T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

Members

Mr Paul Edbrooke — Chair	Ms Chris Couzens
Ms Cindy McLeish — Deputy Chair	Ms Maree Edwards
Ms Roma	Mr Bernie Finn
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Witnesses

Ms Kym Peake, secretary, and

Mr Terry Symonds, deputy secretary, health and wellbeing division, Department of Health and Human Services.

The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee's inquiry into perinatal services in Victoria. This is the eighth hearing to be held by the committee for this inquiry in a series of hearings that have been held in Melbourne and across regional Victoria. These proceedings today are covered by parliamentary privilege, and as such nothing that is said here today can be subject to any court action. Please note that broadcasting or recording of this hearing by anyone other than accredited media is not permitted, and I would ask everyone to ensure their mobile phones and devices are turned to silent. I would like to call our first witness, the Secretary of the Department of Health and Human Services, Kym Peake.

Ms PEAKE — Thank you very much. I might just ask Terry to pass around the presentation for some opening remarks.

The CHAIR — No worries. While we do that I will go through my spiel. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. I now invite you to make a 15 to 20-minute submission, and if we can follow up with questions, that would be fantastic.

Ms PEAKE — Fantastic. Thank you, Chair. I would like to begin by thanking the committee for the opportunity to speak with you today but also acknowledging the traditional owners of the land on which we meet and paying my respects to elders past and present.

Of course we all are deeply aware that safe and high-quality care through pregnancy and in the year that follows is critical to providing a foundation for a good start for life for our children. With over 90 submissions — and as you indicated, Chair, seven public hearings to date — the terms of reference for this inquiry have seen a broad range of issues raised by our health services, clinicians and community members, and while care during pregnancy and in the early days that follow has been the focus of many submissions and witness statements, I am conscious the committee has also considered our system of services and support for families with children up to one year of age.

As you would be aware, a number of departments and agencies from right across government share the design, management and monitoring of this early years service system, and so over today I am pleased that my colleagues Professor Euan Wallace, CEO, Safer Care Victoria, and Kim Little, assistant deputy secretary of the department of education, will also be elaborating on different elements of the system of care that we provide.

My comments today are really focused on public maternity services and the actions that we have taken to strengthen population projections to plan for service capacity, to increase access to level 5 and 6 services — the more complex services in particular — and, importantly, to increase our oversight of the capability of maternity services across the state.

Our model of delivery of maternity care is very much guided by a wellness model, which means that care is designed around the needs of each woman and she is supported to be an active participant in her care. While three out of every four babies are born in a public maternity service, early pregnancy and postnatal care is usually provided in the community by general practitioners and maternal and child health services. Transition in a woman's primary carer reflects that responsibility for perinatal care is a shared responsibility, and that is a very strong characteristic of the system here in Victoria.

While Victorian public maternity services play a central role in birthing, general practice in particular is a critical partner in maintaining good access to safe, high-quality and, critically, local pregnancy care. Access to affordable and quality general practice is absolutely critical but, as the committee is aware, is predominantly a responsibility of the commonwealth, but one that we work very closely with them on.

One accepted high-level measure of safety in the maternity care system is the mortality rate for babies, which Professor Wallace will talk in more detail about. But with the permission of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity chair, I can advise the committee that the 2016 *Victoria's Mothers, Babies and Children* report highlights that Victoria maintains its lowest adjusted perinatal mortality rate in 16 years at 8.8 per 1000 births. Of particular importance is that after almost a decade of steady

improvement the 2016 adjusted perinatal mortality rate for babies born to Aboriginal women in our state was for the first time comparable to babies born to non-Aboriginal women, which is a fantastic result. These critical indicators provide us assurance that for the vast majority of women our services provide safe care and that critical foundation for a good start.

However, we are deeply conscious that our maternity system has failed some Victorian families, identified by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. The cluster of perinatal deaths at Djerriwarrh Health Services during 2013 and 2014 began what has become one of the most significant overhauls of our quality and safety systems in health in many decades. Dr Stephen Duckett and his panel's review of our health system, *Targeting Zero*, really found that as a department we could and should do more in our oversight functions to make sure that we are providing system-wide oversight of quality and safety across our health services, to make sure that we are collecting and sharing better data about quality and safety across the system and using a more systematic approach to quality improvement across our system. A large focus of our last year has been responding to the findings and recommendations of *Targeting Zero*, which again Professor Wallace will talk in much more detail about.

Through the work of the creation of Safer Care Victoria and the Victorian Agency for Health Information we are very focused — as well in Terry's division — on supporting strong leadership in hospital governance with good clinical leaders, effective boards and rigorous oversight; sharing excellence in good practice across our health system so that, where one hospital does something well, other hospitals can follow; and collecting better data about patients' experiences as well as their outcomes and feeding that back to improve patient care.

We see ourselves, as stewards of the health system, as having really three critical responsibilities. The first is to work in partnership with health managers and professionals to advance shared priorities, the second is to manage and respond to emerging risks early and the third is to support the system where challenges or incidents transcend a single service.

If we look at slide 3, our commitment to these responsibilities is really reflected in the tangible steps we have taken towards our goal of zero avoidable harm in our hospitals. Established in 2016 and following the release of *Targeting Zero*, Safer Care is partnering with consumers, clinicians and health services to support continuous improvement in health care. While of course Safer Care is a new agency, they are well supported by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, which has operated to review all cases of stillbirth, maternal, neonatal, infant and paediatric death and morbidity for over 50 years — a really critical part of our infrastructure for quality assurance.

Each year the council's expert clinicians examine the findings of each case in order to provide advice and recommendations to help services, the department and government on strategies to improve the safety and quality of maternity and newborn care. We also publish each year a set of perinatal service performance indicators, which provide information for consumers as well as health services and also provide a basis for us to identify and plan improvements in care through the benchmarking that those indicators provide. We are now including information about private hospitals through that report so that we can build accountability but importantly also transparency across our system.

The Victorian Agency for Health Information — I am just moving quickly through now to slide 5 — is also leading work on how we use that data and information to stimulate informed improvement in clinical care across both public and private hospitals, how we strengthen our local oversight of health and community services and, importantly, how we inform the Victorian community about safety and quality of care in their local area.

We have also recently established the Victorian Clinical Council, looking at a model that had existed in other parts of the country to make sure that we had deep engagement with clinicians but also with patient advocates to make sure that we give good advice to government from their perspectives on how to make the system safer and provide better care to all Victorians. And we have established regional maternal and perinatal mortality and morbidity committees that review all cases of perinatal and maternal death and serious morbidity. Those committees were established after the events at Bacchus Marsh to ensure that our smaller rural hospitals or rural services are supported to review any adverse outcomes, share learnings and strengthen clinical practice. Only 18 months old, I think they have been really successful in bringing together midwives, medical staff, general practitioners and others to confidentially review cases and plan improvements.

We have also established a new statewide perinatal autopsy service which is led by the Royal Women's Hospital and is outlined on slide 6. This service is all about improving timely access to expert investigations for Victorian families who have experienced the loss of a baby and is strengthening education and training for clinicians reviewing perinatal deaths.

Like other jurisdictions, Victoria has a tiered maternity and newborn service system which is described on slide 7. Capability frameworks are something that we have put a lot of effort into, starting from really 2011 but updated in 2015 to describe the minimum requirements for planned care across six levels and to assist health services to provide maternity and newborn care that response to the changing needs of the community. These tools also ensure women are provided consistent care from services with the same capability, regardless of where they live. The recent Auditor-General report commented on the fact that in the last 12 months we have really sought to play a stronger role as system managers who not only rely on health services that devolve governments to self-assess against those capability frameworks but to undertake annual reviews so that we can provide confidence to the whole system and the community that people are operating within their capability.

You might be aware, in both capability frameworks level 1 and 2 services provide low-risk care for women experiencing healthy and uncomplicated pregnancies and for babies born at term, while at the other end of the continuum our highest complexity level 6 services are centralised to Melbourne where the complex clinical, diagnostic and support services are located and available 24 hours a day, seven days a week. What we have also done, as well as improving our oversight, is to make sure that we have more of those level 6 beds available, but also that we have more level 5 care available more locally across the state.

We are very conscious, just moving through to slide 8, that it can never be a matter of just setting and forgetting our system capacity and our system settings. We need to continually be monitoring what is happening with population, with practice, with workforce and taking a more comprehensive approach to planning and workforce development. Today we oversee a network of 54 public maternity and newborn services to provide local access to pregnancy care, with about two-thirds of Victorian women birthing within their local community.

While most women choose to birth in a public hospital, pregnancy care, as I mentioned at the outset, usually begins with a general practitioner, so as we continue our work to reorganise and recalibrate the system to ensure it meets the community's expectations, the commonwealth and general practice are really critical partners for us and we have been doing a lot of work with primary health networks about how their general practitioners work closely with our public health services to make sure that we have local access to high-quality maternity and newborn care.

We expect that the number of births in Victoria will reach about 90 000 over the next decade, and one of the other things that we have put a lot of effort into in the last couple of years is really improving our forecast capability, both through working with DELWP around the whole-of-government population indicators but also recognising that inevitably local health services and local communities are our front line of understanding what is actually coming through the door — so working closely with them to make sure that our projections are agile and adaptive. We do expect that public maternity services will manage about 9500 additional births over the next decade, with most of those births to occur in our northern, western and southern metropolitan region areas, with hospitals in these communities like Sunshine, Northern and Casey accommodating about an extra 5500 births over that time frame. We are responding to those changes and supporting health services to grow the maternity and newborn services that their communities need.

In 2017–18 health services providing planned maternity and newborn care across metro, regional and rural Victoria received an additional $31 million compared to the previous year, and new investment is also providing critical new capacity with the opening of the new Bendigo base hospital in January this year, the new Monash Children's Hospital in March and the new Joan Kirner Women's and Children's Hospital in Sunshine to improve and maintain access to care for our growing western metropolitan communities.

At the same time as managing that growing demand in some areas we are also managing declining demand in others. Over the past decade our rural maternity services have recorded a 13 per cent decrease in births, a trend that we expect to continue and have experienced in communities like Colac and Kyneton. So our focus there is absolutely about preserving and strengthening safe and high-quality maternity care to ensure that we have responsive forward planning, expert clinical leadership and good service governance. We recognise that we need to strengthen regional and local planning, and that is something that we have been doing a lot of work on,

so we are looking at having a statewide service planning framework, which then cascades down into planning frameworks for particular types of services like maternity care but also for particular geographies.

The establishment of rural and regional health partnerships is another way that we are seeking to invent collaborative mechanisms and a greater focus on system leadership by regional health services. A number of these partnerships, which are partnerships between bigger regional services and smaller services, have identified maternity care in the region as a priority to address and build strong networks for referral and for collaboration. We know that as the work of our six regional services changes to provide more complex care, as I mentioned earlier, these services will need to change their workforce models and skill mix, and we know that we need to really be prepared because that sort of adjustment takes planning and time.

While capability levels guide the provision of planned maternity and newborn care, for some women and babies, as I know has been expressed through a number of submissions to you, emergencies and changes to care do happen and a swift emergency response is absolutely vital. Our specialised retrieval service for mothers and babies is highly regarded nationally. Known as PIPER, the paediatric infant perinatal emergency retrieval service for pregnant women, babies and children with serious medical problems each year facilitates about 1,700 transfers for women and babies who require immediate specialised care.

Our work on the newborn capability framework improved clinical definitions of which babies need level 6 care and consistent investment in both level 6 cots and services with level 5 capability, including in bigger regional centres, means that I think we are in a much better position now than we have been in the past in terms of the newborn system. We now have an additional 21 level 6 cots funded into the system since 2011–12, so where it was once necessary to send babies interstate from time to time because of capacity constraints in our level 6 units we have not seen that being necessary for the last three years.

Our monitoring system also tells us that we need to focus on the outflow for babies from level 6 services to get that balance right, so we have been building capacity at services like Barwon, Northern and Sunshine as well as our regional hospitals to be able to rapidly accept babies who are ready to step down from the most intensive care in a level 6 nursery.

We are also of course working with our services to make sure that the workforce is developed so that babies can be nursed closer to their home and family sooner. I might just skip over but just mention very briefly that in that system of having statewide planning and then specific plans around maternity and newborn services we are well advanced in our statewide design service and infrastructure plan development which establishes five priority areas to guide investment in our health system. That is just summarised on page 9, informing when and where we invest in infrastructure, programs and services to meet changing needs, including for really rapidly growing communities in outer northern, western and south-eastern suburbs, as well as through this looking at how we improve integration of care, both within the health system but also with social services as well.

We have also been very focused on looking at clinical stream plans, and the development of the design service and infrastructure plan for the Victorian maternity and newborn service system is also well underway — a plan that will provide a maternity and newborn service system blueprint for the coming five years. Very similar to the focus of this inquiry, that plan is focused on preserving access to high-quality care that is close to home, strengthening our capacity to deliver integrated innovative care and maintaining and building our maternity and newborn workforce. Again, that is just summarised on page 10.

I just wanted to finish with a few comments on how we are trying to respond more effectively to vulnerable communities and communities which have women with additional needs. We know, for example, that one in five Victorian women is obese during their pregnancy, and obesity, like other chronic health issues, increases the risk of poor perinatal outcomes. Through initiatives like our recently released Maternity eHandbook and expanding telehealth, we are providing more clinicians easier access to evidence-based practice guidelines and specialist advice as they care for women with additional clinical needs.

I think those improvements I mentioned earlier in the outcomes for Aboriginal women are in large part due to the investment we have made over a number of years in the Koori maternity services program, which provides tailored flexible maternity care which is culturally safe. Those Koori maternity services are now providing antenatal care to about 75 per cent of Aboriginal women birthing in Victoria and, in partnership with the Victorian Aboriginal Community Controlled Health Organisation, released Koori maternity services guidelines, again to help inform practice. Those guidelines were released in February this year.

Finally, in the space of family violence we have also since the royal commission been doing a lot of work to help increase the role that our health services can play in identifying and providing a first response for victims of family violence. With pregnancy recognised both as a time of escalated risk for violence to begin or to increase, we have been doing a lot of work to establish routine antenatal screening in public maternity services. Seven hospitals have begun work to commence routine antenatal screening for family violence, and that will happen from December this year. The establishment of the Strengthening Hospital Responses to Family Violence in each of these hospitals has provided the foundation to begin this really critical work.

Family Safety Victoria has also been partnering with the Royal Women's Hospital to update the screening questions that are used by health services as well as the referral pathways.

To conclude, as you have heard in a lot of the submissions made to you, maintaining access to a stable and skilled maternity and newborn workforce is one of the major challenges that all systems face, especially for our regional hospitals that are experiencing growth in demand. The nursing and midwifery workforce in particular is ageing, and the impact of these practitioners leaving the workforce is further compounded by the high level of part-time work, which is the preference of a lot of that workforce that is remaining.

While the department continues to support our maternity and newborn workforce with targeted recruitment strategies and training programs — I am happy to go into any of this in a bit more detail — we have also established a nursing and midwifery planning advisory group to provide us with advice on workforce policy and innovation. In the 2016–17 state budget, additional funding was provided to assist public maternity services to review and strengthen their fetal surveillance policies, training and review processes for their workforce, and a new training program delivered by the Royal Women's Hospital has been established for small rural maternity services.

We know that with all of that investment and that emphasis there is still more to do to really reverse the impact of long-term demand on mental health services for women who need them. We are seeing some really great examples of local innovation in this space, but we know that there is more to be done at a system level for vulnerable families to get them the services and support they need, which is why we are supporting services to develop, test and then build the case to replicate initiatives live Healthy Happy Beginnings and the Wangaratta antenatal care project, both of which are really about providing more intense or more substantial outreach in support to vulnerable women to keep them connected to services in their community.

One thing I would leave you with which is a positive is that, while there is still work that we are needing to do on workforce and planning and being ever vigilant around making sure that the capability in our health services is aligned with the services that are being delivered, I am pleased to share with the committee that our most recent Victorian Healthcare Experience Survey data reflects that over 90 per cent of women rated the care they receive in public maternity services as good or very good.

As we work alongside communities, one of the constant refrains for all of us is continuing to ask what are women saying about their experience of care and really putting their experience and outcomes at the centre of all of the work we do. We see that as being a really critical measure of the impact of changes we are making for safe and high-quality care and what will guide our work into the future. I thank the committee for their time. I am happy to answer questions.

The CHAIR — Thanks so much, Kym, and Terry as well. I am sorry. We neglected to welcome you before. Thanks so much for a comprehensive presentation. There are certainly some impressive stats as well. I guess from our perspective as an inquiry, like you, we are looking at some things we can improve on, so I think most of the questions we are going to ask today will be involving some of those. We have heard about some positive statistics; where are the gaps?

I would like to start by asking a question about something you were concluding on — that is, about the midwifery workforce. You have talked about the advisory group — I would love to hear a little bit more about that — and some recruitment and training schemes. We have heard time and time again throughout our hearings both in terms of retention and retirement that this is affecting the midwife workforce in regional areas. What is your view on how we go forward and retain or recruit these people, especially in areas of high population growth?

Ms PEAKE — I think it is equally a challenge where the numbers are low, as it is where there is growth as well. To give this a bit of context, on the one hand we do have one of the highest rates of midwives full-time equivalent per 100 000 of the population, so we are second only to the ACT and NT overall. But, as I indicated in my opening remarks, we do see a trend towards the midwives wanting to work fewer hours, so it is important that we understand not only the overall numbers but the volume of work that is being completed. Similarly with general practitioners, we all know that it is always a challenge to make sure that distribution across the state — so regional distribution and rural work — is achieved.

There are a couple of things that we are doing. The Maternity Connect Program is a program that is about providing placements for rural and regional midwives in large maternity health services so that they do get the breadth of experience and increase their clinical exposure and skills, which is obviously critical to maintaining their midwifery registration but also their experience in providing best quality care. That has been in place since 2012, and there have been 300 completed placements in the program over that period. In fact a number of midwives who have been through the program have sought repeat placements as an opportunity to really retain and refresh their skills. I think that combination of making sure that we continue to provide the access to education and the network of practice — and this will be something that I think Euan will talk about more, the sort of clinical network that we are creating — to provide that sort of peer support to people that we see as being really important for continuous improvement but actually important for retention purposes as well. Terry, is there anything else you wanted to —

The CHAIR — Sorry. Before you speak, Terry, could you clarify your role for the inquiry?

Mr SYMONDS — I am the deputy secretary for health and wellbeing, so both the service and system planning functions that Kym described and the policy and program areas for maternity care fall within my division of the department.

Ms PEAKE — Do you want to talk just a little bit about the advisory groups and the work that they are doing in the growth corridors, as the Chair mentioned, but also in smaller populations?

Mr SYMONDS — Yes. The advisory group will look at the statewide data with us. One of the things I would observe, I suppose, in the data is the distribution statewide. It does not appear to be out of whack in terms of the percentage of births per local area and the percentage of midwives statewide. They roughly align on a kind of rural and regional basis. So the advisory group will look at some of the data with us and think about what funding or additional support needs to be targeted to particular areas.

The other thing I would observe about our state is that rural and regional gets a slightly larger share of the nursing and midwifery workforce support funding from the department. It gets about a third of that funding. Roughly a fifth of births in Victoria happen in rural and regional Victoria, but nursing and midwifery support for rural and regional areas would get about a third of that — about $15 million or something of that order.

The other thing they will do is assist us to work with education providers, and I think on your agenda for the day you have got a session with deans of the schools. They would assist us to work with that — think about a pathway, a pipeline, for development of a future workforce.

The CHAIR — The second question I have got just refers to I think it is page 7 of your presentation where you said:

> Annual re-assessment provides assurance that services with the same capability are providing consistent care to women and babies regardless of where they live.

That is something that certainly I think committee members would agree that we have not heard. The rural areas of course have the same risk factors of BMI and obesity and diabetes but of course different time and distance constraints, but I would say that the perception in Mildura or Warrnambool is not that they are receiving the same capabilities. So just in your opinion is there room for improvement? We are just going on what we have heard. Is there a reason why that perception is different from what is in your presentation?

Ms PEAKE — Yes. I think the Auditor-General's report is really insightful in this regard. What VAGO concluded was that when the capability framework was brought out in 2011 it was really a system of self-assessments by the health services, and we had really relied on an aggregated view of those self-assessments. What we have sought to do in the past 18 months, really since Professor Duckett's report, is to

provide more system leadership in looking at that annual assessment so that it is a bit more of a compliance approach on one level, which is not just relying on self-assessment but is really looking more objectively at what capabilities there are, whether there have been changes in workforce or risk profile, how many procedures outside of the capability of the service have occurred over a 12-month period, and then back that up. In I think three instances Safer Care Victoria has then gone and done a sort of deeper service review. Professor Wallace could certainly talk to the committee a little bit more about that work.

But we also then follow that up with two types of support responses. The first is very much the piece that I talked about earlier: what are the relationships between bigger regional services and smaller rural services to provide the clinical oversight, the referral pathways and the sharing of workforce, so that we can try and keep as much delivery local as possible but make sure that it is safe? The second thing I would refer back to is those regional maternal and perinatal mortality and morbidity committees. They again are all about learning from adverse events and feeding that learning back in to the individual services, so very much a focus on more assurance but then continuous improvement learning and capability building.

Mr SYMONDS — If I could add something, Chair.

The CHAIR — Sure.

Mr SYMONDS — With the way your question was framed, I am not sure if what you were getting at was whether a service description in one part of the state is the same as a service description in another. Are they consistent? Our view would be we are much more consistent now than we ever have been before. The capability framework has helped with that, so a level 3 service in one part of the state offers the same service as a level 3 in a different part of the state, and the department works with them to make sure they are the same. That does not mean that supply is as high as it should be or access is as high as it should be, but I would say we now have a much more consistent measurement and description of services so we know that apples are apples and know what we are talking about in different parts of the state, and that allows us, I think, to plan to fill those gaps with additional workforce, for example.

The CHAIR — Yes, I appreciate that. I guess the way I was posing the question was because we know that emergencies happen, like Kym was saying, and things have to be escalated as well and there are always exceptions to a rule. I was just trying to get, I guess, a broad stoke across the sector.

Ms McLEISH — Thanks for coming in. For the Hansard record, could you explain to us the process of accreditation from maternal services in the state and the body that does that?

Mr SYMONDS — We do not separately accredit each particular department of a health service or hospital. Health services undergo accreditation according to national standards for quality and safety that have been developed by the Australian commission for safety and quality, so they set out the standards. Health services are required to arrange accreditation and then have their accreditation report provided to the Australian commission. We also are notified when accreditation raises issues, and those accreditations are comprehensive. Every service, including services that are contracted by a hospital or health service, are caught up in that accreditation process. So maternity services would definitely be part of that process.

Ms McLEISH — Do they all use the same accreditation process?

Mr SYMONDS — They do. They are accredited against the same standards. I would say, and again I will refer back to Stephen Duckett's review — one of the issues he called out is whether or not the accreditation process is rigorous enough. So, yes, they are all the same, but again it does not mean it could not be better. The accreditation process has been questioned at times for being overly reliant on documentation and good policy rather than getting under the hood and looking at what the actual quality of practice is like. Safer Care Victoria and the Australian commission are thinking about ways that the accreditation process could be a bit more assertive, I suppose, but that applies equally across the entire country, I would say.

Ms McLEISH — It was put to us that there are hospitals that use a different accreditation service — that use the ISO 9001. Are you aware of that?

Mr SYMONDS — Yes. Services are welcome to use —

Ms McLEISH — Do you know how many use that?

Mr SYMONDS — No, I do not. I am very happy to find out for you if you like.

Ms McLEISH — I will be asking it of the next presenter too.

Ms PEAKE — I think it is just important to elaborate a little bit on that. There are two things at play there. All health services are subject to that national accreditation process. They themselves in addition can have processes that they apply internally to measure the quality of their services and report to their board on that. So the two things, I would say, are complementary rather than substitutable.

Mr SYMONDS — That is right. It is mandatory for services to be accredited against the Australian commission standards.

Ms PEAKE — They might also then use other frameworks.

Ms McLEISH — I did not think that was the understanding. I thought that they used ISO.

Ms PEAKE — Yes, internally, but they have to be accredited nationally as well.

Ms McLEISH — Okay. With regard to PIPER you said there were some 17 000 transfers, and we have got about 75 000 births in the state. So 17 000 out of 75 000 is about 22, 23 per cent; is that high?

Ms PEAKE — Again I would say that it is critical to have that sort of service so if things do happen, there is an immediate response. But all of the work that we have been outlining — about making sure that the right type of service is done at each health service, that we are building the capability of the workforce and the referral pathways and the engagement of women earlier in their pregnancy — are all ways of making sure that we minimise the likelihood of there being those sorts of emergency situations and the need for PIPER to be called.

Ms McLEISH — So is it high?

Mr SYMONDS — If I could take that on notice? My number would suggest something close to 1700 rather than 17 000.

Ms McLEISH — With regard to the number of GP obstetricians in the state, do you know how many we have?

Ms PEAKE — Let me have a look. I do not think that I have that with me, but I can certainly take that on notice and come back to you on that.

Ms McLEISH — The reason I ask is we have visited a number of smaller health services that have relied heavily on GP obstetricians, and I wondered if you could comment on that model that you are looking at expanding on or working with the college on to have more GPs trained in that regard.

Mr SYMONDS — Yes, definitely. I might start by echoing the comments from Paul Worley, the new national rural health commissioner appointed by the commonwealth government, who said that rural generalists would be his number one priority in terms of addressing rural health care. By ‘rural generalists’ he means that all GPs are generalists, but rural generalists have exposure and qualifications in more procedural areas such as anaesthetics, surgical procedures or obstetrics. We agree with him that that is a very high priority. Our department funds programs for GP proceduralists. Queensland and New South Wales have more advanced programs in that area, but Victoria would be close behind. There are about 50 positions in Victoria that are funded by the department as rural generalists at the moment to try and increase their exposure. That is not in answer to your first question about how many there are in total, so we will have to take that one on notice, but we think it is a very important area of development.

The other comment I would make is that there has been a lot of investment in rural medical training. Most of our medical schools in universities would now have a rural medical school of some sort. There is no shortage of graduates, but attracting and retaining doctors in rural Victoria is a real issue, and I think we need a pathway that goes from their enrolment and undergraduate education right through to their specialist exposure in GP in rural areas. We have found that students, graduates and doctors who come from rural areas are more likely to stay there. I think it has to be a focus of our effort to identify early those graduates who are from rural Victoria and support them to rotate, pick up skills, be educated and return and practice in rural Victoria. That is something

we will work with the commonwealth and the colleges on. We fund RWAV, the Rural Workforce Agency Victoria, to deliver the rural generalist program on our behalf, but we work with colleges, and we will work with the commonwealth as well on that.

Ms McLEISH — This has been an issue for 20 years plus. Are we still not having it sorted?

Mr SYMONDS — I do not think anyone would say it is sorted anywhere in the country, no.

Ms McLEISH — So the issue of a lack of specialist doctors or GPs in country areas — we have been trying to work at it for 20, 25 years, and we have made no progress?

Mr SYMONDS — I would say we have made progress, but we are challenged. There are still populations declining in parts of rural Victoria, which means that the viability of some services becomes challenged by the nature of changes in population. That is not something we can necessarily change, but I think we have made some progress in terms of the programs that I have talked about being in place to support GPs to do that. They were not in place 15, 20 years ago.

Ms PEAKE — Just one thing I would add is that I think one of the issues for those GPs is the professional isolation that comes from being in a smaller place. One of the things that we have been looking at is how we network those professionals together. I know in Gippsland, for example, they have done some really interesting work with the college around what the peer support and ongoing professional development could look like. They have developed a diploma program, which is a collaboration between the college of obstetricians, the Australian General Practice Training program and the regions' health services and doctors. So I totally agree with Terry. We would never sit here and say this is not something we need to keep working on, but it is a good example of where there has been progress made.

Mr SYMONDS — I would also recommend to the committee the model in place in Wangaratta where an obstetrician based in Wangaratta provides outreach support to GP obstetricians around the region. We think that is a good model, and our department is working with other regions to try and extend the model.

Ms McLEISH — We heard about that when we were in Wangaratta.

Ms BRITNELL — I have got a few questions. The first one is: so far we have heard that there are some challenges. You have mentioned IT and making sure systems talk to each other and that being an important element. We have heard from some specialists and people who work within the services that there are inconsistencies that could be improved. For example, you cannot control how a GP will refer or how one specialist will refer to another, but they are still using systems such as snail mail. We have heard about the fetal monitoring system that works on the wards, and then alongside that is the hospital system that does not talk to the fetal monitoring system. Then you have the system where you have got the private specialists who work with the hospital but are not employed by the hospital, whose system obviously does not talk to the hospital system. It does sound a little bit like there could be, in this day and age of technological advancements, work that could be done to improve that. Is that something that is focused on with the department playing that crucial role of being central?

Ms PEAKE — I think there are a couple of things in that that are really critical. One is the tele-health capability, which is a little bit different to the specific examples you just gave. But it has been a real focus for us to look at how we provide again that access to specialists to provide governance, clinical guidance and support, and that is a space where we are doing a lot of work. The second is in partnership with both our health services but also with a national agency for digital health looking at what the more agile ways are of providing that sharing of records.

It is a space where we have got a long way to go. I think in the past it has been a feature of the IT market. There were only options that were quite complex and expensive IT solutions to provide the more reliable sharing both within a health service but between a health service and primary care. As the IT market itself is evolving we are really looking at how we can provide more incremental improvements rather than trying to do a big, complex implementation. So again I would classify this as a space where it is a practical issue, and it is one for which we need a range of different practical strategies to try and address. But to your question, yes, it is a very high priority for us. We have a new digital health capability that we have built up in the department to really look at what those creative solutions can be.

Ms BRITNELL — It was mentioned to us by an obstetrician gynaecologist that their expertise is in medical procedures and not setting up an office and working it out, even with their business manager being that person to work it out. They were asking for more support and guidance from the department on systems, policies and procedures to actually set that up rather than having to reinvent them themselves.

Ms PEAKE — I think that regional partnership model that we described before too is important in this — having better relationships, network and support between bigger regional services and the smaller services so that they can pool that expertise. As well as the support that the central department plays, there is also that local support as well.

Mr SYMONDS — All of our rural services are part of rural health alliances for ICT investment, which is a cost-share model. Rather than each individual service going it alone across a region they contribute costs towards the shard infrastructure, policy advice, standards et cetera.

Ms BRITNELL — So before they set up? If someone was coming into a region and setting up a business, before they set up they join the alliance or after they have set up they become an alliance member?

Mr SYMONDS — That applies to health services but not necessarily to individual GPs, and I think that is part of the issue.

Ms BRITNELL — No. An obstetrics gynaecology specialist, though, if they came into the region —

Mr SYMONDS — It will not apply to a private obstetrician working in the area, so —

Ms BRITNELL — So that was the example I was referring to, then.

Mr SYMONDS — All right. Okay.

Ms BRITNELL — So they are saying it seems silly they are providing a service to the health department — or, really, to the state of Victoria. They are doing that and it seems like it is back-ended rather than front-ended.

Anyway, I refer to what Cindy was talking about: the problem we have had for 20 years with sourcing GPs, having enough GPs for population demand, in the regions. I would agree that it has improved, but I would think that the ability to have the specialist GPs who have obstetrics, gynaecology and anaesthetics capacity has not improved, as I think you have said. What are the barriers to the GPs who are now filling those gaps that were there 20 years ago to having those extras to be able to provide support to the specialists who are not able to fill the population needs when the demand is high?

Mr SYMONDS — Some of that I think goes to Kym's point about professional support — so making sure that they are part of networks for continued professional development, supervision and access to peer review for particular cases. Making sure that is in place I think is important. The commonwealth I think is about to set up regional training hubs that are already in place — I do not think they are yet, but that I think will help. So that general theme of networking across we think is very important to supporting these GPs, who often work in isolated practice. Maybe they are one in a practice of two or three GPs working in a town and maybe there is another practice in town, but we think being part of a regional group is very important to retaining them, and we think direct funding for the professional development and support for locums to backfill or whatever is required is also important.

Ms BRITNELL — So direct funding is a good plan, but what about professional risk? How are we supporting them with the risk of professional indemnity?

Mr SYMONDS — That is a question I will have to take notice in terms of what support the department has provided for that.

Ms BRITNELL — It is probably more professional risk that is preventing them from stepping into those areas because they do not get the experience to be able to make sure that they have got the skill set to be maintained.

Mr SYMONDS — Sure. Kym mentioned in passing the regional mortality and morbidity committees. Post our experience at Bacchus Marsh we have put in place across every part of Victoria mortality and morbidity

committees, where individual cases, as they would in a large metropolitan hospital, can be reviewed and discussed, and learning is identified and shared for professional development. We think that is a very important initiative that can help with what you are talking about in terms of helping to assess risk and making sure the GPs do not take on risk that is not able to be managed in the service they are working in.

Ms BRITNELL — I think what we learned in the regions as well was that there will be deliveries occurring in an untimely manner with categories 5 and 6, and we do I think have a higher incidence of obesity in the regions than we do in the capital. How do we assist the doctors? We heard about this from a particular GP who has to handle that and learned how to do that in other countries, where you learned quickly or you struggled badly. How can we recognise and support more? I think you have probably already answered this — encouraging kids from the country to go back to the country, supporting professional development. I think recognising that that risk will occur — we have heard, 'Let's put the midwives back into more intense situations', but what about the opposite? What about a week a year for specialists to head out to Portland and Orbost where they can really understand what it is like to find a bed and ring PIPER? Is that something being considered?

Mr SYMONDS — Absolutely. The Wangaratta model is an example of a specialist consultant obstetrician who provides that kind of travel and outreach support. We also think telehealth is relevant to this conversation — I agree with you that rotation of specialists through those areas would help, because trust between individuals is often what underpins effective referral relationships, and I think getting exposure by visiting is important, but telehealth support is also important. It is an area for us to look at improving over time, I think.

Ms BRITNELL — We hear of instances, and I heard of one recently in the region where we had a couple of pretty bad experiences, but they were very, very close. We have got situations like at Warrnambool, for example, where we have got the same amount of theatres that we had 30 years ago. We have got increased population, we have got increased demand, because areas have closed around there, so they have got a bigger catchment. How are we helping those hospitals with the policies where you have got the same amount of theatres and you have got increased births that require more caesarean sections than we had before? That just does not seem to add up. If you are in the hospital and on that board, how could you actually figure that situation out? It seems an impossible situation.

Mr SYMONDS — I would refer back — the Auditor-General's report from only a couple of months ago I think is helpful for saying what has improved and where we still need to go. The example they used was of the northern growth corridor. I might also reflect on the western growth corridor. It does not extend to the south-west — I will come to that — but in those areas we have improved. If I think back perhaps five or six years ago, many women in, for example, the Werribee and Wyndham catchment were travelling in to Sunshine or the Royal Women's Hospital for birthing because they could not get booked at Werribee. Our department worked with Mercy Health to identify what their projected overflow, if you like, was and invested for them to make sure that they could expand maternity capacity. They expanded their birthing by 20 per cent each year for three years to repatriate that demand for women who were otherwise having to travel outside of the catchment.

In the case of northern, the Auditor-General called up an example of where our forecasts had not expected the growth in demand that they were experiencing. They called us on that. We worked with them and adjusted the baseline forecasts that the state had provided to then invest in additional capacity. I think in rural and regional areas part of this is just a work in progress. We are one year in essentially to a new planning process. We have developed plans and we have prioritised plans for the growth corridors around Melbourne, but we have not got yet to all of the rural and regional catchments in terms of that growth plan.

Ms BRITNELL — So if people are meeting in the regions to have their morbidity — and that is great from supporting — the actual physical constraints and the increase in births from a caesarean section perspective alone is not really going to help them in that critical environment. They have got plastics coming down from Ballarat and the theatres are full — an emergency situation.

Mr SYMONDS — Sure. I mean I guess here I would say that this is a conversation between us and the board and management of the health service.

Ms BRITNELL — It is a challenge.

Mr SYMONDS — We have on many occasions adjusted, for example, elective surgery targets for health services to acknowledge additional demand for access to operating theatres to manage maternity growth. We have lightened, I suppose, or relaxed somewhat our pressure on this side to make room ahead of the capital investment required over a longer period of time to deal with both the necessary elective surgery demand and the obstetrics demand.

Ms BRITNELL — Okay. My last question is: what is the department's attitude to breastfeeding rates, and is there a goal or an objective or anything around breastfeeding?

Mr SYMONDS — There is. If I could just turn to my notes on that. Our department certainly has signed up to targets and goals around breastfeeding. When Euan presents he will be able to talk in more detail about that question. I will look at my notes —

Ms BRITNELL — No, I am happy with that.

The CHAIR — While you look up that, Terry, if I could just ask Kym: in your opinion what has been the impact of the loss of commonwealth funding for the national perinatal depression initiative?

Ms PEAKE — Obviously whenever we lose capacity it has a significant impact. The commonwealth withdrew its funding for perinatal emotional health programs in 2015, but we have stepped in to address the gap through a $1.6 million commitment in 2016–17. But it goes to some of the earlier questions — whenever we step in it is a trade-off with other things that we could otherwise have invested in. So in addition to that filling of that gap of $1.6 million we have also grown our investment on top of that, so we are providing an additional $2.8 million recurrently from 2017–18. So in short, in terms of services for people on the ground, we have filled the gap, but that creates a flow-on consequence for what else we can do.

The CHAIR — Thanks, Kym. Over to you, Terry.

Mr SYMONDS — I will need to take it on notice, I am afraid, and come back to you with more information about our actual rates. We report it in our Victorian perinatal services performance indicators report. We share it across services so they are benchmarked. The actual current rates I will take on notice and provide.

The CHAIR — No worries. Thanks, Terry. I think we will leave it there. I just want to say thank you for your time. We know you are extremely busy, and we have asked a very broad range of questions. You have been very well organised in your responses. There are a couple there that you are taking a notice. It would be great if we could have them as soon as possible. Thank you so much for your time today and for coming in.

Mr SYMONDS — Thank you.

Witnesses withdrew.