

**Submission
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SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

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Response to the NSW Parliamentary inquiry “Support for new parents and babies in New South Wales”

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Women in Australia rate postnatal midwifery care lowest when compared to other episodes of maternity service provision. In particular, women report dissatisfaction with the standard and amount of postnatal care and the style of support provided during the early establishment period of breastfeeding (Medew 2010; Mc Kinnon et al. 2014; Burns et al. 2012).

In response to the dissatisfaction with the quality of postnatal care reported by women and midwives, government reviews, both nationally and internationally, have recommended changes to maternity services (Commonwealth of Australia 1999, 2009; Roxon 2010; Gleeson et al. 2014). During the postnatal period the majority of women in NSW meet a multitude of service providers and many lack access to a consistent, continuous relationship with a health professional who they have met several times during pregnancy. This lack of continuity leads to women ‘falling through the cracks’ as their care is delivered in a haphazard and inconsistent way (Priddis et al. 2014; Jenkins et al. 2014).

Postnatal care, provided within contemporary maternity services internationally and across Australia, and has been dubbed the ‘poor cousin’ or ‘Cinderella’ of maternity services (Commonwealth of Australia 1999; Dykes 2005; Forster et al. 2007; Fraser & Cullen 2006; Homer et al. 2002;) reflecting the poor status it has compared to other aspects of maternity care. Because of relatively low mortality rates, and the assumption of low maternal morbidity rates, (Dykes 2009b) postnatal care is under-valued and therefore often under resourced (Bick et al. 2011; Fraser & Cullen 2006). Midwives working within the fragmented system approach postnatal care with a focus on the immediate physical health needs of women after birth, with little attention paid to her psychological and social needs, or understanding longer term health issues (Gamble & Creedy 2009; Mc Kinnon et al. 2014; Fenwick et al. 2013).

There have been a number of attempts to develop innovative approaches of postnatal care that address the dissatisfaction expressed by woman and midwives (Schmied et al 2008, 2009a, 2009 b; Yelland et al. 2009). The catalysts for change include woman’s dissatisfaction as they experience physical problems following the birth of their baby, are unable to gain confidence in caring for themselves or their baby and have limited opportunities to develop a relationship with a midwife that provides continuity of carer¹. In this context, midwives feel frustrated with the care they are providing as they struggle with the day to day issues working within the hospital institution and women feel neglected by the fragmented system (McKinon et al. 2014; Jenkins et al. 2014; Fenwick et al. 2010; Bick et al. 2011; Dykes 2009).

¹ Primary midwife provides the majority of the care throughout the early pregnancy to the end of the postnatal period. Continuity of carer sometimes named one to one midwifery or midwifery caseload practice (Homer, Brodie & Leap 2008).

Research on Postnatal Care models

In Australia, the Shearman report published over two decades ago (NSW Health Department 1989) identified the need to change the system of maternity care. This report, as well as numerous researchers, recommended that maternity services should focus on woman friendly approaches to care and acknowledging the midwives role. It recommended that woman have more access to midwifery care, and there should be implementation of more innovative and flexible approaches to care provision (Demott et al. 2006; Forster et al. 2005; MacArthur et al. 2003; McKellar, McLachlan et al. 2008; Schmied et al. 2009a; Yelland, Krastev & Brown 2009). Yet not much has changed and postnatal period continues to be neglected.

Research conducted in Sydney 2008 by Lyn Passant, found barriers to providing quality postnatal care in the hospital setting as described by midwives and included:

- Staffing numbers and skill mix not seen as a priority i.e. postnatal women need lactation consultant, disparity of allocated women (8 women and their 8 babies per registered midwife as she would be required to oversee the non-midwives and supervise student midwives)
- Lack of support for midwives i.e. ward clerk, postnatal specific educator, opportunity for professional development
- Lack of opportunities to engage with women during the antenatal period to discuss issues regarding postnatal care and preparing for motherhood and get to know the women
- Being unable to spend more time with women (do midwifery) due to competing priorities including non-clinical workload i.e. answering the phone, policing the visitors, organising the doctors, bed management.
- Increasing complex needs of women involved midwives organising and coordinating other health care providers and access other agencies including child protection, housing, police and security as midwife felt there were more women from lower socioeconomic backgrounds and women who often had child protection issues, lack of emotional and financial support, drug and alcohol problems and a higher proportion of younger single mothers. Providing support for this community of women was difficult for midwives working in the acute care setting. (Passant 2012)

Practice changes considered

Practice changes within an acute care setting required challenging the routine ways of providing care and supporting midwives to be able to change their routines and rituals to incorporate a more individualised woman-centred approach. For example the following table highlights some examples of practice change.

Routine fragmented approach	Woman-centred approach
Handover at the desk, woman not aware of what is being discussed, therefore she is not involved in her own care planning.	The clinical handover at the bedside and included the woman. Sitting beside her in a relaxed position, rather than at the end of the bed in an authority figure standing over her.
Postnatal check – involves the midwife examining woman and baby from top to toe and ticking boxes on a care plan, limited conversation occurring.	<i>Self-care assessment approach</i> explaining with the woman what to expect and what is normal after birth.
Didactic / authoritarian approach to education usually not engaged with the woman.	Utilising positive <i>language</i> and sharing information which focused on individualised woman-centred care including family members.

Suggestions from midwives included a space to provide information sharing with women and family members was the development of a space on the ward. Ward environment changes open visiting hours, partners staying overnight so they could support and learn parenting skills, limiting the use of the call bells to only urgent clinical situations to address noise in the ward. (Passant 2012).

New model of care

The most significant innovative strategy to improve postnatal care was the development of “Community Antenatal and Postnatal model of care” proposal. This model addressed the importance of a primary health care model¹². (Commonwealth of Australia 2011; Keleher 2001) and to continuity of care (Roxon 2010). Consideration of the increased role of midwives would also increase job satisfaction for the midwives and ultimately improved care for women.

Barriers to implementation of the new innovation of a community antenatal/postnatal continuity of care model included incorporating the model within the existing budget and staff profile. The managers felt ‘*snowed under*’ or overwhelmed with the managerial aspect

² Primary Health Care incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health (Keleher, 2001).

of their role managers and therefore could not consider reducing their already limited staffing levels. A strategy to enable implementation of such an innovative model at this hospital required the right time and also consideration of additional higher tier level of management support with visionary leadership qualities.

Improved support for new mothers as they transition into their mothering role is much needed in Australian health services. New and innovative models of care which focus on relationship building between the woman and midwife during pregnancy will reap benefits in the postnatal period. These new models of care require health service commitment and support.

Research on Breastfeeding Support

Breastfeeding rates in Australia, and NSW, are well below the WHO recommendations with 9 out of 10 women commencing breastfeeding but only 1-2 in 10 making it to the recommended 6 months of exclusive breastfeeding (AIHW 2009). The most recent Cochrane systematic review on breastfeeding support concluded that the factors which improved ongoing and exclusive breastfeeding were: face to face support, peer and/or professional support, trained personnel, and ongoing contact with a schedule of 4-8 contacts (McFadden et al. 2017).

The literature is abundant in accounts of women's experience of receiving less than optimal support for breastfeeding in the first few weeks after birth. Women report that support provided by health professionals is either 'bossy and judgemental' or provided at a time that is not convenient (Burns et al. 2017; Schmied et al. 2011). Recent research conducted in NSW shows that models of care that can provide the 'right help at the right time' (Burns et al 2017) increases women's satisfaction and confidence in the early stages of motherhood. A change in the way services are provided is required in order to improve mother's experience of breastfeeding support and increase breastfeeding duration rates. For example, an RCT on caseload midwifery care in NSW, the MANGO study (Midwives at New Group Practice Options), explored the maternity outcomes from care by a named caseload midwife compared to standard maternity care (Tracy et al 2013). Breastfeeding on discharge from hospital was higher among the caseload group compared to standard care. The findings also revealed the likelihood that a woman would be breastfeeding at 6 weeks and 6 months was greater in the caseload midwifery group (Tracy et al 2013).

Conclusion

A shift away from the fragmented model of maternity care provision to one which supports continuity of midwifery care and woman centred care will lead to improvements in women's experience of the early transition to mothering, increase women's confidence with their new baby, potentially increase breastfeeding rates and improve the detection of postnatal depression and other psychosocial determinants of health.

Midwives and women have become increasingly dissatisfied with the care provided after birth and the evidence is strong for best practice models of midwifery care. The health

system has an opportunity to align postnatal care of mothers and babies with the evidence for optimal outcomes.

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