T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

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Professor Euan Wallace, CEO, Safer Care Victoria.

The CHAIR — I welcome to these public hearings Professor Euan Wallace, CEO of Safer Care Victoria. Thank you for attending 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.

Welcome, Euan. If we could get you to possibly start with just a brief 15 to 20-minute presentation or talk and then we might ask some questions, if that is okay. I would just like to start with one question: who do you report to in your role as CEO?

Prof. WALLACE — To the secretary.

The CHAIR — So not to the minister?

Prof. WALLACE — My reporting line is to the secretary.

The CHAIR — Thank you.

Visual presentation.

Prof. WALLACE — Thank you for the opportunity first of all to meet with you. Clearly the provision of safe maternity services is something that is very important to Safer Care Victoria, and given my clinical background it is something of a very personal interest to me. I am going to spend, I hope, only 10 or 12 minutes, firstly on Safer Care Victoria. Because we are a new agency — we opened our doors on 1 January this year — I will just give you a sense of who we are and what we are trying to do, and then I will give you a brief overview of the most recent outcomes in maternity services in the state and what of those are driving our agenda.

The mission, the aim of Safer Care Victoria is about providing outstanding health care for all Victorians, always. The challenge for us as an agency of course is that we do not have the privilege of having our hands on any Victorian patients, so we have to deliver this through supporting our 84 health services. We will do this by enabling services to deliver safe, high-quality care and experiences, not just for patients, their carers and families but also for staff, because we know that staff experiences themselves lead directly into quality of patient care and outcomes.

The minister in her engagement with me and our agency as an administrative office has set us this statement of functions. I will leave you with those; I will not go through them in detail. Broadly they are to have a leadership role in quality and safety improvement for our health services across the state, both public and private, and to provide advice to her and to the secretary around issues relating to quality and safety improvement. We do not have a policy and commissioning function. Those lie of course with the department proper and with Terry Symonds's division in particular.

This is what I am going to take you through — very briefly, the most recent birth statistics for our state and some key outcomes highlighting variation. It will become apparent why I am going to highlight variation, because it is variation that takes us to our work agenda. So where there are variations in either practices or in outcomes, that tells us where there are opportunities for improvement. Given the terms of reference of the inquiry, I have a slide on some metropolitan and rural differences, and you have touched upon those in your discussions and meetings to date with other witnesses and actually already this morning with Terry and Kevin. Lastly, I will give you a sense of our current and future work plans for Safer Care.

These data are not yet published. They are in the soon-to-be-released CCOPMM report on Victoria's mothers, babies and children. So 80 000 —

Ms McLEISH — But they are not draft?

Prof. WALLACE — In draft. So there were 80 549 babies born to some 79 390 women. Of those, almost two-thirds of women giving birth in Victoria were themselves born in Australia, so one-third were born overseas, migrating to Victoria and having their families here. Of those migrant women, the most common non-English speaking countries are India and China, and those are quite recent trends over the last 10 years. About one-fifth of births are in our rural hospitals and 75 per cent or so in our metropolitan hospitals. It is fair to

say that 2016 saw the best perinatal outcomes across the state in our state's history. If you compare us with other jurisdictions in Australia or other jurisdictions internationally, we have among the best perinatal outcomes anywhere in the world.

However — and it is an important 'however' — there is variation. There is variation in both care provision and variation in health outcomes for both mothers and babies. There is variation over time, variation between groups of women and variation between hospitals and regions. It is that variation that piques the interest of Safer Care, because as I have said already, where there is variation there are opportunities for improvement. I will touch upon some of the variations. We do not have time to go into all of them, but I am happy to take questions on any aspect of maternity services outcomes.

I am going to take you to what some would say would be the most important outcome, which is perinatal mortality — just to make you immediate experts in perinatal mortality. As you would be aware, it is a composite number. It is a composite of the number of stillbirths, so babies not born alive, from 20 weeks of gestation onwards, and the number of neonatal deaths, babies who are born alive but then do not survive beyond 28 days of life; they die within the first 28 days of life. There are three sets of numbers which will be reported here: the overall perinatal mortality rate, stillbirths and neonatal deaths; then stillbirths; and then neonatal deaths separately. I am going to show you the rates for our non-Indigenous population, the non-ATSI population, and our Indigenous women.

This is the perinatal mortality rate for our non-Indigenous population, and it sits at about 10 per 1000 births, total births. It is actually nine per 1000. You can see there has been a very modest, very slight decline over time, as these data show from 2001 onwards, and the data are grouped in rolling trienniums. That perinatal mortality rate is made up largely of stillbirths, about six per 1000, and neonatal mortality, a bit less. That is a consistent finding around the world: stillbirth rates are always higher than neonatal mortality rates. One of the challenges for Victoria is that where our neonatal mortality rates have declined significantly over time, our stillbirth rate has —

Ms BRITNELL — So the green line is babies born from 23 weeks to term?

Prof. WALLACE — The green line is live births from 20 weeks through to term, so babies born alive but who die in the first 28 days of life. These numbers are all for non-Indigenous women.

These are the equivalent rates for Indigenous women, so it is the overall perinatal mortality, and you can see that in the most recent triennium for the very first time the perinatal mortality rate for Indigenous women giving birth in Victoria is the same as non-Indigenous women. There is no other jurisdiction in Australia where this is so; it is the first time in our state's history.

This is the stillbirth rate. You will see that back in the 2004–06 triennium the stillbirth rate for Indigenous women was lower than that of non-Indigenous women, and both before that period and thereafter it has been higher. But from about 2008 onwards we have seen a consistent progressive decline in the stillbirth rate in our Aboriginal women, a decline that we have not seen in non-Indigenous women, such that in the most recent triennium the stillbirth rate among Aboriginal women is lower than among non-Aboriginal women. Again, I am not aware of any other jurisdiction in Australia where that is so. This is the neonatal mortality rate. The neonatal mortality rate for Indigenous children remains higher than for non-Indigenous children. There are some important trends here because these trends point us to future opportunities for improvement. I am happy to take questions on any of these numbers.

Ms BRITNELL — So that red line remains higher.

Prof. WALLACE — It does.

Ms BRITNELL — It looks lower.

Prof. WALLACE — It is higher than the green line. The comparative line is the green line. Sorry. So the green line is the neonatal mortality for non-Indigenous. We also express perinatal mortality by something called the gestation standardised perinatal mortality ratio. Really this gives us an average, by definition, for the state of 1; and it allows us to look at hospitals in reference to the state average. The hospitals are listed here in descending order of size for our public hospitals. The Royal Women's Hospital is the largest single-site

hospital, then the Mercy, Monash and so on. There are level 6 hospitals, then level 5s and 4s, in descending size. You can see there is some variation.

The variation, again, takes us to opportunities for improvement. So Bacchus Marsh Djerriwarrh Health Services is at the very bottom. Its number is coming down. These data are five-year rolling averages, so every year they lose a year and gain a year. So Djerriwarrh's number, we hope, will come down progressively over four or five years.

But you can see that there is significant variation, so the Mercy Hospital for Women have a GSPMR of about half the state average. So the question is: what are the Mercy doing that we might apply to other services to progressively bring those down? These are not absolute rates; they are referenced to state averages.

The CHAIR — Euan, before you progress with the slides, I am just interested in LRH down at Traralgon, at 1.52. Have you got any explanation for that?

Prof. WALLACE — At the beginning of this year we visited and worked with LRH at Traralgon. We looked in-depth at the babies that are represented in this number, so really asking the question, 'Are there avoidable events in here that changes in care, practices, procedures, guidelines, services, whatever, could make an impact on?'. It would be fair to say that when we met with them at the beginning of this year about last year's numbers, we did not find major avoidable events in terms of in-hospital care. There were some opportunities for improvement around growth restriction, and maybe we can pick up that question when I come to growth restriction, if that is all right.

The CHAIR — Sure.

Prof. WALLACE — So this is growth restriction. Why is growth restriction important? It is important because it is the single most important contributor to stillbirth, except for congenital abnormalities. If you look at known anomalous babies, undetected fetal growth restriction has the largest population attributed to a risk of about 26 per cent. So 26 per cent of stillbirths in normally formed babies can be attributed to fetal growth restriction. So one of the key purposes of pregnancy care is to detect the baby that is not growing well, offer surveillance for the baby and perhaps opt for delivery early.

This is the detection rate of undetected fetal growth restriction, so this is defined as very, very small babies who are still in utero, so they are still not born, at 40 weeks of pregnancy. That might feel like an odd way to approach it, but in essence if you are tiny — these are the smallest 3 per cent of babies — if you are in the smallest 3 per cent and you are still in your mum's tummy at 40 weeks, someone has missed you, because if they had found you they would have delivered you before 40 weeks. Does that make sense? So really this is our way of getting at 'Have the care providers found you and acted appropriately?'.

So back in 2010 when we really started reporting this measure in a meaningful manner across the whole state, 40 per cent of these babies were undelivered. In the most recent report due out later this year, so back from 2016, it is just above 30 per cent. In fact there has been a 23 per cent improvement in detection. We think some of that is related to making this measure visible and then meeting with health services and saying, 'Okay, your rate's a bit high. What can we do to help you to make your rate lower?'. I think you had a meeting with Professor Ryan Hodges from Monash Health earlier in the committee's discussions and he showed you the improvements at Casey Hospital, because about four or five years ago Casey Hospital began a very purposeful journey around reducing the rate of undetected fetal growth restriction.

Here is the data for the whole of the state and for our public hospitals. You can see again there is significant variation. Ballarat Health Services have a 10 per cent rate whereas the Royal Women's Hospital have a 35 or 36 per cent rate. So what is it that some services are doing that is different to other services, and how can we use those lessons to apply to the services that are finding it difficult and improve their outcomes? That is the very discussion that we had at the beginning of this year with our colleagues at LRH in Traralgon. As we looked at their stillbirth cases in detail we think that the detection of growth restriction at that time might have been improved. These are the most recent data, and you can see that LRH are among one of the best performing hospitals in the state now.

Having said that, we think we should set a state target. We have not quite enacted this yet, but we are about to begin a bundle of care — and I will show you at the end — for care improvement with the whole of state, one

of which will be around the detection of fetal growth restriction. So can we teach our midwives, our GP obstetricians and our obstetricians around processes to improve detection? And as we do that we will set a state target probably of around 20 per cent.

Ms McLEISH — Could I ask you, with Ballarat, was this something that they aimed to do, or was it that their practices were already in this direction?

Prof. WALLACE — Obviously I do not have data with me, but if we look back at Ballarat Health Services, like Casey, they have made a purposeful improvement in their detection rates.

Ms McLEISH — Very much so.

Prof. WALLACE — And it is about, 'Okay, guys, what are you doing in Ballarat, and how can we apply that in other places?'.

Ms McLEISH — And has that begun?

Ms BRITNELL — Is it obvious that it was the increase in ultrasound rates compared with however often they were doing ultrasounds for other things?

Prof. WALLACE — We have not sat down and discussed it in detail with Ballarat. I mean, Ballarat actually have some other issues to do with ultrasound. I know Casey much more intimately because until January I was in charge of the Casey service at Monash Health. What Casey did was they reviewed every single case. They had a clinician weekly meeting with midwives, GP obstetricians and obstetricians, who sat down and looked at every case, every baby that was under the third centile that they had missed. They said, 'What is it about her care that we have missed this?'. It is just the short biofeedback loop where clinicians actually said this is important, and you get better at it.

The CHAIR — Can you expand on the trend up there? There are some fairly sizeable major hospitals here — Frankston, Dandenong, Angliss, Sandringham — that kind of stick out like a sore thumb. I gather that we are not just going to blame that on the fact that they are larger hospitals and whatnot. What is it about those larger hospitals that others like Ballarat Health Services are outperforming them in this way?

Prof. WALLACE — We do not know yet, and I think the purpose of Safer Care is to take the practices in one hospital that are apparently doing very well and see if they are different from practices in another hospital that is doing less well; in the same way if you go back to the GSPMR, that perinatal mortality figure where the Mercy hospital has a very low rate, we can ask, 'What is the Mercy doing that we could learn and apply to other hospitals and really lift the performance of all our hospitals?'.

So if you look at not just maternity but at medicine more broadly and look at performance outcomes, the historical approach has been, 'Well, let's beat the underperformers over the head with a stick'. Actually the approach is, 'Let's celebrate the good performers and learn from them and apply it to the ones that are having more difficulties'.

Ms BRITNELL — So what about your Orbosts and Portlands that say they are still delivering but are having trouble with delivering?

Prof. WALLACE — The business rules around some of our smaller services are around absolute numbers of cases to appear on the chart, but where the numbers are so small that we think the numbers are too unstable to appear on a public document, we still publish them for that hospital and meet with that hospital.

Ms McLEISH — One of the things that has actually been raised with us is that there are times when people who are very heavily pregnant walk into the hospital and they have not been under anyone's care up to that point. I wonder if, say, the Women's or one of those hospitals does have a large number of those.

Prof. WALLACE — I think that is true of many of our hospitals, particularly the Sunshines of this world that have a large humanitarian migrant population, who historically have poorer access to care. Then rather than using that and saying, 'Oh well, we've got women who just rock up', it is actually saying, 'Well, as a system manager' — this is now Safer Care — 'why are women just rocking up? Why haven't they accessed care?'.

Some of that is around better understanding what the needs of the women are. Rather than making a system for hospitals, we should be making a system for women.

Given the terms of reference of the inquiry, this is just a summary of some differences and similarities between rural and metro outcomes. Low birth weight rates are the same, preterm birth weights are broadly the same, undetected fetal growth restriction is more common in our metro hospitals than it is in our rural services and perinatal mortality is slightly higher in our rural services, mainly due to the stillbirth rate rather than the neonatal death rate. You can see — and you are already aware of this from your trips around the state — smoking is twice as common in the country as it is in the city. Smoking in the second half of pregnancy is three times as common. Then some outcomes are the same: postpartum haemorrhage, severe perineal tears — very similar, if anything slightly better — but as you have said already this morning, Roma, obesity is much more common in the country. Indigenous women are more likely to live in the country and be looked after by country services than the city and teenage pregnancies are more common in the country. That is important because Aboriginality, teenage status — so young mothers — smoking and obesity all contribute to poorer outcomes.

This now takes me to perineal tears. A piece of work that we are working on with 11 hospitals in particular that have the highest rates is how can we reduce the rate of severe perineal tears? Again there is great variation across the state, so how can we use practice in some hospitals to inform practice in others about improvement? We are going to set a statewide target of around 3 per cent overall, which if you look internationally, is about best practice.

I am aware of the time. This is just a summary slide on maternal mortality. Victoria is pretty much in step with the rest of the country. It is notable that Australia as a nation has a national maternal mortality report. There has not been a report since the 2009–11 triennium, and we are the only jurisdiction to have data ready for the 2014–16 triennium, which we will publish later this year. The reason I am showing you the maternal mortality data is again, given the terms of reference of the inquiry, almost half of all maternal mortality is now due to maternal suicide, and maternal mental health really now needs to be a priority for our state in terms of system improvement and care improvement.

This last slide is a summary of our current and future work. We have a long existing maternity and newborn clinical network that provides clinical leadership across the sector about priorities for improvement. The department itself has published and had in place for some time both maternity and newborn capability frameworks, and they are under review. You have heard already this morning about the regional perinatal mortality and morbidity review committees. They have a regionalised review of adverse outcomes, but they have done much more than that. They have made much stronger relationships between practitioners and between small, rural, subregional and regional hospitals. In answer to some of your questions around GP workforce and GP obs workforce, one of the solutions has to come through better support relationships in the regions. It is something that is called out in the Duckett review.

The network launched a new maternity handbook just a month or so ago. It is getting 100 000 clicks a month or something — 200 000 clicks a month. There is a program that we are running, a pilot with VMIA, around a live maternity service benchmark indicator so hospitals can see, month by month, how they are doing and relate it to the whole state. Instead of waiting for an annual report they can see the data live. I have already talked about the perineal trauma improvement program that we have commenced with 11 hospitals and a maternity bundle that we are developing to reduce stillbirth, reduce hypoxic ischemic encephalopathy — that is, babies with asphyxial brain injury — and improve the rate of undetected growth restriction. And we have just put in place an enhanced research capability at the consultative council so that they can prosecute a more proactive research agenda around issues that look like they are emerging, like maternal suicide.

The CHAIR — Thanks so much, Euan, and thank you for taking some of our questions during your presentation too. Like you said, time is ticking on, so I will start off with some questions if that is okay. We have talked about the pressures on the workforce, and you might have heard us talking with the previous witness about how we tackle that. Are you aware of any incidents of avoidable deaths in the regional areas caused by staff shortages or things that could have been workplace related?

Prof. WALLACE — I am not.

The CHAIR — Thanks. In regards to the cause of maternal deaths in 2016 in your slides obviously suicide at the various time periods there is over-represented as far as your figures go. What is the plan moving forward to tackle that?

Prof. WALLACE — Safer Care currently does not have a strategic plan to tackle it, so the consultative council — or Jeremy Oats, who is chair of the consultative council — in the council recommendations have made a recommendation around a number of initiatives about maternal mental health. Those recommendations are to Safer Care and the department more broadly. We will take those recommendations and in consultation with the sector, with our clinical network, with the department and with the mental health branch, we will develop a strategic piece of work around how we tackle this. This is not going to be a simple solution. As you see from that slide, maternal suicides are spread across a time continuum. They are not all happening in pregnancy; some of them happen months later. Given that they now account for almost half of all maternal deaths, I do think we need a state-coordinated approach to improve detection of depression and other mental health issues and to put in place supports. Again, we are not a policy-commissioning agent, but we do have a role to say, 'We have a problem, and here's a pathway forward'. Do we have a solution today? No. This report landed on my desk about two weeks ago — timely for this inquiry — and I thought it was important, given your terms of reference, that we take it on this morning.

The CHAIR — Thanks. Just in regard to Djerriwarrh and the cluster of deaths there, how confident are you that that situation will not occur again in Victoria?

Prof. WALLACE — Much more confident than I would have been had you asked me that question in July 2015. Djerriwarrh is complex, and you know that. It was not just about maternity services; it was about clinical governance. And the solutions to Djerriwarrh — the proactive solutions to prevent another Djerriwarrh — go way beyond maternity services. The response that the department put in place before Safer Care was established was around the regional perinatal mortality review committees — so these regionalised committees led out of Barwon, Ballarat, Bendigo and Traralgon. Those are key committees because they share not just learnings from deaths but from near misses and they give an early warning alert system to say, 'Actually, we've got a service that's struggling here or has difficulties'.

But much more broadly than that there is the work that the department and Safer Care are doing about governance training for boards, for executives, for clinicians — what questions should we be asking and what data should be coming to boards? And we have just finished a piece of work with the CEOs and with boards around, 'Well, this is the sort of data that should be coming around to boards', so boards have better oversight of the performance of the health service more broadly, not just maternity.

I think we are not finished, Paul, by any means, but we have begun a very purposeful journey — begun before Safer Care was established — to make Victoria among the safest healthcare systems in the world. It is a journey, and it is not an overnight fix, but I am much more confident than I would have been had you asked me that question when the Djerriwarrh thing came to light two years ago.

The CHAIR — Thanks for your honesty, Euan. We definitely appreciate the work you are doing as well.

Ms BRITNELL — Safer Care will address the issues that happened at Bacchus Marsh, but broadly it is going to look at preventing incidents. If an incident has occurred, will the morbidity committees that were set up refer to you, or are there some processes in place where an incident will be referred to you before a mortality occurs or a death occurs? What is the process?

Prof. WALLACE — The processes vary depending on what the event was. All deaths are reviewed by CCOPMM. CCOPMM has a stillbirth committee and a neonatal death committee, and depending on the death, if it is a stillbirth or a neonatal death it is reviewed by one of those committees. So all perinatal deaths are reviewed by CCOPMM. They are also reported through to us, but given that we have got a committee infrastructure that looks after those reviews, we leave them with CCOPMM. There are some non-deaths — so-called sentinel events — and there is a sentinel event reporting program.

Then there are some events that are neither a death nor a sentinel event, and one would expect that those are then reported through the regional M and M committees — those morbidity and mortality committees. However, one of the pieces of work that we began at Safer Care back in March was to rebuild our instant reporting processes, and we are moving to a place where all ISR 1 — all serious events, whether they are in

maternity or orthopaedics or anything else — are reported to Safer Care. We are building the infrastructure in terms of the committee review structure to be able to handle those ISR 1 reports and ensure that services are supported themselves in being able to review them.

It is not unique to Victoria, but one of the things that was highlighted by an external review of incident reporting in Victoria that the department commissioned before we were established was that our health services often struggle with 'What should I report? To whom should I report? How do I get experts to review it?'. We have established two new structures — one is an expert academy and one is called PEER — where we will train clinicians, physios, surgeons, nurses, midwives et cetera in safety system review, human factor review and so on, so that the sector more broadly has a skill set that it can call upon to review incidents when those arise and a better reporting mechanism — something that the Auditor-General has called for and that we have responded to — creating a much better oversight of centralised incident reporting.

So it is complex; it depends on what the incident was. Again, I guess as an extension to the answer to your question: Did we have a coherent, coordinated approach in January? We did not. Do we have one today? We are probably three-quarters of the way to having it in place. We will have in place in the first quarter of next year.

Ms BRITNELL — I cannot remember where I heard it, but I heard of a person who was a midwife in a doctor's clinic and said in the inquiry that they had to figure out what to report. It comes back to my question to the previous people: if there was a system which was able to look at and interface from an IT perspective, then that data could be pulled out, rather than a human having to think, 'Is it reportable?'. I have heard of situations in my previous life in maternity wards where somebody is given the challenge of looking at what has happened and reporting to the health department. It does seem a bit archaic.

Prof. WALLACE — I agree with you. That benchmark indicator project — that is the fourth bullet point from the bottom — actually is an attempt to do that. So it is a list of key outcomes that are drawn directly from the hospitals reporting system. In Victoria almost all hospitals — not all but almost all public hospitals — use a system called a birthing outcome system where they input the birthing outcome data for every pregnancy and it is entered by our midwives. That is the system that is used to report to the department for CCOPMM reports, PSPI reports and so on. What has been missing is that we have not had a distilled set of indicators which have been reported at point of care in the hospital so the hospital itself can look and say, 'How did we go last month?'. They have had to wait for a year for an annual report. That is not to belittle annual reports. I have shown you the growth restriction data. I think the annual reports have contributed to continued improvement across our hospitals. However, if you are just waiting every year for an annual report, you cannot maintain a constant improvement initiative. So this benchmark indicator report is a pool of the key indicators; you could press a button daily if you wanted to in your hospital. One would not do that, but the hospitals can then have a pool on a monthly basis to give them a sense of how they are travelling without people having to think, 'What do I need to be looking at and what is less important?'.

Ms McLEISH — Thank you. I have got a couple of questions, and I am probably thinking more about the rural setting where they may rely more on GP obstetricians or the role of the midwives. I want to look at the chart you had up about the disparity in rural versus metro outcomes in Victoria. The 'undetected severe foetal growth restriction', which has a better outcome in the country — I was wondering if that is because they have a closer role perhaps with the GP obstetrician or if it is due to the role of midwives in those cases.

Prof. WALLACE — I wish we knew the answer to the question, because that of course would be part of the bundle of improving. If I had to speculate — dangerous —

The CHAIR — Please do.

Prof. WALLACE — I think it is probable that in a rural setting the individual woman has better continuity of carer. So she is seeing the same midwife or the same GP for all of her visits or for nearly all of her visits — or the same team of midwives and GPs for all of her visits or nearly all of her visits — whereas in our larger, and particularly our very large, metropolitan hospitals she might see 11 or 12 different people across the course of her pregnancy. If you are seeing the same person, even with equal skill sets, I think you are more likely to detect a growth-restricted baby, because the same clinician could say, 'This just feels the same as it was last month; you haven't really grown very much', whereas if you saw her last month and I saw her this month, I would say, 'It's a bit small; I'll bring you back in a couple of weeks'. Then of course she sees someone else in a

couple of weeks and he or she says, ‘I think you’re a bit small; I’ll bring you back’ — does that make sense? But is that the answer? I do not know.

There is certainly plenty of evidence worldwide, including from Australia, that improving continuity of carer, so women seeing fewer clinicians — it does not matter who the clinicians are, whether they are midwives, GPs or obstetricians — if they see fewer clinicians, their care outcomes are better.

Ms McLEISH — Do you think with our larger hospitals that there is scope or the want or even the flexibility to be able to do that?

Prof. WALLACE — I think there is definitely the want. It is difficult. I have tried to do this at Monash; it is difficult. It is around building teams of clinicians around women. Is it possible? It is possible.

Ms McLEISH — We talked earlier about risk and you mentioned the boards. I can think of two separate country hospitals — one that still has obstetrics and one that does not. The one that continues to have it has had a GP obstetrician-midwife model that has been going very successfully for a very long time. But in another country town they had a death and they had a close call, and the board looked very closely at it and thought, ‘The risks for us are too high’, and it has been at the board level that they have been unwilling to go down that path. Would you like to comment?

Prof. WALLACE — I can understand. The death of a baby is traumatic to any health service looking after women when it is a big health service, but its impact on a small service where often the care providers — the midwives, the doctors looking after the women — know the family, their kids go to the same school, they shop in the same supermarket, the impacts are much greater. They are very traumatic events, not just for the woman and the family; they are very traumatic events for the health services. Sometimes that is forgotten.

So particularly post-Djerriwarrh I can understand why boards would look at events like that and say, ‘We shouldn’t be doing this anymore’. I view my role and Safer Care’s role as being about bringing a level of objectivity and support to some of those decisions, to say, ‘These are the options for your service, for your town and the neighbouring towns’. You have touched upon it this morning in the context of Warrnambool. If smaller maternity services around Warrnambool, for example, close down, what does that mean for patient load at Warrnambool and what does that mean for the overall experience and outcomes for all women in the south-west? I do not think that closing small hospitals’ maternity units is necessarily or always the best outcome for anybody, and there are usually alternative solutions. Notwithstanding that, we do have a rural workforce challenge, without question. How do we build capability in our workforce? And you have touched upon that already this morning. Our role is to work with services to help them understand why events happen, to help them understand opportunities, to put in place processes, systems — relationships usually — with other services locally and regionally to make sure that we can deliver the best services for Victorians. Victorian women typically want to have the babies in their home town. That is not an unreasonable request.

Ms McLEISH — I was born in a small country hospital — about 1000 people in that town — which has not had birthing for a very long time. My last question is: how are homebirthing statistics reflected in your presentation?

Prof. WALLACE — I have not shown you homebirthing statistics. The homebirth rate in Victoria is about half a per cent overall. As you know there are two public homebirth programs, one out of Western, Sunshine, and one out of Monash Health at Casey Hospital in Berwick. Those two programs are now probably in a steady state of looking after between 60 and 100 women a year — so very, very small numbers.

It is fair to say that Safer Care Victoria does not have an agency view on homebirth. My personal view is it is an unrealised opportunity. If you look at jurisdictions that look very like us, so England and Wales, the homebirth rate is 5 per cent — so it is 10 times higher than it is in Victoria. My college, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, have not historically been supportive of homebirth for reasons I do not really understand. The evidence says that where midwives are suitably trained and there are integrated hospital supports where there is a need, homebirthing is very safe. Indeed the National Institute for Health and Care Excellence in the UK — NICE in the UK — and the RCOG, my other college, the London college, say that homebirth should be the birth of choice for women having their second or subsequent baby who are well and healthy and whose previous pregnancy and birth was uncomplicated. The evidence shows that

for women having their second baby, where they have had a previously healthy pregnancy and normal birth, their birth is more likely to be uncomplicated at home than it is in hospital.

The CHAIR — Sorry; where are those recommendations from?

Prof. WALLACE — From the National Institute for Health and Care Excellence in the UK and the RCOG — so the Royal College of Obstetricians and Gynaecologists — in London. It is the UK RCOG rather than our own college. There is a lot of debate and argument about homebirth, but I am in published press, in peer-reviewed press and lead press supporting homebirth. I think it is an unrealised opportunity for Victorian women for whom it is appropriate. We have lots of health services that could adequately support homebirth. The department itself published a homebirth framework either last year or the year before based on the experiences from Sunshine and Casey.

The CHAIR — I think we will conclude there, Euan. Thank you so much for your time today, and thank you for answering such a broad range of questions too.

Prof. WALLACE — Thank you. Thank you for your time.

Witness withdrew.