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| Maternal and Child Health Service guidelines |
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| To receive this publication in an accessible [email Maternal and Child Health Service](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au>  Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.  © State of Victoria, Department of Health and Human Services September, 2019  Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.  ISBN 978-1-76069-905-5 (Print) ISBN 978-1-76069-906-2 (pdf/online/MS word)  Available at [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health>  Printed by Finsbury Green, Melbourne |
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# Introduction

The Victorian Maternal and Child Health (MCH) Service is a free universal primary health service available for all Victorian families with children from birth to school age. The MCH Service consists of three components: the Universal MCH program, the Enhanced MCH program and the 24-hour MCH Line.

The MCH Service is provided at over 650 MCH centres located in 79 local government areas across the state, allowing families to easily access services close to where they live. Victorian parents attend over 800,000 Key Age and Stage and additional consultations in the universal MCH program, 12,000 families receive more intensive support with the Enhanced MCH program and the MCH Line takes 108,000 calls a year (2017–18).

These guidelines inform the maternal and child health framework for Victoria. They identify the relationship between key policy documents that govern the MCH Service. The guidelines update effective governance arrangments, policy and legal context, Aboriginal self-determination, diversity, workforce, funding criteria and data collection.

In January 2019, MCH and Early Parenting functions moved from the Department of Education and Training (DET), to the health portfolio of the Department Health and Human Services (the department), strengthening the integration of these services. The department established a new Maternal, Child and Family Health Branch within the Child, Family and Community Health Group (Health and Wellbeing Division).

The new branch enables the department to build on universal supports to improve maternity and neonatal care, strengthen maternal child health and development, expand early parenting support, provide strong support for parents, and better target interventions to support children, mothers and families experiencing vulnerability.

This edition of the **MCH Service guidelines** applies from 2019 and updates the **MCH Service guidelines 2011.**



# 1. MCH framework

The MCH framework provides a integrated service delivery architecture for the Victorian MCH Service. The framework brings together contemporary theory and best practice. The MCH framework consists of:

**Maternal and Child Health Service guidelines** (2019)

**Maternal and Child Health Service standards** (2011)

**Maternal and Child Health Service clinical practice guidelines**

**Maternal and Child Health Universal program guidelines – currently Maternal and Child Health Service: practice guidelines** (2009)

**Enhanced Maternal and Child Health program guidelines** (2017)

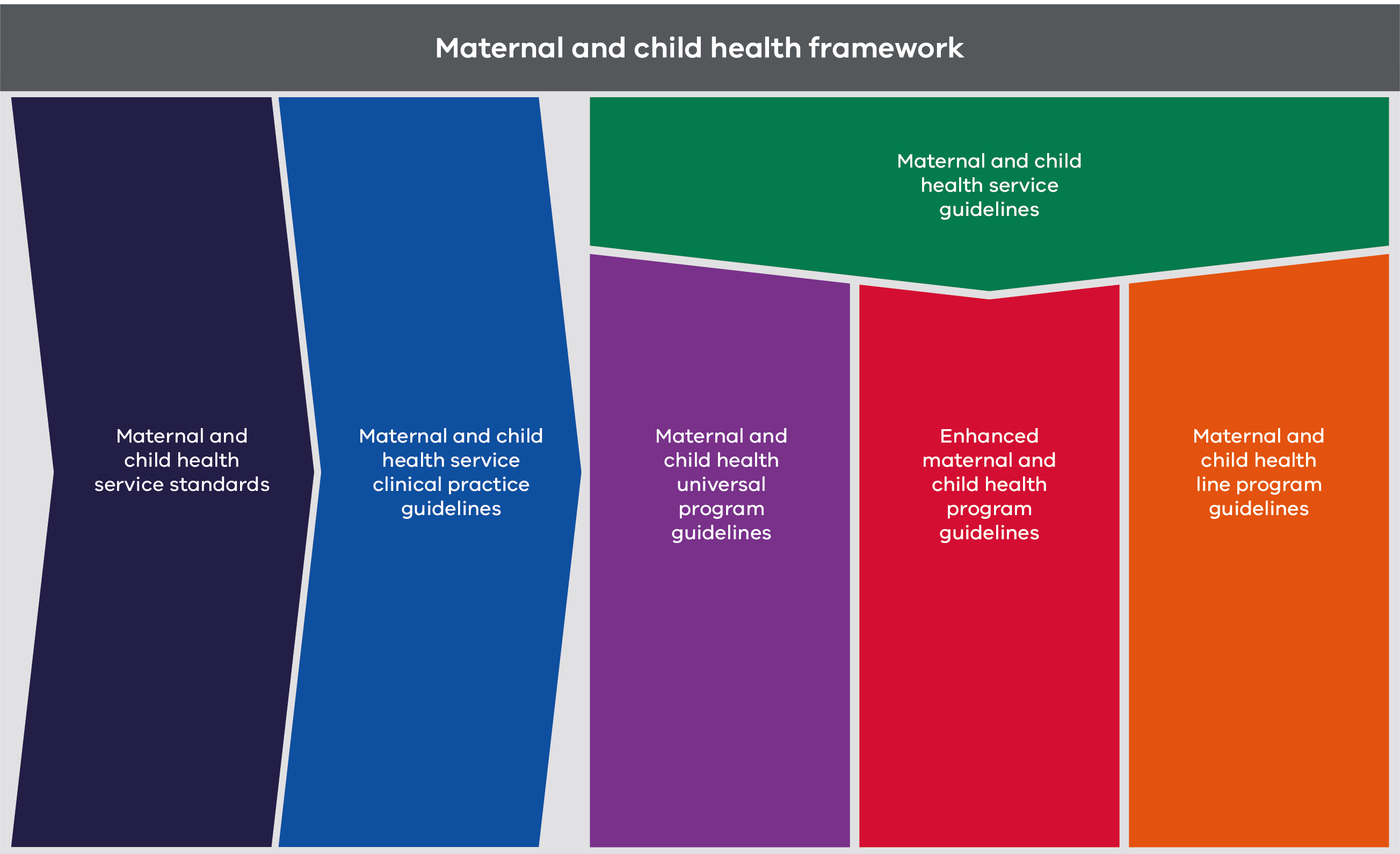
**Maternal and Child Health Line program guidelines**

It supports the delivery of consistent and high-quality MCH services by MCH Service providers for all Victorian children and families.

The framework embraces the operational delivery component of the service through the **MCH Service guidelines** with clinical practice supported by the overarching **MCH Service standards** and **MCH Service clinical practice guidelines** (CPGs).

The Victorian MCH service is provided through three intergrated programs: the Universal MCH (UMCH) program, the Enhanced MCH (EMCH) program and the MCH Line. The MCH program guidelines inform service provision.

Figure 1: The MCH framework provides the overall relationship of the documents that drive the Victorian MCH Service



The MCH resource map in Appendix A comprises supporting documents to the key documents in the framework.

## 1.1 The MCH Service guidelines

These guidelines inform MCH Service providers about the MCH framework, governance, MCH workforce, policy, legislation, funding, performance measures and data collection obligations to support the delivery of professional, safe and high-quality care within the MCH Service.

## 1.2 The MCH Service standards

The MCH Service is guided by the **MCH program standards (2009, reissued 2019)** thatprovide an evidence-informed platform for the consistent delivery of high-quality, safe and inclusive MCH services in Victoria. The **MCH program standards** support the provision of clinical and corporate governance within the MCH Service. The MCH program standards are being reviewed and updated to include Safer Care Victoria’s **Clinical governance framework** and will be released as the MCH service standards in 2020.

The MCH Service framework recognises the Victorian MCH nursing profession has developed professional standards for competent MCH nursing practice and documentation. They set the accepted standard of the profession for a Victorian MCH Nurse and include:

* + The **Competency standards for the maternal and child health nurse in Victoria** developed by the Victorian Association of Maternal and Child Health Nurses ANMF (Victorian Branch).
  + The **Documentation standards for maternal and child health nurses in Victoria** (the documentation standards) developed by the Victorian Association of Maternal and Child Health Nurses ANMF (Victorian Branch), the Victorian Maternal and Child Health Coordinators Group and the Australian Nursing and Midwifery Federation (Victorian Branch).

The Victorian MCH service standards exceed the [**National standards of practice for maternal, child and family health nurses**](https://www.mcafhna.org.au/Resources.aspx#52611-standards) **(2017)**, providing the unique Victorian context for MCH nursing practice.

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| **Supporting documents**  [MCH program standards](https://www.education.vic.gov.au/childhood/professionals/health/Pages/mchpolicy.aspx) <https://www2.health.vic.gov.au/maternal-child-health>  [Victorian Association of Maternal and Child Health Nurses](http://www.vamchn.org.au/) <http://www.vamchn.org.au/>  [National standards of practice for maternal, child and family health nurses](https://www.mcafhna.org.au/Resources.aspx#52611-standards) <https://www.mcafhna.org.au/Resources.aspx#52611-standards> |

## 1.3 The MCH clinical practice guidelines

The department supports quality improvement at a system level by encouraging the use of evidence in clinical practice to optimise outcomes for children and families. The **MCH clinical practice guidelines** are being developed to support nurses to provide best-practice and evidence-informed care pathways for specific clinical circumstances on a readily available platform.

MCH nurses will be supported in their practice with clinical practice guidelines that link to [statewide clinical networks](https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-networks/clinical-network-maternity) designed for both hospital and community settings.

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| **Supporting documents**  [Statewide clinical networks](https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-networks/clinical-network-maternity) <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-networks/clinical-network-maternity> |

## 1.4 The MCH program guidelines

The **MCH program guidelines** provide clear, standardised clinical practice and and service guidance to MCH Service providers, local government, MCH nurses and workforce. These include:

* **Universal MCH program guidelines (MCH practice guidelines 2009)**
* **Enhanced MCH program guidelines 2018**
* **MCH Line program guidelines (in development)**

The guidelines establish a coherent and consistent approach for high quality program delivery across the state which is supported by the department and Municipal Association of Victoria (MAV). The program guidelines communicate program objectives, model and resources to strengthen service delivery.

Program guidelines are developed in consultation with representatives of the MCH workforce, the Maternal and Child Health and Parenting Expert Reference Group, MAV, the Australian Nursing and Midwifery Federation (Victorian Branch) (ANMF Vic), consumers and key stakeholders.

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| **Supporting document**  [MCH clinical practice guidelines (CPGs)](https://www.education.vic.gov.au/childhood/professionals/health/Pages/mchpolicy.aspx) <https://www2.health.vic.gov.au/maternal-child-health> |



# 2. The MCH Service

The MCH Service is a free universal primary health service for all Victorian families with children from birth to school age. The service is provided in partnership with local government (respresented by MAV), health services and the department with the aim to promote and optimise health, wellbeing, safety, development and learning outcomes for children and their families.

The MCH Service provides a comprehensive and focused approach for the promotion, prevention and early identification of the physical, emotional and social factors affecting young children and their families. The MCH Service supports child and family health, wellbeing and safety, focusing on maternal health and father-inclusive practice as a key enabler to optimise child learning and development.

Investing in high-quality programs that support optimal child, maternal and family health, wellbeing, safety, development and learning has lifelong benefits to children’s health, educational and social outcomes. This is particularly so for children with additional needs.

A vision, mission, goal, principles and standards guide MCH service provision to ensure high quality care and outcomes for Victorian families. These parameters are summarised with the key outcomes of the service in the logic model in Appendix B.

## 

## 2.1 Vision

To optimise the health, wellbeing, safety, learning and development of all Victorian children and their families, from birth to school age so that they can live a life they value.

## 2.2 Mission

To engage with all families in Victoria with children from birth to school age to take into account their strengths and vulnerabilities, and to provide timely contact and ongoing primary health care in order to improve their health, wellbeing, safety, learning and development.

## 2.3 Goal

To promote health, wellbeing, safety, learning and developmental outcomes for children and their families, providing a holistic approach to the physical, emotional and social factors affecting families in contemporary communities.

## 2.4 Principles

The MCH Service is underpinned by 10 guiding principles. The first principle, ‘Child, maternal and family-centred practice’, places the child, mother and family as the central focus of the service. The remaining supporting principles encompass the child, mother and family, support father-inclusive practice, and promote holistic, responsive and accountable care. The relationship of these principles is shown in Figure 2 and described in Table 1.

Figure 2: MCH principle model

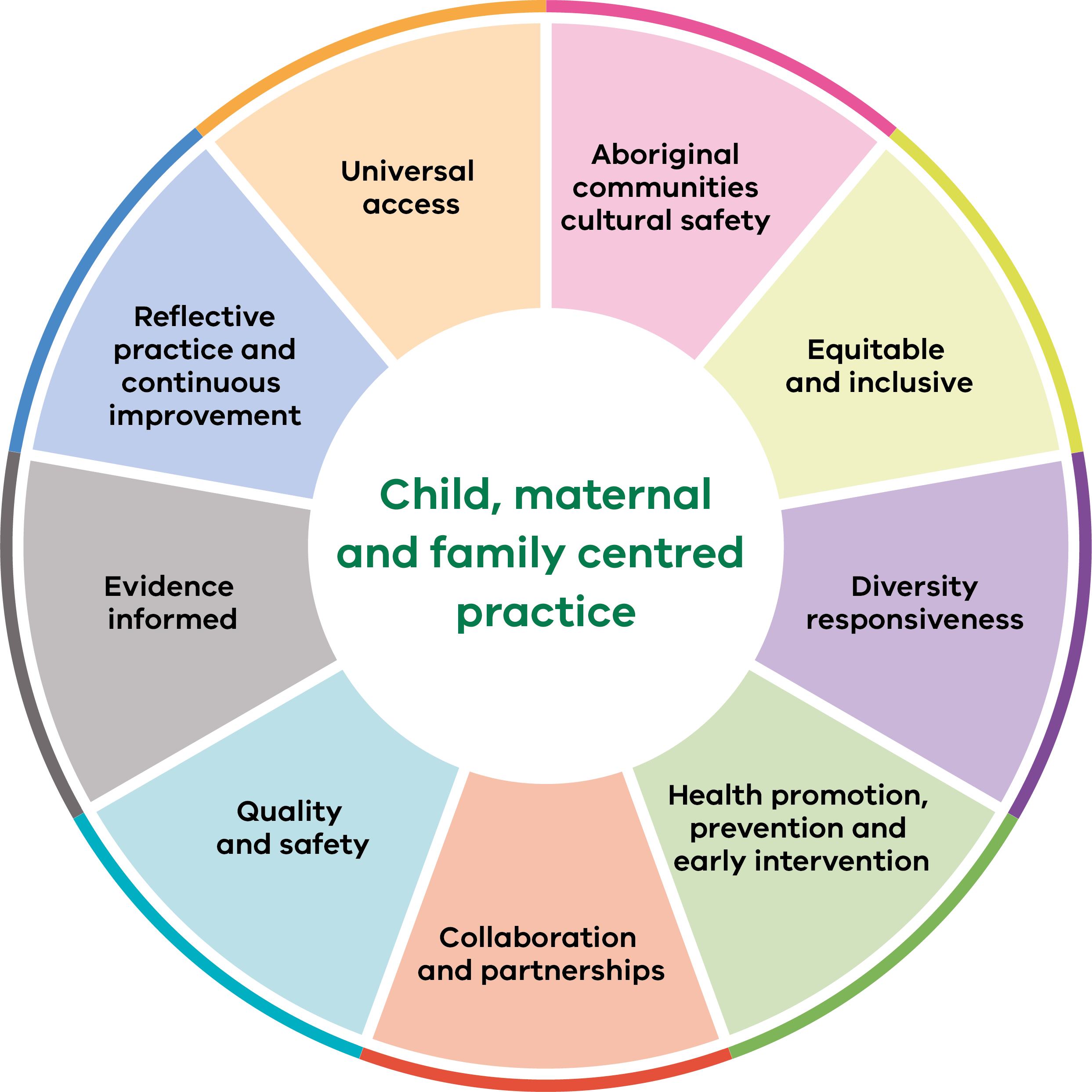


Table 1: MCH principles

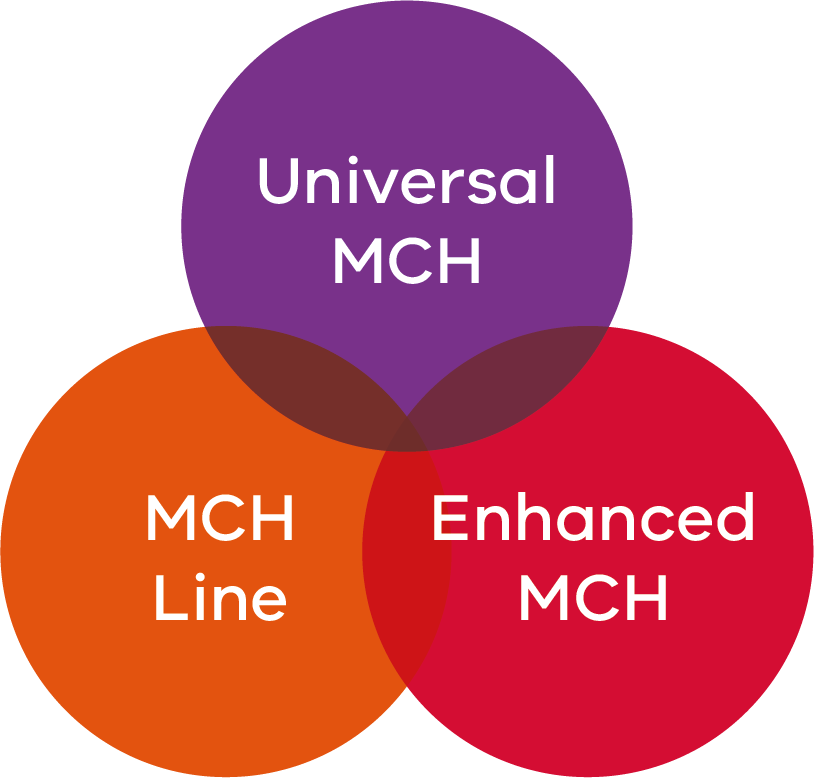
| Principle | How we apply it in our work |
| --- | --- |
| Child, maternal and family-centred practice | The MCH Service works in partnership with families by building on and supporting individual and family/carer strengths, applying an intersectional approach and reflecting their needs and preferences.  The best interests of the child are paramount when making decisions or acting to optimise health, wellbeing, safety, learning and development.  A mother’s health and lifestyle, particularly in the perinatal period, is a critical determinant to the health and wellbeing outcomes of her children and family.  Father-inclusive practice is integral to the health, wellbeing, safety, learning and development of the mother and child.  Family engagement optimises outcomes for the child, mother and the family wellbeing. |
| Universal access | The MCH Service is universally available, free, and accessible for all Victorian families with children from birth to school age.  The MCH Service is delivered flexibly to meet the individual needs of the child, mother and family, to facilitate optimal engagement.  Services are acessible in the right space at the right time for children, mothers and families.  Children, mothers and families receive an integrated and coordinated approach, to support continuity of care through the midwifery, neonatal and MCH service systems. |
| Victorian Aboriginal communities’ cultural safety | Families have the choice to engage with Aboriginal services that support the advancement of self-determination and self-management in the delivery of MCH Service programs.  The MCH Service provides culturally safe practices that enable optimal health, wellbeing and safety outcomes for children, mothers, families and staff belonging to Victorian Aboriginal communities.  The MCH Service focuses on addressing inequalities and disparities in health outcomes for Victorian Aboriginal communities. |
| Equitable and inclusive | The MCH Service supports equity in health, wellbeing, safety, development and learning outcomes for children, mothers and families.  Equitable opportunities for children promote their optimal health, wellbeing, safety, learning and development outcomes.  MCH Services and programs are inclusive for all children, mothers and families, and are delivered at a level and intensity that is proportionate to child’s and families’ experience of vulnerability. |
| Diversity responsiveness | MCH services are sensitive and responsive to diversity in children and families.  The MCH Service identifies and responds to the intersectionality of children, parents and families within communities.  The MCH Service focuses on addressing inequalities and disparities in health outcomes for diverse and emerging communities. |
| Health promotion, prevention and early intervention | Anticipatory guidance, health promotion and prevention all aim to give children, mothers and families the best likelihood of optimal health, wellbeing, safety, learning, and development outcomes.  Early intervention is supported by identifying children, parents and families experiencing vulnerability, empowering them to act and facilitating the earliest possible opportunity for engaement with services.  The MCH Service focuses on improving early childhood development milestones for children experiencing vulnerability, through health promotion and intervening early. |
| Collaboration and partnerships | The MCH Service works in partnership with children, mothers and families, building on individual and family/carer strengths, reflecting their needs and preferences, and taking intersectional factors into account.  The MCH Service works in collaboration and partnership to improve the continuity of care across maternity, neonatal, health and family support services and within early years settings.  Collaboration and partnership with children, parents and families enable the MCH service to intervene early to support families to engage with health and early years services. |
| Quality and safety | MCH services monitor and analyse clinical practice and service delivery for effectiveness and to drive service improvement.  The MCH Service recognises the fundamental influence of MCH nursing clinical leadership in achieving high quality and safety in practices to decrease variations and mitigate risk.  Appropriate safeguards are in place to ensure the safety of children, mothers and families and the MCH workforce.  MCH services engage with parents, families and communities as consumers and stakeholders to ensure a quality service. |
| Evidence informed | MCH practice and initiatives are evidence informed and research findings are implemented to help children and families achieve the best outcomes.  The MCH Service delivers evidence informed, health promotion and early intervention strategies to optimise health, wellbeing, safety, learning and development outcomes. |
| Reflective practice and continuous improvement | MCH Service delivery focuses on child and family centred practice combined with continuous reflection, monitoring and evaluation.  Continuous improvement occurs within the MCH Service to ensure best practice and to adapt to the changing needs of the Victorian community.  Measurement of performance and progress is benchmarked and used to drive improvement in service quality and manage risk. |

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## 2.5 Components of the Maternal and Child Health Service

There are three components of the MCH Service:

* the Universal MCH (UMCH) program
* the Enhanced MCH (EMCH) program
  + the Maternal and Child Health (MCH Line) program.



The MCH Service logic model provides a high-level overview of the MCH Service in Victoria. It outlines the inputs to the service and the activities and outputs that are delivered through each component program (UMCH, EMCH and the MCH Line) and sets out the short-, medium- and long-term outcomes for children and families who access the service.

See Appendix B for a full description of the MCH Service logic model.

### The Universal Maternal and Child Health program

The UMCH program delivers a free, universally accessible, statewide service for all families with children from birth to school age. The program supports children, mothers, fathers, carers and families with an emphasis on health promotion, prevention, parenting, developmental assessment, early detection and referral and social support. It also provides a platform for identifying children and families who require further assessment, intervention, referral and support and brings families together to foster social networks and strengthens community connections though the flexible service capacity.

The program has contact with all Victorian children from birth to school age, through 10 key age and stages (KAS) consultations as well as a flexible service capacity.

#### KAS activity framework

The UMCH program consists of 10 KAS consultations with a maternal and child health nurse. The KAS consultations are a schedule of contacts for all children and their families from birth to school age. They include an initial home visit, and consultations at two, four and eight weeks, and four, eight, 12 and 18 months, and at two and three and a half years of age.

The **KAS activity framework** was implemented statewide from 2009. The framework:

* comprises three key components – monitoring, promotion of health, learning and development and intervention
* identifies the core activities for the 10 universal consultations that the MCH Service offers to all Victorian children and their families
* is intended to be complemented by opportunistic activity by MCH nurses, based on their clinical judgment and in response to parental concern
  + provides evidence-based health information consistent with the health promotion activities listed for each key age and stage consultation.

#### Flexible service capacity

UMCH models promote ease of access and engagement for children and families who require additional support outside the KAS consultations. Additional consultations and a range of other activities, including drop-in sessions, are available for these families via a flexible funding model. There are several categories of flexible service capacity activities.

##### Additional consultations

Consultations are available for children and families experiencing vunerability and/or who have identified additional needs that cannot be fully met through the KAS consultations. Each KAS consultation is recorded once. If the assessment takes two consultations, the second consultations is recorded as an additional consultation.

Telephone consultations

The provision of advice and support to families over the telephone regarding the health, wellbeing, safety, development and learning of the child and family are also considered an aspect of the flexible funding. This does not include administrative phone calls such as appointments and general enquiries. The Universal MCH Service funding includes an adminstrative component that incorporates phone enquiries and appointments associated with the 10 KAS consultations.

##### Group sessions

First-time parent group (FTPG) sessions are a required activity within this component. Active engagement and inclusive practice of fathers and carers is vital to service delivery of FTPGs.

Group sessions may be targeted for Aboriginal, culturally and linguistically diverse communities, working parents, teenage parents or families with shared experiences of vulnerability. Parent groups provide health promotion and prevention, build parenting capacity, offer parenting support and enhance social engagement and community connections.

##### Community strengthening activities

A community strengthening activity requires a sustained effort to increase active engagement, collaboration and partnership among community members, groups and orgranisations. Activities may include health and parenting programs targeting children and families led by other services.

MCH involvement in supported playgroups or engaging families to facilitate place-based and community-led groups are further possiblities within in this area.

##### Family violence consultation

In addition to the KAS consultations and the flexible component, a specific family violence consultation can be provided to a family if the MCH nurse has completed a consultation where any one of the following occurs:

* the MCH nurse was unable to complete the family violence questions (for example, at the four-week KAS consultation) because the partner or other family members were present, or
* family violence has been disclosed or identified and more time is required for discussion or to complete a safety plan, or
* the MCH nurse suspects the family is experiencing family violence and requires additional time for exploration and discussion, or
  + the MCH nurse or family member/s require a joint consultation with a specialist family violence practitioner.

Family violence consultations are led by the MCH nurse. In some cases, the MCH nurse may choose to hold a joint consultation with a family support worker, Aboriginal health worker, and/or specialist family violence practitioner.

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| **Supporting resource**  [Family violence MCH guidance](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |

### **The Enhanced MCH program**

The EMCH program responds assertively to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. This service is provided in addition to the components offered through the UMCH program. It provides a more intensive level of support, including short-term case coordination or management in some circumstances. Support may be provided in a variety of settings, such as the family’s home, an MCH centre or another location within the community.

The primary focus for the EMCH program is families experiencing a period of vulnerability due to two or more of the factors:

* mother/parent is less than 20 years of age
* infant/child is identified as being of Aboriginal or Torres Strait Islander descent and is not actively attending the UMCH program
* family is socially isolated (housing, cultural group, transport, unemployment)
* parent expresses and/or demonstrates poor attachment towards their infant/child
* a mental health issue is currently impacting parenting capacity
* substance abuse issues are currently impacting parenting capacity
* family violence is currently impacting safety, parenting and infant/child development
* current intervention from child protection
* infant/child born with congenital abnormalities
* infant/child with complex growth, health and developmental issues
* concern on the part of the assessing nurse, or
  + families who are not currently engaged with the UMCH program.

The EMCH program is expanding to support 15 per cent of Victorian families with children from birth to three years of age with an average of 20 hours of support as part **of Early years reform plan (2017–18)**. This will be fully implemented from July 2020.

To support the expansion of the EMCH program, the **EMCH program guidelines** were revised and published in 2018, and **Clinical supervision guidelines** for the EMCH program were developed.

The purpose of the clinical supervision guidelines for the EMCH program is to provide:

* a clear definition of clinical supervision and the use of reflective practice for EMCH nurses
  + best practice guidance on the provision of clinical supervision, taking into consideration various demographics.

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| **Supporting documents**  [EMCH program guidelines](https://www.education.vic.gov.au/Documents/childhood/professionals/health/enhancedmchprogguidelines.pdf) <https://www2.health.vic.gov.au/maternal-child-health>  [Early years reform plan 2017–18](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health>  [Clinical supervision guidelines](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |

### The MCH Line program

The **MCH Line** is a 24-hour telephone service supporting Victorian families with health and parenting concerns for children from birth to school age, staffed by MCH nurses. The MCH Line links families to the UMCH and EMCH programs and offers assisted referrals to a range of health and family support services, including emergency services.

The MCH Line responds to the immediate concerns of callers using evidence-informed practice by providing quality guidance, information, support and counselling. The most common calls relate to sleeping and settling, childhood illness, breastfeeding, nutrition, childhood conditions including allergies and skin conditions and immunisation queries.

The MCH Line is staffed by MCH nurses employed by the department. The MCH Line program guidelines are under development.

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| **Supporting information**  [MCH Line](https://www.education.vic.gov.au/parents/services-for-parents/Pages/mch.aspx#link44) <https://www.betterhealth.vic.gov.au/health/serviceprofiles/maternal-and-child-health-line> |

## 2.6 Additional supports for MCH programs

### MCH app

The MCH app provides time-saving features such as personalised notifications, important contact numbers (such as the MCH Line), and evidence-informed responses to common child health, wellbeing, safety learning and development questions. It provides information for parents about KAS consultations and reliable online information on parenting topics.

The MCH app includes an interactive child growth tracker, enabling families to monitor their baby’s growth progress. In addition, the app’s content continues to be translated into community languages to promote access for culturally and linguistically diverse families.

The MCH app is funded and operated by the department.

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| **Supporting resource**  [MCH App](https://www.betterhealth.vic.gov.au/campaigns/maternal-and-child-health-app)  <https://www.betterhealth.vic.gov.au/campaigns/maternal-and-child-health-app> |

### My Health, Learning and Development Book

The My Health, Learning and Development book is given to the parents of every newborn child in Victoria. It includes information about:

* services that support families, including the Maternal and Child Health Service
* appointments to keep
* your child’s growth and health record
* your child’s immunisation record
* birth details
* key age and stages visits information and record.

It also allows parents to add personal details about their child's development, with space for photos and plastic sleeves for important documents. It provides a way of communicating between parents, healthcare professionals and other healthcare providers.

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| **Supporting resource**  For any queries email the [Maternal and Child Health Service](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au>. |

### MCH Nursery Equipment program

The **Nursery Equipment program** was established to provide safe nursery equipment for vulnerable Victorian families where a safety concern has been identified by a maternal and child health nurse using the MCH safe-sleeping checklist. The program is open to families with a child 0–12 months of age, with demonstrated low income, and who are engaged with the UMCH or EMCH.

The available nursery equipment includes a cot ensemble (including a cot, mattress and mattress protector) and car restraints. Refer to the **Nursery Equipment program guidelines** for details of program eligibility and ordering.

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| **Supporting documents**  [Nursery Equipment program](http://www.each.com.au/service/maternal-and-child-health-nursery-equipment-program/) <http://www.each.com.au/service/maternal-and-child-health-nursery-equipment-program/>  [Nursery Equipment program guideline](https://www2.health.vic.gov.au/maternal-child-health)s <https://www2.health.vic.gov.au/maternal-child-health> |

### More help for mums and dads initiative

The Victorian Government has committed to a comprehensive package of new parent and early childhood supports to help every parent.

#### Newborn **first aid for first time parents**

This intiative will strengthen and support universal access to basic first-aid training for first time parents, with a focus on engaging fathers. First-time parents will be provided with essential information, advice and education regarding the care of their newborn in an emergency.

#### Baby bundle for first-time parents

First-time parents will be provided with a hamper of nursery essentials including a nappy bag, teething toy, a growsuit, muslin wrap, safe-sleeping bag, a first-aid kit, a sun hat, toothbrush and four Victorian picture books. The hamper will also include information relating to safety and parenting that complements the items in the bag which support parents of children in their early years.

The baby bundle is provided to all Victorian first-time parents at the time of their child’s birth via their maternity hospital (or via their MCH nurse if they did not give birth in a Victorian hospital).

#### Sleep and settling

Sleep and settling are common issues affecting families with children aged from birth to school age. The importance of sleep on a child’s long-term development, and for the wellbeing of families, sees the implementation of a comprehensive and integrated sleep and settling initiative over three platforms:

* UMCH sleep and settling sessions
* UMCH outreach
* MCH Line telephone consultations.

#### Early parenting centres

The expansion of early parenting centres, including building seven new centres and refurbishing two, will deliver better access, support and advice to Victorian families who are experiencing more serious and persistent challenges with parenting, including:

* sleep,settling or feeding difficulties
* attachment issues
* infant and child behavioural issues.

#### Child and baby seat installation checks

Parents and grandparents will be able to access free child restraint installation and safety checks through Neighbourhood Houses and community organisations. This program will ensure the families have the skills and confidence to use and adjust child restraints to reduce the risk of mortality and morbidity in car accidents.

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| **Supporting resource**  For any queries email the [Maternal and Child Health Service](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au>. |



# 3. Governance of the Maternal and Child Health Service

The MCH Service is provided to Victorian families through a partnership between the department and local government.

Organisational governance provides the foundation for a quality service. It should enable public entities to perform efficiently and effectively and to respond strategically to changing demands.

Governance encompasses the way public entities are directed, controlled and held to account. It includes the processes that make, communicate, monitor and assess decisions important to the future of a public entity.

In a high-quality MCH Service, effective governance and management requires a strong understanding of, and demonstrated compliance with, financial accountability and reporting requirements, as well as operational requirements and standards through relevant legislative and other governance frameworks. This chapter sets out these requirements and discusses the elements that enable good organisational governance for the MCH Service.

## 3.1 MAV and local government

The Municipal Association of Victoria (MAV) is a statutory body established by the **Municipal Association Act 1907**(Vic) to promote the interests of local government and represent Victorian councils, including local government contributions to the statewide policy direction for the MCH Service.

Local governments have a statutory and social responsibility for planning for their local communities, and supporting the health and wellbeing of Victorian children and families through local-level policies.

Councils take a place-based approach to planning, funding and infrastructure, as well as the coordination and delivery of services for children and families. They are responsible for the delivery and monitoring of the UMCH and EMCH programs.

Councils may directly employ the MCH workforce, including nurses and other health and early years professionals. The workforce operates under the control of the council or contracted provider.

## 3.2 Victorian State and Local Government Agreements

In September 2014, the **Victorian State–Local Government Agreement 2014** (VSLGA) was signed by the Victorian Government and MAV. The VSLGA acknowledges the key role of local government in improving coordination and strategic planning of government services at the local level.

In December 2018, the department updated the **Partnership Agreement between the Department of Health and Human Services and the Municipal Association of Victoria 2018–23**. The VSLGA and the Partnership Agreement provide an overarching framework to guide the range of existing and future agreements and activities undertaken by the department and local government, including:

* the negotiation of memoranda of understanding on specific programs between the MAV and the department
* the negotiation of funding and service agreements between the department’s regional offices and specific local government councils
* planning, policy, program development, service coordination and evaluation at statewide, regional and local government levels.

In May 2017, the MAV and DET signed a **Memorandum of Understanding (MOU)** that articulates the commitment of each to a collaborative and cooperative approach to the planning and delivery of early childhood services. The parties to the MOU agreed to the principles that guide the partnership between state and local government for the planning, funding and provision of the MCH Service. The MOU supplements the VSLGA and builds on previous MOUs. The current MOU concludes in December 2020.

In April 2017, the **Supporting children and families in the early years compact** between DET, the department and local government (represented by MAV) was developed and entered into for a period of 10 years (2017–27) to formalise a closer working relationship to lift outcomes for young children and families. The compact is a high-level, overarching commitment between the three parties. The MCH Service MOU forms an implementation agreement under this overarching framework.

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| **Supporting documents**  Municipal Association Act 1907 <http://www.mav.asn.au/who-we-are/governance/rules/part-1>  [Victorian State–Local Government Agreement 2014](https://www.localgovernment.vic.gov.au/our-partnerships/victorian-state-local-government-agreement) <https://www.localgovernment.vic.gov.au/our-partnerships/victorian-state-local-government-agreement>  [Partnership Agreement between the Department of Health and Human Services and the Municipal Association of Victoria 2018–23](https://dhhs.vic.gov.au/sites/default/files/documents/201902/Partnership%20Agreement%20between%20the%20Department%20of%20Health%20and%20Human%20Services%20and%20the%20Municipal%20Association%20of%20Victoria%202018-2023.PDF) <https://dhhs.vic.gov.au/publications/partnership-agreement-between-dhhs-and-municipal-association-victoria>  [MAV and the Department of Education and Training (DET) Memorandum of Understanding](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years#mou) <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years#mou>  [Supporting children and families in the early years compact](https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx> |

## 3.3 Leadership and accountability

MCH Service providers must have a strong understanding of governance and accountability requirements for the MCH services they provide. Clinical MCH nursing leadership is critical to achieving quality and safety within the MCH Service and is discussed in section 4. MCH Service providers, and the MCH workforce they employ, must comply with relevant legislation, policies and procedures to support the provision of a safe environment and service for children and families and staff. The legislation governing the MCH Service is discussed in section 6.

The MCH Service is positioned within the local government accountability framework, which includes: a council plan over four years or more, a strategic resource plan, an annual budget, and an annual report outlining the performance for the year as measured against the council’s plan and budget. Alongside this accountability framework, there are a number of other local government planning processes that MCH services participate and engage with. The **Public Health and Wellbeing Act 2008** (Vic) further requires councils to prepare a four-year municipal health and wellbeing plan or include health and wellbeing matters in their council plans.

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| **Supporting document**  Public Health and Wellbeing Act 2008 <https://www2.health.vic.gov.au/about/legislation/public-health-and-wellbeing-act3.4 Municipal early years plans> |

**Municipal early years plans** (MEYP) are local area plans designed to provide a strategic direction for the development and coordination of education, care and health programs, activities and other local developments that affect children 0–6 years and their families. All councils have undertaken these early years planning processes, which consider the specific needs of the municipality. In most cases, MEYPs include, but are not limited to, services that are funded and/or delivered by councils and might include information regarding MCH services in the council area.

The MAV **Resource guide to municipal early years planning (2018)** encourages a partnership approach where all community partners work towards an agreed vision and common outcomes for young children and their families across a municipality.

In addition, many local governments outline their long-term strategic vision through a health and wellbeing and/or community plan. The MEYP maybe incorporated or complements these plans.

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| **Supporting documents**  [Municipal early years plans](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/municipal-early-years-plans) <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/municipal-early-years-plans>  Resource guide to municipal early years planning <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/municipal-early-years-plans>  [Supporting children and families in the early years compact](https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx> |

## 3.4 Department of Health and Human Services

The department delivers health and human services, drives reform and provides regulatory oversight. Within the department, there are two divisions; a central division and an operational division. The department has a central office in Melbourne and operational offices located in departmental areas.

The department’s vision is to achieve the best health, wellbeing and safety of all Victorians so that they can lead a life they value. The department seeks to break disadvantage, not by reinforcing dependency, but by working to harness all of government’s resources to build capability, opportunity and inclusion. Most people want to be connected to their communities and experience a good life. Their health, safety and wellbeing rely on being able to participate fully in the community and economy and access services they value. The department’s purpose is to help them to get there.

To do this successfully, the department’s work focuses on four strategic directions:

* person-centred services and care
* local solutions
* earlier and more connected support
  + advancing quality, safety and innovation.

These directions are documented in the [**Department of Health and Human Services strategic plan**](https://dhhs.vic.gov.au/publications/department-health-and-human-services-strategic-plan) and articulated as outcomes, priority actions and key results. Each MCH Service provider must enter into a service agreement with the department for the provision of MCH services.

The department’s **Service agreement information kit** provides information for organisations that have a service agreement with the department. The kit is designed to provide general guidance for organisations funded by the department with information about the service agreement clauses and the applicable departmental policies. An organisation’s service agreement with the department, and applicable laws or legislation, take precedence over the information kit.

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| **Supporting documents**  [Department of Health and Human Services strategic plan](https://dhhs.vic.gov.au/publications/department-health-and-human-services-strategic-plan) <https://dhhs.vic.gov.au/publications/department-health-and-human-services-strategic-plan>.  [Service agreement information kit](https://fac.dhhs.vic.gov.au/service-agreement-information-kit) <https://fac.dhhs.vic.gov.au/service-agreement-information-kit> |

Central divisions

The central office organisational structure is divided into divisions structured on a portfolio basis, each focusing on an area of responsibility. This approach provides a better capacity to develop policies, manage service systems, design funding and support the delivery of the department’s responsibilities.

Maternal and Child Health is located within the Health and Wellbeing division and under the Family and Community Health portfolio. The central office also manages the provision of statewide resources for clinical practice and coordinates funding initiatives.

#### Principal MCH Nurse Advisor

The Principal MCH Nurse Advisor provides high-level strategic and expert clinical practice advice to inform statewide policy. The MCH Principal Nurse Advisor works in partnership with MAV, and engages with consumers and stakeholders to optimise child, maternal and family health, wellbeing, safety, learning and development outcomes**.**

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| **Supporting resource**  For queries in relation to reporting, resources and funding` initiatives, email the [MCH Service](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au>. |

### Operational divisions

Offices within operational divisions, connect the department’s central office with services, and work in partnership to ensure that policy direction and outcomes are delivered on the ground. Victoria has four divisional offices that include 17 area-based teams who work with the local community.

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| **Supporting resources**  To locate local operational division/area and for further information, visit the Our organisation page on the Department of Health and Human Services website  The department’s website also has [contact information for the area department offices](https://dhhs.vic.gov.au/locations-dhhs-offices-victoria) <https://www.dhhs.vic.gov.au/locations-dhhs-offices-victoria>. |

### Service improvement plans and reporting

MCH services are required to report to the department through the March data, annual report and **IRIS** quarterly reports and **service improvement plans** (SIPs).

To inform divisonal and statewide improvement activity and service planning, the department requires MCH Service providers to submit an annual SIP. The MCH SIP tool is sent to MCH Service providers by the department each year with guidelines for development and submission.

Some of the priority action areas for improvement as outlined in the SIP include measures to increase access for vulnerable families to the MCH Service including Aboriginal and Torres Strait Islander and diverse communities, increased participation in the UMCH program through KAS consultations and the utilisation of the additional family violence visits.

See section 11 for details of MCH data and reporting requirements.

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| **Supporting resources**  Email the [IRIS team](mailto:iris.data@dhhs.vic.gov.au) <iris.data@dhhs.vic.gov.au>.  [Email the Maternal and Child Health Service](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au> for details. |

## 3.5 Research involving MCH clients

Prior to allowing an external researcher access to MCH Service staff, parents, children or information regarding children and parents, MCH Service providers should ensure that approval for the research has been obtained through the Centre for Evaluation and Research at the department. All research requests should be referred to the Centre for Evaluation and Research.

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| **Supporting resource**  [External research application form](https://www.dhhs.vic.gov.au/research-applications-external-organisations-and-individuals) and for further information <https://www.dhhs.vic.gov.au/research-applications-external-organisations-and-individuals> |



# 4. MCH workforce

The MCH Service is delivered by qualified MCH nurses. More than 1,400 MCH nurses are employed by local government, MCH Service providers and the department to provide services in Victoria. MCH nurses are also employed by early parenting centres (EPCs). MCH nurses have a broad scope of practice, which equips them to provide safe and competent nursing care, across general, midwifery and maternal, child and family health nursing.

This chapter outlines the qualification requirements for MCH nurses, together with measures that facilitate their ongoing professional development and clinical support. This ensures a sustainable MCH nursing workforce and promotes quality and safety within the MCH Service.

## 4.1 MCH nurse qualification

In order to practice as a MCH nurse in Victoria, a MCH nurse is required to hold current registration with AHPRA as:

* a Registered Nurse (Division 1)
* a Registered Midwife, and
* in addition to the above registrations, hold an accredited postgraduate degree/diploma (or equivalent) in maternal and child health nursing.

In order to practice in Australia, registered nurses and midwives must be registered with the **Australian Health Practitioner Regulation Agency** through the **Nursing and Midwifery Board of Australia** (NMBA).

### Victorian MCH nurse qualification equivalence requirement

In addition to holding registration with AHPRA as a registered nurse and midwife, MCH nurses wishing to join the workforce from interstate or overseas are also required to demonstrate an equivalent level of postgraduate education in child and family health (maternal and child health nursing). La Trobe University, RMIT University, the Victorian Government and MAV collaborated to develop the **MCH qualification requirement equivalence flowchart**, which is used to assess whether the registered nurse and midwife demonstrates they hold an accredited postgraduate degree/diploma (or equivalent) in maternal and child health nursing.

The MAV Maternal and Child Health Policy Advisor is the MCH Service providers' point of contact for interpretation of qualification equivalence. Contact the **MAV Maternal and Child Health Policy Advisor**.

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| **Supporting resources**  [Australian Health Practitioner Regulation Agency](https://www.ahpra.gov.au/) <https://www.ahpra.gov.au/> (AHPRA)  [Nursing and Midwifery Board of Australia](https://www.nursingmidwiferyboard.gov.au/) <https://www.nursingmidwiferyboard.gov.au/>  [MAV Maternal and Child Health Policy Advisor](http://www.mav.asn.au/who-we-are/contact-us) <http://www.mav.asn.au/who-we-are/contact-us>  [MCH qualification requirement equivalence flowchart](https://www.mav.asn.au/__data/assets/pdf_file/0011/6968/MCH-Qualification-flowchart-Approved-2014.pdf) <https://www.mav.asn.au/\_\_data/assets/pdf\_file/0011/6968/MCH-Qualification-flowchart-Approved-2014.pdf> |

## 4.2 Delivery of MCH programs

The UMCH, EMCH and MCH Line programs are each led and staffed by MCH nurses who meet the qualifications requirements listed in 4.1.

### Clinical MCH leadership

Clinical MCH nursing leadership is fundamental to achieving quality and safety within the MCH Service. MCH nursing leadership positions are drawn from the MCH nursing workforce including the positions of MCH nurse coordinator and team leader.

### Universal MCH program and MCH Line

The UMCH program and the MCH Line are each led and delivered by MCH nurses who meet the qualifications requirements listed in 4.1.

### Enhanced MCH program

The EMCH program is led and delivered by MCH nurses who meet the qualifications listed in 4.1.

EMCH allied health and early parenting practitioners

The EMCH program may also include other practitioners and allied health professionals within their team, whose involvement complements the role conducted by MCH nurses. Team members may include, but are not limited to:

* Aboriginal health
* cultural
* drugs and alcohol
* early years and parenting
* family support
* mental health
* psychology
* social work.

While a multidisciplinary approach is encouraged with the EMCH program, it is led and mainly delivered by MCH nurses.

EMCH team members employed to support and complement the skills of MCH nurses are to have relevant qualifications and/or experience to practice within the program.

### MCH business support / customer service

The MCH Service provider may also include business support or customer service positions that assist with the delivery of an efficient and effective service.

## 4.3 Clinical supervision

Clinical supervision is distinctly different from operational supervision. It is a support mechanism within which service delivery, organisational, developmental and emotional experiences are shared in a secure and confidential environment in order to enhance skills and knowledge.

Clinical supervision contributes to greater clinical skills, experience, confidence and resilience. Effective clinical supervision using reflective practice allows practitioners to apply knowledge and increase skills, which leads to better practice, reduced burnout and lowers staff turnover. There is also a clear and established role for supervision when integrated with other health workforce planning.

Regular clinical supervision and critical incident debriefing is an integral aspect of achieving quality and safety within the MCH service, supporting the clinical practice and wellbeing of the MCH Service workforce. MCH Service providers are responsible for the provision of clinical supervision and to facilitate reflective practice for all MCH nurses and other members of the MCH workforce.

Additionally, **Clinical supervision guidelines for Enhanced Maternal and Child Health program** were developed in 2018 to support MCH nurses delivering the MCH program and the expansion of the EMCH program.

The **MCH practice and service guidelines** and the Nursing and Midwifery Board of Australia **Professional standards** have more information on reflective practice and clinical supervision.

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| **Supporting documents**  [Clinical supervision guidelines for Enhanced Maternal and Child Health program](https://www.education.vic.gov.au/childhood/professionals/health/Pages/mchpolicy.aspx) <https://www2.health.vic.gov.au/maternal-child-health>  [MCH practice and service guidelines page](https://www.education.vic.gov.au/childhood/professionals/health/Pages/mchpolicy.aspx%3e) <https://www2.health.vic.gov.au/maternal-child-health>  [‘Professional standards’ page](https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx) <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx> |

## 4.4 MCH nurse workforce reform

MCH workforce initiatives have been developed in response to sector feedback and to ensure a sustainable MCH nursing workforce is adequate to meet population demand and expansion within the MCH Service. Current initiatives include: MCH nursing scholarship program, student clinical placement grants, graduate program grants, **Transition to practice guidelines** and incentives for hard-to-staff positions.

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| **Supporting document**  [Transition to practice guidelines](https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/nursing-and-midwifery-graduates) <https://www2.health.vic.gov.au/maternal-child-health> |

### MCH nursing scholarships

The MCH Nursing Scholarship is a statewide initiative to support registered nurses and midwives to undertake a postgraduate program of study in child and family health nursing. The financial support provided assists in ensuring the MCH nursing workforce is sustainable and able to meet future service needs.

### Aboriginal midwifery and MCH scholarship program

A strengthened Aboriginal health services workforce contributes to culturally safe care, and improved outcomes for Aboriginal people. Aboriginal nurses, midwives and MCH nurses have a significant role to play in positively influencing the health of Aboriginal clients.

To support the career aspirations of Aboriginal and Torres Strait Islander graduate nurses, midwifery and MCH scholarships are available.

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| **Supporting resource**  For further information on current [MCH scholarships](file:///C:\Users\09760459\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\90EZGAKE\MCH%20scholarships) please [email the Maternal Child Health Service](mailto:mch@dhhs.viv.gov.au) <mch@dhhs.viv.gov.au>. |

**Clinical Placement Grant**

The Clinical Placement Grant provides financial assistance for MCH Service providers to support MCH nurse students to apply their theoretical knowledge in a supportive learning environment and develop competent clinical and professional skills.

Clinical placement allows MCH nurse students to experience working in partnership with parents and achieve the competencies required for MCH practice as outlined in the Victorian Standardised MCH Nursing Clinical Assessment Tool.

### Graduate program grants

The Graduate Program Grant provides financial assistance to MCH Service providers to support graduate MCH nurses in their first year of practice. The graduate year program is informed by the **Transition to practice guidelines**.

### Transition to practice guidelines

These guidelines provide guidance and consistency for MCH Service providers and graduate MCH nurses. They describe best practice, and support quality and safety within the MCH service. They provide a flexible model which supports the effective transition to practice, while recognising the specific and varying capacity of individual MCH Service providers.

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| **Supporting document**  [Transition to practice guideline*s*](https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/nursing-and-midwifery-graduates) <https://www2.health.vic.gov.au/maternal-child-health> |

### Hard-to-staff incentive

These targeted incentives ensure all MCH Service providers can attract and retain MCH nurses and provide a high-quality service that meets the needs of their local communities.

The incentives help to attract MCH nurses to work in remote and rural areas where MCH Service providers find it difficult to recruit staff. They include incentive payments, relocation and recruitment costs, accommodation and motor vehicle hire costs, secondment opportunities, rotation opportunities and development of casual bank staff.

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| **Supporting resources**  For further information on current workforce reform please [email the Maternal Child Health Service](mailto:mch@dhhs.viv.gov.au) <mch@dhhs.viv.gov.au>. |



# 5. Policy context

The MCH Service is a critical component of, and operates within, the broader health, family and early childhood service systems. In recent years, there has been an increased focus and investment in early childhood services to support the health, wellbeing, safety, learning and development of all Victorian children and families. The department is responsible for developing and delivering policies, programs and services that support the health, wellbeing and safety of all Victorians.

A strong Victorian government policy agenda commits to investing in the early years and includes:

* a commitment to access, equity and inclusion
* recognition of the importance of early childhood development and protective factors for children’s safety and ongoing health, wellbeing, safety, learning and development
* a focus on the provision of consistently high-quality services to Victorians to better meet their needs across a range of services.

The department has committed to deliver better access to antental, maternal and child health, and parenting support services by increasing assistance for new Victorian parents.

## 5.1 Early childhood policy directions in Victoria

The **Early childhood reform plan** outlines the Victorian Government’s vision for early childhood to create a higher-quality, more equitable and inclusive early childhood system. The reforms focus on strengthening universal services while supporting systemic change, and are targeted at supporting children and families who are experiencing vulnerability. The department and DET together have a leadership role and work in close partnership with all local government service providers and community partners to deliver the reforms under four key directions:

* providing more support for parenting
* making early childhood services more accessible and inclusive
* supporting higher-quality services and reducing disadvantage in early education
  + building a better service system.

In order to realise the priorities, which are set out in the **Roadmap for reform: strong families, safe children**, the government is developing new pathways to support children experiencing vulnerability and their families. The pathways approach looks at how all parts of the child health and family system connect and work with children and families experiencing vulnerability, as well as how this system is connected to other service platforms, including universal and specialist services.

The proposed pathways to support these children and their families (early help, targeted and specialist care and continuing care) are based on need. This approach shifts away from the primary, secondary and tertiary structure of the current system, which divides services and creates barriers to families accessing the support they need. Advancing Aboriginal self-determination and self-management is embedded in the pathways approach.

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| **Supporting document**  [Roadmap for reform: strong families, safe children](https://dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children) <https://dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children> |

### Providing more support for parenting

Children learn most in their early years from those adults with whom they have the closest relationships, and families are the primary influence on children’s learning and development. It is in the child’s best interest for there to be effective, sustained and collaborative partnerships between families and all professionals. Providing more support for parents is a key priority for the Victorian Government, and the MCH Service is an important component of the government’s approach for this, through the **Early childhood reform plan**.

The important contribution of parents as their child’s first educator is recognised in the **Play, learn and grow resources**. Further support for Aboriginal parents as first educators of their children is also a priority action in **Marrung: Aboriginal education plan 2016–26**.

State government reforms to provide more support for parenting include expansion of the MCH line, progressive expansion of the EMCH program to support children up to the age of three, and an additional MCH visit to women and children at risk of family violence. Supported playgroups have been established across the state, and connections between first-time MCH parent groups and community playgroups have been strengthened.

The ‘More help for mums and dads’ intiative, announced in 2018, includes basic newborn first-aid training for parents, seven new early parenting centres and refurbishment of two existing, sleep and settling support across new parent groups, MCH Line and home-based packages, Baby Bundle for first time parents, and payroll tax exemption for all paid parental leave.

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| **Supporting documents**  [Early childhood reform plan](https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx>  [Play](https://www.education.vic.gov.au/Documents/childhood/professionals/support/), learn and grow resources <https://www.education.vic.gov.au/Documents/childhood/professionals/support/>  [Marrung: Aboriginal education plan 2016–26](https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx) <https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx> |

### Making early childhood services more accessible and inclusive

Universal access is the foundation of the MCH Services and making early childhood services more accessible and inclusive is one of the key directions outlined in the Victorian Government’s **Early childhood reform plan.** The government’s vision is that every child in Victoria can access and benefit from early childhood services. Improving Aboriginal children and families’ access to and participation in MCH services, and the cultural inclusivity of MCH service providers are identified as priority actions in **Marrung: Aboriginal Education Plan 2016-2026**.

The **Victorian early years learning and development framework** (VEYLDF) practice principles of equity, diversity and high expectations for every child, guide all early childhood professionals to ensure that all children have equitable access to resources and opportunities to support their health and wellbeing, learning and development. At the national level, there is also a focus on universal and inclusive provision of early childhood services. The delivery of universally available, free, and accessible services in a flexible and responsive way is a key principle of the Council of Australian Governments’ **National framework for universal child and family health services**.

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| **Supporting documents**  [Early childhood reform plan](https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx>  [Marrung: Aboriginal education plan 2016–26](https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx) <https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx>  [Victorian early years learning and development framework](https://www.education.vic.gov.au/childhood/professionals/learning/Pages/veyldf.aspx) <https://www.education.vic.gov.au/childhood/professionals/learning/Pages/veyldf.aspx>  [National framework for universal child and family health services](https://www.health.gov.au/internet/main/publishing.nsf/Content/nat-fram-ucfhs) <https://www.health.gov.au/internet/main/publishing.nsf/Content/nat-fram-ucfhs> |

### Supporting higher-quality services and reducing disadvantage in early education

The Victorian Government is committed to supporting children’s participation in kindergarten. Through the **Early childhood reform plan**, kindergartens will receive additional ‘school readiness’ funding so children who need more support will get it. Additional funds have also been allocated to provide new early childhood facilities and to support kindergarten services to improve their quality.

The department is committed to increasing participation in kindergarten, particularly for those children known to child protection. MCH services are in a unique position to work in partnership with families to promote access to universal and targeted kindergarten programs for children.

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| **Supporting documents**  Early childhood reform plan <https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx> |

### Building a better service system

The Victorian Government recognises the importance of prevention and early intervention to equip children with the foundations for a healthy life. An early intervention approach can apply to a range of areas for children and families experiencing vulnerability, from emerging health issues to children with special needs or families at risk of or experiencing family violence. MCH, health and family services work in partnership to provide the right assistance early, reducing the risks of harm and expensive intervention. This is one of the guiding principles in the Victorian Government’s **Roadmap for reform** that supports children’s optimal health, wellbeing, safety, development and learning.

Integrated family services play an important role in early intervention, through supporting parenting skills and capacity in families with additional needs. The introduction of The Orange Door in Victoria (a key recommendation in **Report of the Royal Commission into Family Violence)**, strengthens integrated delivery of services for women and children in need across the state. Through its contact with all young children and families in Victoria, the MCH service is well placed to identify issues early and to assist children and families in accessing the appropriate supports, including referral pathways into [**The**](https://orangedoor.vic.gov.au/) **Orange Door**.

The **Victorian early years learning and development framework** (VEYLDF) sets out outcomes and practices to guide all early childhood professionals, including MCH nurses, in their work with families and young children. It provides a shared language across the system to support collaborative practice of early childhood professionals. The VEYLDF recognises that from birth, children’s health, wellbeing, safety, learning and development are interdependent.

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| **Supporting documents and resources**  [Using the Play, Learn, Grow Resources in the Maternal and Child Health Service](https://www.education.vic.gov.au/Documents/childhood/professionals/support/) <https://www.education.vic.gov.au/Documents/childhood/professionals/support/>  [Marrung: Aboriginal education plan 2016–26](https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx) <https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx>.  [National framework for universal child and family health services](https://www.health.gov.au/internet/main/publishing.nsf/Content/nat-fram-ucfhs) <https://www.health.gov.au/internet/main/publishing.nsf/Content/nat-fram-ucfhs>.  [Report of the Royal Commission into Family Violenc*e*](http://www.rcfv.com.au/) <<http://www.rcfv.com.au/>>  [The](https://orangedoor.vic.gov.au/) [Orange Door](https://orangedoor.vic.gov.au/) <https://orangedoor.vic.gov.au/>  [Victorian early years learning and development framework](https://www.education.vic.gov.au/childhood/professionals/learning/Pages/veyldf.aspx#link36) (VEYLDF) <https://www.education.vic.gov.au/childhood/professionals/learning/Pages/veyldf.aspx#link36> |

## 5.2 Partnerships and collaboration

Effective partnerships with families and between health, family and early years service providers are essential to ensure continuity of care for families. The MCH Service providers work in partnership with health, education, welfare and disability sectors to provide coordinated, multidisciplinary care and integrated service delivery. The MCH service is responsible for working collaboratively with others involved in the current or future care of the child and family. Communicating effectively and sharing relevant information to support a continuum of care between services improves outcomes for children and their families.

Information sharing is a two-way flow of information between MCH services and health, family and early years services. MCH Service providers are required to maintain up-to-date knowledge of relevant information sharing polices and legislation, including the information sharing legislation developed as part of the Victorian Government’s response to the report of the Royal Commission into Family Violence.

The Child Information Sharing Scheme established under the **Child Wellbeing and Safety Act 2005** is discussed in more detail in section 6.1. The MCH service will be supported with training, guidance and resources, by the department and MCH Service providers to assist MCH nurses with early intervention and referral to specialist family violence support services.

Successful partnerships with families achieve shared objectives, and enable timely and appropriate support. Achieving better outcomes for children and families also relies on coordinated, integrated health, family and early years service systems that provide continuity of care, and are capable of responding to the emerging and changing needs of children and their families in a local community setting.

This section disusses the role of the MCH Service providers in partnering with families, responding to concerns about children, ensuring continuity of care, and engaging in local service partnerships and priorities. Partnerships between health, family and eary years services help to ensure these systems work cohesively and collaboratively to support children and families.

The strength of the linkages and interactions is an important focus for MCH services in taking a systems-thinking approach that actively identifies partnerships and collaboration, and areas where this can be further developed, in response to the needs of the local community.

### Partnering with families

Effective MCH Service providers actively work with families to plan for, provide and improve services. Partnering with families as consumers means that families can inform the care they receive, and that services consider the preferences, needs and circumstances of families.

MCH Service providers must consider the needs of the child and family through a strengths-based approach. Treating families with dignity and respect includes sharing information with them, and encouraging them to participate and collaborate in services.

MCH Service providers partner with families in a number of ways:

* leaders value and promote the importance of families as partners in service provision
* staff are supported and equipped with tools and resources to engage and respond to the needs of families
* roles, processes and systems reinforce family-centred practice
* services seek the view of families in service provision and are open to continuous improvement
  + services obtain and record informed consent from families, including ensuring that families understand how their information will be collected, stored, used or disclosed in accordance with law.

Families have different capacities to be involved in planning and guiding services, and are typically more active partners when they believe their involvement is constructive and valued, and when they have the time and skills to get involved. When working with families, services should consider how parents’ diminished sense of influence may affect their consequent involvement with the service. In response, services should use a variety of flexible and family-sensitive models for engaging families, and supporting them to build their confidence and capacity.

Overall, there are many benefits to effective and equitable partnering with families, including improvements in health, wellbeing, learning, development and safety, quality and cost effectiveness, as well as improvements in family and staff satisfaction.

### Continuity of care with maternity and neonatal services

Continuity of care means that children and families experience a coherent and connected journey through the maternity and neonatal services and the MCH Service system, with the aim of reducing fragmentation and conflicting advice, and promoting timely access to services that are tailored to individual needs and expectations. This is also important when children and families are supported through the EMCH program as well as the UMCH program, or when families move between local government areas.

The **Continuity of care: a communication protocol for Victorian public maternity services and the Maternal Child Health Service** (2004) promotes seamless service provision to women and infants during the transition from hospital to home. The protocol is used widely and extensively by the MCH services and public hospitals. Maternity and neonatal services and MCH services are part of a continuum providing antenatal, intrapartum and postnatal care for women and infants.

The protocol is set out in stages and details communication requirements for all mothers and babies and for vulnerable families at the following points:

* antenatal
* postnatal
* neonatal/special care unit
* domiciliary service
  + discharge from maternity services.

Continuity of care is also facilitated by a shared understanding of care pathways among MCH services, staff and the services and other professionals they work with. These practices and processes are strongly linked to collaboration and partnership between MCH Service providers and other services. It is important that MCH Service providers establish and maintain effective communication and care planning and coordination processes to facilitate coherent and connected MCH services.

For some families, such as those presenting with significant child or family risk factors, continuity of care is paramount in supporting safety and wellbeing. In these circumstances, fragmentation across different services is a particular concern and may result in failure to resolve issues before they escalate. A greater focus on continuity of care and collaboration between professionals help to engender the best possible care. Regardless of circumstances, it is in the child’s best interests for effective, sustained and collaborative partnerships between families and all professionals.

Continuity of care and service integration contribute to improved outcomes for children and families, lead to greater levels of satisfaction with the services and support received, and enhance feelings of self-control, safety and support.

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| **Supporting document**  [Continuity of care: a communication protocol for Victorian public maternity services and the Maternal Child Health Service (2004)](https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive)  <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive> |

### Local service partnerships

The MCH Service is part of the broader service system that builds on the identification of child, family and community needs at a local level, across the health, education, justice, social services and non-government sectors. The VEYLDF practice principle ‘Partnerships with professionals’ promotes the development of multidisciplinary early years networks to drive a culture of collaboration and inquiry and to support continuity of practice between services.

In addition to MCH services, these local early years networks may include:

* maternity and neonatal services
* general practitioners
* kindergarten and early childhood education and child care service
* early parenting centres
* indigenous organisations
* early childhood intervention service / National Disabilty Insurance Scheme
* parenting and family service
* school nursing services
* child protection services
* Child FIRST
* The Orange Door
* family violence services
  + specialist adult services such as those addressing disability, drug and alcohol abuse, and mental illness.

Linkages with other initiatives and networks, including Best Start and Primary Care Partnerships may further enhance the capacity of MCH services to support families. MCH Service providers also work closely with local communities, including Aboriginal and culturally and linguistically diverse communities.

By working closely with other health, family and eary years services within early years networks, families who are not already engaged with an MCH Service provider can be identified and referred to their local service. This is particularly beneficial for families experiencing vulnerability who may not otherwise receive support from the MCH Service.

MCH Service providers have the flexibility to design innovative service models that support service integration and collaboration while maintaining the universal nature of the service. Strategies that promote service integration include co-locating services, establishing interdisciplinary teams, sharing protocols and using common assessment frameworks and referral tools, as well as joint service delivery.

## 5.3 Supporting children and families in the early years compact

The **Supporting children and families in the early years compact** focuses on improving outcomes for children and their families from the antenatal period up to school age.

The compact, between DET, the department and the MAV, on behalf of local government, was agreed in 2017 as an action through the Victorian Government’s **Early childhood reform plan 2017.** The MCH Service supports progress towards and achievement of these outcomes by providing the UMCH, EMCH and MCH Line services for Victorian children and families.

The purpose of the compact is to:

* clarify state and local government **roles and responsibilities** in the planning, funding and delivery of early years services for children from the antenatal period up to school age
* strengthen a shared focus on **improving outcomes** for all children across Victoria supported by sharing of evidence, results and best practice
* establish a **strategic foundation** for the effective planning and delivery of agreed system reforms, including the creation of a more connected service system that has sufficient flexibility to support local innovation and responses
* support timely identification of **vulnerable children**, effective inclusion and sustained engagement of families in universal services and supported referral to other services
* build community understanding of the **importance of the early years** and how families can support their children’s learning, health and development
  + provide **consistency** in the availability, accessibility, quality and connectedness of services for young children and their families, across locations in Victoria.

Through this compact, the parties seek the following outcomes for Victoria’s children and their families, which are measurable and link to the government’s broader reform agenda for young children and their families:

* All young children are engaged, confident and creative learners.
* All children are safe, cared for and experience optimal health and development.
* Families feel well supported by high-quality, inclusive services for children and families in the early years.
* Vulnerability, location and disadvantage do not determine outcomes for young children.
  + Families are connected to culture, actively participate in community life and can access help when and where they need it.

The compact is implemented through place-based local governance arrangements across the 17 department areas.

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| **Supporting documents**  [Supporting children and families in the early years compact](https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx>  [Early childhood reform plan](https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx> |

## 5.4 Early childhood agreement for children in out-of-home care

The [**Early childhood agreement for children in out-of-home care**](https://www.education.vic.gov.au/childhood/professionals/health/outofhomecare/Pages/earlychildhoodagreement.aspx)(the agreement) reflects a key purpose of the **Supporting children in the early years compact**. Children in out-of-home care (OoHC) come from a range of backgrounds and cultures and will have varying experiences of harm and trauma in their lives. OoHC placements vary in duration from overnight to several years, depending on the individual circumstances of the child. The constant movement of children in and out of care presents significant challenges for the services and practitioners that support them.

The parties to the agreement include the Victorian Aboriginal Child Care Agency, the Victorian Aboriginal Children and Young People’s Alliance, the Centre for Excellence in Child and Family Welfare, Community Child Care Association, Victorian Aboriginal Educational Association Incorporated, Vic Tas Primary Health Network Alliance and the Victorian Healthcare Association.

Through this agreement, the department, DET and local governments will work with key sector peaks and stakeholders to prioritise and support the learning, development, health and wellbeing of young children in OoHC through access to high-quality health care and early childhood education and care experiences.

Child protection ensures notifications are provided to the designated local government contact in the placement LGA on a fortnightly basis for all young children entering care or changing a placement in that area. This applies for all children from birth to school age placed in any local government area, and is the responsibility of the child protection office where the case is allocated.

The roles of MCH Service providers in the agreement include:

* identification and enrolment
* ongoing engagement, assessments, and referrals
  + support for transitions.

The agreement states that all young children in OoHC are engaged with the MCH Service and are referred to an EMCH program if not already engaged with a UMCH program or when additional support is required.

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| **Supporting documents**  [Early childhood agreement for children in out-of-home care](https://www.education.vic.gov.au/childhood/professionals/health/outofhomecare/Pages/earlychildhoodagreement.aspx) <https://www.education.vic.gov.au/childhood/professionals/health/outofhomecare/Pages/earlychildhoodagreement.aspx>  [Supporting children in the early years compact](https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx>. |

## 5.5 The Orange Door

Support and safety hubs, known as **The Orange Door**, help families and children affected by or experiencing family violence and those families who need support with the wellbeing and development of their children. This was a key recommendation of the Royal Commission into Family Violence and the **Roadmap for reform**as part of a long-term plan to end family violence in Victoria and help better support and protect children experiencing vulnerability.

The Orange Door represents a major change in the way specialist family violence and family and children services are coordinated and connected to local services, including MCH, to respond to family violence and children experiencing vulnerability. Child FIRST(Child and family information, referral and support teams) will transition into The Orange Door as it is implemented.

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| **Supporting resource**  [The](https://orangedoor.vic.gov.au/) [Orange Door](https://orangedoor.vic.gov.au/) <https://orangedoor.vic.gov.au/> |

### Child FIRST / Child Wellbeing (The Orange Door)

Child FIRST is the entry point into family services. Child FIRST teams are located across Victoria and their services are delivered in local areas by community service organisations.

If significant concerns for the wellbeing of a child are present, but no concerns that they are at risk of significant harm, a referral to Child FIRST or The Orange Door is indicated.

Referring to Child FIRST or The Orange Door is indicated where families:

are experiencing difficulties that affect their parenting and family life

are experiencing significant parenting problems that may be affecting the child's development

are experiencing family conflict, including family breakdown

are under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement

are young, isolated or unsupported

are experiencing significant social or economic disadvantage that may adversely impact on a child's care or development.

Through its contact with all young children and families in Victoria, the MCH Service is well placed to identify issues early and to assist children and families in accessing the appropriate supports.

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| **Supporting resource**  Contact numbers to make a referral in each local government area are listed on the [Child and family services information, referral and support teams](https://services.dhhs.vic.gov.au/referral-and-support-teams) website <https://services.dhhs.vic.gov.au/referral-and-support-teams>. |

## 5.6 National framework for universal child and family health services

Victorian policy builds on the national direction where there is a focus on universal and inclusive provision of early childhood services. The delivery of universally available, free and accessible services in a flexible and responsive way is a key principle of the Council of Australian Governments’ **National framework for universal child and family health services** (2011 and [updated 2013](http://www.health.gov.au/internet/main/publishing.nsf/content/nat-fram-ucfhs)). The framework focuses on universal health services available to all children and their families from birth to eight years, but emphasises the provision of additional, targeted or specialist and intensive services for families with additional needs or for those children where a health or development need has been identified.

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| **Supporting document**  [National framework for universal child and family health services](https://www.health.gov.au/internet/main/publishing.nsf/content/nat-fram-ucfhs) (2011 and [updated 2013](http://www.health.gov.au/internet/main/publishing.nsf/content/nat-fram-ucfhs)) <https://www.health.gov.au/internet/main/publishing.nsf/content/nat-fram-ucfhs> |



# 6. Legislative context

This chapter outlines relevant legislation and regulations that apply to the MCH Service and MCH Service providers.

## 6.1 Child Wellbeing and Safety Act 2005

The **Child Wellbeing and Safety Act 2005** guides the operation of the Child Safety Commissioner, the Victorian Children’s Council and the Children’s Services Coordination Board. This Act states the requirements regarding birth notices, the sharing of certain confidential information to promote child safety and sets out principles that should be used for guidance in the development and provision of government-funded and community services for children and their families. The Child Wellbeing and Safety Act contains the **Child Safe Standards** which apply to MCH Service providers. The **Child Wellbeing and Safety Act** also established the Child Information Sharing Scheme which applies to MCH Service providers from 27 September 2018.

Section 5 of the **Child Wellbeing and Safety Act** sets out the principles upon which the development and provision of services for children and families should be based. In particular, s. 5(3) states that the providers of services to children and families should:

* + 1. ‘protect the rights of children and families and, to the greatest extent possible, encourage their participation in any decision making that affects their lives;
    2. acknowledge and be respectful of the child's individual identity, circumstances and cultural identity and be responsive to the particular needs of the child;
    3. make decisions about intervention by the providers of services into a child's or family's life and about access by a child or family to those services in a timely manner being mindful of any harmful effects that may be caused to the child by a delay in making decisions or providing services;
    4. ensure that families are made aware of the services available to them and of the benefits these services can provide, especially to those families in most need of assistance;
    5. co-operate with other services or professionals to work in the interests of the child and family.’

### Birth notices

The **Child Wellbeing and Safety Act 2005** also sets out requirements regarding the birth notification process. The Act stipulates that the birth notification is to be forwarded by the hospital or, if the birth did not occur in a hospital, the doctor or midwife that cared for the mother at the birth, to the Chief Executive Officer of the council of the district where the mother resides, within 48 hours of the child being born. It is then the responsibility of the Chief Executive Officer to forward the birth notice to the relevant MCH nurse at the MCH centre within that local government, who contacts the mother and invites her and her family to access the MCH Service.

### Child Safe Standards

The **Victorian Government’s Child Safe Standards** are established under the **Child Wellbeing and Safety Act 2005** to improve the way organisations that provide services to children protect them from abuse and neglect and respond to child abuse, or allegations of abuse, that may occur within their organisations. Compliance with the **Child Safe Standards** is compulsory under the **Child Wellbeing and Safety Act 2005** for all organisations providing services to children, including all entities that operate a MCH centre, and aim to drive cultural change in organisations so that protecting children from abuse is embedded in the everyday thinking. The **Child Safe Standards** provide direction to the processes MCH Service providers and other services must implement in order to create and maintain a child safe organisation.

The Commission for Children and Young People (Commission) established by the **Commission for Children and Young People Act 201*2***is responsible for the oversight and enforcement of the **Child Safe Standards**, and collaborates with the department to ensure organisations are compliant. The Commission may inspect MCH centres to ensure MCH Service providers comply with the **Child Safe Standards**.

In addition, the department's **Healthcare that counts framework** provides principles and processes for health services, including MCH Service providers, to improve care for children experiencing vulnerability in Victorian health services that align with the **Child Safe Standards**.The **Healthcare that counts framework** articulates the role of health providers, including MCH Service providers, to support best practice. It provides guidance to help MCH Service providers embed organisational governance, pathways and policies that are indicators of best practice directed to children experiencing vulnerability and their families or carers.

### Child Information Sharing Scheme

The Child Information Sharing Scheme is established by Part 6A of the **Child Wellbeing and Safety Act 2005** to encourage services to collaborate and work together to promote the wellbeing and safety of children. The Child Information Sharing Scheme permits organisations and services that are prescribed information-sharing entities (ISEs) to request and share confidential information that does not constitute ‘excluded information’ about any person to promote children’s wellbeing or safety and to give precedence to the wellbeing and safety of a child over the right to privacy. MCH Service providers are prescribed as information-sharing entities under the **Child Wellbeing and Safety (Information Sharing) Regulations 2018**from 27 September 2018.

The Child Information Sharing Scheme encourages practitioners to use existing information-sharing legislative provisions where available, such as disclosing confidential information as part of a mandatory report to child protection under the **Children, Youth and Families Act 2005**, and provides additional permission to disclose confidential information to other prescribed information-sharing entities or the person with parental responsibility of the child for the purpose of promoting the wellbeing and safety of a child or group of children. Information may be shared under the Child Information Sharing Scheme to enable the entity receiving the information to make decisions, assessments or plans relating to a child, initiating or conducting an investigation, providing services relating to a child or managing any risk to a child or a group of children.

MCH Service providers should share information and collaborate as permitted by the Child Information Sharing Scheme and other existing legal obligations and permissions. For further information and guidance on complying with the Child Information Sharing Scheme, consult the **Child information sharing ministerial guidelines**.

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| **Supporting documents**  [Child Wellbeing and Safety Act 2005](http://classic.austlii.edu.au/au/legis/vic/consol_act/cwasa2005218/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/cwasa2005218/>  [Victorian Government’s Child safe standards](https://www.education.vic.gov.au/school/principals/spag/safety/Pages/childsafestandards.aspx) <https://providers.dhhs.vic.gov.au/child-safe-standards>  Commission for Children and Young People Act 2012 <https://ccyp.vic.gov.au/about-the-commission/legislation/  Healthcare that counts [framework](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/healthcare-that-counts-framework) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/healthcare-that-counts-framework>  [Child information sharing ministerial guidelines](https://www.vic.gov.au/maram-practice-guidance-and-tools#child-information-sharing-scheme-resources) <https://www.vic.gov.au/maram-practice-guidance-and-tools#child-information-sharing-scheme-resources> |

## 6.2 Family Violence Protection Act 2008

### Family Violence Information Sharing Scheme

The Family Violence Information Sharing Scheme is establised by Part 5A of the **Family Violence Protection Act 2008** to enable services to work together to assess and manage family violence risk. The Family Violence Information Sharing Scheme permits prescribed information sharing entities (ISEs) and risk assessment entities (RAEs) to share information to assess and manage family violence risk. MCH Service providers are prescribed as an information sharing entities under the Family Violence Protection (Information Sharing and Risk Management) Regulations 2018 from 27 September 2018.

Information may be shared under the Family Violence Information Sharing Scheme when consent and other requirements are met. The **Guidelines on the Family Violence Information Sharing Scheme** set out all of the requirements for sharing under the Family Violence Information Sharing Scheme.

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| In any MCH context where family violence is present, both information-sharing schemes should be applied to ensure that child wellbeing issues, which may or may not arise from the family violence, are addressed.  MCH Service providers are required to share information with prescribed organisations, proactively and in response to requests that meet the threshold for sharing. This facilitates a collaborative approach to early intervention and promotes the safety and wellbeing of families and children. Both information-sharing schemes enable information sharing without consent where a child is involved. A child’s right to safety and wellbeing is paramount. The schemes give precedence to the child’s right to safety and wellbeing over any individual’s right to privacy. |

### Family violence Multiagency Risk Assessment and Management Framework (MARAM)

The **Royal Commission into Family Violence** and the **Education State Early Childhood Reform Plan** highlighted MCH services as a key platform for identifying and responding to family violence. The transition to parenthood is a time of heightened family violence risk, and MCH Service providers are in a unique position to identify and respond to family violence risk, as it has contact with almost every Victorian family in this high-risk period.

The **Family violence multiagency risk assessment and management framework** (MARAM) is establised by Part 11 of the **Family Violence Protection Act 2008***.* The MARAM will be implemented in 2020 following professional development of the workforce.

MCH nurses currently use the **Common risk assessment framework** (CRAF) to assess family violence risk. The new **Family violence multiagency risk assessment and management framework** (MARAM) builds on the CRAF and is supported by a suite of risk identification, screening and assessment tools. Under the MARAM, children are recognised as victim survivors in their own right and the MARAM practice guidance includes considerations about children.

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| **Supporting documents**  [Family Violence Protection Act 2008](http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/consol_act/fvpa2008283/) <http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/consol\_act/fvpa2008283/>  [Guidelines on the Family Violence Information Sharing Scheme](https://www.vic.gov.au/family-violence-information-sharing-scheme) <https://www.vic.gov.au/family-violence-information-sharing-scheme>  [Royal Commission into Family Violence](https://www.rcfv.vic.gov.au/) <https://www.rcfv.vic.gov.au>  [Education State early childhood reform plan](https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/earlychildhood.aspx>  [Common risk assessment framework](https://www.thelookout.org.au/family-violence-workers/risk-assessment-management/common-risk-assessment-framework-craf) <https://www.thelookout.org.au/family-violence-workers/risk-assessment-management/common-risk-assessment-framework-craf>  [Family violence multiagency risk assessment and management framework](https://providers.dhhs.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework) <https://providers.dhhs.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework>  [Family Safety Victoria and MARAM practice guidance and tools](https://w.www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management/maram.html) <https://w.www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management/maram.html>  [MCH information sharing tool kit](https://www.mav.asn.au/__data/assets/pdf_file/0017/21626/MCH-Information-Sharing-Toolkit-Oct-2018.pdf) <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years> |

## 6.3 Children, Youth and Families Act 2005

The **Children Youth and Families Act 2005** provides the legislative basis for an integrated system of services for children experiencing vulnerability, young people and their families. The legislative context promotes the safety, stability and healthy development of children. It also places a strong emphasis on the need to consider the impacts of cumulative harm and to preserve cultural identity.

In accordance with the Act, the best interest of the child is paramount. These principles have resonance for the broader health and community services infrastructure, including MCH services The decision-making principles of the Act highlight the importance of involving children and families in decision-making processes, and of providing them with assistance and support to do so in a meaningful way.

Additional principles provide a framework for decision making in relation to Aboriginal children and families. These provide a stronger basis for ensuring that Aboriginal children remain within or connected to their community and culture.

### Mandatory reporting

Mandatory reporting refers to the legal requirement of certain professional groups to report a reasonable belief of child physical or sexual abuse to child protection authorities.

In Victoria nurses are mandated reporters under the **Children, Youth and Families Act 2005**and must make a report to the child protection service of the department, if:

* in the course of practising their profession or carrying out duties of their office, position or employment
* they form a reasonable belief, that a child has been or is at risk of significant harm, as a result of physical or sexual abuse, and
  + the child’s parents have not protected or are unlikely to protect the child from that abuse.

The report must be made as soon as practicable after forming the belief and after each occasion on which they become aware of any further reasonable grounds for the belief.

#### Reasonable belief

A belief is considered to be reasonable if a reasonable person, doing the same work, would have formed the same belief on those grounds, based on the same information.

Grounds for forming a belief are matters of which the person has become aware and any opinions in relation to those matters.

#### Contact child protection

To make a report, you should contact the child protection intake service covering the local government area where the child normally resides.

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| **Supporting resource**  To access details on the local government areas covered by each intake service, visit [Child protection contacts](https://services.dhhs.vic.gov.au/child-protection-contacts) <https://services.dhhs.vic.gov.au/child-protection-contacts> |

#### Immediate concerns

To report concerns that are life threatening, you should contact Victoria Police using Triple Zero.

To report concerns about the immediate safety of a child outside of normal business hours, you should contact the After-Hours Child Protection Emergency Service on 13 12 78.

#### Identity of reporter

The identity of a reporter must remain confidential, unless:

* the reporter chooses to inform the child or family of the report
* the reporter consents in writing to their identity as the reporter being disclosed
* a court or tribunal decides it needs this information in order to ensure the safety and wellbeing of the child
  + a court or tribunal decides that in the interests of justice the evidence needs to be given.

It is often considered best practice to inform the family that you have made a report, where appropriate. Being transparent about your concerns and making a report to child protection, in circumstances where it is safe and appropriate to do so, can be beneficial for the young person, the family and your ongoing role with them.

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| **Supporting documents**  [Step-by-step guide to making a report to child protection or Child FIRST](https://providers.dhhs.vic.gov.au/step-step-guide-making-report-child-protection-or-child-first-pdf) <https://providers.dhhs.vic.gov.au/step-step-guide-making-report-child-protection-or-child-first-pdf>  [Child protection manual’s ‘Manatory reporting advice’](http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/mandatory-reporting) <<http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/intake/mandatory-reporting>> |

### Child in need of protection

In addition to the mandatory reporting obligations imposed on mandatory reporters under the **Children, Youth and Families Act 2005***,* any person who believes on reasonable grounds that a child is in need of protection may report that belief and the reasonable grounds for it to a police officer or the department. Therefore any member of the MCH workforce, whether or not a nurse, can make such a report without breaching any obligation of confidentiality imposed on them.

### Children’s best interests

The **Children Youth and Families Act 2005** places children’s best interests at the heart of all decision making and service delivery relating to children, young people and families with additional needs. In relation to the MCH Service, the Act sets out principles that give prominence to children’s best interests.

The **Best interests case practice model** is designed to inform and support professional practice in family and early parenting services, child protection and placement and support services. It provides a foundation for working with children, including the unborn child, young people and families. The **Best interests case practice model summary guide** provides an easy to use summary of the core aspects of the best interest’s case practice model. MCH nurses are identified at the information-gathering phase regarding safety and development of a child, and at the action phase as a fundamental universal service that can provide assessments and referral for children and families.

The summary guide is supported by specialist practice resources which provide a more comprehensive approach to understanding the model.

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| **Supporting documents**  [Children Youth and Families Act 2005](http://classic.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/cyafa2005252/>  [Best interests case practice model summary guide](https://www.dhhs.vic.gov.au/publications/best-interests-case-practice-model-summary-guide) <https://www.dhhs.vic.gov.au/publications/best-interests-case-practice-model-summary-guide>  [Best interests case practice mode*l*](http://www.cpmanual.vic.gov.au/our-approach/best-interests-case-practice-model) <http://www.cpmanual.vic.gov.au/our-approach/best-interests-case-practice-model> |

## 6.4 Health Records Act 2001

The **Health Records Act 2001** is a framework to protect the privacy of individuals’ health information, which includes any personal information that is collected in providing a health service. It regulates the collection and handling of health information in Victoria. The Act’s purpose is to promote fair and responsible handling of health information by protecting the privacy of a person’s health information that is held in the public and private sectors, providing individuals with a right of access to their health information and providing an accessible framework for the resolution of complaints regarding the handling of information. Complaints about interferences with privacy are handled by the Health Services Commissioner.

MCH Service providers are subject to the **Health Records Act 2001** and it is the responsibility of each individual organisation to ensure it has clearly expressed policies in line with the Health Records Act. Disclosure of information in accordance with the Child or Family Violence Information Sharing Schemes will not constitute a breach of the **Health Records Act 2001***.* A member of the MCH workforce who has to resolve an information privacy problem should do so with the assistance of their line manager(s) and in accordance with their organisation’s information privacy policy.

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| **Supporting document**  [Health Records Act 2001](http://classic.austlii.edu.au/au/legis/vic/consol_act/hra2001144/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/hra2001144/> |

## 6.5 Privacy and Data Protection Act 2014

The **Privacy and Data Protection Act 2014** pertains to personal information held by the department, councils and other MCH Service providers. Personal information is inclusive of objective or subjective information in relation to an individual whose identity is evident, or can reasonably be ascertained, from the information, contained within the record but does not include health information that is covered by the **Health Records Act 2001**.

If a client is not satisfied with or concerned by the MCH Service provider’s handling of their personal information, they may make a complaint to the relevant Council’s Privacy Officer or make a complaint to the Privacy Commissioner.

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| **Supporting documents**  [Privacy and Data Protection Act 2014](http://classic.austlii.edu.au/au/legis/vic/consol_act/padpa2014271/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/padpa2014271/>  [Health Records Act 2001](http://classic.austlii.edu.au/au/legis/vic/consol_act/hra2001144/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/hra2001144/> |

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| **Note**  The**Privacy and Data Protection Act 2014** does not apply if the personal information held by the MCH Service provider is governed by the **Health Records Act 2001**. |

## 6.6 Freedom of Information Act 1982

The major premises of the **Freedom of Information Act 1982** are that individuals have a right to know what information is held by government departments and agencies about themselves as well as information about the operation of agencies. This Act promotes the prompt and low-cost disclosure of this information subject to exemptions. Exempt documents include those affecting others’ personal privacy (s. 33) and those containing material obtained in confidence (s. 35).

Councils are subject to the **Freedom of Information Act**and MCH Service providers must respond to requests to provide information held by them in accordance with their policies and procedures developed in accordance with the **Freedom of Information Act**.

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| **Supporting document**  [Freedom of Information Act 1982](http://classic.austlii.edu.au/au/legis/vic/consol_act/foia1982222/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/foia1982222/> |

## 6.7 Public Records Act 1973

The **Public Records Act 1973** established the Public Record Office of Victoria, the state archival authority. The **Public Records Act 1973** provides for the preservation, management and utilisation of the public records created or received by public officers, which includes government departments and councils. The Act provides that public records containing ‘personal or private’ material can be closed to public inspection for a certain period. Many records relating to children and young people in ‘care’ in Victoria are closed under the **Public Records Act** for a period of 99 years from the date of the record's creation.

The legal requirements for disposal of MCH records is primarily located within this Act, however other considerations do apply. In particular it should be noted that it is an offence under the **Crimes (Document Destruction) Act 2006** for individuals or organisations to destroy documents they know are reasonably likely to be required in a future legal proceeding if the intention is to prevent them from being used in evidence. The creation of this offence also serves to assist the preservation of public records that may provide evidence or ‘reasonable grounds’ for disclosure of improper conduct by a public officer or public body (see the **Protected Disclosure Act 2012**).

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| **Supporting documents**  [Public Records Act 1973](http://classic.austlii.edu.au/au/legis/vic/consol_act/pra1973153/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/pra1973153/>  [Crimes (Document Destruction) Act](http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/num_act/cda20066o2006352/) 2006 <http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/num\_act/cda20066o2006352/>  [Protected Disclosure Act 2012](http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/num_act/pda201285o2012279/) <http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/num\_act/pda201285o2012279/> |

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| **Note**  The **Family Violence Protection Amendment (Information Sharing) Act 2017** (the Amending Act) establishes an information sharing scheme by amending the Family **Violence Protection Act 2008** and other laws, including the **Privacy and Data Protection Act 2014** (PDP Act) and the **Health Records Act 2001** (HR Act). The Privacy and Data Protection and Health Records Acts do not prevent mandated professionals from reporting suspected cases of child abuse to child protection or MCH services prescribed under the Information Sharing Schemes. One of the key changes to the PDP Act and the HR Act is the removal of the word ‘imminent’ from several provisions in the Information Privacy Principles (IPPs) and the Health Privacy Principles (HPPs).These provisions previously referred to a ‘serious and imminent threat’, which was the threshold that, if established, permitted the collection, use and disclosure of an individual’s personal and health information in order to lessen or prevent the threat. The Office of the Victorian Information Commission and Health Complaints Commissioner provides guidance in respect to these changes. |



# 7. Aboriginal children and families

Self-determination is vital for improving Victorian Aboriginal communities’ health, wellbeing and safety. The Victorian Government is committed to **self-determination** as the guiding principle in Aboriginal Affairs and is working closely with the Aboriginal community to understand what self-determination means for Aboriginal Victorians.

According to the National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal self-determination is:

the ability of Aboriginal people to determine their own political, economic, social and cultural development as an essential approach to overcoming Indigenous disadvantage.[[1]](#footnote-2)

Australian and international evidence demonstrates that self determination is the only policy approach that has produced effective and sustainable outcomes for Indigenous peoples as outlined in **Korin Korin Balit-Djak (2017).**

The department’s Aboriginal health, wellbeing and safety strategic plan, **Korin Korin Balit-Djak**commits the department to supporting Aboriginal communities to develop and deliver policies and services. This is because Aborignial communities are best placed to deliver strategies that build a culturally safe system to better support vulnerable children and families.

Connectedness to culture builds stronger individual and collective identities, and promotes self-esteem, resilience and improved health, wellbeing and safety outcomes for Aboriginal children and families.

A culturally safe and responsive service system is one in which non-Aboriginal people take responsibility to understand the importance of culture for Aboriginal people – and by taking responsibility to ensure there is no assault, challenge or denial of their identity and experience.

The department has an Aborignial and Torres Strait Islander cultural safety framework that aims to assist the department and mainstream health and community services to strengthen cultural safety in the workplace and in the services they deliver.

Aboriginal culture is extremely diverse hence it is important that Aboriginal people be given choices in MCH services. State and national frameworks and strategic plans that guide and promote Aboriginal self-determination, cultural safety and the best outcomes for Aboriginal children and their families are provided.

While there has been an improvement in recent years, there is an ongoing gap between the participation rates of Aboriginal children and all children across the 10 KAS consultations. The Aboriginal Maternal and Child Health Initiative (AMCHI) was established to improve access to and participation in the UMCH program, and provide culturally responsive and high-quality services to all Victorian Aboriginal families.

Through this initiative, the Victorian Government worked with Victorian Aborigional communities to co-design a MCH service delivery model that provides more culturally responsive and high-quality services, through both Aboriginal community-controlled organisations (ACCOs) and current MCH Service providers. The service model focuses on: ensuring MCH centres are culturally safe; providing Aboriginal families with flexibility in how they access MCH Services; choice to engage with Aboriginal staff in the delivery of the MCH Service; a seamless and integrated approach; and strengthening relationships and partnerships between mainstream MCH Service providers and ACCOs.

The department’s Aboriginal and Torres Strait Islander cultural safety framework (2019) and Cultural safety continuum reflective tool (2019) provide support and guideance for MCH Service porviders.

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| **Supporting resources**  [Self-determination](https://w.www.vic.gov.au/aboriginalvictoria/policy/self-determination.html) <https://w.www.vic.gov.au/aboriginalvictoria/policy/self-determination.html>  [Aboriginal and Torres Strait Islander cultural safety framework (2019)](https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework) <https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework>  [Cultural safety continuum reflective tool (2019)](https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework) <https://www.dhhs.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework> |

## 7.1 Victorian Aboriginal Affairs Framework 2018–2023 (VAAF)

The Victorian Government has developed the **Victorian Aboriginal Affairs Framework 2018–2023** (VAAF) as an overarching framework to bring together government and Aboriginal communities to create a better future for Victoria’s Aboriginal population. The shared vision is ‘all Aboriginal Victorian people, families and communities are healthy, safe, resilient, thriving and living culturally rich lives’. Significantly, the VAAF aligns government strategies within six domains and outlines self-determination enablers and guiding principles to support attaining the goals and objectives.

The department has five key Aboriginal health, wellbeing and safety strategies to improve the health, wellbeing, safety, needs and aspirations of Aboriginal Victorians:

* Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027
* Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027
* Aboriginal governance and accountability framework
* Wungurilwil Gapgapduir: Aboriginal children and families agreement
* Dhelk Dja: safe our way – strong culture, strong peoples, strong families

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| **Supporting documents**  [Victorian Aboriginal Affairs Framework 2018–2023 (VAAF)](https://w.www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework/victorian-aboriginal-affairs-framework-2018-2023.html) <https://www.vic.gov.au/aboriginalvictoria/policy/victorian-aboriginal-affairs-framework/victorian-aboriginal-affairs-framework-2018-2023.html>  [Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>  [Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/balit-murrup) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/balit-murrup>  [Aboriginal governance and accountability framework](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/governance-accountability) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/governance-accountability>  [Wungurilwil Gapgapduir: Aboriginal children and families agreement](https://dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement) <https://dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement>  [Dhelk Dja: safe our way – strong culture, strong peoples, strong families](https://www.vic.gov.au/familyviolence/newsletter/edition-18/ground-breaking-aboriginal-family-violence-agreement-launched.html) <https://www.vic.gov.au/familyviolence/newsletter/edition-18/ground-breaking-aboriginal-family-violence-agreement-launched.html> |

## 7.2 Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027

The **Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027** provides an overarching framework for action to advance self-determination and improve the health, wellbeing and safety of Aboriginal Victorians. The plan sets out the Victorian Government’s vision and direction for ensuring positive outcomes for Aboriginal Victorians across the breadth and depth of its activities.

The department works in partnership with Aboriginal Victorians, Aboriginal community-controlled organisations and other parts of government and mainstream service providers to ensure that the priority areas outlined in Korin Korin Balit-Djak are developed, implemented and delivered.

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| *Korin Korin Balit-Djak* means ‘Growing very strong’ in the Woi wurrung language, spoken by members of four Victorian aboriginal communities that lived in adjoining estates in the Port Phillip region. |

[**Balit Murrup: Aboriginal social and emotional wellbeing framework**](https://dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework) is a companion document to Korin Korin Balit-Djak.

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| *Balit Murrup* means 'strong spirit' in the *Woi-wurring* language |

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| **Supporting documents**  [Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>  [Balit Murrup: Aboriginal social and emotional wellbeing framework](https://dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework) <https://dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework> |

## 7.3 Wungurilwil Gapgapduir: Aboriginal children and families agreement and strategic action plan 2018

The **Wungurilwil Gapgapduir: Aboriginal children and families agreement and strategic action plan 2018** is a tripartite agreement between the Aboriginal community, the Victorian Government and community service organisations.

Wungurilwil Gapgapduir outlines a strategic direction to reduce the number of Aboriginal children in out-of-home care by building their connection to culture, country and community. MCH Service providers have a defined role in the **Early childhood agreement for children in out of home care** to achieve these outcomes.

Wungurilwil Gapgapduir is guided by the government’s vision for Aboriginal self-determination and to ensure that all Aboriginal children and young people are safe, resilient and can thrive in culturally rich and strong Aboriginal families and communities. It follows the release of **Korin Korin Balit-Djak in 2017**, which serves as a 10-year plan to revolutionise the way Victoria’s health and human services work with Aboriginal communities.

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| *Wungurilwil Gapgapduir*, means ‘strong families’ in *Latji Latji*, the language of the *Latji Latji* nation centred on the Mildura area. |

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| **Supporting documents**  [Wungurilwil Gapgapduir: Aboriginal children and families agreement and strategic action plan 2018](https://dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement) <https://dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement>  [Early childhood agreement for children in out of home care](https://www.education.vic.gov.au/childhood/professionals/health/outofhomecare/Pages/earlychildhoodagreement.aspx) <https://www.education.vic.gov.au/childhood/professionals/health/outofhomecare/Pages/earlychildhoodagreement.aspx>  [Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak> |

## 7.4 Dhelk Dja: safe our way – strong culture, strong peoples, strong families 2018–2028

The **Dhelk Dja: safe our way – strong culture, strong peoples, strong families 2018–2028** is the key Aboriginal-led Victorian agreement that brings together Aboriginal communities, Aboriginal services and government to work together to ensure that Aboriginal children, families and communities are stronger, safer, thriving and living free from family violence.

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| *Dhelk Dja* means ‘good place’ in *Dja Dja*, the language of the *Dja Dja Wurrung* people, who are the Traditional Owners of the lands of central Victoria. |

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| **Supporting document**  [Dhelk Dja: safe our way – strong culture, strong peoples, strong families](https://dhhs.vic.gov.au/publications/strong-culture-strong-peoples-strong-families-10-year-plan) [2018–2028](https://dhhs.vic.gov.au/publications/strong-culture-strong-peoples-strong-families-10-year-plan) <https://dhhs.vic.gov.au/publications/strong-culture-strong-peoples-strong-families-10-year-plan> |

## 7.5 Aboriginal and Torres Strait Islander cultural safety framework: for the Victorian health, human and community services sector

The Aboriginal and Torres Strait Islander cultural safety framework has been developed to assist the department and mainstream Victorian health, human and community services to create culturally safe environments, services and workplaces.

The cultural safety framework is for:

* every person and every mainstream organisation to take responsibility and work together to create culturally safe services and workplaces
* Aboriginal and Torres Strait Islander staff and clients, who have a right to culturally safe workplaces and services.

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| **Supporting documents**  [Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>  Aboriginal employment strategy 2016-2021  <https://www.dhhs.vic.gov.au/publications/aboriginal-employment-strategy-2016-2021> |

## 7.6 Marrung: Aboriginal education plan 2016–2026

The **Marrung: Aboriginal education plan 2016–2026** seeks to leverage existing universal early childhood and education platforms in recognition that all services have a responsibility to meet the learning and development needs of Victorian Aboriginal communities. Marrung recognises the importance of tailored program responses, including those led by the Victorian Aboriginal community, which can provide targeted effort to achieving outcomes for Aboriginal children and their families.

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| *Marrrung* means Murray Cypress pine tree (*Callitris columellaris*) in the *Wemba* language, which has its origins in the area along the tributaries of the Murrumbidgee River. The form of the tree represents branches of education and knowledge. |

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| **Supporting document**  [Marrung: Aboriginal education plan 2016–2026](https://www.education.vic.gov.au/about/programs/Pages/marrung.aspx) <https://www.education.vic.gov.au/about/programs/Pages/marrung> |



# 8. Diversity

Responding to diversity is critical to ensure positive and equitable health and wellbeing outcomes for all Victorians. This means that services should be both universally accommodating and targeted to specific population groups as required. Communities to be specifically considered include:

Aboriginal communities (section 7)

cultural, linguistic and faith communities

refugees and people seeking asylum

people with disability

people from lesbian, gay, bisexual, trans, intersex and gender diverse (LGBTIQ) communities.

In recognition that communities are not homogenous, services must take into account different characteristics – such as sex, gender identity, sexual orientation, ethnicity, culture, religion, language, age, disability, mental health, socioeconomic status, visa status, social isolation and geographic location. These characteristics can overlap to further exacerbate disadvantage and create barriers for children and families. Consideration should also be given to how these characteristics affect children and families in different ways:

Victoria’s diverse community is comprised of many groups with varied health characteristics and requirements for care. In order to best serve the Victorian Community, the department offers targeted health care and services to these key health **populations**.

**Designing for diversity** is the department’s initiative to embed systemic consideration of the needs of diverse communities into its work. Through an intersectional approach (diversity within diversity), the resources recognise the interconnected nature of identities and social categorisations. The resources also provide a blueprint for policy developers, service designers and program managers to better consider and plan for the needs of diverse populations.

The **Designing for diversity** principles provide a guide to help MCH services embed diversity from the onset of service delivery. The principles strongly align with the department’s commitment to person-centred services and care and advancing quality, safety and innovation. The principles are:

access and equity

inclusiveness

responsiveness

empowerment and self-determination.

MCH Service providers are further guided in the development of policies, and practice guidelines by departmental state and federal government frameworks and strategic plans to promote diversity responsiveness. The department has collated these in **Designing for diversity: key documents**

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| **Supporting resources**  [Populations](https://www2.health.vic.gov.au/about/populations) <https://www2.health.vic.gov.au/about/populations>  [Designing for diversity: key documents](https://www2.health.vic.gov.au/about/populations/designing-for-diversity) <https://www2.health.vic.gov.au/about/populations/designing-for-diversity> |

## **8.1 Children and families from culturally and linguistically diverse communities, encompassing people seeking asylum and refugee communities**

MCH Service providers are culturally aware and responsive to children and families who hold a particular cultural or linguistic connection attributable to their place of birth, ancestry, ethnic origin and religion. Children and families seeking asylum or from refugee communities have specific health and wellbeing needs, and a partnership approach with MCH Service providers and other specialised services is best practice.

MCH Service providers collect information on the cultural identity of clients, including country of birth, preferred language and if an interpreter is required. This practice facilitates interpreter bookings and promotes the identification of resources required to provide a culturally responsive service at a local and state level.

### Delivering for diversity: cultural diversity plan 2016–2019

The department has developed the **Delivering for diversity: cultural diversity plan 2016–2019** to meet its cultural diversity planning obligations under the **Multicultural Victoria Act 2011**.This takes place in the context of a whole-of-government approach to cultural diversity planning.

The plan aligns with Victoria’s multicultural objectives to:

* maximise the benefits of our cultural diversity
* build the capacity of culturally and linguistically diverse communities
* promote social cohesion and community resilience
  + ensure our services and infrastructure respond to the cultural diversity of our state.

The department continues to embed cultural diversity to improve departmental policies, programs and services through its **Cultural diversity plan**. These communities include those with a long-established presence in Victoria, as well as recently arrived migrants, refugees and people seeking asylum.

### Language services

The department allocates funding for interpreters for departmental programs and funded services. **Language Loop** (formerly VITS) provides on-site, telephone and video remote interpreting service for the MCH Service.

The department’s **Language services policy** supports and responds to the needs of linguistically diverse people, including migrants, refugees and people seeking asylum and those who use sign language. It identifies when language services should be offered to clients based on policy requirements and best-practice service delivery. MCH Service providers are encouraged to develop their own language services policies and procedures consistent with the **Language services policy**. The department’s **How to work with interpreting and translating services** is a practical guide to using language services effectively, and it outlines diversity responsiveness within service provision.

Language Loop provides a comprehensive online booking facility. Bookings for onsite interpreters can be made via the Language Loop website. Each user is required to quote their pin number and enter a password (provided by Language Loop). For further information contact Language Loop.

Use of the online booking facility enables better planning and centralised management of interpreter bookings. The online booking facility should be used to:

* make bookings
* confirm current bookings
  + avoid double booking.

#### Onsite interpreting services

The department has a contract with Language Loop to provide onsite interpreting services provided by qualified and accredited interpreters for departmentmental programs and funded services.

#### Telephone interpreters

Language Loop provides a telephone interpreting service available 24 hours a day, seven days a week. Telephone interpreting may not be appropriate in some circumstances, such as where the conversation will cover sensitive or stressful topics, or if an interview is likely to be longer than 60 minutes.

#### Video remote interpreting

Video remote interpreting uses audio-visual technology – such as a video conferencing system, a laptop or tablet to provide face-to-face communication between a client and an off-site interpreter. It can be used for Auslan and spoken languages.

For instructions on using the interpreting service or a list of interpreting phone numbers, see the **Language Loop information kits**

Alternatively, call Language Loop on 03 9280 1955 for more information.

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| **Supporting documents**  [Delivering for diversity: cultural diversity plan 2016–2019](https://dhhs.vic.gov.au/publications/delivering-diversity-cultural-diversity-plan-2016-2019) <https://dhhs.vic.gov.au/publications/delivering-diversity-cultural-diversity-plan-2016-2019>  [Multicultural Victoria Act 2011](http://classic.austlii.edu.au/au/legis/vic/consol_act/mva2011280/) <http://classic.austlii.edu.au/au/legis/vic/consol\_act/mva2011280/>  [Language Loop](file:///C:\Users\09760459\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\90EZGAKE\Language%20Loop) <https://www.languageloop.com.au/>  [Language services policy](https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines) <https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines>  [How to work with interpreting and translating services](https://dhhs.vic.gov.au/how-work-interpreting-and-translating-services) <https://dhhs.vic.gov.au/how-work-interpreting-and-translating-services>  [Language Loop information kits](https://www.education.vic.gov.au/school/teachers/management/community/Pages/interpreting.aspx) <https://www.education.vic.gov.au/school/teachers/management/community/Pages/interpreting.aspx> |

## 8.2 Children and families where a family member has a disability or impairment

Disability or impairment includes:

* total or partial loss of body function or a body part
* the presence of organisms (such as HIV or hepatitis C) that may cause disease or impairment, malformation or disfigurement of the body
* mental or psychological disorders
* conditions that may result in a person learning more slowly.

MCH Service providers must be sensitive to the needs of children and parents with a disability including:

* seeking to understand the effect of the disability on the child and family
* providing a flexible service that recognises the strengths, wishes and desires of the person with a disability in their family context
* enabling parents with a disability to develop and maintain skills through modelling, practice and feedback to ensure generalisation (the ability to apply skills learned in one setting or situation to another)
* understanding the National Disability Insurance Scheme (NDIS) and supporting families to access it
* understanding the early childhood early intervention services and supporting families to access them
  + seeking secondary consultation from disability services where required.

The NDIS delivers services and support to children and family members with permanent and significant disability in Australia.

The **Practice guidelines: National Disability Insurance Scheme and mainstream services interface** support MCH Service providers to build their knowledge and practice skills in working across the National Disability Insurance Scheme (NDIS) and mainstream services.

### Auslan Video relay interpreting

Where a client is hearing impaired and Language Loop is not able to provide face-to-face Auslan and spoken language interpreting, the department’s Video Relay Interpreting Service, accessed via the internet, is a designated service for hearing impaired clients to make it possible for deaf people to communicate in Auslan with hearing people in the same room.

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| **Supporting document**  [Practice guidelines: National Disability Insurance Scheme and mainstream services interface](https://providers.dhhs.vic.gov.au/service-providers/practice-guidelines-ndis-and-mainstream-services) <https://providers.dhhs.vic.gov.au/service-providers/practice-guidelines-ndis-and-mainstream-services>  [Language Loop](https://www.languageloop.com.au/) <https://www.languageloop.com.au/>  [Language services policy](https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines) <https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines> |

## 8.3 Children and families from LGBTIQ communities

Victoria is committed to providing a fair and safe society for LGBTIQ communities that upholds human rights, confronts discrimination and respects diversity. Parents, carers and children who are same-sex attracted, trans, gender diverse or have an intersex variation need access to inclusive and responsive services to address their specific health and wellbeing needs.

For further information on people with intersex variations see the **Health and wellbeing of people with intersex variations information and resource paper** and [information sheets](https://www2.health.vic.gov.au/about/populations/lgbti-health/health-of-people-with-intersex-variations).

### Rainbow Tick guide to LGBTIQ inclusive practice

The **Rainbow eQuality guide** was developd to assist mainstream health and community service agencies identify and adopt inclusive practices and become more responsive to the health and wellbeing needs of LGBTIQ people and communities. Inclusive practice is an essential part of the delivery of health and human services, not an add-on or afterthought.

The **Rainbow eQuality Guide** is evidence based and informed by the LGBTIQ practice principles:

* affirmation – affirm the dignity and value of LGBTIQ people’s sexual orientation, gender identity and intersex status
* freedom from discrimination – ensure LGBTIQ preople live their lives free from discrimination
  + access and equality – provide LGBTIQ inclusive services.

The **Rainbow eQuality guide** is the department’s guide to improvement of LGBTIQ service provsion and assists services, including MCH Service providers, to become LGBTIQ inclusive and provides a framework for quality assurance.

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| **Supporting documents**  [Health and wellbeing of people with intersex variations Information and resource paper](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/health-wellbeing-people-with-intersex-variations-information-resource-paper) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/health-wellbeing-people-with-intersex-variations-information-resource-paper>  [Rainbow eQuality guide](https://www2.health.vic.gov.au/rainbowequality) <https://www2.health.vic.gov.au/rainbowequality> |



# 9. MCH funding

This chapter details the funding of the MCH Service. Fact sheets on each of the programs are available on the department’s website.

## 9.1 Universal MCH program funding

The UMCH program is provided through a partnership between the department and local government, and is funded in accordance with the principles outlined in the **Memorandum of understanding (**MOU), which provides for equal (50:50) contribution between the department and local governments. The UMCH program is delivered directly by local government or via MCH Service providers on behalf of local governments.

Funding for the UMCH program is population based and calculated on the total number of children aged 0–6 years enrolled (active and non-active). This data is collected by MCH Service providers on 31 March each year. Data for 0–1 years is proportionally increased to give a projected full year figure.

The UMCH program is funded for:

* KAS consultations
* flexible service capacity
  + an additional weightings formula, incorporating disadvantage and rurality, is also applied to the funding,

For detailed information, including a funding calculator, for the UMCH program refer to the **Universal Maternal and Child Health program funding fact sheet**.This is updated each year to reflect increases in the unit price and any changes to additional weightings.

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| **Supporting documents**  [MAV and the Department of Education and Training (DET) Memorandum of Understanding](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years#mou) <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years#mou>  [Universal Maternal and Child Health program funding fact sheet](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |

### Funding for KAS consultations

Funding for KAS consultations is based on the total number of children eligible to receive services at the specified KAS consultations and the time allocation for each consultation. A total of 6 hours and 45 minutes is allocated for all KAS consultations. Each KAS consultation has an agreed time allocation for funding purposes and is outlined below.

Table 2: Schedule of KAS consultations

| KAS consultation | Time |
| --- | --- |
| Home visit | 60 minutes |
| 2 weeks | 30 minutes |
| 4 weeks | 60 minutes |
| 8 weeks | 30 minutes |
| 4 months | 30 minutes |
| 8 months | 45 minutes |
| 12 months | 30 minutes |
| 18 months | 45 minutes |
| 2 years | 30 minutes |
| 3.5 years | 45 minutes |

### Funding for the flexible service capacity

Funding for the flexible service capacity is based on three hours of service for 40 per cent of children 0-1 year of age and three hours of service for 40 per cent of the average number of children in each age in the 0–6 year age group. The flexible component equates to approximately 25–30 per cent of service activity.

This component of the UMCH program funding can be used to provide any of the following flexible service capacity activities:

* additional consultations
* telephone consultations
* group work, including first time parent groups
  + community strengthening activities that do not involve clients.

### Additional weighting formula

The department applies an additional weighting formula to the UMCH program funding using the Accessibility/Remoteness Index of Australia (ARIA) and the number of maximum Family Tax Benefit (FTB) recipients with a child aged 0–6 years. This additional of weightings reflects the increased cost of service delivery in rural settings and the additional resources required in areas of socioeconomic disadvantage and high need.

Funding to local governments and MCH Service providers is sent monthly through the Funded Agency Channel – Service Agreement Management System (SAMS) payment and is identified as UMCH program funding.

### Additional family violence

In response to family violence, the department, from 2017, has funded an additional one hour of service for reasons related to family violence including:

* where family violence has been disclosed
* where family violence is suspected
  + where there has been no prior opportunity to ask about family violence.

Additional family violence visits are fully funded by the department. Funding includes a base funding calculated on 10 per cent of the children enrolled in the 0–1 age cohort and a weighted funding for a further five percent of children in the 0–1 age cohort and are allocated to local government and MCH Service providers based on levels of disadvantage.

For detailed information, including a funding calculator, for the additional family consultations refer to the **Universal Maternal and Child Health program funding fact sheet**.This is updated each year to reflect increases in the unit price and any changes to additional weightings.

Funding for local governments and MCH Service providers is sent monthly through the Funded Agency Channel Service Agreement Management System (SAMS) payment and is identified as ‘Family violence’.

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| **Supporting resource**  [Universal Maternal and Child Health program funding fact sheet](https://www.education.vic.gov.au/Documents/childhood/professionals/health/Universal_MCH_Program_funding_2018-19_Fact_Sheet.pdf) <https://www2.health.vic.gov.au/maternal-child-health> |

## 9.2 Enhanced Maternal and Child Health program funding

The EMCH program is fully funded by the department. Funding is allocated according to socioeconomic disadvantage, calculated on the number of Family Tax Benefit recipients in a local government area and rurality using the Accessibility/Remoteness Index of Australia (ARIA). Through the Early Years Reforms, the EMCH program is being expanded over a three-year period from 2018–19 to 2020–21. Once fully expanded, the EMCH program will provide an average of 20 hours of direct or indirect service delivery per family in metropolitan areas and rural regions and will be funded for an average 22.67 hours per family in recognition that delivery of services in rural areas takes longer.

Funding to local governments and MCH Service providers is sent monthly through the Funded Agency Channel – Service Agreement Management System (SAMS) payment and is identified as EMCH funding. In addition, funding for clinical supervision is sent annually.

For detailed information, including a funding calculator, for the EMCH program refer to the **Enhanced Maternal and Child Health program funding fact sheet** which is updated each year to reflect increases in the unit price and expansion over the three year period.

### Growing communities, thriving children

The Growing communities, thriving children intiative provides funding for children’s initiatives in nine councils at the rural and metropolitan interface, that have unique challenges with rapidly growing populations or a mix of urban and rural communities.

Funding to local governments is sent monthly through the Funded Agency Channel – Service Agreement Management System (SAMS) payment and is identified as Growing communities, thriving children funding.

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| **Supporting resource**  [Universal Maternal and Child Health program funding fact sheet](https://www.education.vic.gov.au/Documents/childhood/professionals/health/Universal_MCH_Program_funding_2018-19_Fact_Sheet.pdf) <https://www2.health.vic.gov.au/maternal-child-health>  Email the [Maternal and Child Health Service](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au>. |

## 9.3 MCH Line funding

The MCH Line is fully funded by the department to provide 24-hour telephone advice and support to families with young children from birth to school age.

# 10. MCH performance measures and targets

These MCH Service guidelines are an adjunct to the department's service agreement and they complement service agreements between the department and local government in the delivery of MCH services. The Victorian Auditor-General’s report **Early childhood development services: access and quality** identifies a pattern of progressive decline in the attendance of children, particularly after eight weeks, for the 10 KAS assessments. The report recommends that the department work in partnership with the MAV and MCH Service providers to identify and act to mitigate this fall in attendance after the first visit.

Performance targets are specified in the service agreements signed by each MCH Service provider and the government’s current financial year service delivery Budget Paper 3 (BP3) measures.

In May 2013, the government introduced the use of objective indicators in the **2013–14 Budget Paper No. 3 Service Delivery** (BP3) to provide information on progress in the achievement of objectives. The government also made a commitment in BP3 to report progress figures in each department’s annual report. This commitment continues.

Targets are expected to focus on increasing KAS participation rates from the 8-week to the 3.5-year consultations, breastfeeding for the whole population and reducing the gap between Aboriginal and non-Aboriginal participation rates. Targets for family violence consultations and information sharing have been identified to reflect current policy.

Individual municipal targets for the EMCH Service are aligned with the EMCH program guidelines.

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| **Supporting documents**  [Early childhood development services: access and quality](https://www.parliament.vic.gov.au/vufind/Record/84838) <<https://www.parliament.vic.gov.au/vufind/Record/84838>>  [2013–14 Budget Paper No. 3 Service Delivery](https://www.dtf.vic.gov.au/previous-budgets/2013-14-state-budget) <https://www.dtf.vic.gov.au/previous-budgets/2013-14-state-budget> |

Table 3: MCH performance targets

| Service component | Performance measure | Statewide target |
| --- | --- | --- |
| Children aged 0–1 enrolled in MCH services from birth notifications received within the current financial year  (BP3 measure) | Percentage of infants enrolled from birth notices received within current financial year | 99% of infants |
| Key age and stage (KAS) consultations | Percentage of KAS consultations completed[[2]](#footnote-3)  Home visit: 100.1%  2 weeks: 96.7%  4 weeks: 97.1%  8 weeks: 95.9%  4 months: 94.1%  8 months: 85.8%  12 months: 83.4%  18 months: 74.2%  2 years: 70.6%  3.5 years: 64.2% | Benchmark for KAS consultations completed  Home visit: 100%  2 weeks: 98%  4 weeks: 98%  8 weeks: 96%  4 months: 95%  8 months: 90%  12 months: 85%  18 months: 75%  2 years: 70%  3.5 years: 65% |
| Fully breast-fed infants | Percentage of fully (exclusively and predominantly) breast-fed infants at defined ages | On discharge:  2 weeks:  3 months:  6 months: |
| Partially breast-fed infants | Percentage of partially breast-fed infants at defined ages | On discharge:  2 weeks:  3 months:  6 months: |
| EMCH hours of service | Hours of service  (Direct and indirect service delivery hours) | As per service agreement |
| Family violence consultation | Number of family violence consultations completed  (<1-year enrolments) | As per service agreement |
| Request information sharing (Under CISS and FVIS) | Number of requests completed | Benchmark |
| Response information sharing (Under CISS and FVIS) | Number of responses completed | Benchmark |

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## 10.1 MCH performance targets

The statewide targets guide the development of **service improvement plans** (SIPs). between the department and MCH Service providers. These targets are articulated in funding and service agreements.

## 10.2 Early Years Compact priorities

The **Early Years Compact** board has agreed on three statewide priorities, focused on supporting children experiencing vulnerability and families, for the first year. MCH Service providers are required to incorporate targets to improve outcomes and participation for all children experiencing vulnerability as outlined in the Early Years Compact.

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| **Supporting document**  [The Early Years Compact](https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx) <https://www.education.vic.gov.au/about/educationstate/Pages/theearlyyearscompact.aspx> |

## 10.3 Local performance indicators

MCH Service providers also have the ability to identify and respond to local priorities through:

* + **Know your council** and the **Local government performance reporting framework**
  + municipal early years plans
  + Best Start Partnership
  + Early Years Partnerships

## 10.4 National performance indicators

The **National framework for universal child and family health services** articulates a national framework for universal child and family health services that promotes consistency of service across Australia, provides an evidence base for service improvement and progressing towards national performance monitoring and outlines the compilation of national population health data for the purposes of comparison both across Australia and targeted populations. The framework does not seek to prescribe specific service delivery mechanisms or restrict flexibility in delivering innovative services to meet the needs of communities.

The Victorian MCH Service provides consultations that are consistent with, and collects data in adjunct to, the national performance indicators in their annual reports which are available at a municipal, divisional and state level.

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| **Supporting documents**  [Local government performance reporting framework](https://www.localgovernment.vic.gov.au/strengthening-councils/performance-reporting) <https://www.localgovernment.vic.gov.au/strengthening-councils/performance-reporting>  [National framework for universal child and family health services](https://www.health.gov.au/internet/main/publishing.nsf/Content/AFF3C1C460BA5300CA257BF0001A8D86/$File/NFUCFHS.PDF) <https://www.health.gov.au/internet/main/publishing.nsf/Content/AFF3C1C460BA5300CA257BF0001A8D86/$File/NFUCFHS.PDF> |



# 11. MCH data and reporting requirements

Data collection is an integral part of the MCH Service and should be consistent across the state. Data from MCH services is collected through web-based information management systems for each child and their family. This data is used to monitor children’s development, and collectively to drive improved service quality and stronger outcomes for children and their families.

Accurate data collection allows the department and MCH Service providers to track and measure the benefits of MCH services in order to inform future service improvement initiatives and reforms. Data is also used to determine whether each MCH Service provider is delivering the MCH programs and achieving the performance targets in accordance with the relevant service agreements.

Definitions relating to data are outlined in Appendix E.

## 11.1 Universal MCH program Data

### Annual reports

MCH Service providers send annual reports to the department each year (from 1 July to 30 June). The annual report provides valuable information such as birth notification rates, enrolment and non-enrolment, participation rates in the KAS consultations, Aboriginal participation, counselling and referral activities, and breastfeeding rates.

The MCH Service providers collate the information for the annual report from the electronic health record system used by local governments and other MCH Service providers. The generated report reflects both the universal and enhanced components of service delivery. The department uses the annual report to plan and implement programs, and as indicators of health and wellbeing.

### Workforce data

MCH workforce data is collected annually by MCH Service providers. The data informs development of responsive workforce initiatives to ensure a sustainable MCH workforce across Victoria. This data is also used to allocate clinical supervision funding for the EMCH program.

### March data

The department collects data on the number of enrolments in the current and previous years including active and non-active children for ages 0–6 years is requested annually in March. This data is used by the department to determine annual funding allocations for each municipality.

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| **Supporting resources**  [Fact sheet: Universal Maternal and Child Health program funding 2018–19](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health>  [CDIS Speedy Steps](http://www.mav.asn.au/what-we-do/sector-development/cdis#processes) <http://www.mav.asn.au/what-we-do/sector-development/cdis#processes> |

## 11.2 Enhanced MCH program data

The EMCH program data is collected and collated separately from the UMCH program data. It is important that all children within a family who are receiving service by the EMCH program should be added to the case details, regardless of age.

EMCH data provides the department and MCH Service providers with information including, hours of service delivery, client demographics, issues that the nurse and family have identified for inclusion in the service plan, whether a family has completed their service plan, and hours of service delivered.

This is to promote the key element of the EMCH program, as a flexible mode of care. This is intended to allow MCH Service providers to flexibly use their funding to best address the specific needs of their individual communities and get the best results. The MCH data toolkit in Appendix E outlines counting rules for EMCH services.

The IRIS data system is utilised to collect data from the EMCH program. EMCH program data is forwarded to the department quarterly by 15 October, 15 January, 15 April and 15 July to iris.data@dhhs.vic.gov.au.

The department makes available free of charge for all municipalities across Victoria the Integrated Reports and Information System (IRIS), including training and automatic upgrading of software.

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| **Supporting resources**  Enhanced MCH program data should be [emailed to the Department of Human Services](mailto:iris.data@dhs.vic.gov.au) <iris.data@dhs.vic.gov.au> quarterly.  Please contact the [IRIS help desk](mailto:IRIS.helpdesk@dhhs.vic.gov.au) <IRIS.helpdesk@dhhs.vic.gov.au> on 03 9616 6919. |

## 11.3 MCH Line program data

The following demographic data is collected in the Client Enquiry Record Enhanced System (CERES) program with each call:

* postcode
* age of the child
* callers relationship to the child
* call issue
* referral
* call outcomes.

## 11.5 Victorian and Australian Early Childhood and Community Data

The Victorian and Australian, Early Childhood and Community (VCAMS) Data and Australian Early Development Census (AEDC) offers informed data for targeted federal, state and local government interventions.

### Victoria

The **Victorian Child and Adolescent Monitoring System** (VCAMS) and annual **State of Victoria’s children report** provide information on measures of children and young people’s health, wellbeing, safety, learning and development outcomes identified in the VCAMs framework. MCH Service providers contribute directly to the VCAMs data through provision of the MCH annual report

The VCAMS framework comprises 150 indicators as agreed by the Children’s Service Coordination Board. It incorporates 35 outcomes that relate to aspects of children’s health, development, safety, learning and wellbeing in four categories – the child, families, community, and supports and services.

The data used to report against the 150 VCAMS indicators is drawn from a range of Victorian Government departments as well as the Australian Bureau of Statistics and other research bodies. MCH Service providers are in a unique position to influence these outcomes

MCH Service providers can source these data sets to identify inequalities within communities and development of effective strategies to optimise the state of wellbeing, health and safety of all children and families.

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| **Supporting documents**  [Victorian Child and Adolescent Monitoring System](https://www.education.vic.gov.au/about/research/pages/vcams.aspx?Redirect=1) <https://www.education.vic.gov.au/about/research/pages/vcams.aspx?Redirect=1>  [State of Victoria’s children report](https://www.education.vic.gov.au/about/research/Pages/reportdatachildren.aspx) <https://www.education.vic.gov.au/about/research/Pages/reportdatachildren.aspx> |

### Commonwealth

The Australian Early Development Census (AEDC) is a population-based measure of how children have developed by the time they start school. It looks at five areas of early childhood development domains: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge. Community AEDC results are reported publicly as data tables, maps and community profiles, and these can be accessed through the **AEDC data explorer** and AEDC user guide: local government.

The AEDC census data provides a snapshot of children's development that can inform communities and support planning, policy and service delivery. The **Australian Bureau of Statistics** provides population and community profile data relating to children and families as collected in the Australian Census. The AEDC and ABS data support responsive local MCH Service planning and delivery, the development of Municipal Early Years Plans and inform Early Years Networks.

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| **Supporting documents**  [AEDC data explorer](file:///C:\Users\09760459\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\90EZGAKE\AEDC%20data%20explorer) <http://www.aedc.gov.au/data>  [AEDC user guide: local government](https://www.aedc.gov.au/resources/resources-accessible/aedc-user-guide-local-government) <https://www.aedc.gov.au/resources/resources-accessible/aedc-user-guide-local-government>  [Australian Bureau of Statistics](https://www.abs.gov.au/) <https://www.abs.gov.au>. |

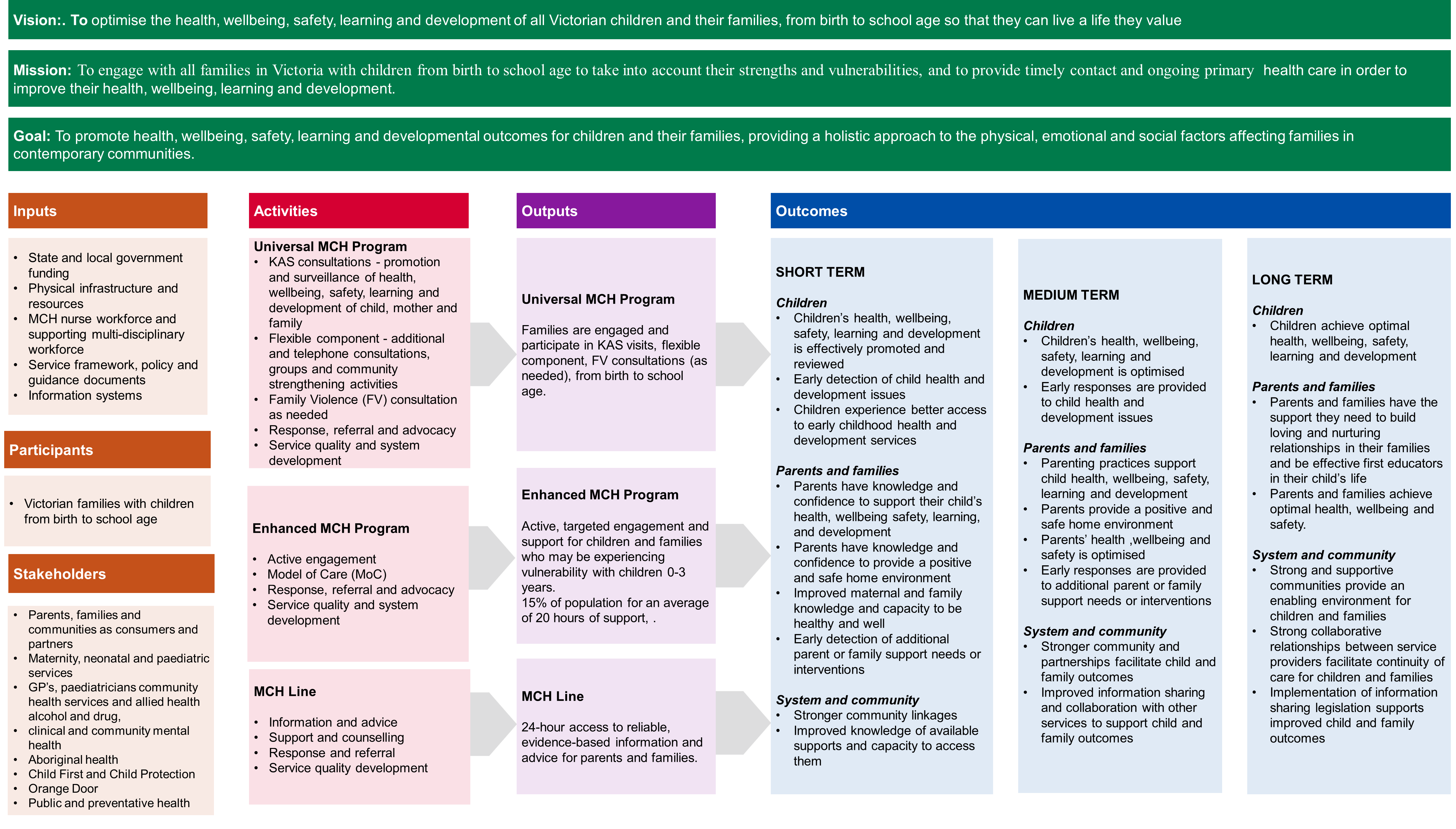


# Appendix A: MCH framework resource map

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| Maternal and child health framework: resource map |

| Maternal and child health service standards | Maternal and child health service clinical practice guidelines | Maternal and child health service guidelines | Maternal and child health universal program guidelines | Enhanced maternal and child health program guidelines | Maternal and child health line program guidelines |
| --- | --- | --- | --- | --- | --- |
| Maternal and child health program standards (2009 reissued 2019)  **…………..……** | Safer Care Victoria Paediatric Clinical Practice Guidelines  **…………..……**  Safer Care Victoria  Neonatal  eHandbook  **…………..……**  Safer Care Victoria  Maternity eHandbook  **…………..……**  Maternal and Child Health  (under development) | Transition to practice guidelines (2018 reissued 2019)  **…………..……**  Child Information sharing and family violence information sharing toolkit – maternal and child health (2018 reissued 2019)  **…………..……**  Innovation Practice guide for MCH Services (2017 reissued 2019)  ………………  Nursery Equipment Program Guidelines for ordering  (2013 reissued 2019) | Practice note – additional family violence consultation (2018 reissued 2019)  **…………..……**  Perinatal mental health and psychosocial assessment (2013 reissued 2019)  **………………..**  Universal maternal and child health program funding (2018 reissued 2019)  **…………..……**  First time parent group guide (2001 reissued 2019) | Clinical supervision guidelines – enhanced maternal and child health (2018 reissued 2019 | MCH Line – policies and procedures (2018) |

# Appendix B: Victorian Maternal and Child Health Service logic



# Appendix C: Maternal and Child Health program changes and professional development

The central office of the department is responsible for driving improvements in the MCH Service in partnership with the MAV and local government.

The department is pivotal in responding to and implementing the direction of state and national government departments and agencies. Recent program changes, policy direction and professional development include:

| Year | Development | Source |
| --- | --- | --- |
| 2012 | NHMRC infant feeding guidelines | [National Health and Medical Research Council – Infant Feeding Guidelines: information for health workers](https://www.nhmrc.gov.au/about-us/publications/infant-feeding-guidelines-information-health-workers) <https://www.nhmrc.gov.au/about-us/publications/infant-feeding-guidelines-information-health-workers> |
| 2012 | Biannual MCH Conference | [Municipal Associtation of Victoria– Maternal and Child Health Conferences](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/mch-conferences) <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/mch-conferences> |
| 2013 | Nursery Equipment program guidelines | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2013 | Perinatal mental health and psychosocial assessment | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2014 | Victorian breast-feeding guidelines | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2014 | Play, Learn and Grow | [Using the Play, Learn and Grow resources in the Maternal and Child Health Services](https://www.education.vic.gov.au/Documents/childhood/professionals/support/Using%20the%20Play,%20Learn,%20Grow%20resources%20in%20the%20Maternal%20and%20Child%20Health%20Service.pdf) <https://www.education.vic.gov.au/Documents/childhood/professionals/support/Using%20the%20Play,%20Learn,%20Grow%20resources%20in%20the%20Maternal%20and%20Child%20Health%20Service.pdf> |
| 2015 | Bridges Out of Poverty Training | [Social Solutions Workshops – Strategies for Professionals and Communities](http://socialsolutions.com.au/workshops/bridges-out-of-poverty/) <http://socialsolutions.com.au/workshops/bridges-out-of-poverty/> |
| 2016 | Protecting children: mandatory reporting and other obligations – train the trainer program for early childhood services | Updated resource  [Step-by-step guide to making a report to child protection or Child FIRST](https://providers.dhhs.vic.gov.au/step-step-guide-making-report-child-protection-or-child-first-pdf) <https://providers.dhhs.vic.gov.au/step-step-guide-making-report-child-protection-or-child-first-pdf> |
| 2016 | Innovation practice guide for MCH Services | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2017 | Brigance III Training | [Education and Training – MCH training](https://www.education.vic.gov.au/childhood/professionals/profdev/Pages/mchtraining.aspx) <https://www.education.vic.gov.au/childhood/professionals/profdev/Pages/mchtraining.aspx> |
| 2018 | Enhanced Maternal and Child Health program guidelines 2018 | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2018 | Biannual EMCH expansion professional development days | [Municipal Associtation of Victoria– Maternal and Child Health Conferences](https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/mch-conferences) <https://www.mav.asn.au/what-we-do/policy-advocacy/social-community/children-youth-family/maternal-and-child-health-children-0-6-years/mch-conferences> |
| 2018 | Clinical supervision guidelines for the Enhanced MCH program | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2018 | Trauma informed practice training – MERTIL | [MERTIL](http://www.mertil.net.au/) <http://www.mertil.net.au/> |
| 2018 | Family violence information sharing and child information sharing legislation | [Training for information sharing and MARAM](https://www.vic.gov.au/training-for-information-sharing-and-maram) <https://www.vic.gov.au/training-for-information-sharing-and-maram> |
| 2019 | MARAM MCH leadership training | [MERTIL](http://www.mertil.net.au/) <http://www.mertil.net.au/> |
| 2019 | Autism professional development | [health.vic – Maternal and Child Health Service](https://www2.health.vic.gov.au/maternal-child-health) <https://www2.health.vic.gov.au/maternal-child-health> |
| 2020 | MARAM Professional development update | To be released in 2020 |
| 2020 | Sleep and settling professional development | To be released in 2020 |
| 2020 | First-time parent group first-aid update professional development | To be released in 2020 |

# Appendix D: Child and family information

## Record keeping for children and families

The My Health, Learning and Development Record (the ‘Green Book’) is given to all parents in hospital when their baby is born to enable them to keep and record their child’s milestones, health, growth, development and immunisations throughout childhood.

## Record keeping for children in out-of-home care

When a child comes into out-of-home care, it is important for the Green Book to be given to the carer. This will help ensure that there are no gaps in health care for the child and that the care is right for the child.

If the record is not available, then a new Green Book can be issued by the MCH nurse. If a child’s record is lost, it can be replaced by the MCH nurse.

## Record keeping for MCH services

A secure, electronic health record system must be used by all MCH Service providers. Service providers must ensure that all client information is entered into the information systems supplied by the MCH Service provider. Information systems are required to have appropriate security capability and must ensure that user logins are allocated, audited and managed for each individual. All MCH Service providers must have a system in place to ensure the capture and maintenance of complete electronic patient records. The system must facilitate the capture of client information in alignment with the [Documentation standards for maternal and child health nurses in Victoria](http://www.vamchn.org.au/mchstandards.aspx) <http://www.vamchn.org.au/mchstandards.aspx> so as to support MCH nurses to accurately reflect both consultations for clients and other professionals.

The documentation standards are available through the Victorian Association of Maternal and Child Health Nurses.

# Appendix E: MCH data toolkit

The data toolkit provides definitions to terms utilised by the department for the collection of MCH data.

## 1. Total number of birth notifications

The birth notification alerts the MCH Service provider that a birth has occurred. Birth notifcation applies in the case of every birth in Victoria, whether the child is born alive or stillborn, except for the delivery of a non-viable foetus. For further information refer to birth notification from the [Child, Wellbeing and Safety Act 2005](http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/consol_act/cwasa2005218/) <http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/vic/consol\_act/cwasa2005218/>.

## 2. Enrolments

A new baby is considered as enrolled in the MCH service, at the relevant MCH centre once the MCH service has made contact with the family or, in the case of older children, once the family has made contact with the MCH service and authorising to transfer or enrol of child.

### Number enrolled from birth notifications received this financial year

Relates to the number of infnats enrolled from birth notifications received in the current financial year.

### Number enrolled from birth notifications received last financial year

Relates to the number of infants enrolled from birth notifications received in the previous financial year but enrolled in the current financial year.

### Number of new enrolments

Includes new enrolments of infants enrolled in the current financial year or born in the other age group years.

Enrolled in CDIS is active for universal service’ and considered to be active or receiving MCH services.

### Active child health records

Active is defined as a child who attended a MCH centre at least once during the financial year.

### Non-active child health records

Non-active is defined as a child who has not attended a MCH centre at least once during the financial year. Permanet inactive (or closed) infants are those children who have moved interstate or overseas or are deceased. Children who have died or moved interstate or overseas are not counted in either the March or June data reports.

### Total number of infants

All enrolled children who are currently attending or not at a MCH centre. This is a count of both active and non-active infants, but does not inlcude those children that are deemed permanent inactive.

### Transfers out

Transfers to other MCH Service providers should be attended in a timely manner to provide continuity of care for children and their families.

#### The following process should be followed when transferring a client in from a Child Development Information System (CDIS) council:

* A caregiver contacts a new MCH service and authorises the transfer of their child’s, or children’s history from their previous service.
  + With caregiver permission, the MCH nurse then transfers the child health record to the new MCH service.

The child client record remains at the previous MCH service site until the primary caregiver gives permission to transfer the child to another MCH service.

Specific permission needs to be given for others listed in client relationships, this includes parents, siblings and carers.

#### The following process should be followed when transferring a client in from a non-CDIS council:

* Create new client on CDIS.
* The transfer request should be emailed to only the generic MCH email box. The request is required to nominate the electronic format (for example, PDF, Microsoft Word) preferred by the MCH Service provider requesting the transfer.
* Transfer of the child’s/client’s record in a form that is acceptable to the receiving MCH Service provider are to be emailed only to the generic MCH council or other Service Provider address, not a MCH centre.
* It is important that when a transfer request is made, a response is carried out by the relevant MCH service within three working days
  + Client history received from previous MCH Service providers should be attached to the CDIS client record

#### The following process should be followed when transferring a client out to a non-CDIS council

* The transfer request should be emailed to only the generic MCH Service provider's email box. The request is required to nominate the electronic format (for example PDF, Microsoft Word) preferred by the MCH Service provider requesting the transfer.
* Transfer of the child’s/client’s record in a form that is acceptable to the receiving MCH Service provider are to be emailed only to the generic MCH council or other service provider address, not a MCH centre.
* It is important that when a transfer request is made, a response is carried out by the relevant MCH service within three working days.
  + Client history received from previous MCH Service providers should be attached to the CDIS client record.

A working knowledge of the Acts of Parliament and regulations within which the MCH Service providers operate on both an organisational and clinical practice is fundamental and is outlined in [CDIS Speedy Steps: transfer process](https://www.mav.asn.au/__data/assets/pdf_file/0019/4465/CDIS-transfer-process.pdf) <https://www.mav.asn.au/\_\_data/assets/pdf\_file/0019/4465/CDIS-transfer-process.pdf>. This is intended as a useful starting point for new and existing MCH service providers and each of the MCH centres.

#### Closure of client file

A child’s health record is closed in the following circumstances and will not be recorded in data for MCH annual reports:

* client has transferred to a non-CDIS MCH Service provider
* client has moved interstate
* client has moved overseas
* client has declined service
* client is receiving services from another care provider
* no longer receiving MCH service
* stillbirth
* client is deceased
  + data entry error.

#### Re-activation of child

If a child returns to Victoria from interstate or overseas to the MCH centre they previously attended, they will need to be made active again. If the child returns from overseas and attends a different MCH centre, the centre-held history is transferred to the new centre following parental consent for transfer of records.

### First-time mothers

A first-time mother is one who has a live baby for the first time. In the case of multiple births, a mother is only counted as a first-time mother once, not, for example, twice for twins.

## 3. Analysis of non-enrolled birth notifications

Non-enrolled birth notifications includes infants who have not attended the MCH Service provider where the birth notice was revcieved. Classifications include attended another MCH Service provider, the death of the infant occuring within one month, stillbirths, anticpated enrolments for the following financial year, or other non-enrolled birth notices for the curent financial year.

The total of number enrolled from birth notifications and non-enrolled birth notifications equals the number of birth notifications received this financial year.

## 4. Key ages and stages (KAS) consultations

### Total count of KAS consultations

The MCH universal serivce which provides 10 KAS consultations from birth to 3.5 years including an intial home visit and consultations at 2 weeks, 4 weeks, 8 weeks, 4 months, 8 months, 12 months, 18 months, two years and 3.5 years of age for all chidlren and their families. The KAS is recorded for:

* number of KAS activities completed – Aboriginal and Torres Strait Islander
* number of KAS activities completed – non-Aboriginal and Torres Strait Islander
  + total number of KAS activities completed – Aboriginal and Torres Strait Islander and Non-Aboriginal and Torres Strait Islander.

Data collection of KAS consultations depends on the following points:

* Consultations are recorded in the child’s clinical data record and on the child health record. KAS consultations must be recorded as either ‘Aboriginal and/or Torres Strait Islander’ or ‘non-Aboriginal or Torres Strait Islander’. ‘Aboriginal and Torres Strait Islander’ refers to a parent self-reporting themselves and their child as being of Aboriginal and/or Torres Strait Islander origin.
* Where an MCH nurse carries out a KAS consultation on a child in the EMCH service, this consultation must be recorded in the Universal MCH data collection system, not in IRIS.
* The first home visit to the family following the birth of the child is the only home consultation recorded as a KAS ‘home consultation’.
  + Each KAS consultation is **only recorded once**, at the completion of the assessment. If the assessment takes two consultations, the first consultation is recorded as an additional consultation.

Participation rates for KAS consultations are calculated to performance measures against performance targets as outlined in Part 10 of MCH Service guidelines.

Table A: Calculation of participation rates key ages and stages

| KAS | Participation rate |
| --- | --- |
| Home visit | Number of home visits as a percentage of total child health records of children aged 0–1 year |
| 2 weeks | Number of 2-week visits as a percentage of total child health records of children aged 0–1 year |
| 4 weeks | Number of 4-week visits as a percentage of total child health records of children aged 0–1 year |
| 8 weeks | Number of 8-week visits as a percentage of total child health records of children aged 0–1 year |
| 4 months | Number of 4-month visits as a percentage of total child health records of children aged 0–1 year |
| 8 months | Number of 8-month visits as a percentage of total child health records of children aged 0–1 year plus 1–2 years divided by 2 |
| 12 months | Number of 12-month visits as a percentage of total child health records of children aged 0–1 year plus 1–2 years divided by 2 |
| 18 months | Number of 18-month visits as a percentage of child health records of children aged 1–2 years plus 2–3 years divided by 2 |
| 2 years | Number of 2-year visits as a percentage of total child health records of children aged 2–3 years |
| 3.5 years | Number of 3.5-year visits as a percentage of total child health records of children aged 3–4 years plus 4–5 years divided by 2 |

## 5. MCH flexible capacity activities

Flexible service capacity relates to all activities undertaken by the Universal MCH program that are not identified as KAS consultations. The type of consultation is recorded as one of the following activities:

* additional consultations
* telephone consultations
* group work
  + community strengthening activities that do not involve clients.

### Brigance screening

If a consultation appointment is scheduled to complete a Brigance III screen subsequent to the KAS consultation, it is recorded as an additional consultation. Brigance developmental screening provides a shared language for seamless referral pathways and collaborative partnerships across all practitioners working with children and families experiencing vulnerability

## 6. MIST

Denotes the Melbourne Initial Screening Test (MIST) where the MCH nurse perform vision screening as part of a general developmental assessment for children aged 3.5–4.5 years. The MIST vision screen is undertaken for all children at the 3.5-year KAS, unless they are under the ongoing care of an ophthalmologist.

## 7. Opportunistic immunisation

Opportunistic immunisations are recorded for every immunisation a MCH nurse provides within a KAS or additional consultation.

## 8. Counselling and referrals for child health and wellbeing

### Counselling

A counselling session is recorded when additional guidance is provided specific to an identified health concern. This should not to be confused with the range of information expected to be provided as part of the MCH schedule of activities at the KAS consultation. Therefore, not all consultations by the MCH nurse are counted as counselling, only those outside the range of information and/or in more specific depth than that expected to be provided at the KAS consultation. An additional consultation will typically require counselling to be included in line with identified reason for the visit.

The issues that pertain to child health and wellbeing counselling are:

* visual, auditory
* communication
* developmental dysplasia of the hip (DDH)
* congenital anomaly, growth, development
* potentially disabling condition
* accident
* illness
* nutrition altered
* dental/oral.

The issues that relate to mother and family counselling, and inclusive of fathers and carers are:

* emotional
* physical
* social interaction impaired
* domestic violence
* family planning.

### Referral

A referral is recorded when communication is made to the referral agency with the consent of the primary caregiver. The exception is in the case of mandatory reporting when primary caregiver consent is not required. A referral includes a referral form, written letter, email or phone call to the referral agency.

A referral implies that counselling and referral occurs during a consultation. It is possible to provide counselling and referral at a consultation for more than one identified child health and wellbeing issue.

**In addition to the issues covered in counselling, child protection notification is included in referrals**.

## 9. Counselling and referrals for mother/family counselling

See Item 8 for counselling and referral definitions. The issues that relate to mother/family counselling and referral are emotional, physical, social interaction impaired, domestic violence and family planning.

## 10. Breast feeding of babies

Breastfeeding status is recorded on discharge and at 2 weeks, 3 months, 4 months, 6 months and 8 months. It is recorded using the World Health Organization (WHO) definitions:

* exclusively breastfeeding – requires that the infant receive breast milk, including milk expressed or from a wet nurse. It allows the infant to receive drops or syrups (vitamins, minerals, medicines). It does not allow the infant to receive anything else
* predominately breastfeeding – requires that the infant receive breast milk (including milk expressed or from a wet nurse) as the predominant source of nourishment. It allows the infant to receive liquids (water, water-based drinks, fruit juice, and oral rehydration solution), ritual fluids and drops or syrups (vitamins, minerals, medicines). It does not allow the infant to receive anything else, particularly non-human milk or food-based fluids
  + partially breastfeeding – requires that the infant receive breast milk and solid or semi-solid foods. It allows for the infant to receive any food or liquid including non-human milk.

For the purpose of the annual report, only two categories are reported: ‘fully’ and ‘partially’ breastfeeding. The WHO ‘exclusive’ and ‘predominant’ categories are combined to constitute ‘fully’ breastfeeding.

The breastfeeding rate is calculated as the number of mothers’ breastfeeding at discharge, at 2 weeks, at 3 months and at 6 months, as a percentage of total infants (active and non-active) aged 1–2 years.

There are internationally recommended terms defining breastfeeding practices which are used to guide breastfeeding data collection and reporting as described by the [Indicators for assessing infant and young child feeding practices – part I: definitions](https://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/) <https://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/> (World Health Organization 2008).

## 11. Number of Aboriginal and/or Torres Strait Islander origin children

All governments throughout Australia have agreed to cooperate in sharing information that will improve the health of Aboriginal and Torres Strait Islander people. The department requires MCH nurses to provide information on the Indigenous status of every child attending each MCH centre.

This information is used to:

* identify the main health problems for Victorian Aboriginal and Torres Strait Islander children and their families
* provide appropriate intervention to improve the health, development and wellbeing of Aboriginal and Torres Strait Islander children and their families
* record the total number of identified Aboriginal and Torres Strait Islander children aged 0–6 years
* record the number of Aboriginal and Torres Strait Islander children who have attended each of the 10 KAS consultations
  + record the number of Aboriginal and Torres Strait Islander children aged 0–6 years who have attended the service at least once during the current financial year.

The official definition of an Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as being Aboriginal or Torres Strait Islander and who is accepted as such by the community with which the person associates.

In using this definition, it is important to remember that determining Aboriginality will depend upon the parent or guardian identifying their child as an Aboriginal or Torres Strait Islander.

MCH nurses cannot be certain whether any child is Aboriginal or Torres Strait Islander without asking the parent or guardian of every child born in Australia. The standard question for Indigenous Status is as follows:

Is your child of Aboriginal or Torres Strait Islander origin?

* No
* Yes, Aboriginal
  + Yes, Torres Strait Islander

(For children of both Aboriginal and Torres Strait Islander origin, mark both ‘Yes’ boxes.)

MCH nurses need to record Aboriginal status and Torres Strait Islander status separately. The answers to the question ‘Is your child of Aboriginal or Torres Strait Islander origin?’ should be clearly recorded on the MCH data system as ‘Yes’ or ‘No’.

When a parent is not present, the person answering for them should be in a position to do so. That is, this person must know well the child about whom the question is being asked and feel confident to provide accurate information about them. This question must always be asked regardless of an MCH nurse’s perceptions based on appearance or other factors.

## 12. Family violence

### Family consultation

A specific family violence consultation may be provided to a family if a MCH nurse has completed a consultation where any one of the following occurs:

* the MCH nurse was unable to complete the family violence questions (for example, at the four-week KAS consultation) because the partner or other family members were present, or
* family violence has been disclosed or identified and more time is required for discussion or to complete a safety plan, or
* the MCH nurse suspects the family is experiencing family violence and requires additional time for exploration and discussion, or
  + the MCH nurse or family member/s require a joint consultation with a specialist family violence practitioner.

The consultation is to be conducted in a location that is most suitable and safe for the MCH nurse, child and mother, this may be in their home, MCH centre or at a location in the community.

### Family violence consultation details

MCH nurses currently use the **Common risk assessment framework** (CRAF) to assess family violence risk. The new **Family violence multiagency risk assessment and management framework,** (MARAM) builds on the CRAF. As the MARAM is implemented in MCH Services, data collection will be updated to reflect the MARAM. The following data tool information is reflective of the CRAF.

Data is collected to reflect the assessments and actions within a family consultation.

* family violence assessment completed
* family violence identified in family violence assessment
* safety plans created
* family violence consultations which led to referral
* counselling conducted
  + referral completed.

#### Safety plans

It is important to help the mother or other family member to plan ways to increase their safety should they need to leave their home quickly or feel unsafe or in danger. Safety plans can be either written or verbal dependent upon the needs and risk to the mother or other family member. It is important to consider the risk and safety of the mother or other family member should a safety plan be found by the perpetrator.

The mother or other family member should take part in developing the safety plan with the MCH nurse. At a minimum, the safety plan should include:

* list the contact numbers for a family violence organisation (local and 24-hour)
* list emergency contact numbers
* identify a safe place for the mother or other family member to go and how to get there
* identify a family member, friend or neighbour who can help in an emergency and how to get there
* identify a way for the mother or family member to get access to money in an emergency
* identify a place to store valuables, medical needs such as prescription medicines, inhalers et cetera, and important documents so they can be quickly and safely accessed in an emergency
* discuss the needs of infants and/or children
  + discuss any issues that may hamper the mother or other family member from fulfilling the safety plan.

#### Referrals

To provide continued support to families, MCH nurses may determine a need to refer to other services. Referrals can include:

* specialist family violence services
* Child FIRST
* police
* specialists in child trauma where the child needs a specialist therapeutic response
* a legal centre/service
* GP or other medical professional/service
* the family may require case coordination or links to an existing care team to support them to navigate the service and broader system
  + police and the department must be notified in circumstances where child abuse is suspected.

#### Professionals present

Family violence consultations are to be led by the MCH nurse. In some cases, the MCH nurse may choose to hold a joint consultation with a family support worker, bi-cultural or Aboriginal Health Worker, and/or specialist family violence practitioner. To reflect collaborative practice and information sharing, other professionals present during the family consultation are recorded and included in the MCH annual report. An extensive range of services and practitioners can be identified.

#### Location

* office/MCH centre
* client’s home
  + other

## 13. Enhanced Maternal and Child Health program counting rules

The counting rules are as follows.

Count in the first quarter of the financial year:

* ongoing cases at the beginning of the quarter, and
  + new cases opened during the quarter.

Count for the remaining three-quarters of the financial year:

* + new cases opened during the quarter.

The number of case closures will no longer be recorded.

Example:

Ongoing cases at the beginning of the financial year = 5

New cases opened during the first quarter = 1

New cases opened during the second quarter = 2

New cases opened during the third quarter = 0

New cases opened during the fourth quarter = 1

Number of clients receiving a service (5 + 1 + 2 + 0 + 1) = 9

Cases should not be closed for data collection purposes; rather, they should be closed when the client is discharged from the EMCH program. The length and intensity of contact by the EMCH program with a family is a matter for professional judgment based on the complexity of family needs and efficient and effective service provision for families, but must be reviewed at 20 hours of service as per EMCH guidelines.

**Note:** Funding arrangements require that KAS consultations delivered by the EMCH program are reported in the Universal MCH data collection system – CDIS and Xpedite.

The data toollkit provides definitions to terms utilised by the department for the collection of MCH data. The definitions follow the annual report template and those used in CDIS.

# Appendix F: Supporting documents

## Relevant legislative requirements

[Charter of Human Rights and Responsibilities Act 2006](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/7379cff5e33da38dca257d0700051af8!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/7379cff5e33da38dca257d0700051af8!OpenDocument>

[Children, Youth and Families Act 2005](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/3f6acb377b6aaecaca2583300003a086!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/3f6acb377b6aaecaca2583300003a086!OpenDocument>

[Child Wellbeing and Safety Act 2005](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/6794fe060ecd3045ca258338000477fa!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/6794fe060ecd3045ca258338000477fa!OpenDocument>

[Financial Management Act 1994](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/0b4e1c0f18e088fbca257e740016ffbb!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/0b4e1c0f18e088fbca257e740016ffbb!OpenDocument>

[Health Services Act 1988](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/f5db38e98bb3b63fca258314001b18b5!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/f5db38e98bb3b63fca258314001b18b5!OpenDocument>

[Health Records Act 2001](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/c9e5d05360a29382ca258314001aea30!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/c9e5d05360a29382ca258314001aea30!OpenDocument>

[Information Privacy Act 2000](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/888531ee4fd65b5cca257d570024131b!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/888531ee4fd65b5cca257d570024131b!OpenDocument>

[Occupational Health and Safety Act 2004](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/97b21dee74173e6aca25831400049704!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/97b21dee74173e6aca25831400049704!OpenDocument>

[United Nations Convention on the Rights of the Child 1990](http://www2.ohchr.org/english/law/crc.htm) <http://www2.ohchr.org/english/law/crc.htm>

[United Nations Declaration on the Rights of Indigenous People 2010](http://social.un.org/index/IndigenousPeoples.aspx) <http://social.un.org/index/IndigenousPeoples.aspx>

[Working with Children Act 2005](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/e91f7781500807b7ca2582fd0007fefe!OpenDocument) <http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/e91f7781500807b7ca2582fd0007fefe!OpenDocument>

## Policy resources

[Child Information Sharing Scheme](https://www.vic.gov.au/childinfosharing) <https://www.vic.gov.au/childinfosharing>

[Client incident management system](https://providers.dhhs.vic.gov.au/cims) <https://providers.dhhs.vic.gov.au/cims>

[Department of Human Services Standards](https://providers.dhhs.vic.gov.au/human-services-standards) <https://providers.dhhs.vic.gov.au/human-services-standards>

[Department of Human Services policy and funding plan](https://www.dhhs.vic.gov.au/publications/policy-and-funding-guidelines-health-and-human-services) <https://www.dhhs.vic.gov.au/publications/policy-and-funding-guidelines-health-and-human-services>

[Family Violence Information Sharing](https://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.html) <https://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.html>

[Human Services Standards Aboriginal culturally informed resource tool](https://providers.dhhs.vic.gov.au/human-services-standards-aboriginal-culturally-informed-resource-tool-word) <https://providers.dhhs.vic.gov.au/human-services-standards-aboriginal-culturally-informed-resource-tool-word>

[Intensive Family Services Guidelines](https://providers.dhhs.vic.gov.au/intensive-family-services-program-guidelines-word) <https://providers.dhhs.vic.gov.au/intensive-family-services-program-guidelines-word>

[Korin Korin Balit Djak: Aboriginal health, wellbeing and safety strategic plan](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak) <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>

[NDIS in Victoria](https://www.vic.gov.au/ndis/rollout-in-victoria.html) <https://www.vic.gov.au/ndis/rollout-in-victoria.html>

[Practice guidelines: NDIS and mainstream services](https://providers.dhhs.vic.gov.au/service-providers/practice-guidelines-ndis-and-mainstream-services) <https://providers.dhhs.vic.gov.au/service-providers/practice-guidelines-ndis-and-mainstream-services>

[Procedural requirements: Referral and consultation Child Protection, Child FIRST and Integrated Family Services](https://providers.dhhs.vic.gov.au/procedural-requirements-referral-and-consultation-child-protection-child-first-and-integrated) <https://providers.dhhs.vic.gov.au/procedural-requirements-referral-and-consultation-child-protection-child-first-and-integrated>

[The Orange Door (Support and Safety Hubs)](https://www.vic.gov.au/familyviolence/support-and-safety-hubs.html) <https://www.vic.gov.au/familyviolence/support-and-safety-hubs.html>

[Reportable Conduct Scheme](https://ccyp.vic.gov.au/reportable-conduct-scheme/) <https://ccyp.vic.gov.au/reportable-conduct-scheme/>

[Roadmap for Reform: Strong Families Safe Children](https://dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children) <https://dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children>

[Service Agreement Information Kit](http://fac.dhhs.vic.gov.au/service-agreement-information-kit) <http://fac.dhhs.vic.gov.au/service-agreement-information-kit>

[A strategic framework for family services](https://providers.dhhs.vic.gov.au/strategic-framework-family-services-pdf)  <https://providers.dhhs.vic.gov.au/strategic-framework-family-services-pdf>

[Wungurilwil Gapgapduir: Aboriginal children and families agreement](https://dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement) <https://dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement>

# Appendix G: Glossary

| Term | Definition |
| --- | --- |
| **Aboriginal** | Aboriginal refers to a person descended from an Aboriginal person. The term Aboriginal has been used in this document and includes Aboriginal and Torres Strait Islanders. |
| **Child, maternal and family centred practice** | The approach to identification and management of the child, mother and family that focuses on the strengths of each individual family. |
| **Case coordination** | Case coordination includes communication, information sharing, and collaboration, in partnership with the family and health, family and community services. |
| **Child, maternal and family centred practice** | The approach to identification and management of the child, mother and family that focuses on the strengths of each individual family. |
| **Collaborate/collaboration** | To work together, with other members of the Maternal and Child Health Service, and/or other health and family services and organisations, and/or with the family to achieve unified goals so as to optimise the child’s health, wellbeing, learning, development and safety. |
| **Cultural and linguistic diversity**  **(CALD)** | The term CALD refers to the children and families who hold a particular cultural or linguistic connection attributable to their place of birth, ancestry, ethnic origin and religion. |
| **Cumulative harm** | Cumulative harm refers to the serious impact for the child of continuing or recurring actions, omissions and behaviours over time. Harm that arises from either a single traumatic incident or a series and pattern of events and circumstances is equally serious. The central aspect of harm is the outcome for the child, which is by determined by the impact on the child's stability and development. |
| **Development** | Development is a core dimension for considering a child's best interests. It covers the areas of life where all children need opportunities, encouragement and support throughout childhood to develop to their full potential. |
| **Equity** | An equitable society is one in which all can participate and prosper. The goals of equity must be to create conditions that allow all to reach their full potential. In short, equity creates a path from hope to change |
| **Family** | Is inclusive of carers as well as parents. It may include those people who consider themselves a family (whether or not they are related by blood or marriage). Aboriginal children are born into a broad community of care that consists of immediate family, extended family and the local community |
| **Family centred practice** | The approach to identification and management of the child, mother and family that focuses on the strengths of each individual family. |
| **Father** | Refers to a male caregiver who provides parenting to a child. The definition includes biological and social fathers (such as stepfathers, foster carers, male partners) and father figures such as uncles and grandfathers. |
| **Governance** | A system through which the Maternal and Child Health Service is responsible and accountable, and continually improves quality and safety for children and families accessing the Service. Governance comprises clinical governance; responsibility for the safe and quality service delivery and corporate governance; and responsibility for the corporate structures supporting service delivery. |
| **Health** | A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. |
| **Incident** | An event, including an accident, that resulted in, or had the potential to result in, harm to the child, or family, or a member of the maternal and child health workforce, including physical or emotional injury, ill-health or other loss. |
| **Infant and child** | The terms ‘infant’ and ‘child’ are used to refer to the child, infant or unborn infant who is the focus of the services that are being provided by the MCH Service |
| **Inclusion** | Empowering access to opportunity, addressing structural inequalities, tackling unconscious bias and developing inclusive organisation |
| **Intersectionality** | A theoretical approach that understands the interconnected nature of social categorisations – such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age – which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group |
| **Maternal and child health nurse** | In order to practice as a MCH nurse in Victoria, a MCH nurse is required to hold current registration with APHRA as a Registered Nurse (Division 1) and a Registered Midwife. In addition to the registrations, hold an accredited postgraduate degree/diploma (or equivalent) in maternal and child health nursing. |
| **Maternal and child health service** | Refers to the overarching, state-wide Maternal and Child Health Service. ‘MCH centre(s)’ refers to individual centres located within each local government council area that provides Maternal and Child Health programs. |
| **MCH Service provider(s)** | The entities that provide Maternal and Child Health programs, including councils, ACCHOs, health services or any other person or entity engaged by a council to provide the programs on its behalf or is otherwise engaged or funded by the department to provide MCH programs. |
| **Mother** | Refers to a female caregiver who provides parenting to a child. The definition includes biological and social mothers (such as stepmothers, foster carers, female partners) and mother figures such as aunts and grandmothers. |
| **Parent and Carer** | The terms ‘parent’ and ‘carer’ are used interchangeably to describe the person or people who have substantial responsibility for ongoing care and support of the child, infant or unborn infant for whom the MCH Service is being provided. This parent may or may not be the biological parent; they may be a step-parent, foster parent, grandparent, or other carer |
| **Safety** | Safety is the foundational dimension for considering a child’s best interests. Adequate safety is a prerequisite for every child’s development and stability. A child experiences safety by having the basic care they need for their immediate and future stability and healthy development and by being protected from any harm and its adverse consequences for their immediate and future stability and healthy development. |
| **Setting** | The surrounds in which the MCH Service is delivered. This may include, but not be limited to the MCH centre, within a child’s, mother’s or other family member’s home; over the telephone; as part of other health services or organisations; within groups; and in local facilities and buildings. |
| **Significant harm** | Significance must be defined in a way that is specific to the case. Justice O'Brien in the Supreme Court (Buckley vs CSV 1992) identified significant as:   * ‘more than trivial or insignificant, but need not be as high as serious … and * (is) ‘important’ or ‘of consequence’ to the child’s development * it need not have lasting or permanent effect, nor necessarily be treatable |
| **Specialist services** | Services with specific expertise that cater for a defined group of clients with similar concerns, for example, sexual assault services, drug and alcohol services and mental health services. |
| **Support** | Indicates the provision of information, advice, education, counselling and other relevant activities by the maternal and child health workforce to the family. |
| **Universal services** | Services established for and accessed by a large proportion of the population, for example, schools, general medical practices and maternal and child health services. |
| **Vulnerable child** | Children and young people are vulnerable if the capacity of parents and family to effectively care, protect and provide for their long term development and wellbeing is limited – *Victoria's vulnerable children: our shared responsibility strategy 2013–2022* |
| **Vulnerable family** | The family may be at risk of adverse health and wellbeing outcomes due to individual, parental or family experience or circumstances. |

# Appendix H: Text-equivalent descriptions of figures

Figure 1: The MCH framework provides the overall relationship of the documents that drive the Victorian MCH Service

First column

* MCH service standards

Second column

* Maternal and child health service clinical practice guidelines

Third column headed ‘Maternal and child health guidelines’ is split into three sub-columns:

* Maternal and child health universal program guidelines
* Enhanced maternal and child health program guidelines
  + Maternal and child health line program guidelines

Figure 2: MCH Principle model

At the centre of the model is ‘Maternal, child and family-centred practice’

Around the outside are:

* Universal access
* Victorian Aboriginal communities’ cultural safety
* Equitable and inclusive
* Diversity responsiveness
* Health promotion, prevention and early intervention
* Collaboration and partnerships
* Quality and safety
* Evidence informed
* Reflective practice and continuous improvement

Appendix B: Victorian Maternal and Child Health Service logic model

Vision: All Victorian children and their families will have the opportunity to optimise their health, wellbeing, safety, learning and development during the period of a child’s life from pre-birth to school age.

Mission: To engage with all families in Victoria with children from birth to school age (and unborn children) to take into account their strengths and vulnerabilities, and to provide timely contact and ongoing primary health care in order to improve their health, wellbeing, learning and development.

Goal: To provide health, wellbeing, safety and development outcomes for children and their families, providing a comprehensive and focused approach to managing the physical, emotional and social factors affecting families in contemporary communities.

First column

Inputs:

* State and local government funding
* Physical infrastructure and resources
* MCH nurse workforce and supporting multiidisciplinary workforce
* Service framework and guidande
  + Information systems

Pariticipants:

* + Victorian families with children from birth to school age

Stakeholders:

* Maternity services
* Family services
* Multidisciplinary support teams
* Primary, secondary and tertiary health and human services and networks
  + Safety and Support Hubs

Second column

Activities:

* Universal MCH program
* Engagement and outreach
* KAS consultations (development monitoring, health promotion, learning — play, learn and grow)
* Secondary screening
* Family violence consultations
* Parent groups
* Response, referral and advocacy
  + Service quality and system development

Enhanced MCH program:

* Active engagement
* Case coordination
* Ongoing assessment
* Response, referral and advocacy
  + Service quality and system development

MCH Line:

* Information and advice
* Support and counselling
* Response and referral
  + Service quality development

Third column

Outputs

Universal MCH program:

* Families are enagaged and participate in MCH visits from birth to school age

Enhanced MCH program:

* Active, targeted engagement and support for children and families who need additional help and may be at risk of poor outcomes

MCH Line:

* 24-hour access to reliable, evidence-based information and advice for parents and families

Fourth column

Outcomes

Short term

Children:

* Children’s health, wellbeing, safety, learning and development is effectively monitored
* Early detection of child health and development issues
  + Children experience better access to early childhood health and development services

Parents and families:

* Parents have knowledge and confidence to support their children’s health, wellbeing, learning, safety, development
* Parent have knowledge and confidence to provide a positive and safe home environment
* Improved parent knowledge and capacity to be health and well
* Early detection of additional parent or family support needs or interventions

System and community:

* Strong community linkages
* Improved konwledge of available supports and capacity to access them

Medium term

Children:

* Children’s health, wellbing, safety, learnng and development is optimised
  + Early responses are provided to child health and development issues

Parents and families:

* Parenting practices support child health, wellbeing, safety, learning and development
* Parents provide a positive and safe home environment
* Parents’ health and wellbeing is optimised
  + Early responses are provided to additional parent or family support needs or interventions

System and community:

* Strong community and parternships facilitate child and family outcomes
  + Improved inforamtion sharing and collaboration with other services to support child and family outcomes

Long term

Children:

* Children achieve optimal health wellbeing, safety, learnng and development

Parents:

* Parents have the support they need to build lvoing and nurturing relationships in their families and to be effective first educators in their child’s life

System and community:

* Strong and supportive communities provide an enabling environment for children and families
* Strong collaborative relationships between MCH Service providers facilitate continuity of care for children and families
* Implementation of information sharing legislation supports improved child and family outcomes

1. National Aboriginal Health Strategy Working Party (NAHSWP) 1989, *A national Aboriginal health strategy*, National Aboriginal Health Strategy Working party, Canberra. [↑](#footnote-ref-2)
2. 2017–18 MCH annual report data [↑](#footnote-ref-3)