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**ANMF (Vic Branch)  
Submission to the  
Parliament of  
Victoria Family and  
Community  
Development  
Committee**

**Inquiry into  
Perinatal  
Services**

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Secretary  
ANMF (Vic Branch)

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## Introduction

The Australian Nursing and Midwifery Federation (Victorian Branch) [ANMF (Vic Branch)] represents nurses and midwives who provide care and treatment to women and babies across the full continuum of the pregnancy and birth journey including pre-pregnancy, antenatal, labour and birthing, postnatal, special care nurseries, neonatal intensive care, maternal and child health, mental health and community health. Our members work in both the public and private sectors and in bed based and non-bed based services. ANMF (Vic Branch) is in regular contact with nurses and midwives who provide direct services to women and their families and therefore we are well placed to provide a clinician's perspective of current issues facing maternity and newborn services.

The ANMF (Vic Branch) believes that the professions of midwifery and nursing are vital to the delivery of services to improve psychosocial and clinical outcomes for mothers and babies.

ANMF (Vic Branch) welcomes the opportunity to provide advice to the Parliament of Victoria's Family and Community Development Committee Inquiry into Perinatal Services.

ANMF (Vic Branch) commends the Committee for commissioning this inquiry and looks forward to working with the Committee, including our preparedness to participate in any public hearings that may be convened by the Committee, as it establishes priorities for recommendations to Government.

The ANMF (Vic Branch) considers any new initiatives must be targeted to achieve maximum effect for vulnerable women including those women who are categorised in areas of identified disadvantage:

1. Aboriginal and Torres Strait Islander
2. Women with a disability or chronic health issues
3. Women with mental health disorders (particularly those who may be untreated) and who are planning to become pregnant
4. Women from regional or remote Australia (in low socio-economic circumstances or disadvantaged by distance from health facilities)
5. Women from non-English speaking backgrounds
6. Women in non-traditional cultures
7. Women experiencing family violence

## Preamble

The ANMF is mindful that there are a range of understandings and applications of the term “perinatal”. For example, the World Health Organisation defines the perinatal period as 22 completed weeks of gestation to seven completed days after birth (1). The Australian Institute of Health and Welfare defines the perinatal period *for data collection purposes* as being from 20 weeks completed gestation to 28 days after birth, noting that within Australia the statistical and legal definitions vary (2). Mental Health Services have traditionally considered the perinatal period as being inclusive of conception. In addition, for the mother, the puerperium (postnatal period) lasts for 6 weeks after birth, by which time the uterus should be involuted and returned to sit in the pelvis.

Nonetheless there are well established links between maternal pre pregnancy health and well-being and maternal and baby outcomes. It is also accepted and acknowledged that the period from conception to age 2 is the time when foundations are laid for health right across the life span (3).

The importance of a woman’s physical and mental health should be central to every aspect of maternity care and any intervention which creates a positive impact for one mother and one baby can have long lasting intergenerational benefits across the society.

Currently the emphasis of maternal health surveillance is predominantly on women’s health in pregnancy and the immediate postpartum period. The Maternal Health Study showed that the prevalence of maternal depression was higher when the first child was 4 years of age than at any point in the first 18 months postpartum (12).

*The Committee should ensure that recommendations to Government clarify the time period to which funding and programs may apply. The ANMF believes that improvements in psychosocial outcomes will be best achieved by providing services beyond the first year after birth*

### **Victorian Priorities as stated by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)**

Victoria is fortunate to have a comprehensive perinatal data collection and reporting system. CCOPMM is the statutory authority which reports on the perinatal data and makes recommendations in accordance with the *Public Health and Wellbeing Act, 2008*.

The themes identified by CCOPMM in the most recent data sets show some continuity. In analysing 2012 and 2013 data, CCOPMM focused on obesity, foetal growth restriction, CTG monitoring and family violence (4).

In 2017, the priorities highlighted by CCOPMM based on 2014-2015 data clinical deterioration and avoidable perinatal mortality. (5) CCOPMM highlighted the following key findings (6).

#### **a) Maternal mortality**

The impact of pre-existing health conditions such as diabetes obesity and cardiovascular disease is a major challenge for health services.

Complex psychosocial circumstances continue to be a key factor in maternal mortality, including drug and alcohol abuse, mental health conditions and family violence. CCOPMM also made comment that deaths related to suicide and domestic violence may be underestimated in the current data set (7).

**b) Perinatal mortality**

Perinatal mortality rates remain high for a number of vulnerable groups in the community including:

- Aboriginal women
- Women born in sub Saharan Africa, Oceania, southern and eastern Europe and southern and central Asia
- Multiple pregnancies
- Women who gave birth to babies preterm or with foetal growth restriction

**c) Aboriginal outcomes**

In 2014 and 2015 health outcomes for Aboriginal mothers and babies are significantly poorer than for non-aboriginal mothers and babies, although some indicators have shown a trend to improvement.

39.9 percent of Aboriginal women smoked at any time during pregnancy including 30.1 percent who continued to smoke in the second half of pregnancy. This compares with 9.4 percent of non-Aboriginal women smoking at any stage and 5.4 percent who continued to smoke in the second half of pregnancy.

Aboriginal babies were 41 percent more likely to be likely to be born pre term (less than 37 weeks gestation) as compared to non-Aboriginal babies.

Aboriginal babies were 60 percent more likely to be born with a low birthweight than non-Aboriginal babies.

9.4 percent of Aboriginal women giving birth were younger than 20 years compared to 1.7 percent of non-aboriginal women (**8**).

The Aboriginal Families Study Policy brief #5 highlights the important role of primary health care services in safeguarding mothers' health and recovery in the postnatal period. It also emphasises enhanced discharge planning, collaborative frameworks to ensure maternal health in pregnancy is communicated to services providing postnatal care and strategies to ensure seamless transition between antenatal and postnatal care, among other things (**9**).

The ANMF (Vic Branch) response to this submission will focus on measures we consider are directly relevant to improving outcomes within the CCOPMM identified indicators for mothers and babies as well as reducing maternal mortality trends related to mental health disorders (27).

## **1. The availability, quality and safety of health services delivering services to women and their babies during the perinatal period**

The ANMF (Vic Branch) is supportive of the concept around the DHHS Capability Frameworks as a process to objectively determine the resources that are required at particular levels of service provision, and which health services can provide particular services. It is the view of the ANMF (Vic Branch) that DHHS should monitor all Victorian hospitals' self-assessment of where they currently sit within the frameworks guidelines.

Nonetheless, the Victorian *Maternity and Newborn Capability Framework, 2010* (10) requires consultation and review as it is no longer a contemporary guide as it does not align with the *Defining Levels of Care for Victorian Newborn Services, 2015* (11).

### **A. Pregnancy care**

Pregnancy care includes:

- Foetal and maternal physical checks at regular intervals
- Breast feeding education
- Quit smoking programs
- Family violence screening and referral
- Mental health risk screening and referral
- Child safety education
- Vaccination advice – maternal and baby
- Oral health screening and advice
- Preparation for discharge post birth

Pregnancy and birth is a time in a woman's life when vulnerability is heightened and empowerment is an opportunity. It is critical that sufficient numbers of midwives are available to provide personalised treatment, advice and care to all women during pregnancy and birth. It is equally critical that referral services are available for women who require additional treatment eg when disclosure has occurred regarding intimate partner abuse.

Most health service antenatal clinic templates provide insufficient time to enable midwives to provide all pregnancy care required. In relation to mental health screening, midwives need appropriate education and training to perform this screening and an increase in consultation time.

Murdoch Childrens Research Institute recommends re-designing antenatal care to take account of the need to give attention to social factors, such as family violence, because these factors place the health of the mother and child at risk (12).

#### ***Recommendations:***

***Additional funding should be provided to health services to increase the consultation times allowed for women accessing public antenatal care***

***Telehealth should be a mainstream option to minimise women's need to travel to access pregnancy care***

***Assistance with transport and accommodation should be available if a woman is required to travel to access care***

***Improve women's access to mental health support and treatment by providing perinatal mental health nurses to work with midwives and with referred clients at each public maternity service. This would be an effective and economical measure that would be capable of:***

- 1. Continuing to ensure midwives and MCHN are appropriately educated to routinely conduct the screening, and***
- 2. Ensuring that every women identified has access to early mental health interventions at the time and place it is needed***

#### **B. Labour and birthing (intrapartum) care**

Mothers in Victoria are often not able to access a midwife who is solely responsible for her care. A mother in labour requires 1:1 care from a midwife who is able to be present for the whole time of the woman's normal labour, or induction or caesarean section. Health service policies and procedures in Victorian maternity services are prescriptive in all areas except staffing. It is sometimes impossible to fulfil the requirements of policies due to inadequate number of midwives available. Hospital policies are designed taking account of evidence and best practice but the policies do not acknowledge the number of staff that may be required to fulfil the inherent requirements.

The National Institute for Health and Care Excellence (NICE) Guidelines (**14**) recommend that there is one to one midwife care for each woman in established labour. When midwives are required (as is the case currently) to run from room to room, the woman receives disjointed care from an overburdened midwife. This poses a risk to safe care and contributes to women's dissatisfaction with care.

Demand in birth suite is not predictable. It is not possible to provide one to one care unless midwives are rostered in advance. Serious clinical deterioration requires mobilisation of significant resources at short notice. At night, the medical, pathology and theatre backup is less than by day, creating heightened risk at night.

The time of birth cannot be accurately predicted at the commencement of a shift. At least two midwives (or a midwife and a doctor) are required to attend every birth in order to fulfil all requirements of hospital policies regarding monitoring and treatments mandated for safe care of mother and baby.

In complex cases additional midwives and doctors are required to attend the birth. Increasing numbers of Victorian mothers experiencing pregnancy labour and birth have a greater number of risk factors and more complications than previously. The following trends are known to increase clinical risk to the patient and increase the complexity of labour and birth care.

Chronic diseases are more prevalent eg diabetes and obesity. Between 2009 and 2013 the rate of obesity was static (**15**). Approximately 4 out of every 10 mothers (43%) were overweight or obese between 2014 and 2015 (**16**). More recent individual hospital data which is unavailable to the ANMF may show a further increase in obesity rates, as our members report this seems to be the case.

The percentage of spontaneous vaginal birth (least complex) has been steadily decreasing from nearly 70% in 1995 to around 50% in 2013 (**26**). This is likely to reflect the interventions required to manage risk in increasing numbers of pregnancies. The trend to less spontaneous births and more complex births has continued in 2014 and 2015 (**17**).

In addition to the mother's right to expect SAFE care, she also has a right to midwife care that facilitates the establishment of a mother baby bond that sustains a lifetime relationship.

The opportunity to have skin to skin contact with her baby and early initiation of breastfeeding is the right of every woman. These experiences are also known to enhance the likelihood of successful breastfeeding to 6 months. When 1:1 midwifery care is available an expert and empathetic midwife will facilitate mother and baby to spend the necessary time to get to know each other, in a safe environment of unobtrusive surveillance and assistance as required. Many mothers are not able to access this vital support immediately post birth because midwives are caring for more than one woman in labour.

ANMF (Vic Branch) members who are midwives regularly raise their concerns about unsafe staffing with their health service managers and feel powerless to improve the situation.

Multiple reports into patient safety and avoidable harm in hospitals in the UK – Midstaffordshire Trust/Francis Report; the Morecambe Bay Investigation; and the Berwick Report have all demonstrated that when hospital administrators/managers do not act on the reports of nurses and midwives about unsafe staffing and skills mix levels and do not provide funding for adequate staffing levels, there is a failure of patient [centred] care, of compassionate care and an increase in avoidable harm and deaths in the patient population (**18** and **19**). In 2016 the report *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm* was released and this report also made observations and recommendations regarding the pivotal role of midwives and nurses in raising concerns about quality and safety (**28**).

***The Safe Patient Care Act 2015 should be amended to ensure that 24 hours per day and 7 days per week one midwife is rostered to every birthsuite that is open and available. The number of birthsuites that are open and available at a particular health service should be declared transparently by the health service and DHHS***

### **C. Postnatal (postpartum) care in hospital**

There has historically been a low level of consumer satisfaction with postnatal care in Victoria. The PinC report (**20**) articulated midwives' concerns with their ability to provide woman centred postnatal care. In 2006, prior to the 2007 introduction of the current midwife to patient ratios, Forster et al concluded that "staffing was highlighted as a major factor impacting on the provision of postnatal care". Although some postnatal ratios have improved, comments reported relating to staff distress remains relevant today (**21**). In 2008, Forster et al concluded that women have anxiety and fears around early parenting and their changing role, with many women expressing a view that they would prefer to stay in hospital longer (**22**).

Between 2012 and 2015 state-wide data shows that breastfeeding was initiated by approximately 95% of babies born at 37+ weeks. The rate of babies being exclusively breastfed at discharge was 78% (**23**). The perinatal data for 2015 and 2016 shows no improvement in these figures (**24**). Mothers are more inclined to request or consent to the use of formula for their babies due to their own fatigue and due to the inability of midwives to spend time assisting with a breast feed.

Between 2012 and 2015, the rate of use of formula in public hospitals for breast fed babies has remained constant at around 25.2% (**15**) and the state-wide average in 2015 was 28.6% (**24** and **25**). Despite hospital policies supporting the WHO 10 steps of Breastfeeding, there are insufficient midwives and lactation consultants to provide the necessary support to assist women.

There are no women or babies in hospital who do not require high levels of midwifery care, education and observation. There has been a conscious effort to decrease length of hospital stay for

postnatal women. In 2013, 85.9% of women had a postnatal length of stay of 3 days or less. 59.5% had a length of stay of 2 days or less (26). Current length of stay data would be available from DHHS and individual hospitals. Midwives report that they feel pressured to send women home within shorter timeframes than the midwife believes is appropriate for individual women. Midwives who visit postnatal women at home confirm the view of their hospital colleagues that women are being sent home “early” and with inadequate support.

Midwives report that the quality of patient care is compromised because they are too busy to sit with a woman to assist with a breast feed or to listen to her explain her fears and concerns. Breast feeding rates are significantly affected by the giving of formula to a baby and 25% of term breastfed babies are receiving formula in Victorian public hospitals. The importance of assisting mothers and babies to establish breastfeeding cannot be overrated. Babies who are breastfed have a reduced risk of respiratory illnesses and infections of the ear and gastrointestinal tract. Breastfeeding has also been shown to protect babies from SIDS and diabetes and heart disease later in life. Women who have breastfed have lower rates of cancer of the breast and ovaries. In vulnerable populations, eg Aboriginal and Torres Strait Islander and other groups, breastfeeding is a protective mechanism which cannot afford to be lost if we are to achieve improved outcomes in these groups.

The quality of patient care from the point of view of women, as extensively surveyed over the past 20 years, is not optimal. From the point of view of midwives also, it is not good (20, 21 and 22) ANMF members who are midwives working in postnatal wards are very concerned that at the end of a shift they feel there are many tasks that they have not been able to get to, worse, they feel that they are letting women down because they do not have the time to provide reassurance and education to help the mother build confidence.

In many health services, due to insufficient midwives available in birth suites, midwives rostered to postnatal wards are routinely utilised to staff birthing suites. This increases the likelihood of a mother being unable to access appropriate postnatal midwife support.

***Recommendations:***

***The Safe Patient Care Act 2015 should be amended to ensure that 24 hours per day and 7 days per week one midwife is rostered to every 3 mothers and babies plus one midwife in charge***

***Nurse Practitioner with Paediatric Notation models of care should be facilitated by DHHS to assist with the care of sick neonates nursed with their mothers in a postnatal ward***

***To better cater for mothers and sick neonates, Transition Units should be developed when new infrastructure is being planned***

**Postnatal care in the home**

The Victorian Midwifery Homecare Group is a Special Interest Group of the ANMF comprising midwives from across Victoria, including private providers of home visiting services, who benchmark, provide professional development opportunities and lobby for improved access to domiciliary midwifery services for women. The VMHG have provided the following comments:

*It is becoming much harder to complete the clinical care that is required because the mothers and babies health needs are often quite complex. All domiciliary services report the following: increasing complexity of patient conditions, early discharge from hospital, increasing traffic congestion meaning longer driving times to visit women and their babies, fatigue issues due to working long hours alone, phone contacts increased by at least 30%, regular missed meal breaks and midwives working beyond their shift time to complete paperwork.*

*There is not a problem for some women and babies to go home from hospital in 6, 12 or 24 hours, but more resources are needed if these women are to provide quality care at home. Innovative systems such as telemedicine and electronic hand held clinical pathways can help us streamline our services. To provide holistic care to women and their families at home, additional services such as those available in hospital must be available. For example interpreter services, dietician, physiotherapy, mental health nurses, and wound consultants.*

*The Domiciliary services should be staffed by midwives with not less than 3 years' experience and each rostered midwife should have access to a car, phone and security plan. Additional equipment includes scales, blood pressure machines, oxygen saturation monitors, wound management equipment and resuscitation equipment. Domiciliary services in regional and metropolitan health services require a dedicated midwife manager.*

*There is an increase in the following types of work in the community: wound management (particularly women who have a high BMI), women who have mental health plans, women and/or partners with substance use issues, babies who are the subject of child protection orders.*

*There needs to be a total review of the funding model. Currently only one or two home visits are funded and no home ancillary services are available to women and babies. It is not safe to send women home without proper supports in place. A woman who leaves hospital 12-24 hours after discharge should ideally receive a daily visit for one week, at which time transfer to the Maternal and Child Health Service would take place.*

### **Vulnerable women and home visiting**

*Many vulnerable women are not visited at home due to safety concerns for midwives and other staff. For example, women who have been assessed as having a history of drug use, or an abusive partner/ family members, will be asked to return to hospital for a check-up. These women are arguably more in need of a home visiting service than many others due to their inability to leave home.*

*The system must provide flexibility for these women. For example the opportunity for longer length of stay in hospital, assistance with transport to return to hospital, increased resources to allow midwives and others to safely visit the woman's home and community options where postnatal advice and assistance can be accessed.*

*An educated and experienced workforce with appropriate vehicle and equipment infrastructure is required to provide postnatal care in the home. A sufficient number of midwives who are experienced enough to work independently in the community must be rostered.*

*The VMHG recommends that depending on travel time and complexity of the clinical needs, one midwife could ordinarily be expected to do 4 postnatal visits in one day, additional to phone calls and data entry that is required.*

*Currently midwives visit between 4 and 5 women per day generally, with up to 8 women visited on regular occasions.*

*The health service must ensure that midwifery education services specific to postnatal care in the home will be provided to midwives working in this unit.*

### **Maternal and Child Health Nursing Service**

The Universal Maternal and Child Health nursing service is the foundation of these preventive strategies and performs a pivotal role in the primary prevention and early intervention of vulnerability. MCH nurses are uniquely positioned to equip new mothers and families with the skills and knowledge required to competently care for their babies or young children and therefore prevent – and make interventions – around the known risk factors contributing to vulnerability. This is similarly recognised by the Honourable Philip Cummins, Emeritus Professor Dorothy Scott and Mr Bill Scales who observed in their Report to the *Protecting Victoria's Vulnerable Children Inquiry* January 2012 that:

*Victoria's antenatal and maternal and child health services are a cornerstone of its universal, early intervention and prevention program covering all children and are particularly important in the early care of vulnerable children. These services must be better resourced to meet the specific and demanding needs of Victoria's vulnerable children and their parents (Page xxxiv).*

ANMF commends the Victorian government's work to support vulnerable children through the Early Childhood Reform Plan announced in the 2017 budget and notes here that the Victorian Maternal and Child Health nursing service is well placed to collaborate with mental health nurses, midwives and other health professionals to support mothers children and families in the community.

#### **Recommendations:**

***Review the DHHS Postnatal Care Guidelines for Victorian Health Services to ensure funded access for women to midwife postnatal care via midwife home visits, day stay centres and phone counselling as required for at least 7 days***

***Fund midwife lactation consultants to provide specialist breast feeding support and information***

***Adequate referral and treatment options must be available for women whilst under the care of postnatal care in the home***

## **2. The impact that the loss of commonwealth funding (in particular the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families**

*Depression is the leading contributor to the global burden of disease and is responsible for many more years of life lived with a disability, reduced productivity, increased health expenditure, impact on families and caregivers, and premature mortality than chronic heart disease and cancer.*

*Severe perinatal depression, anxiety and exposure to intimate partner violence are among the leading causes of maternal death. Maternal depression during pregnancy is associated with preterm birth, low birthweight and early cessation of breastfeeding.*

*Currently the emphasis of maternal health surveillance is predominantly on women's health in pregnancy and the immediate postpartum period (12).*

Midwives and nurses were actively engaged in the National Perinatal Depression Initiative, and welcomed the program because it filled a gaping hole in service provision for vulnerable women. Some midwives were provided with education and training to perform screening of depressive disorders associated with the National Perinatal Depression Initiative and incorporated this screening into their routine antenatal care.

The loss of this Commonwealth funding stream has impacted on the ongoing education for nurses and midwives within Victoria. The initial ongoing support by the Victorian Government was welcomed, and gave services time to make other arrangements or in many cases plan to cut the service. This has once again left a significant gap in services for women. It is ironic that as we increase risk assessment, we see a decrease in the options for referral and treatment. Midwives report that this is a very challenging ethical and clinical scenario which is regularly experienced in some antenatal clinics.

At Sunshine Hospital, the Perinatal Emotional Health Program (PEHP) demonstrated an average reduction in length of stay within the maternity services of 1.7 days, calculating a saving of \$2635 per patient bed day or \$806,310 per annum based on 306 patients in 2014.

The Western Health Sunshine Hospital website explains that the Perinatal Emotional Health Program (PEHP) is the Victorian Government response to the National Perinatal Depression Initiative. PEHP is committed to early detection, support and treatment for pregnant women who have chosen to birth with Western Health and are experiencing feelings such as sadness and anxiety during pregnancy and early parenthood. The Program team works closely with the midwives, obstetricians and paediatricians within Maternity Services at Sunshine Hospital.

In the Loddon Mallee region, Bendigo Health runs a program called the Maternity Support Program. This service provides 0.8 EFT social worker and 0.2 EFT midwife. When the PEHP was cut, the Bendigo Health maternity services program decided to help fund the PEHP from their own budget which invariably results in a disadvantage to that hospital's ability to properly fund other clinical services. The total PEHP is 1:0 EFT and covers the whole Loddon Mallee region and is considered a vital but inadequately resourced service.

Higher demand for mental health services, and longer length of stay in maternity units is the economic cost of not intervening early. The loss to society and the broader economy is even greater.

Early experiences determine whether a child's developing brain architecture provides a strong or weak foundation for all future learning, behaviour, and health (Centre on Developing Child. A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behaviour and Health for Vulnerable Children; Harvard University, 2007). Mental health problems during early years can have enduring consequences if left unresolved not only by placing individuals at increased risk of difficulties in adult life, but also by placing increased pressure on limited community service resources. Suffering and negative outcomes can also cause intergenerational cycles which become larger problems to address (Austin M, Perinatal Mental Health: opportunities and challenges for psychiatry. *Australasian Psychiatry* 2003; Vol 11; 399-403). There is robust evidence that the onset of many adult psychological problems have their origins in childhood and adolescence. Families affected by parental mental illness are at particularly high risk (Royal Australian and New Zealand College of Psychiatrists. Position Statement 56: Children of Parents with a Mental Illness, 2009).

Commonwealth funding has been reduced to Community Health Centres (CHCs) in Victoria. CHCs historically provided a range of services including Drug and Alcohol workers, Youth mental health

services, women's health services and post hospital care home services. The actual services which have been cut vary from region to region.

In terms of women and their babies in the perinatal period, the benefit of programs such as Quit Smoking, pre pregnancy dietary and activity advice to reduce BMI, and fertility and family planning advice is known to improve maternal and neonatal outcomes.

***Recommendations:***

***Victorian Government to reinstate PEHP funding and to consider models of care where midwives work together with perinatal mental health nurses to provide risk screening and therapeutic solutions for individual women, both in hospitals and in the community***

***Victorian Government to fund Community Health Centres to embed Women's Health programs co-ordinated by women's health nurses and midwives to provide pre pregnancy advice, education and referral. In rural locations, outreach services should be provided***

***Victorian Government to consider Nurse Practitioner models in Community Health Centres to provide primary health and maternity care***

### **3. The adequacy of the number, location, distribution, quality and safety of health services dealing with high risk and premature births in Victoria**

Babies who were born early (before 37 weeks gestation) comprised 8.4 per cent of all births – an increase of 0.2 percent from 2013. The number of preterm births has steadily increased since 1985 (31).

In 2015, DHHS described 7 levels of newborn services in Victoria with Level 6A and 6B being neonatal intensive care descending to Level 1 which is a normal healthy term baby.

#### **Safety and quality**

Levels 1 and 2 – With implementation of the DHHS policy *Keeping mothers and babies together* neonates which were previously cared for in Special Care Nursery are now cared for in postnatal wards, co-located with their mothers, without dedicated staffing for the neonate. This created improved capacity in the nursery sector. However due to the lack of staffing provided and the minimal education provided to midwives caring for these unwell babies, it has placed pressure on postnatal services and diminished the quality of care that midwives are able to provide to women during their short postnatal stay. As mentioned above, these women and babies are also sometimes unable to access appropriate care post discharge due to the restrictions inherent in current guidelines.

Levels 3, 4 and 5 - Includes high acuity babies, often with respiratory support, eg Bubble CPAP &/or High Flow Nasal respiratory support. The nurse in charge has a full patient load on top of managing a high acuity unit. Scarce nurse educator EFT is often inappropriately used to cover admissions and other workload, meaning vital staff education does not occur. All hospitals in these categories have Code Blue policies which see the SCN staff provide first responder assistance at category 1 caesarean sections or any neonatal code blue called in delivery suite. The remaining babies in the nursery are often left in the care of junior staff and with staffing levels that might be as high as 1:6. Various levels of nursing experience are unable to be catered for with first year graduate nurses on rotation counted as core staff. This is sub optimal skill mix.

Level 6 - All of the above issues and critically ill neonates often require 3 or 4 nurses to provide treatment and assist medical staff during admission, stabilization and emergency procedures. NICUs

require an ERN (emergency response nurse) "floater" or "admission nurse" in addition to the in-charge and direct nursing care staff. The ERN attends all high risk deliveries, emergency intubations, "red bell" or collapsed babies within the unit and code green obstetric cases and paediatric code blues in delivery suite and theatre. Care of a neonate in NICU is just as complex and critical as care of an adult in ICU. Babies who require IMV/CPAP are nursed at 1:2 due to non invasive respiratory support, this type of baby is often very unstable and requires ventilator back up to avoid intubation.

Neonatal nurses report high levels of stress and fatigue due to inadequate skill mix and inadequate numbers of staff. It is the role of neonatal nurses to provide expert care for tiny very unwell babies and to support and reassure the baby's parents with compassion and concern. This is extremely difficult in situations which are under resourced.

Nurses also report that it is not possible to provide a safe and supportive learning environment for junior doctors and nurses due to the issues outlined above. This has flow on impacts in terms of recruitment and retention of an appropriately skilled workforce in neonatal services. For example, Junior medical staff working unsupported and unsupervised to "gain experience" attending resuscitation and caesarian sections, does not encourage a long term desire to work in neonatal units.

### **Neonatal readmission rates**

In 2015 -2016, the statewide average public hospital rate of unplanned neonatal readmissions within 28 days of discharge was 4.0 percent. Internationally reported readmission rates after childbirth range from 1.5 percent to 5.0 percent. Unplanned readmission represents a deviation from the normal course of postnatal recovery. Australian and international studies demonstrate that any maternity related readmissions, particularly of newborns, are preventable with effective discharge procedures and early access to home and community based support (32).

Neonatal nurses and midwives in postnatal wards and postnatal care in the home services are very cognizant of their inability to provide appropriate discharge advice and support. This is an issue that affects women's confidence in parenting and increases anxiety and should be addressed by properly staffing these areas.

### **Improving the experience of women and babies**

- Provide more choices and more autonomy for women
- Sufficient nursing and lactation support to empower women to gain the confidence to manage the care of her unwell baby
- Staffed transition units for mothers and babies to keep mother and baby together
- Neonatal nursing liaison and advanced practice roles to promote consistency in standards and to provide education and support to junior staff so that mothers receive consistent advice from confident professionals
- Assistance with transport and accommodation for families when the mother and baby are transferred to another hospital
- Improved response times for retrieval services
- Regional transfers wherever possible. Currently there are barriers experienced to some cross region transfers because the retrieval service is based in metropolitan Melbourne
- Recent changes to data collection methods has decreased transparency of statewide neonatal capacity. Nurses worry that this may further erode the woman's opportunity to access care close to home
- Capability Frameworks for neonatal units are prescriptive for medical expertise but not for nursing expertise. The previous *Guidelines for Neonatal Services* included requirements for nurse educators and nurses with particular levels of experience and qualification levels as

required. This information is not included in the current *Defining levels of care for Victorian newborn services* Nurse believe this impacts on the quality of nursing care in units.

- Neonatal hospital in the home, with outreach services where required
- Lactation consultants providing home visits to improve breastfeeding rates

**Recommendations:**

***Review the current funding arrangement so that safe and appropriate nurse/midwife staffing levels are available to meet neonatal care needs.***

***Create neonatal nurse advance practice roles in all health services to provide a consistent level of expertise and care provision. This will improve standards immediately and also provide a pathway to Nurse Practitioner for those nurses. This initiative should not be confined to Level 5 and 6 hospitals. The Neonatal Nurse Practitioner role in less complex services can provide a consistent level of expertise and liaison with nurses, midwives and medical staff providing neonatal care in various environments (including postnatal wards)***

#### **4. The quality and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births**

Many of the previous and subsequent responses in this submission go to the heart of quality and safety and therefore will impact on the adverse outcomes named in this question.

There are two other comments to make:

1. The current risk reporting systems in Victoria – in both public and private hospitals – do not encourage participation. The systems in place are not user friendly and need urgent replacement. A culture of safety for health practitioners who report clinical adverse outcomes or near misses must be implemented. Risk reporting should be encouraged and learnings should be shared.
2. Aboriginal women have higher rates of stillbirth and pre-term birth than the general population. Action is required to ensure that Aboriginal women, particularly those who have had previous pregnancy loss, are treated as high risk with the choice of proactive early intervention, eg antibiotics when membranes are ruptured at 22 weeks. A focus on hospital policies and practices where Aboriginal women are treated is essential to ensure that the cycle of pregnancy loss is interrupted.

#### **5. Access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria**

Access by women to appropriate care across the perinatal journey is dependent on the availability of a skilled multidisciplinary workforce.

Issues vary across geographical regions but two issues are common: excessive workload leading to stress and fatigue and limited support for formal education qualifications.

**Midwives** in Victoria are generally fully employed. However, the majority do not work full time and many work small time fractions eg 1-2 days per week. Anecdotally, this is the same across rural and metropolitan regions. Analysis is required of the Victorian workforce to understand whether a change in workplace factors would affect the time fraction worked. Midwives often work in more than one

workplace and sometimes in employment outside midwifery and our members advise that this is to mitigate against the excessive stress of chronic understaffing that they experience in the workplace.

In metropolitan areas when recruitment occurs, it is very often at the expense of another health service nearby who must also recruit. It is a constant cycle. Midwives who are dissatisfied just change employer rather than engaging to work for change in one workplace. Midwives report dissatisfaction about not being able to provide safe care and about not having their concerns acted upon by hospital managers.

There are three pathways to obtain midwifery registration: undergraduate double degree Bachelor of Nursing and Midwifery (4 years); undergraduate Bachelor of Midwifery (3 years); postgraduate Diploma of Midwifery (1 year).

Each year some Bachelor of Midwifery graduates have had difficulty finding employment. Health services, rural and regional in particular prefer to have a workforce that also has nursing registration.

The post graduate “employment” model should continue to be supported by Government as a pathway to midwifery. Registered Nurses who are enrolled in the postgraduate diploma of midwifery are employed and paid by a health service during the period of study. The health service rotates the registered nurse/student midwife through the various areas in maternity services to gain clinical experience. On days that the registered nurse is employed she is able to work within her scope of practice as a Registered Nurse. This has been a preferred method of midwife recruitment for many rural services that refer to it as “grow your own”.

The employment model is also supported by DHHS with an approximately \$18,000 training and development grant per student per year to the health service. ANMF is concerned that this program does not appear to be as common as it once was and would like to see greater transparency in the funding arrangements with health services.

LaTrobe University Bendigo has approximately 20 students per year; 107 students have graduated in the past 5 years. Commonwealth Supported Places are available in this course which reduces the fees from approximately \$20,000 to around \$12,000. Federation University Ballarat and Churchill also provides the postgraduate diploma in midwifery.

Support is also required for the continuation of double degree courses in rural areas. Recently, Federation University cancelled the double degree course delivered at Churchill, which had previously enrolled 30 students per year. Churchill graduation numbers no longer meets the midwife attrition rate in Gippsland.

In addition to the pathways to midwifery, the existing workforce requires ongoing support to capacity build. It is recommended that nurses and midwives be supported to obtain formal qualifications in mental health nursing, alcohol and other drugs and midwifery. This will provide a sustainable basis for ongoing support for new graduates and other staff who do not have the specialist skills.

There is a plethora of continuing professional development opportunities which are often run by city hospitals in rural settings at considerable cost to nurses and midwives. Providing support to achieve formal qualifications will ensure a local resource will be available for women and for other nurses and midwives in the rural area on an ongoing basis.

**Scholarships and grants should be allocated to assist nurses and midwives to achieve:**

- **Post Graduate Diploma of Mental Health Nursing**
- **Certificate 4 in Alcohol and other Drug training**
- **Postgraduate Diploma of Midwifery**
- **Postgraduate Diploma or Masters in Child Health**
- **Diploma in Breastfeeding Management**
- **Nurse Practitioner**

## **Models of care**

### **Caseload**

*Continuity of carer in the provision of maternity care has been strongly recommended and encouraged in Victoria and throughout Australia. Many hospitals responded by introducing caseload midwifery, a model in which women are cared for by a primary midwife throughout pregnancy, birth and the early postnatal period (29).*

A study comparing standard maternity care with one to one midwifery support (COSMOS) found that women who were randomly allocated to receive caseload care were less likely to have a caesarian birth, more likely to have a normal birth and less likely to have epidural pain relief during labour. There were also positive outcomes for babies and the mothers reported more positive experiences of labour and birth (29).

### **Public hospital planned homebirth programs**

Two programs have been operating in Victoria since 2009 – at Casey Hospital and at Sunshine Hospital. CCOPMM reported favourable outcomes for the public homebirth programs. Births are attended by 2 midwives (5).

### **Collaborative arrangements between private midwives and public hospitals**

Only one health service – Northern Health – has developed this program. A 12 month external review is underway currently and during ANMF's involvement with development and implementation of the program. Reports are that outcomes have been positive.

The ANMF has been a stakeholder in the development and review of midwifery continuity models of care across Victoria since 2004. Research is underway to examine the sustainability of caseload midwifery in Australia (30) there appears little doubt that this model of care provides great benefits to most women who experience it. However there have been some real concerns from the perspective of the workforce in relation to fatigue, lack of support by employers, inadequate remuneration for hours worked and isolation from the mainstream of a health service. It is important that this model of care be reviewed carefully in the Victorian context to understand what could be done better to achieve the known improved outcome for women.

## **6. Disparity in outcomes between rural and regional and metropolitan locations**

The Australian Institute of Health and Welfare summarised 2015 data thus:

*Australians living in rural and remote areas tend to have shorter lives, higher levels of disease and injury and poorer access to and use of health services compared to people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to a range of factors, including a level of disadvantage related to education and employment*

*opportunities, income and access to health services. People living in rural and remote areas may also have more occupation-related and physical risk, such as farming or mining work and transport-related accidents. The proportion of adults engaging in behaviours associated with poorer health, such as tobacco smoking and alcohol misuse, are also higher in these areas.*

*Higher death rates and poorer health outcomes outside major cities, especially in remote areas, also reflect the higher proportion of the population in those areas who are Aboriginal or Torres Strait Islander.*

*Despite poorer health outcomes for some, the Household, Income and Labour Dynamics in Australia (HILDA) survey found that Australians living in small towns (fewer than 1,000 people) and non-urban areas generally experienced higher levels of life satisfaction compared to those living in Major cities.*

Dr Ruth Stewart presented to the Rural and Remote conference in Cairns in 2017 following her work on the closure and re-opening of birthing services in remote areas around Australia. Rural and remote birthing services have been closing for several decades. The rationales behind these closures are often concerns about safety, economic resources, and professional indemnity. Many developed nations have experienced similar trends in closure of rural birthing services. These closures have considerable implications for patients, communities, clinical workforce and health services in rural areas. Many non-metropolitan community members continue to lobby for the reinstatement of local birthing care as they seek safe, equitable service access and high quality care. After many years of closures, the state of Queensland in Australia has seen increased interest and success in restarting remote birthing services.

Qualitative analysis of the results found key enablers, barriers, tasks and processes can be categorised into thematic groups; the largest of which were associated with *workforce, funding and safety*.

It is the ANMF's view that cessation of birthing services in small centres in Victoria over the past 10 years have been driven by the same cohort of factors. It is important for Government to hold current information about the demographics of the workforce and to provide incentives and support to the midwifery and medical workforce in rural areas. Where it is not possible to continue birthing services, it is important firstly, to provide as much pregnancy care and postnatal care locally and secondly, when that can't be achieved, to utilise mobile outreach services and financial assistance to assist a woman and her baby to achieve as close to equity of access as possible.

***Recommendations:***

***Targeted education assistance should be provided to rural nurses and midwives to ensure a viable sustainable midwifery and nursing workforce is available***

***Telehealth should be a mainstream option to minimise women's need to travel to access pregnancy care. Mobile, outreach services should be established to visit groups of women who live distant from health services***

***Assistance with transport and accommodation should be available if a woman is required to travel to access care***

## 7. Identification of best practice

The ANMF would welcome the opportunity to provide further information on any of the following programs which we believe enhance, or have the potential to enhance, the experience and clinical outcomes for mothers and babies in Victoria:

### Existing programs

- MCHN enhanced home visiting
- Barwon Health neonatal home visiting program
- Regional Mortality and Morbidity meetings have improved the focus on review and response to clinical incidents, and should continue but need further development
- Bendigo Maternity Support Program
- Perinatal Emotional Health Programs
- Northern Health Collaborative Arrangements between Private Midwives and a Public Hospital
- Uniting Care Mother Baby Unit for mothers with substance use issues
- Post graduate Diploma Midwifery Employment model
- Maternity Connect
- Vic Pic
- Women's Growing Together Parenting Kit – under evaluation (app, book, for use in collaboration with health professionals)
- Neonatal Education Training Service – well regarded although cost has recently increased
- Family Birth Centres
- Vic Maternal and Child Health Line
- Consumer organisations providing advice and education to both consumers and to professional groups, eg Post and Ante Natal Depression Association; Australian Breastfeeding Association

### Programs to consider

- Nurse Practitioner outreach services from high level NICU and SCNs to smaller services and home based care models
- Nurse Practitioner models within Community Health Centres to provide primary health care to women and babies
- Antenatal and postnatal care provided by midwives and GPs in small rural communities
- Shared care protocols between larger and smaller services
- Pre pregnancy education and counselling with the aim of reducing the effect of pregnancy risk factors such as obesity, diabetes, mental health disorders
- Embedded Womens Health Programs in Community Health Centres
- Hybrid collaborative models between maternal and child health nursing services and hospital in the home and postnatal care in the home services (Some Local Government MCHN services do not accept babies until they are 2.5kg)

## Recommendations

- 1. The availability, quality and safety of health services delivering services to women and their babies during the perinatal period:**
- 1.2 *Additional funding should be provided to health services to increase the consultation times allowed for women accessing public antenatal care*
- 1.3 *Telehealth should be a mainstream option to minimise women's need to travel to access pregnancy care*
- 1.4 *Assistance with transport and accommodation should be available if a woman is required to travel to access care*
- 1.5 *Improve women's access to mental health support and treatment by providing perinatal mental health nurses to work with midwives and with referred clients at each public maternity service. This would be an effective and economical measure that would be capable of:*
  - a) *Continuing to ensure midwives and MCHN are appropriately educated to routinely conduct the screening, and*
  - b) *Ensuring that every women identified has access to early mental health interventions at the time and place it is needed*
- 1.6 *The Safe Patient Care Act 2015 should be amended to ensure that 24 hours per day and 7 days per week one midwife is rostered to every birth suite that is open and available. The number of birth suites that are open and available at a particular health service should be declared transparently by the health service and DHHS*
- 1.7 *The Safe Patient Care Act 2015 should be amended to ensure that 24 hours per day and 7 days per week one midwife is rostered to every 3 mothers and babies plus one midwife in charge*
- 1.8 *Nurse Practitioner with Paediatric Notation models of care should be facilitated by DHHS to assist with the care of sick neonates nursed with their mothers in a postnatal ward. The preliminary, immediate step is to establish positions for advanced clinical practice nurses in neonatal services*
- 1.9 *To better cater for mothers and sick neonates, Transition Units should be developed*
- 1.10 *Review the DHHS Postnatal Care Guidelines for Victorian Health Services to ensure funded access for women to midwife postnatal care via midwife home visits, day stay centres and phone counselling as required for at least 7 days*
- 1.11 *Fund midwife lactation consultants to provide specialist breast feeding support and information*
- 1.12 *Adequate referral and treatment options must be available for women whilst under the care of postnatal care in the home*

2. **The impact that the loss of Commonwealth funding (in particular the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families:**
  - 2.1 *Victorian Government to reinstate PEHP funding and to consider models of care where midwives work together with perinatal mental health nurses to provide risk screening and therapeutic solutions for individual women, both in hospitals and in the community*
  - 2.2 *Victorian Government to fund Community Health Centres to embed Women's Health programs co-ordinated by women's health nurses and midwives to provide pre pregnancy advice, education and referral. In rural locations, outreach services should be provided*
  - 2.3 *Victorian Government to consider Nurse Practitioner models in Community Health Centres to provide primary health and maternity care*
3. **The adequacy of the number, location, distribution, quality and safety of health services dealing with high risk and premature births in Victoria**
  - 3.1 *Review the current funding arrangement so that safe and appropriate nurse/midwife staffing levels are available to meet neonatal care needs.*
  - 3.2 *Create neonatal nurse practitioner roles in all health services to provide a consistent level of expertise and care provision. This initiative should not be confined to Level 5 and 6 hospitals. The Neonatal Nurse Practitioner role in less complex services can provide a consistent level of expertise and liaison with nurses, midwives and medical staff providing neonatal care in various environments*
5. **Access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria**
  - 5.1 *Scholarships and grants should be allocated to assist nurses and midwives to achieve*
    - *Post Graduate Diploma of Mental Health Nursing*
    - *Certificate 4 in Alcohol and other Drug training*
    - *Postgraduate Diploma of Midwifery*
    - *Postgraduate Diploma or Masters in Child Health*
    - *Diploma in Breastfeeding Management*
    - *Nurse Practitioner*
6. **Disparity in outcomes between rural and regional and metropolitan locations**
  - 6.1 *Targeted education support should be provided to rural health services to ensure a viable sustainable midwifery and nursing workforce is available*
  - 6.2 *Telehealth should be a mainstream option to minimise women's need to travel to access pregnancy care. Mobile, outreach services should be established to visit groups of women who live distant from health services*
  - 6.3 *Assistance with transport and accommodation should be available if a woman is required to travel to access care*

## Conclusion

The ANMF supports the policy views expressed by the Healthy Mothers Healthy Families research group, Murdoch Children's Research Institute. The policy brief summarises findings from an Australian longitudinal study of over 1500 first time mothers and their firstborn children. One in five mothers experienced emotional and/or physical abuse by an intimate partner in the year after having a baby. This translates to 14,000 Victorian families a year affected by family violence in the course of a child's first year of life. (3) The same study found that almost one in 3 women reported depressive symptoms between pregnancy and four years postpartum. (12)

There is a compelling case for health services to complement the current focus on high quality clinical care with equivalent attention to social factors such as family violence that also place the health of the mother and child at risk. (3)

Concurrently the ANMF is well aware of the pressures on high level acute maternity and neonatal services in Victoria and the difficulty that some women experience in accessing those services.

Midwives, neonatal nurses, mental health nurses and maternal and child health nurses are well equipped to provide improved services to women from conception through the pregnancy and child rearing journeys through innovative and cost effective programs. The type of care provided by the nursing and midwifery professions is highly skilled, caring and compassionate and regulated by professional standards of practice and Codes of Ethics.

The ANMF urges the Committee to seriously consider adopting the recommendations in this submission. The ANMF is most willing to provide further information and looks forward to participating in the further work of the Committee as it works towards developing recommendations for Government.

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