CITY OF MELBOURNE SUBMISSION: PERINATAL SERVICES

INTRODUCTION

The City of Melbourne (CoM) welcomes the opportunity to make this submission to the Victorian Government Family and Community Services Committee Inquiry into perinatal services.

Perinatal care is an essential and life-saving service that provides support for pregnant mothers during and immediately after birth. The perinatal period is defined in the National Health Data Dictionary as the period that commences at 20 completed weeks of gestation and ends 28 days after the birth. As such, CoM's Maternal and Child Health (MCH) service is only one contributing service provider in a multi-jurisdictional service system that includes midwives, general practitioners, hospitals and mental health service providers, among others.

The predominate focus of this submission is the experience of the CoM MCH service in supporting mothers of newborn infants and relates to the following issues before the Committee:

- the availability, quality and safety of health services delivering services to women and their babies during the perinatal period
- the adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high-risk and premature births in Victoria
- the quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births.

CITY OF MELBOURNE SERVICES

The City of Melbourne MCH service forms part of the Family Services team within the Community Services branch. The MCH program is jointly funded by State and local governments. CoM has a funding agreement with the Department of Education and Training (DET) to provide the core MCH service, including birth notifications.

Under the *Child Wellbeing and Safety Act 2005*, when a baby is born to a mother residing in the CoM municipality, a birth notification is sent to CoM MCH services. The CoM Centralised Booking Officer will input the baby's details into the Maternal and Child Health System (MaCHS), a bespoke database system. The new mother is contacted to arrange an initial home visit and subsequent appointments for key and stage consultations. The Centralised Booking Officer will allocate the home visit appointment to the appropriate MCH Centre within CoM. In accordance with DET Key Ages and Stages Framework, the CoM Maternal and Child Health Service Team provides 10 key age and stage consultations from birth to 3.5 years old.

The City of Melbourne has MCH centres located at:

- Carlton (Family Services main office)
- Docklands
- East Melbourne
- Kensington
- North Melbourne (Abbotsford Street)

- North Melbourne Community Centre (Buncle Street)
- Southbank
- South Yarra

All eight MCH centres are staffed by registered nurses with qualifications in midwifery, maternal and child health and immunisation.

Over the 2015-16 financial year, 1261 infants were enrolled in MCH services in the City of Melbourne from birth notifications during that year - this included 870 first time mothers. Sadly, there were 11 stillbirths in the period and a further three babies died within one month of their birth.

KEY ISSUES COM MATERNAL AND CHILD HEALTH SERVICE

Inadequate service integration and coordination

Effective responses for pregnant and new mothers require strong collaboration, communication and coordination between acute, allied health and community based support services.

System failure around case coordination is a far too common experience for women and babies and this is particularly the case for high risk and premature babies. Mothers and babies are often discharged from hospital too early and there is no clear and consistent system for communicating the needs and progress of mothers and babies to the MCH service - the same service that will be the main designated source of on-going support.

Inadequate hospital in the home and domiciliary support

In addition there is often a gap in the delivery of in-home support provided to families with premature babies. While hospitals may provide 'hospital in the home' services, this is often for a limited period only. These families can struggle with the care of a premature baby and this in turn, can place pressure on the MCH service to provide the required intensive support.

The already limited and artificially truncated in-home service response from the acute service sector is amplified for some of the most vulnerable families. For families where family violence has been identified, hospitals often make a decision not to send domiciliary staff out to the home in order to protect the safety of their staff. While this is an understandable decision, it is often not communicated effectively or in a timely way to MCH services, resulting in a lack of service provision for families and particularly newborn infants when they are at their most vulnerable.

These decisions also mean women and babies are then required to travel to hospital for their first postnatal visit. While ensuring staff are safe is understandably of utmost importance this should not be at the cost of mother and baby.

A further complication of the above process is that MCH services are not always alerted to family violence risks and regularly only find out about these risks when they have gone to the initial home visit. This increases the risk carried by these nurses and is linked back to the hurdles outlined above.

Most importantly it is the woman and child who remain the most vulnerable. They have fewer people watching out for them, isolating them further at a universally identified period of extreme risk in a context of family violence, not to mention health and wellbeing.

An added complication is that when service is provided, it is often too limited and of too short a duration to effectively meet the needs of families. A major concern is the considerable gap in time between discharge from hospital and enrolment in CoM services. This means that parents may be missing out on the range of services that can be provided at the most crucial time of their development – when bonding and healthy routines can be established.

Private hospitals don't provide domiciliary support to families once they are discharged and this also represents a gap in the current service system.

Communication

There is inconsistent communication between obstetric hospitals and MCH services. This is due to a lack of robust systems - currently the reliance is on individual staff members to ensure information is shared. There is also a lack of a shared digital platform that would hold all information and be visible to all health care providers.

In the absence of a shared digital platform, information is often shared in an ad hoc manner resulting in questionable reliability.

Failure to care for the most vulnerable

Tertiary hospitals provide initial care for women with mental health issues. On discharge there is an expectation that care will be taken up by the community sector however the demand frequently exceeds capacity. This leaves some of the most vulnerable women in a position of anxiety and uncertainty with MCH and other allied services trying to manage risks to mother and baby whilst urgently attempting to broker support back into the mental health system.

City of Melbourne has a large culturally diverse cohort. This includes those from refugee backgrounds or international students residing in Australia whilst studying. These groups may be especially vulnerable due to a range of complex interrelated factors such as isolation, language difficulties, lack of awareness of, or limited access to services and supports, increased mental health issues, family violence, poor health outcome and developmental delays. The complexities of spousal and student immigration bureaucracy can also increase stress on families. Often family violence has been identified for many of these women.

Additionally, CoM supports many families who have no Medicare who are discharged earlier than others due to high hospital costs. Additional financial pressure is placed on the family if there are any complications. Lack of Medicare excludes families from accessing most health care support available and this in turn increases the pressure on community resources to meet this gap.

Early identification and assessment of vulnerability and risk should be improved within the hospital system so that more comprehensive information can be provided to the MCH service.

High risk and premature infants

When babies have been admitted to a specialist unit like a Neonatal Intensive Care Unit, due to prematurity or other health issues the sharing of information encounters further barriers. It is often dependent on individual staff from MCH networking with staff in these units to ensure that communication occurs in the timeliest manner.

When this is absent, MCH are often informed of the discharge of premature and very low birth weight babies after the fact and, are not included in any of the discharge planning processes. This issue is worse when the special care unit is situated in a private setting. This lack of information can lead to a delay in getting MCH into the home to support the transition to care by parents, impacting on breastfeeding, bonding and the mental health of family members.

It should also be noted there are ongoing issues transitioning high risk premature infants into auxiliary services - more so for families accessing private obstetric and paediatric services e.g. occupation therapy, speech therapy with continuing medical support and Early Intervention Services.

SUMMARY

In summary, pregnant and new mothers and their children, deserve and require a better coordinated service system less reliant on ad hoc goodwill. There needs to be systemic change across the multi-jurisdictional service platform including stronger interface collaboration, vastly improved communication and robust early identification and assessment of vulnerabilities and risks (before discharge) for families, babies and staff. This needs to occur across acute, allied health and community based support services and across public and private health systems.