with families)

WHAT IS WORKING WELL - KEY STRENGTHS OF THE KAS FRAMEWORK INCLUDE THE FOLLOWING:

The strong universal platform provided by the Universal MCH Service, including the KAS Framework and Flexible Service Capacity

Supported by the Flexible Service Capacity of the Universal MCH Service, the KAS Framework is the foundation of early identification, intervention and referral for Victorian mothers, parents, children and families. It is the linchpin to promoting maternal health and wellbeing, (and the health and wellbeing of the father and/or other parent), optimising infant and child health wellbeing and development, and promoting optimal family functioning. Through its role in making early identification and intervention, including for families experiencing vulnerability or at risk, it is the gateway to referral to more targeted or intensive services. These include the Enhanced MCH Program, or other specialist services supporting mothers, families and children including Early Parenting Centres [**EPCs**], specialised services (including relating to family violence and child protection) and/or specialist allied health or medical practitioners.

Comprehensive Guidance set out by the MCH Service Framework

The KAS Framework is supported by clear and comprehensive written guidance as set out in the MCH Service Framework[1], and specifically the MCH Service Practice Guidelines[2]. This promotes consistency of MCH nursing practice and service delivery across Victoria, promoting quality and safety and reducing clinical risk.

Access to additional targeted and more intensive support for mothers, parents, children and families

The Enhanced Maternal and Child Health Nursing Program [EMCHP] is an extension of the Universal MCH Service, providing additional more intensive and outreach support to families experiencing vulnerable, who are at risk, or in extra need of support.[3]

ANMF members have identified the critical role performed by the EMCHP, and its interconnectedness with the Universal MCH Service. The capacity of the EMCHP to meet the needs of families experiencing vulnerability or who are identified as being at risk, directly impacts the capacity of the KAS Framework to

[1] *Maternal and Health Service Guidelines*, State of Victoria, Department of Health, November 2021.
[2] *Maternal and child health service practice guidelines* 2009
Reissued June 2019. State of Victoria, Australia, Department of Health. Originally published by the Department of Education and Training. Reissued June 2019 due to machinery of government changes.
[3] *Enhanced Maternal and Child Health Program Guidelines* Version 2.0 July 2025 State of Victoria, Australia, Department of Health.

meet the needs of Victorian families and children. Any shortfalls in EMCHP place pressure on the Universal MCH Service.

The KAS Framework is comprehensive

Guided by the MCH Service Practice Guidelines[4], the KAS Framework include 10 KAS consultations, which in turn involve comprehensive assessment, early identification, intervention and referral for Victorian mothers, parents, children and families**.**

Free and universally available

The KAS framework is free, and universally available to every mother/parent with a child from birth to school age. Access to the MCH Service is not dependent on wealth or Medicare card. Refugees, and people without a Medicare card can also access the MCH Service. Combined, these factors improve equitable access to the MCH Service. And subsequently improve health, wellbeing and development outcomes for the Victorian community.

The comprehensive educational preparation of the MCH nurse

Design of the MCH Service is founded upon it being delivered an MCH nurse who holds registration with the Australian Health Practitioner Regulation Agency [Ahpra] as:

I. A registered nurse; and,
II. A midwife; and,
III. Additionally, hold an accredited post graduate diploma (or equivalent) in child and family health.

This comprehensive educational preparation gives the MCH nurse a broad scope of practice. This equips the MCH nurse to safely and competently deliver the KAS Framework in the community, to children, parents, families and mothers as early as 24 hours after birth (and in the antenatal period if required), through puerperium and into early childhood. The MCH nurse is educationally prepared to implement the KAS Framework make comprehensive assessment, early identification, early intervention and referral regarding:

I. Infant/child health, wellbeing and development
II. Maternal health and wellbeing
III. Health and wellbeing of other parent
IV. Family functioning and myriad factors impacting family
V. Presence of risk and protective factors.

Continuity of Care

Crucially, the broad scope of practice of the MCH nurse provides significant inherent strengths to the MCH Service Framework, resulting in:

- Increased continuity of care
- Decreased fragmentation of care
- Improved opportunity to develop trusting client /practitioner relationships

[4] *Maternal and child health service practice guidelines* 2009

- Increased focus on preventative care
- Increased capacity to provide timely care and make early interventions

There is a plethora of research which supports these factors being pivotal to quality of care, the health and wellbeing of children, mothers and families and that they bring far reaching and enduring health and society wide benefits[5].

The MCH Service is relational, so is contingent upon there being a trusting relationship between the MCH nurse, and their clients. In turn, continuity of care is a crucial enabler to the development of trusting relationships. The broad scope of practice of the MCH nurse is therefore the linchpin to achieving continuity or care, high-quality care and optimising participation in the MCH Service.

The flexible service capacity

The flexible service component of the Universal MCH service allows MCH nurses to adapt MCH Service delivery to meet specific individual and community need. This includes providing additional consultations, and parent groups (new time parent groups, mothers groups, dads groups, rainbow parents) to educate, assess, empower and support mothers, parents and families.

These groups are often adopted to local community need, and are both an enabler and an extension of the KAS Framework

Delivered locally, in the community in the community and infrastructure

The MCH Service is delivered locally, in buildings established in local government areas, over 100 years. This means that mothers/parents and families can easily access their local MCH centre. This promotes participation in the KAS Framework.

Regional and rural areas - the Lifeblood of the community

In regional or rural areas, the MCH nurse is often the lifeblood of the community, and sometimes the only midwife in town.

There are often not specialist medical staff or allied health staff in rural and regional areas, and the local General Practitioner may not be experienced in paediatric or women's health.

In highlighting that the MCH nurse is the lifeblood of her local community, a participant from the ANMF MCH KAS Refresh Focus Groups advised as follows:

> *'I am used a lot for antenatal information as the only midwife in town - FDIU visits, for termination. The local medical centre is locum GP's no OBSGPS at all - at risk to my mothers.'*

[5] Schmied, V., Homer, C., Kemp, L., Thomas, C., Fowler C., and Kruske, S., (2008) Literature Review The role and nature of universal health services for pregnant women, children and families in Australia May 2008; Briggs, C. (2007) Nursing practice in community child health: Developing the nurse-client relationship. Contemporary Nurse (2006-7) 23: 303-311.

'Early Intervention screening occurs at each visit with the ability to move to a Brigance assessment for the unique needs of a child.'

'I have at times up to 15 depressive mothers on my books - with poor access to mental health services here. The poor access to GP's I have mothers contacting me for their older children's health advice too - eg 12yo with injuries etc. I am just saying this to give weight to the importance of this role of an independent sole R+R MCHN.'

The strengths identified above are universally reflected in responses to the ANMF Survey, with participants repeatedly identifying the following core strengths:

'The comprehensive educational preparation of the MCH nurse. The strong universal platform provided by the Victorian MCH Service and KAS Framework. Additional targeted and more intensive support for mothers, parents' children and families. For example, to the Enhanced MCH Program Early Parenting Centres. Comprehensive Guidance set out in the MCH Service Framework. For example, the MCH Service Guidelines and MCH Service Practice Guidelines.'

In addition, participants further identified the following strengths of the KAS Framework:

'The 10 core consultations for all families from birth to 3.5 years'

'A free primary health care service.'

'Consistency with all MCH guided by our frameworks, guidelines and legislation
The breadth of the support, literacy, guidance, information, referral and respect for parents in their role of experts with their child. Opportunistic discussion and administration of NIP immunisation program. MCH completes Family Violence and Emotional Health and Wellbeing screening at each KAS visits. MCH complete MARAM and Safety plan for each family at least once and often more regularly.
Respectful therapeutic relationship with parents enables disclosure and honest discussion on their concerns impacting their child, their parenting and themselves.
Enabling and supporting parents to identify their strengths and to create a child focused approach to parenting. Parents understand at each KAS the specific aspect of child development and wellbeing to be discussed and explored. Parents complete a child development questionnaire at each KAS across all the domains of child development.
Each KAS enables the emotional health and wellbeing or parents to be explored, discussed and action on and the importance of a well caregiver in meeting the needs of a child and what this looks like. Each KAS provides an opportunity for parent's to be exposed to playgroups and other parenting group to enhance their capacity and greater inclusion with the development of their child. Enable families to develop a local connection with their community that would otherwise not happen. Families are aware of the path moving forward and provided with strategies, recommendation and evidence-based resources rather than relying on social media and other resources not backed by evidence. Parents will often discuss important topic relating to themselves as parent's or their child that would not feel comfortable discussing with their GP. Parents are informed of the importance of good enough parenting and what this looks like. Parents will often reach out to their MCH nurse for additional support or information due to the respected relationship with their MCH nurse allowing much earlier intervention than would otherwise occur.'

2.Challenges and pain points
a. What are the biggest challenges and pain points for KAS checks?
i.Prompts: When there's too much to fit into a visit, what gets prioritised — and what gets dropped? Where do you feel the most time pressure, duplication, or system confusion for families? (prompt: overlaps with other checks)

ANMF (Vic Branch) members have universally rejected the suggestion that MCH nursing care is 'dropped', the overall framing on this question, and the flawed presumption there is duplication of care.

Our members universally advise that nothing 'gets dropped', that every assessment and intervention within each KAS Consultations is essential (as set out in the MCH Service Practice Guidelines).

Like all registered nurses or midwives, MCH nurses prioritise quality care. Prioritising MCH nursing care is germane to practising the professions of nursing and midwifery.

Applied to KAS consultations, where a mother/ child / family presents with an urgent or pressing need, such as relating to family violence, the MCH nurse adapts to meet the immediate and most critical need of the mother/ child / family. Where necessary the MCH nurse will arrange an additional consultation to complete all remaining elements of the KAS consultation.

For the avoidance of doubt nothing is 'dropped' because everything is critical.

At the same time, there are pressure points. These include:

Increased Client Complexity

ANMF members have universally identified that client acuity and complexity have increased. Whilst MCH nurses are generously equipped to meet the complex needs of mothers, parents' children and families, they are sometimes obstructed from doing so due to excessive and inappropriate MCH nurse caseloads, and staffing constraints caused by inadequate funding.

This impact can be exacerbated when there is insufficient capacity (due to inadequate funding) to accept referrals into the Enhanced MCH Program, meaning that clients experiencing vulnerability or who are at risk, and need additional support are cared for within the Universal MCH Service. This creates additional pressure on the Universal MCH Service and reduces the available time to deliver KAS Consultations. This reality illustrates the interconnectedness of each element of the MCH Service, and the need to increase funding to the Enhanced MCH Program to ensure funding is proportionate to meet identified need.

ANMF Survey

This reality is reflected in feedback from participants below, including impacts on MCH nurse, fatigue and morale.

> *'We are seeing a more complex clientele who need more time than is available within the existing KAS visit. This leads to more additional visits as well as extended visits to ensure families are provided with the individualised care they need.'*

'One of the key challenges and barriers to delivering KAS consultations is the increasing complexity of the role and the limited time available within appointments. Maternal and Child Health nurses are a highly skilled and experienced workforce; however, they are continually being asked to incorporate additional assessments, frameworks, and documentation requirements into a standard 45-minute consultation.'

'Over the past decade, several significant programs and practice frameworks have been introduced, including MOSAIC, PEDS, PEDS-R, and MARAM, to name just a few. Despite these increasing demands, consultation times have only increased by approximately 15 minutes.'

'At the same time, the needs of our clients have become considerably more complex. Maternal and Child Health nurses are frequently addressing growth and developmental concerns, parental mental health issues, family violence, social isolation, and a range of psychosocial challenges alongside the core components of child health and wellbeing assessments.'

'The combination of increasing client complexity and expanding program requirements places significant pressure on clinicians to deliver comprehensive, high-quality care within a limited timeframe. This can impact the depth of support and intervention that can reasonably be provided during a single consultation. Furthermore, the cumulative effect of these increasing responsibilities is contributing to workforce fatigue and burnout. Highly skilled clinicians are striving to meet growing expectations while maintaining safe, high-quality care, often without a corresponding increase in time or resources. This ongoing pressure is affecting workforce wellbeing, job satisfaction, and sustainability, creating challenges for staff retention and the long-term capacity of the service to meet community needs.'

'Over my 24 years working within Maternal and Child Health, I have seen a steady increase in the number of requirements that need to be covered during a KAS consultation. Many of these additions have been extremely valuable, particularly the inclusion of MARAM.'

'However, the challenge is that parents also need time and space to ask questions and discuss their concerns. Increasingly, the amount of information that must be covered within the consultation timeframe means there is often insufficient time left for these important conversations. As a result, some of the fundamental aspects of supporting parents are not able to be done, such as demonstrating how to play and interact with their child, how to read and share books together, and how to be fully present and responsive in their child's daily experiences.

These interactions are critical to a child's development and to strengthening the parent-child relationship, yet they can be difficult to address adequately when consultation time is heavily focused on meeting growth assessment, family wellbeing, mental health, family violence and documentation requirements.

In addition, we are seeing increasing complexity in the needs of children and families presenting to the service. Managing these issues effectively within a 45-minute consultation is becoming increasingly challenging. Nurses are often required to address developmental, psychosocial, family violence, and broader wellbeing concerns, while also meeting extensive assessment and documentation requirements.

This growing complexity places significant pressure on the workforce and increases the risk of burnout. Many nurses are experiencing emotional fatigue as they move from one complex consultation to the next, often with little or no time between appointments to debrief, reflect, or

regroup. Without adequate time to process challenging consultations, there is a risk not only to staff wellbeing, but also to the sustainability of delivering high-quality, family-centred care.

While the additional requirements introduced over time have strengthened the service in many ways, consideration must also be given to the consultation time available, the increasing complexity of presentations, and the importance of supporting both families and the nurses providing their care.'

'To allow for adequate assessment of maternal mental health during a time of significant transition and adjustment, in addition to family violence assessment takes more than the allocated 45 minutes, more so when issues are identified and further sensitive discussion and referral is required.'

'Busy diaries and often appts run over due to complexity and needs.'

'Time constraints, increasing complexity of families, checkboxes rather than individualised care, overwhelmed service- workload stress, psychological/ vicarious trauma, structure of visits within time over quality.'

'Time constraints, progressive vulnerabilities within community, documentation becoming extreme.'

'Time
Complex mental health
Disclosure of family violence
Social isolation
A lot of Universal families would have been EMCH
EMCH clients now even more complex - drugs FV etc..'

'1. Limited time with the clients. 2. Interpreters running late or cancelling last minute. 3. Doubling up of documentation on CDIS. 4. Clients want continuity of care and when they see a different nurse every time, they are more likely to dis-engage.'

'The combination of increasing client complexity and expanding program requirements places significant pressure on clinicians to deliver comprehensive, high-quality care within a limited timeframe. This can impact the depth of support and intervention that can reasonably be provided during a single consultation. Furthermore, the cumulative effect of these increasing responsibilities is contributing to workforce fatigue and burnout. Highly skilled clinicians are striving to meet growing expectations while maintaining safe, high-quality care, often without a corresponding increase in time or resources. This ongoing pressure is affecting workforce wellbeing, job satisfaction, and sustainability, creating challenges for staff retention and the long-term capacity of the service to meet community needs.' Participant ANMF KAS Focus Group

'While the additional requirements introduced over time have strengthened the service in many ways, consideration must also be given to the consultation time available, the increasing complexity of presentations, and the importance of supporting both families and the nurses providing their care.' Participant ANMF KAS Focus Group

'Time constraints in servicing more vulnerable families. Service value to other providers - GPs not understanding or valuing the service and encouraging families see them rather than the MCH service.'

'Time constraints, more complexity for universal families.'

Inadequate funding

There is inadequate funding to the MCH Service, meaning:

I. In some LGAs KAS consultations are rationed. For example, some LGAs do not provide KAS beyond 8 months, leading to mothers and families scrambling to access the MCH service in another LGA.

II. There is significant pay disparity for MCH nurses across the state and vast differences in the terms and condition or employment of MCH Nurses. This impacts the capacity of LGA's to attract and retain MCH nurses, which in turn has compounding impacts on MCH service delivery. Please see Appendices 2, 3 and 4 which provide a snapshot of these disparities.

III. Shortfalls in MCH nurse EFT, or limited pool or relief staff to backfill planned or unplanned leave.

ANMF survey

The impacts caused by inadequate funding were reflected in feedback from ANMF survey participants as outlined below:

'There is an inability to see older children due to staffing and population growth. Appointments for older children suffering due to growing birth number and younger babies the priority.' Participant ANMF KAS Focus Group

'While we have funded EFT positions within the service, our capacity is significantly impacted by a limited pool of relief staff. As a result, we are often unable to backfill annual leave, sick leave, and other unplanned absences. This creates workforce shortages and reduces our ability to maintain service delivery levels.

Consequently, appointment availability is affected, particularly for older children, where we are seeing a reduction in consultation capacity. This places additional pressure on existing staff and can lead to delays in families accessing timely support and assessment services.' Participant ANMF KAS Focus Group.

'Time restrictions, calendars are too full, understaffed, insufficient leave coverage, movement of staff into acting leadership roles. no space in calendar if clients need to cancel or reschedule'

'Not enough time to complete all expected tasks in each consultation.
Inadequate consideration of acuity of clients in different socio-economic LGAs
Limitation of service to younger babies when understaffed - disadvantaging older babies and children.'

'- TIME - Assessments (child, mother, family), parental/primary care education, referrals and documentation requirements expected of nurses far exceeds allocated time to complete KAS appointments. Families are more complex than ever before and nurses are not provided enough time to support this, especially with increasing expectations of what nurses assess/provide in KAS visits.
- Family engagement - without adequate time and staffing, clients lose sight of the value of the service and disengage.

- STAFFING ISSUES - difficulty in hiring staff, staff shortages - lack of cover for annual leave, not being covered for personal leave, leaving clients feeling undervalued and frustrated by MCH service, with frequent cancelling or changing of appointments, lack of continuity of what nurse they are seeing, leading clients to not valuing the service or disengaging from service all together.'

'Lack of staffing (caused by lack of funding, our municipality has ample of MCHN willing to work) leading to disengagement of families due to multiple cancellations and restricted diary availability to book appointments.'

'Time and funding constraints. Always fully booked and unable to provide appointments to families in a timely manner'.

'There is reduction in services available for the number of children being picked up earlier through MCH doing additional developmental checks at the KAS visits eg SACS assessment. Increased wait times and reduction in services being covered by NDIS so what is the point when a child needs speech therapy, but the parents can't afford treatment and NDIS reject applications. It feels like there is no point to doing the SACS assessment if there aren't the resources/therapies available.

'The number of children and their parents who are eligible for enhanced MCH far outweighs the service capacity'

'There are a number of practical challenges to delivering KAS consultations within the current service environment. These include increasing complexity of family needs, the time required to undertake comprehensive assessments and provide appropriate health promotion and anticipatory guidance, and the additional coordination required when families require referrals or more intensive support.

For rural and geographically dispersed MCH services, travel time and the availability of appropriate local referral pathways can also impact the capacity to provide timely and flexible consultations. Families may experience barriers such as transport, distance, limited local services and competing family or work commitments.

There are also challenges balancing scheduled KAS consultations with the need to respond to families requiring additional consultations, follow-up, referrals, child protection involvement or Enhanced MCH support. At times, the complexity of individual families means that their needs cannot be adequately addressed within the allocated consultation time.

Funding and workforce allocation are a significant consideration. Current funding and EFT allocations do not always reflect the increasing complexity of presentations, the broader expectations placed on MCH services, population needs, travel requirements in rural areas, and the time required to deliver the KAS Framework effectively. The demands on MCH services have continued to increase, while funding has not necessarily kept pace with the true cost of delivering the service.

The recent funding uplift is welcomed and provides some much-needed recognition of the pressures being experienced by MCH services. However, there is a concern that the uplift may be viewed as a short-term or "band-aid" response rather than addressing the underlying issue of whether the current funding model adequately reflects the true cost of delivering the MCH service and the KAS framework.

It is hoped that funding arrangements will continue to be reviewed, with future funding appropriately aligned to the actual workload, workforce requirements, complexity of families, rurality and the full scope of work undertaken by MCH services. Sustainable and appropriately resourced funding is essential to ensure MCH nurses have the capacity to deliver high-quality, relationship-based continuity of care and provide the follow-up, coordination and referrals required to support families effectively.

The KAS framework itself provides a strong foundation for practice; however, adequate and sustainable funding, workforce capacity and flexibility in how consultations are delivered are critical to ensuring the framework can be implemented effectively and remains responsive to the changing needs of Victorian families'

Insufficient infrastructure to meet population growth/community need

In some LGAs (particularly interface areas) infrastructure has not kept pace with population growth meaning LGAs cannot deliver the full KAS Framework to their whole community because there is nowhere to deliver it from. LGAs are forced to ration the MCH Service.

62% of ANMF survey respondents advised that MCH Service infrastructure was inadequate to meet community need. This is self-evidently a significant barrier to achieving optimal participation rates, as it reduces the number of KAS Consultations that can be offered. Victorian families and children cannot participate in KAS consultations which are not offered to them.

ANMF urge caution when interpreting participation rates. To avoid false and misleading conclusions, ANMF highlights that any interpretation of participation rates must look below the surface and examine factors which obstruct participation rates and may
otherwise, skew data.

To assist an informed analysis on this point, it would assist to review data for each LGA identifying KAS consultation participation rates

1. In the preceding twelve months
2. In the preceding five years.

This information was previously publicly available but no longer is.

Excessive or inappropriate MCH Nurse Workload

MCH nurse workloads differ significantly across the state and are often inappropriate or excessive. This disparity is reflected in Appendix 1.

These excessive workloads create an intensification of work for MCH nurses and underpin the 'time constraints' expressed by our members.

There is no agreed or reliable workload management tool to accurately determine MCH nurse EFT and caseload. This is reflected in ANMF survey results with one participant summarising that;

'Our tool states we are fully staffed but have 200+ children on a waitlist - so the tool isn't working'.

In contrast, ANMF modelling indicates that the workload for each MCH nurse should be no more than 110-120.

Longer term MCH Service reform must therefore include MCH nurse workforce planning and funding to ensure these caseloads are achieved universally across Victoria.

As a starting point, MCH nurse workforce data is required on:

1. The required current EFT of MCH nurse in each LGA and across the state
2. The actual current EFT of MCH nurses in each LGA and across the state
3. The current EFT shortfall of MCH nurses in each LGA and across the state

To ensure supply matches demand, MCH nurse workforce data is also required on:

1. The number of people who have completed the Post Graduate Diploma (or equivalent) in Child and Family Health within La Trobe, RMIT and Federation Universities, annually over the last five years.
2. The number of people who are currently enrolled in and expected to complete the Post Graduate Diploma (or equivalent) in Child and Family Health within La Trobe, RMIT and Federation Universities overt the next two years.

In the short term, existing pressures on the MCH Service should not be seen as a justification to reduce the essential MCH Service or the robust universal platform. This would simply increase pressure on other components of the MCH service and significantly weaken the universal platform and foundation for early identification, intervention and referral for Victorian mothers, parents, families and children.

Inadequate and unacceptable delays in responding to MCH nurse referrals

MCH nurses make timely assessment intervention and where required make referrals to specialist medical or allied health practitioners, or targeted services. There is no deficiency in the way MCH nurses assess, and make early identification, and refer mothers, parents and children requiring timely specialist or targeted care. They are adept at this, including for those experiencing vulnerability or at risk.

However, there is often no one to accept the referral, or significant waiting times to see a specialist medical or allied health practitioner. The MCH nurse must hold the family in the interim. This not only further increases MCH nurse workloads and pressure on the KAS Framework, but such delays are the antithesis of achieving early identification intervention. This is unacceptable given the imperative of making timely intervention for children.

Having made early identification and referral to a specialist medical or allied health practitioner, our members report significant and unacceptable delays in accepting the referrals as per below:

'GP 1 to 2 week wait
Dentist 1 to 2 week wait
Speech Therapist 1 to 2 year wait
Developmental assessment - 2-3 year wait in public system
Mental health services - long wait times for non-urgent.
Paediatrician via GP – up to two years
ECEI/NDIS - 3/4 month wait
Occupational Therapist T 6 to 8 months wait.
Psychologist – 6 months to 12 months. ' Participant ANMF KAS Focus Group

3.Evidence:

a. Where is KAS practice/guidance/information not keeping pace with current evidence? (prompt on area(s) with biggest gaps, evidence source)

On the whole, KAS practice/guidance/information is keeping pace with current evidence.

ANMF Survey

Participants from the ANMF MCH KAS Refresh Focus Groups summarised as follows:

> *'Hip and gait reviews meet RCH guidelines, and MCH nurses are extensively educated on this screen*
>
> *Early Intervention screening occurs at each visit with the ability to move to a Brigance assessment for the unique needs of a child*
>
> *The PEDS R – most up to date/ evidence based*
>
> *Brigance – 'Early Intervention screening occurs at each visit with the ability to move to a Brigance assessment for the unique needs of a child'*
>
> *Family Violence Screening -Our Family Violence questions meet community requirements especially when we are the only health professional asking the question each time we see a mother. Research says a woman needs to be asked up to 16 times about DV until they disclose - we do this for the unique needs of a child'* .

4.Family experience:

a. What changes could we make to KAS that would encourage more families to engage with KAS beyond the initial visits? (prompt on existing ideas – e.g. group-based delivery, virtual, optional attendance, focus on first time families etc; alignment of visit timing with consumer need)

Provide Adequate Funding

Additional and adequate funding is required:

I. to allow LGAs to offer all 10 KAS Consultations, and initiative under flexible service component of Universal MCH service (new time parents groups, new mums groups, dads groups) allowing LGAs to meet specific needs of local community
II. to ensure MCH service infrastructure keeps pace with population growth
III. to ensure the salaries and terms of conditions of MCH nurses are consistent across the state and provide parity with the public sector
IV. implement the KAS Framework, including having capacity to pivot and meet the additional needs of need of mothers, parents, children and families.

Implement measures to promote continuity of care

Continuity of care is critical to building trusting relationships. Because MCH nursing is relational, continuity of care is critical to optimising KAS participation.

Continuity of care also reduces MCH nurse workloads.

Provide funding and undertake workforce planning to achieve the minimum MCH nurse caseloads below:

Ensure that MCH Nurse Caseloads are not more than 110- 120.

Support delivery of KAS consultations via outreach

Better allow KAS Consultations to be provided via outreach. Some LGAs offer the 3.5-year-old KAS via outreach into kindergartens and early years settings, achieving very high KAS participation rates.

Provide more education to mothers, parents and families:

I. about what the MCH service offers and the importance of the KAS checks, ie to ensure their child can reach their full potential.
II. the service is free, that qualified and experienced staff with many years of nursing experience enhances the nurse's ability to cover and identify many areas of health care.
III. Providing more group education (mum's groups, dad's groups or other groups to meet local community need)

Improving the availability of appointments and provide adequate time/opportunity for MCH nurses to build trusting relationships.

Care must be provided in a timely way, according to clinical need and clinical risk. Therefore, MCH nurse workloads must be reasonable, and the MCH Service must be funded to ensure MCH nurses can offer additional KAS consultations in a timely way, to meet clinical need, and to allow time and opportunity for MCH nurse to build trust with families.

Provide more administrative support.

Allow MCH nurses more control over their diaries and scheduling of KAS consultations.

Ensure access to the Enhanced MCH Program

Provide more funding for EMCHP so that families at risk or experiencing vulnerability can be supported by EMCHP making room for other clients to have their scheduled KAS appointments.

ANMF survey

These suggested improvements are universally reflected and repeated in the feedback from ANMF Survey Participants as demonstrates in the snapshot below:

> *'Continuity of care. Easy accessibility to centres Consistency between MCH delivery of information'.*
>
> *'Being able to attend a local centre and have continuity of care with the same MCH Nurse.'*
>
> *'Administrative support. Continuity of care. Community engagement. Child/family friendly infrastructure. Adequate time for each family allowing trust and time for disclosures.'*
>
> '*Location of the centre, flexibility of appointment times, continuity of care.'*
>
> *'Glen Eira MCH service has offered Outreach service to grand multi and childcare centres for over 20 years. Our 3.5-year KAS are probably the best in the state.'*
>
> *'Continuity of caregiver. Accessibility of centre. Peer engagement'.*
>
> *'Building relationships through continuity of the same MCH nurse.'*
>
> *'Continuity with a nurse that the mother likes. Having a reasonable choice of appt days and times. Family feeling that they can ask questions and not being rushed through appt.'*
>
> *'Availability and timing of appointments. Continuity and consistency. Location of centre. Flexibility.'*
>
> *'Continuity of care, seeing the same nurse from HV through all KAS visits. I hear this a lot from my clients, they like seeing the same nurse and going to the same centre. The clients I see who have been rescheduled to different nurses and centres are more likely to disengage with service.'*
>
> *'Factors that increase the participation of mothers, parents, children, and families in KAS consultations include timely access to services, continuity of care, and the availability of a well-supported workforce. Families are more likely to attend and engage with consultations when*

appointments are offered at the right time, are responsive to their needs, and when follow-up appointments can be scheduled more frequently where additional support is required.

Workforce capacity is also a critical factor. Adequate staffing levels and access to relief staff help ensure that consultations are not delayed or cancelled and that families can receive consistent care from clinicians who have the time and capacity to build trusting relationships. A workforce that is supported and not experiencing high levels of burnout is better able to deliver high-quality, family-centred care and actively engage families in discussions about their child's health, development, and wellbeing.

The availability of group programs and parenting education sessions can further enhance participation by providing accessible opportunities for learning, peer support, and connection with services. Groups can help families feel more connected, reduce social isolation, and increase confidence in accessing ongoing support.

Early and timely intervention is another key enabler of participation. When concerns are identified and addressed promptly, families are more likely to remain engaged with the service and benefit from appropriate support pathways. Timely intervention can prevent issues from escalating and promotes better outcomes for children and families.

Ultimately, participation is strengthened when services are accessible, responsive, adequately resourced, and delivered by a sustainable workforce that has the capacity to provide timely appointments, more frequent follow-up, group-based support, and early *intervention opportunities.'*

'Continuity with mch nurse. Being local is crucial. Meet families where they are at. Flexibility with day and time of consults available.'

'The relationship to the nurse is highly influential. The location of the MCH Centre being nearby helps. The availability of appointments ie not waiting 2-3 weeks.'

'Culturally appropriate and responsive practice, continuity of nurses, flexible diaries, feeling safe.'

'Continuity of MCH Nurse, centre close to home, open hours that suit availability. Free and universal for all. Trust that the nurse's qualifications are of a high standard to bother attending and that they can pick up any issues and give good, safe advice. That there are *appointments available when they call to make an appointment in a timely manner.'*

'Connection with MCH nurse. Understanding, knowledge and importance regarding the breadth of MCH for families. Playgroups and first Time parents' groups Opportunistic discussion with parents of the KAS such as at immunisation sessions and playgroup sessions Ability to offer outreach for older children.'

'Having the MCH visits carried out close to home and being easily accessible. Some families like to see the same MCH Nurse. FTPG held within the community so parents can meet other FTP's and form a connection to another family who live close by and are easy to catch up with after the group.'

'Continuity of care is prioritised. Additional visits are accommodated to high needs families for children of all ages until school age.'

'MCH centres being located in the neighbourhoods which encourages participation. Appointment availability in a timely manner, being able to reschedule clients if they cancel or child is sick? That the clients know MCH nurses are well qualified (triple degree). voluntary and free service, non-judgemental welcoming staff. Continuity of care.'

'Continuity of care provider and consistency of advice. Accessibility of centres and proximity to home of families.'

'Extra admin time to actually follow clients up, call them to invite them in. Offer more outreach appts. Offer more toddler and preschool outreach programs within childcare and kinders by MCH nurses.'

'Continuity Not being rescheduled or cancelled. Positive experience, trauma informed, family led Continuity of care.'

'Ability to adapt to families' situations eg. Offering home visits to mothers for the first 4 weeks who have had a c section and are unable to attend centre.'

'Trusted service, continuity of care, delivery of information consistently. Flexibility of appointment times and sites. Easy to access. Minimal wait times for rescheduling appointments. Vaccination during KAS visits as it is difficult to book with a GP in Regional areas and where Immunisation service is not available. Making the following appointment with the parent while finishing the current appointment. Multiple ways to contact the service, mobile phone for text messages, email and phone messages.'

'Trust and good rapport between the client/s and MCHN, through continuity of care. The option of outreach appointments for clients (extra time required to offer outreach). Client's having an idea of what to expect at each appointment. Working in partnership with families and addressing their particular concerns/needs as opposed to the MCHN just ticking boxes.'

'Convenient centre location. Continuity of care with the same 1 or 2 nurses. MCHN having more autonomy over their calendar, enabling them to prioritise their families. Open minded nurses with up-to-date information. Additional services eg supported playgroup, INFANT program, sleep and settling programs, lactation consultations, new parent group. Availability in MCH calendars to rebook families, at times, there is no capacity due to staff shortages.'

'Continuity of care, a reliable, trusted service with flexibility of appointments. Client focused, meaning MCHN have the opportunity to use their clinical judgement to pivot during the appointment to meet the clients' needs at the time.'

'Continuity of care of families. Families continued understanding of primary health care and developmental surveillance during 0-6 years of age.'

'A known MCH nurse. Consistency in location for appointments. Accommodation for time and listening to parents, aiming to resolve worries and concerns or offering to refer to somebody who

can assist. Knowledge on important and relevant factors or sourcing reputable information for families that aligns with their culture and interests.'

'Engagement with the nurse / continuity of carer. Ease of getting an appointment. Outreach to those that can't get to a MCH Centre.'

'A number of factors can increase the participation of mothers, parents, children and families in KAS Consultations, particularly within a rural LGA.'

Continuity of care and strong relationships are particularly important. Families are more likely to engage when they have an established relationship with a known and trusted MCH nurse who understands their family circumstances, knows their history and can provide consistent support over time. In rural communities, where families often have strong connections to the local community, having a familiar MCH nurse can be an important factor in building trust and encouraging ongoing engagement.

Connecting families with their local community also supports participation. First Time Parent Groups and New Parent Groups provide an important opportunity for families to meet other parents, develop social connections and become familiar with their local MCH service and other community services. Linking families with local libraries, playgroups, early years services, community groups and other supports helps position MCH as a connection point within the community rather than simply a scheduled health appointment.

Offering services locally and reducing the need for families to travel significant distances is also important in a geographically dispersed rural LGA. Flexible appointment options and consideration of families' transport, work and other commitments can help reduce barriers to attendance.

Offering immunisations in conjunction with MCH services and in line with the National Immunisation Program can provide another valuable opportunity to engage families. Where appropriate, combining immunisation with KAS Consultations can reduce the number of appointments families need to attend and provides an opportunity to discuss the child's health, growth, development and wellbeing more broadly.

A welcoming, family-centred and strengths-based approach is essential. Families are more likely to participate when consultations are responsive to their individual needs, culturally respectful and focused on what matters to them.

Overall, continuity of care, a known and trusted MCH nurse, accessible local services, opportunities to connect with other families and the broader community, and a flexible and family-centred approach are key factors in supporting participation in KAS consultations. In a rural setting, the relationships MCH develops with families, and the wider community are particularly important in supporting sustained engagement**.**

b. What are the critical activities that families want/need to know about that should be prioritised? What activities/processes/ways of working make the most difference to families?

All of the activities within the KAS Framework are critical. None of them are unnecessary or optional.

The KAS Framework is the universal platform for early identification, intervention and referrals. It is the gateway to early identification, interventions and referral to additional or targeted services.

The MIST cannot be dropped, if not done by an MCH nurse, it may not be done at all. Especially in regional or rural areas.

The MCH Service must maintain a comprehensive universal platform (provided by the KAS framework and flexible service component) and be able to respond to additional need as it presents in each KAS Consult. It is not either/ or. It is both. This was strongly reflected in ANMF survey responses as follows;

> *'All assessments required are documented to be completed at certain ages to allow timely assessments at ages of relevance.'*
>
> *'They are all important.'*
>
> *'All areas are important to assess to ensure optimal development and outcomes.'*
>
> *'We are guided by these practice guidelines to make our practice aligned and consistent. If due to other competing priorities, they may be completed at another visit. Parents have the option not to engage in all aspects, but we have an obligation to address and offer. If MCH unable to meet the practice guidelines on a regular basis discussion with Team Leader to unpack and formulate a plan to address strategies to assist and support staff.'*
>
> *'The elements of each KAS consultation form part of a comprehensive assessment and should not be considered optional. However, the timing and order may need to be adjusted according to the child's and family's immediate needs, clinical priorities, consent and available consultation time, with any incomplete components documented and followed up.'*
>
> *'Not optional but if they are not covered at that particular KAS appointment it can be addressed at the next appointment. This is where continuity of care is important so the MCHN can build a relationship with the family.'*
>
> *'Because every consult is an opportunity to guide, assess and further enhance the skills of our parents.'*
>
> *'All aspects of what we provide are vital to the gold standard of our service.'*
>
> *'I cannot believe you are asking this question.'*
>
> *'The core components of the KAS Consultations outlined in the MCH Service Practice Guidelines should be considered essential to ensure consistent, safe, and high-quality care. While the delivery approach may be adapted to meet individual family needs and circumstances, the key elements of the consultation should not be viewed as optional.'*
>
> *Mental health and family violence assessments are critical to supporting wellbeing in the home and best outcomes for children.'*

5.Service efficiency:

a. What activities are prioritised during KAS visits when there is too much to fit into the visit?

As described above, prioritising care is germane to MCH nursing and interwoven into nursing practice. MCH nurses prioritise assessments and interventions in each KAS Consultation. Where required, the MCH nurse schedules an additional consultation, as reflected by ANMF MCH nurse members;

> *'I focus on the immediate need of the client if the time frame does not allow KAS completion, I book another appointment to do so'. ANMF MCH KAS Refresh Focus Group Partcipant.'*

At the same time, some ANMF survey participants identified intensification of work, and 'work arounds' (including working overtime) to ensure all activities are completed. This reality underscores a need to undertake proper MCH nurse workforce planning (ensuring reasonable MCH nurse workloads). It is not a justification to dilute the essential universal platform provided through the KAS Framework and Universal MCH Service.

b. Where are there opportunities to build flexibility into the KAS visits? (prompts where might families need more/fewer visits; what components might be considered optional; what aspects could be delivered by others?)

No components of the KAS Framework are optional. All are essential.

The KAS framework is the linchpin to early identification, assessment and referral. It is the foundation of the universal platform.

No element of the KAS Framework can be undertaken by a non MCH nurses. The MCH nurse is the core strength the MCH Service**.**

6.System integration:

a. What needs to be in place to reduce duplication across the system, and minimise confusion for families? (prompt on implications for KAS with Thriving Kids (TK) developmental checks at pre-kinder and pre-school)

There is not currently duplication 'across the system'.

However, the proposed use of TK funding in Victoria has created significant confusion, and concern that the TK initiate will not add value to existing services.

Under the KAS framework, MCH nurses already make early identification and intervention for mothers, parents, children and families. This includes assessing developmental delay and neurodevelopmental difference. This starts at birth and continues into preschool in every KAS consultation. Assessments consider the child's overall physical health, and the surrounding context of maternal and parental health and family functioning.

To ensure the TK Initiative adds value in the Victorian context, ANMF recommends that the TK initiative be utilised to improve the capacity of the medical and allied health workforce to accept and respond to referrals in a timely way.

ANMF Survey

Feedback from ANMF survey participants demonstrate that MCH nurses commence assessing for developmental delay and neurodevelopmental difference from birth, and in doing so, consider the child's overall physical health, and the surrounding context of maternal and parental health and family functioning. See feedback from survey participants below:

> *'From the first visit, checking for developmental milestones and behaviours typical for each KAS visit. At each visit, talk with parents and explore their concerns to assess whether a referral for further assessment and early intervention is needed.'*
>
> *'From birth for developmental delay. From 8 months for neurodevelopmental issues.'*
>
> *'From birth! Officially from the 4-month KAS.'*
>
> *'From the first time we see them. Always assessing development'.*
>
> *'At all visits, this is assessed. Picking up developmental delay and neuro-divergence steadily increases as the children get older, as delays become more obvious.'*
>
> *'From the minute they are born through physical and PEDS assessments. SACS / Brigance as they are a bit older.'*
>
> *'12mths. I have identified possible delay/neuro developmental difference in an 8 mth old baby who at 12 and 18mths continued to show signs and was then diagnosed with ASD by 2yrs.'*

'At every KAS. P19 From the first visit - personally I ask all families of history and am openly discussing variance in all my consults to reduce stigma.'

'Developmental delay is assessed from birth. Mosaic assessment for neuro- developmental difference commences officially from 12m KAS, however factors that could predispose a child for neuro developmental difference can be identified at earlier KAS visits.'

*'Assessment begins at the **first home visit and continues at every KAS consultation** through ongoing developmental surveillance, observation, discussion of parental concerns and use of age-appropriate screening tools. Possible developmental delay or neurodevelopmental difference may become clearer at later consultations, but concerns should be identified, monitored and referred whenever they first emerge rather than waiting for a particular age.'*

MCH nurses make timely referral to a multitude of specialist health practitioners and more targeted services.

However, there are significant and unacceptable delays in accepting the referrals as per below:

I. GP - 1 to 2 week wait
II. Dentist - 1 to 2 week wait
III. Speech Therapist 1 to 2 year wait
IV. Developmental assessment - 2-3 year wait in public system
V. Mental health services - long wait times for non-urgent.
VI. Paediatrician via GP – up to two years
VII. ECEI/NDIS - 3/4 month wait
VIII. Occupational Therapist - 6 to 8 months wait
IX. Psychologist – 6 months to 12 months.

Accordingly:

I. There is no deficit in the early identification of developmental delay or neurodevelopmental difference by MCH nurses within the KAS Consultations.
II. There is a significant deficit in the capacity of the medical and allied health specialist workforce to respond to referrals made by MCH nurses.
III. Funding for TK should be directed to increasing the capacity of the medical and allied health specialist workforce to accept referrals from MCH nurses in a timely way, which meets community's need and is consistent with principles of early intervention.

The unacceptable delays in referrals being accepted is universally reflected and repeated in the feedback from ANMF Survey Participants. For example:

'We are no longer able to refer families to public allied health services if they are not on a pension, low income, Aboriginal TSI, or under CHild protection. So many families are unable to afford Speech

Pathology, Occupational Therapy, or Physiotherapy in the private system or the wait if over 12months depending on the reason for referral.

'Public Paediatric clinics are also a long wait. Private are very expensive.'

'GP, ndis, speech, QEC, OT, paediatric physiotherapy, hearing tests, optometrist. Paediatrician via GP. Wait times for Paeds is up to 2 years. Speech is 12 months or more. NDIS is long and seems to take ages to contact families.

'NDIS. At least 8 weeks for initial assessment with no guarantee of funding

'GP. Hard for families to find bulk billed and some cannot afford out of pocket costs.'

'Paediatrician. Long waitlists for public. Also waitlist for private and requires out of pocket costs'

'Allied health (eg speech OT etc). Often months long waitlist and some won't take non NDIS clients'

'The Orange door. A few weeks and I have found the support they offer at times is limited. They often close referral if client is hard to reach which is common for complex clients who are at capacity. Meaning the referral required taking up time and space if MCH service'

'Child protection. Response time pending on level of concern. Often requires overtime when needing to report or cancelling if other KAS appointments in order for the MCH nurse to have time to contact.'

'Local mental health triage line. Will contact client within the day however requires MCH to be on hold or wait for call back for hours again taking time from other appointments.'

'Local community health: ridiculous waiting periods (6 months plus) and closed books for audiology/speech. Community health services now available only to health care card holders. Refer to audiology/speech/OT/ECIS/GP.'

'GP- sometimes expensive if not bulk billing. Lack of experience with babies/kids for many GPs. Speech therapists- long wait lists. Psychologists/paeds- long wait lists and we are left holding the family in a very vulnerable position.'

'Perinatal Emotional Health Program- week to two weeks wait. Salvation Army- housing and food parcel. Loved & Shared-clothing, prams, toys, baby essentials. Are able -parent pathways.'

'Refer alot to Gp, VVED, Monash emergency, physio, optometrists, lactation consultants, EPC for sleep and settling support. Also, NDIS for early intervention. In my past clinic I made the referrals to NDIS and Monash link for CALD FAMILIES. Wait times are long through NDIS. Cannot be specific as we don't always get told when the referrals are picked up by the provider.'

'Try to access public health eg feeding clinic speech but 90% time rejected. Each are also regularly rejected.'

'*Audiology at Bendigo Health currently 9 months. Speech therapist at Bendigo Health 2-3 months. Only initial assessment. Paediatrician in Public health - over 12 months. Paed Physio in Public system 4+ months.'*

'There is a large variety of allied health, and some are easier to get into than others. Most specialist services in our area have months to wait. Speech pathology on its own is non-existent requiring another condition or NDIS to see anyone. Eczema nurse usually timely. Pediatrician within a few months. Doctors - sometimes next day or week others have months to wait for a particular doctor.'

7. **Any other reflections**
   a. **Are there any other elements you'd like noted for consideration in the KAS refresh?**

The MCH Service is well recognised as the 'Gold Standard' of maternal and child health services.

The high regard for the MCH Service is in no small part due to the broad scope of practice of the MCH Nurse, who is educationally prepared to deliver the KAS Framework.

The MCH nurse is the linchpin of the MCH Service. Similarly, the KAS Framework is necessarily comprehensive as it is the foundation, and universal platform for Victorian prevention program for families and children, including those experiencing vulnerability or at risk.

Consultation with ANMF (Vic Branch) MCH nurse membership reinforces the essentiality of the KAS Framework, and its interconnectedness with the Enhanced MCH Program and the MCH Line. No component of the MCH Service should be seen in isolation from the other. Combined, they provide a robust universal platform plus targeted and more intensive outreach services for families and children who need additional support.

However, the MCH Service is facing significant pressure, arising from inadequate funding, wide disparities in the salaries and terms and conditions of MCH nurses, and the need for statewide system of clinical governance. Resolving these challenges is achievable and necessary to ensure the needs of the Victorian community are met.

Since its inception, the MCH Service has adapted to meet the changing needs and demographics of the Victorian Community. MCH nurses have always been at the forefront of identifying and championing the need for change, so they are equipped to meet the needs of their local community. Changes have always been purposed ion strengthening the MCH Service, never diluting it.

One hundred years after its inception, it is time once again to listen to the voices of MCH nurses to ensure the Victorian MCH Service is equipped to meet the needs of the Victorian community, adapts to increased population and client complexity, and demographic changes.

On behalf of ANMF MCH nurse members, ANMF looks forward to continuing to contribute to identifying and implementing measures to ensure the ongoing and sustainability of the MCH nursing workforce.

Other key terms and conditions

ANNUAL LEAVE	34 LGAs have 5 baseline weeks of annual leave - half of the 68 LGAs who retain MCH services (11 who have returned to the pubic sector also have 5 weeks annual leave). Many, but not all also have Christmas closedown without loss of pay.
PERSONAL LEAVE	Ranges from low end of 12 days per annum (Greater Dandenong immunisation nurses) through to top end of 24 days per annum (Nillumbik). Public sector has 12 days 1st year, 14 days 2nd, 3rd & 4th year, and 20 days 5th year and beyond. The Award provides 16 days 1st year, 18 days years 2-4, & 25 days 5th year and beyond
DAILY ADMIN TIME	Ranges from unspecified (In many EAs eg Strathbogie)/determined by Coordinator (Whitehorse), to 2.5 hours per day (Melbourne) or 25% of working hours (Banyule/Baw Baw)

MCH Nurse Pay Rates

COUNCIL *those with higher quals rates rolled into base rate have been excluded.	CURRENT TOP MCH RATE	% BEHIND TOP RATE	CURRENT LGA MCH COORDINATOR RATE	% BEHIND TOP RATE	CURRENT MCH ENHANCED ALLOWANCE RATE	% BEHIND TOP RATE	
Merri-bek City Council *Metro MEA	$71.22	0.00%	$76.21	16.61%	$71.98	3.29%	* 2025 rate
Mooney Valley City Council	$70.81	0.58%	$77.89	14.10%	$74.35	0.00%	
City of Whittlesea	$70.55	0.95%	$88.87	0.00%	$73.72	0.85%	*EA at ballot
City of Melton	$70.26	1.37%	$82.82	7.30%	$72.02	3.24%	*EA as voted up
Darebin City Council *Metro MEA	$69.94	1.83%	$76.93	15.52%	$73.43	1.25%	
Horsham Rural City Council	$69.38	2.65%	$76.32	16.44%	$71.12	4.54%	
Public Sector (Nov 2026)	$65.52	8.70%	$68.79	29.19%	$65.52	13.48%	*no enhanced rate
Public Sector (Nov 2027)	$73.84	-3.55%	$77.53	14.63%	$73.84	0.69%	
Bottom range							
Corangamite Shire Council	$58.89	20.94%	$64.77	37.21%	$61.83	20.25%	
Rural City of Wangaratta	$58.87	20.98%	$64.75	37.25%	$61.80	20.31%	
Indigo Shire Council	$57.47	23.93%	$63.21	40.59%	$60.34	23.22%	
Alpine Shire Council	$55.52	28.28%	$61.07	45.52%	$58.29	27.55%	* 2025 rate
Strathbogie Shire Council	$55.19	29.05%	$60.70	46.41%	$55.19	34.72%	*no enhanced rate

HIGHER QUALIFICATIONS ALLOWANCE RATES PER WEEK

COUNCIL	Hospital Certificate 4%	% BEHIND TOP RATE	Post Grad 6.5%	% BEHIND TOP RATE	Masters/PHD 7.5%	% BEHIND TOP RATE	
Top range							
City of Melbourne *Metro MEA	$104.84	21.56%	$170.36	0.00%	$196.57	0.00%	
Darebin City Council *Metro MEA	$127.44	0.00%	$150.61	13.11%	$173.79	13.11%	
City of Port Phillip	$100.15	27.25%	$162.75	4.68%	$187.79	4.68%	
Yarra City Council *Metro MEA	$97.15	31.18%	$157.86	7.92%	$182.15	7.92%	
Stonnington City Council	$93.86	35.78%	$152.76	11.52%	$176.32	11.48%	
Public Sector (Nov 2026)	$65.80	93.68%	$107.00	59.21%	$127.30	54.41%	***PHD $164.60**
Public Sector (April 2028)	$111.30	14.50%	$180.90	-5.83%	$209.00	-5.95%	***PHD $278.30**
Bottom Range							
Benalla Rural City Council	$47.00	171.15%	$76.37	123.07%	$88.12	123.07%	
Mansfield Shire Council	$47.00	171.15%	$76.37	123.07%	$88.12	123.07%	
Maribyrnong City Council *Metro MEA	$48.64	162.01%	$79.05	115.51%	$91.21	115.51%	
Indigo Shire Council	$40.65	213.51%	$66.05	157.93%	$76.22	157.90%	
Hume City Council *Metro MEA	$40.92	211.44%	66.54	156.03%	$76.89	155.65%	

Workloads : MCH Client Workload Ratio Per EFT

Top range	WORKLOAD
Buloke Shire Council	**80 per EFT**
Loddon Shire Council	**100 per EFT**
Benalla Rural City Council	**100 per EFT**
City of Melbourne *Metro MEA	**100-115 per EFT**
Kingston City Council	**110 per EFT**
Bottom range	
Wodonga, Mornington, Mitchell, Indigo, Hume, Hobsons Bay, Casey, Ballarat	**130 per EFT**
Warrnambool City Council	**132 per EFT**
Southern Grampians Shire Council	**135 per EFT**
City of Greater Geelong	**140 per EFT**
Yarra Ranges Shire Council	**140 per EFT**

***to hand back services**