T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warrnambool — 11 October 2017

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Witnesses

Ms Rachael Lee, practice coordinator,
Ms Julianne Clift, director of nursing, and
Ms Janene Facey, maternity nurse unit manager, South West Healthcare.

The CHAIR — We are lucky enough today to have Julianne Clift, who is the director of nursing. The format we usually take is we allow everyone to have a chat to us for 10 minutes, and then we ask questions. We might actually get you out of the way first, Julianne, because it would be a very bad look for us to be holding up the director of nursing for South West Healthcare today.

Ms CLIFT — I have new theatres that I have got to deal with.

The CHAIR — You are putting the pressure on us now! I am just going to speed-read this then. I welcome to these public hearings Ms Rachael Lee, practice coordinator; Ms Julianne Clift, director of nursing; and Ms Janene Facey, maternity nurse unit manager from South West Healthcare. 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 spent a proof copy of the transcript.

Julianne, we might start with you. If you would like to give us a 10-minute spiel, then we might ask some questions if that is okay.

Visual presentation.

Ms CLIFT — I have got a presentation. I thought you might be interested in some of the data around the services.

That slide is a bit hard to see, but basically this is just an overview. In 2016–17 the Warrnambool Base Hospital did 653 births for the financial year, and that is just a graph of the deliveries. It would be nice if it was a flat line, but obviously obstetrics is a bit hit-and-miss when people come in. To date we have had 218 births this financial year. If you look at the mother's age, 34 per cent of our patients are between 31 and 35 years of age; over 35 is 18 per cent; and 18 to 20 is 3.8 per cent. Most of the deliveries are at term, which is 522; post-term there are 80; and pre-term there were 44 deliveries. There were 37 Indigenous births. These are some of our KPIs. We certainly like to encourage mothers not to smoke after 20 weeks, but obviously there were 47 cases of people who continued to smoke over that period of time.

With the demographics, obviously we cover a fairly wide area. Fifty-nine per cent of our deliveries came from Warrnambool, 18 per cent from Moyne, 11 per cent from Corangamite, 8 per cent from Glenelg and 4.2 per cent from the lower Grampians.

With the next slide — and I know you will not be able to read the numbers — you can see the distribution of where the deliveries are coming from. The orange colour on the left is Portland. They were 51 deliveries that we did from Portland. I think you will find that a couple of years ago when their services were not as extensive, we were probably doing about 100 of their deliveries. That has come down since they have got more services there. The top yellow area would be Hamilton — that was 13 — and then to the right you have got the Terang and Camperdown area. So that gives you a bit of the distribution.

There is a lot more risk management with maternity these days, so we do have a lot of non-admitted presentations that come to the ward. As you can see it is really the risk criteria, so decreased fetal movements and closer fetal wellbeing surveillance. For example, if someone was post-term, we would get them to come in for regular monitoring to make sure that that pregnancy was going okay.

Regarding interventions, inductions of labour are up to 44 per cent. I think you will find that there are a couple of probably environmental things around that. There is certainly an increase in gestational diabetes. Some of those are diet controlled and some are on insulin. I think that is a reflection of some of the lifestyle, obesity and diet changes in society. We have inductions because 10 per cent of babies have fetal growth restrictions, and 12 per cent of interventions are because the pregnancy is greater than 41 weeks. We do not like them to go much further than that.

We run a continuity midwifery program. It is a midwife-led program. It is for lower risk births, and about 150 births are considered low risk that we care for through that model.

On staffing, a lot of areas in Victoria I know are short of midwives. I am not saying that we are flush with midwives, but we are not too badly off for midwives. We have 58 midwives working in the maternity area. We have a lot in that middle area range where they are probably having their own children and working only about four shifts a fortnight. At the other end the older midwives are probably working a bit higher FTE — or the ones that are training, so that is the way it goes. That equates to 34 full-time equivalent staff in the maternity area, and that includes the women's health clinic.

We actually have 16 beds in the unit, but we operate on 12 beds. For 650 deliveries probably even 12 beds is fairly generous, although there are days when it is really busy. Last week we had 16 patients; this week I think we are down to six patients. That is the nature of looking after maternity patients.

They are all public patients on our ward. None of the obstetricians take patients privately, and I think that was a reflection of the cost of insurance for the obstetricians for private patients.

Education is a really important aspect for us and I think the whole hospital. I think that is where you keep the skill levels of your nursing staff. We have two midwifery educators covering four days a week. We do have student midwives, we have medical students and we have paramedic students. That can actually be a challenge, to try and get enough deliveries for them to see when we have only got a fairly small unit in some respects. We also provide training for our midwives. I think that Warrnambool has been very good in trying to maintain the level of training for their midwives, to ensure that supply of midwives. We usually have one or two registered nurses who have been doing general nursing for a while and then do their midwifery training. We provide them with clinical placements and then we provide a postgraduate midwifery program. We usually have one to two of them a year. Each year we take two double-degree nurses out of their training and again they spend time in midwifery and in the general side of the hospital. We provide them with that program. We take two of those a year.

We did receive funding from the Victorian Managed Insurance Authority to provide PROMPT training. PROMPT is scenario-based training, which has been really beneficial for the staff. We were funded $70 000 to run that program. We are getting a little bit of money at the moment — about $7000. Because it was a pilot project we were only able to run it at Warrnambool. We have Camperdown campus as well, and we do obstetric services at Camperdown. We did run that program at Camperdown. We would be keen to look at that program as a regional program, where we could employ our educator to go out to Portland, Camperdown, Terang and Hamilton to do that particular program. The dilemma sometimes is in the way we get our funding. It may be that Hamilton will get some funding, Portland will get some funding, Terang may get some funding and you sort of get this disjointed training, when it would be good to develop the resources in one area and go out and do that outreach education.

It is important to note that we actually do not employ direct-entry midwives. That is because we do have some general patients, who have gynaecology surgery for example, that we sometimes put in the maternity ward, so we need to know that they can care for both general patients and midwifery patients. That is why we do not employ direct entry.

We have a level 3 special care nursery, which cares for 34 weeks and above. There are eight cubicles. We average about four babies. It is staffed by midwives, but we are lucky to have one postgraduate neonatal intensive care trained nurse there, and obviously we do have paediatricians.

With the women's health service, we provide antenatal services and gynaecological services. Liz Uren has her private rooms up there as well. If you want to talk about that more, I will let Rachael talk a bit more about the women's health service later on.

Just touching on Camperdown, they have some antenatal services there. The obstetricians go there. That was 2015–16. I spoke to them this morning, and in 2016–17 they had 37 deliveries. The challenge I think for the small hospitals is maintaining the skill levels when they do not have a lot of deliveries. I suppose if something does go wrong, it is the transport of the patients to a larger health service.

I thought I would run through some of the challenges. The girls can talk a bit more about some of the challenges operationally. I think transfers to tertiary services, particularly for special care nursery or babies, can be a challenge. It can be a challenge to get beds and it can be a challenge to have the conversation that the mother and the baby need to be transferred.

In relation to support to smaller services I think I have probably got it more on the other dot point with smaller regional hospitals. I think Liz touched on the governance expectations for us, but that is difficult when actually our governance is South West Healthcare with our board. It does not extend to the other hospitals. We have a governance responsibility, but I suppose it is the legal side of those ramifications. If we provide advice to them and something goes wrong, how does that literally work?

Ambulance access and wait times due to location: that can be a challenge for the women. I know Liz touched on one. We had a 31-weeker recently who said it would be quicker for her to drive to us than to wait for an ambulance to come. For example, there is one ambulance in Portland. If the ambulance goes out of Portland, that leaves Portland without an ambulance. We do use non-emergency patient transport as well, and that provides a really good service, but often in these instances you might need more of emergency, and you are relying on AV.

I probably will just touch on the fact that, particularly with the cancer centre, we are having more patients from Mount Gambier. It took one of my staff an hour and a half on the phone to try to organise a patient to get back to Mount Gambier because of cross-border issues, so that is something else. As you can see from that map, we do not get deliveries for Mount Gambier, because obviously they provide obstetric services, but it is just one of the other issues we are dealing with.

We probably do not have perinatal palliative care services.

Regarding the sustainability of the morbidity and mortality reviews, there has been a funded program to have a regional morbidity and mortality review, where we all get together with Geelong and the other hospitals in the region. That has been a pilot project, but there is no guarantee of funding for that, although I think there is an expectation that that is maintained. For example, I think Rachael spends quite a few hours out of her normal job actually putting the information together to do that process, but I think that is a really important thing that we need to do.

I have got IT elsewhere because I share Liz's pain. Having said that, we are in a privileged position in that we do have Centricity, which is an electronic fetal monitoring system, and not many hospitals have that. We have had it for many years. The Women's has got it and we have it, and we are about to put it into Camperdown. The benefit of that is that the obstetricians at home can log on and see a trace from a woman, so it is great. There are issues, but we have got some good things as well.

Our antenatal clinic is a private model. It is funded through the MBS, as Liz touched on.

Regarding perinatal mental health services, Nicholas is here from South West Healthcare. I will let him talk to that.

We do have accommodation at Rotary House, although again with the cancer centre I think that is getting a bit harder to access — some days, not all the time. I am sure we are getting to the stage where we could have additional accommodation for those people travelling from outside the area.

I have also put in theatre capacity. If the redevelopment of the hospital occurs, I think we would be looking at an increase in theatres. There is potential then to have maybe an emergency theatre that we can use for emergency caesars. But at the moment the theatres are fully booked with elective surgery, so if there is an emergency caesar, they have to quickly finish something and get the patient in. We do have staff in theatre up to 9.30 or 10 o'clock, and after that they are on call.

I have probably touched on that I think education is key. Sometimes we do not have enough resources put into education. I think it is something on which we can do better.

Regarding information technology, we do have three systems. We have TrakCare, which is used across the hospital; we have Centricity, which does the fetal monitoring and records a lot of our data and care for the patients; but because we run a private clinic and TrakCare cannot do MBS billing, we have Genie, which is more a GP MBS-type system up in the women's health clinic.

Liz touched on the bariatric patients. Anyone with a BMI of 50 or greater is transferred out.

Regarding breastfeeding support, I take on board what Liz said about the lactation course: it is quite onerous, and it is hard to maintain the competencies.

There are probably a couple of other things I have thought of since then. Just to let you know, we do have quite a few Department of Health and Human Services referrals for our babies, and that can be challenging for the staff, particularly if the babies are going to be taken away from the parents.

Regarding maternal and child health, having worked in other states, I think Victoria still has a very particular model for maternal and child health, which is based with councils. I cannot talk for them, but that must feel fairly isolating, I would have thought, in some respects. I know other states have moved to having maternal and child health nurses within the community health sections of hospitals. That may not be an issue.

Just to reassure you, if we do send our midwives out on home visits, which we do, we do risk assessments before they can go and visit. I do not know if you can totally rule out snakes, but certainly dogs. Some of our cars at the moment are getting GPS systems put in them, but that is not all the cars at this stage; it is a fairly expensive exercise.

The CHAIR — Thank you, Julianne. Do you mind if we ask you some questions now?

Ms CLIFT — That is fine.

The CHAIR — I am conscious of the fact that we are running well over time already, but just in regard to the issue around transporting patients with non-emergent AV, what is the percentage of women in the south-west coast region that require a level 6 service? Just off the top of your head if you can give us an impression.

Ms CLIFT — I will probably let the girls talk to that. It is probably not actually a lot.

Ms FACEY — No. I could not give you a number off the top of my head, but with some of the scenarios it is similar to what Julianne just said. We had a 31-weeker last week. She rang. She had signs that things were not going so well with her pregnancy. She was advised to ring an ambulance. She lived at Carpendeit, which is down the other side of Camperdown somewhere. She was advised to get an ambulance. She said, 'I'm not getting an ambulance. I'm going to drive'. She was advised again, 'Yes, get an ambulance'. She said, 'It'll take me 2 hours to get there', and she was here within an hour. Her husband drove her. That is just an example. Even people who live in the isolated parts of the community actually realise and recognise that they are not going to get to hospital in a timely manner.

Ms LEE — It is not necessarily level 6 either, because we are meant to only take 34 weeks and above, so that is a 6 to 8-week period of women we can take. Even to transfer them to Geelong sometimes to get that next level up — the level 6 are probably our only real premmies, our really sick babies, but we often have to transfer women —

Ms FACEY — We have good communication with PIPER. I think that has actually improved a little bit, certainly since I have been unit manager over the last 18 months. If you have that communication with PIPER, as long as we let them know what is happening, they are relatively supportive. Usually it is timely, that transfer from South West Healthcare to Melbourne. It is more the people coming in from, say, Hamilton or Portland that we have issues with.

Ms CLIFT — I would probably say that one or two every three months would go to a level 6. It is not a huge number.

Ms FACEY — I think there were seven last financial year.

The CHAIR — Committee, we might just direct some questions to Julianne so we can get her on the road.

Ms BRITNELL — Can you elaborate a little bit more on the issues in this part of the world around the public and private systems and how they work together? I am talking more about as an institution — not necessarily the obstetricians who are private — and the effects of women having babies at, say, St John's versus the base and how you sort out the challenges of funding.

Ms CLIFT — Obviously we do not have any more babies at St John's, because they closed that a couple of years ago. Basically, like all our VMO services, they are all private. It does not matter whether it is obstetrics, whether you are having your hip replaced or whether you need general surgery, the majority of our patients see private consultants. In the case of obstetrics, they did see the private consultants in their rooms. I think it was about five years ago that they relocated to the hospital and it was set up as a women's health clinic, as an MBS clinic.

Public patients at the moment are bulk billed. At the moment we do have them pay a co-payment of $100 at the commencement of their antenatal care, but if they have a healthcare card they do not pay that $100.

Ms BRITNELL — I am sorry, I did not shape the question very well, but I am meaning from public-private health institutions. I know we do not have the births anymore, but the births stopped at St John's because of the challenges of the funding. As a director of nursing, trying to make the budget work when you have other specialties, is it hard? The same result could be happening with orthopaedics, for example, because it is really difficult when you are in the country to make sure you get that balance right between having enough private patients to take the burden off the public health system. I am just wanting to get some more information around that from you.

Ms CLIFT — I suppose from an obstetric perspective, on the financial impacts, if that is what you are looking for, budgetwise we budget for what we believe the deliveries are going to be, so that is fine. Obviously if a straightforward, normal delivery stays in hospital longer than you would normally expect, then that does start to burden us financially. But the majority of patients still have the option to be public or private if they come to the hospital. If we are challenged with beds and patients are happy to go to St John of God, we would certainly transfer them back to St John of God. I am still not sure if I am answering your question.

Ms BRITNELL — Does that happen?

Ms CLIFT — Yes, and patients ask to go to St John of God too from the ED. Sometimes whether we can get them to St John of God will depend on whether there are consultants who can take the patient. Sometimes that is an issue.

Ms BRITNELL — You mentioned the training. Deakin University — has that played a —

Ms CLIFT — I had that down.

Ms BRITNELL — Can you elaborate on the challenges we have had in the last couple of years?

Ms CLIFT — Yes. Certainly over the last couple of years there has been the risk of Deakin University closing. We do get the majority of our registered nurses and our midwives from Deakin University. If Deakin had closed, it certainly would have been a loss to this community and to the supply of nurses that we have to the hospital. Undoubtedly particularly the midwives that come out of South West Healthcare and Deakin down here are well-respected across the state. I have a friend who works at Monash, and they love the level of expertise of the staff that come out of South West Healthcare. I think that is really admirable — the level of the staff that we have in the organisation. To lose Deakin I think would have certainly impacted on that.

Ms BRITNELL — Dr Uren talked about having high schools. How important is Deakin University to this town and our ability at the hospital to be sustainable?

Ms CLIFT — We would interview probably 70 graduates that come out of Deakin University on an annual basis looking for positions. It certainly provides that opportunity, particularly for this region where I think unemployment is still one of the highest in the state. As one of the biggest employers in the town, having that flow of students from Deakin is good for the town itself and the economy, and they do not have to travel or go away, because they probably would not travel to do their training elsewhere.

Ms BRITNELL — Can I just clarify — when you said that you do not employ directly, and I do not remember what the terminology was, that was people who have just trained in midwifery, not general?

Ms CLIFT — Yes.

Ms BRITNELL — We heard about a model in part of Victoria where midwives come in with their patients privately, so they do not use the hospital. They work with the hospital but they are not employed by the hospital. Would that be something that would be worth considering?

Ms CLIFT — I think it is something that we could look at, but we have not at this stage looked at that model.

Ms BRITNELL — Because your staffing issues have not warranted it?

Ms CLIFT — At this stage our staffing is satisfactory. In fact I have got some of the midwives working elsewhere in the hospital at the moment. But I am trying to keep their skill levels in both areas because I know that at some stage we will have an exodus of midwives and we will need to put them in.

Ms BRITNELL — Can you just elaborate slightly on the referrals from the Department of Health and Human Services. Are they increasing? Are you seeing more challenges with family functionality? How do you manage that, because you have more postnatal care I imagine?

Ms CLIFT — I will let Janene —

Ms BRITNELL — Perhaps when you go, she can answer that one, because I do not want to hold you up.

Mr FINN — I have only got one question, and that is: you mentioned before that you are doing very, very well in some areas but there are some issues; could you prioritise the top three? If the Treasurer were to walk through the door and pull out his chequebook, what would you hit him for?

Ms CLIFT — Certainly I would have to say the theatres and the emergency department. We have a wonderful facility but that part of the hospital is still fairly old. I think there are some challenges and some work that we need to do around specialist clinics. To provide public specialist clinics we would not have the real estate to do that within the organisation. I certainly would like to put a lot more resources, if I could, into training and maintaining the expertise of the staff.

Mr FINN — So you think you need to physically expand the hospital in order to provide services that the community needs?

Ms CLIFT — Yes.

The CHAIR — I think you have just given Roma her next adjournment debate for the Treasurer.

Ms BRITNELL — I think we have already mentioned it a few times.

Ms CLIFT — I am sure I have missed something —

Ms BRITNELL — Drug and alcohol.

Ms CLIFT — Drug and alcohol.

Dr CARLING-JENKINS — You listed as one of your challenges perinatal palliative care, and then in the description you said that you do not have that. So can you describe the need for that and what that service would look like if you were able to put that in?

Ms CLIFT — I think that was something that I would give to Janene. I think for adults we have a wonderful palliative care service, but we have challenges with paediatrics, because for paediatrics really we do not have a palliative care service but we are quite innovative to make sure we do so that children do not have to go to Melbourne to die and that sort of thing.

Dr CARLING-JENKINS — Sure. I would be very interested in expanding on that. The other quick question is around the fact that you mentioned that the induction of labour is up to 44 per cent. You mentioned a couple of reasons for that. I wonder if you could expand on that. I guess I am really interested in natural births versus intervention births and how that might be on the increase. Why would that be, and have you seen that increase over two to five years? What kind of time frame?

Ms CLIFT — Again I think the girls are probably better placed to do that. Even long before Bacchus Marsh it really has been that risk management for women. When you had a normal delivery in the past — because I was a midwife in the past, I can go back a while — you would listen to the fetal heart; it was a really normal process. Now because of risk management we always do a CTG monitor when a person comes in and we very carefully monitor people. There is nothing worse than having a delivery go wrong and losing a baby, so people are going to tend probably more towards caution to make sure that you have a safe outcome.

The CHAIR — At this point, Julianne, I reckon we will free you up to go back to work.

Ms CLIFT — Thank you. I would love to stay. I hope that helped.

The CHAIR — Thank you so much for your time. We do appreciate it. If we can, we will hold on to Janene and Rachael. If you could make some brief statements and then we will ask you some questions too. I think we have already got some questions in our heads for you. Perhaps if we start with you, Rachael.

Ms LEE — A lot of what Julianne has said is on my list as well, but one of the biggest things for me in running the antenatal service is the database issues that Dr Uren touched on.

We set this clinic up in 2011. One of the private obstetricians used to run all the antenatal services from his practice, and he was retiring so he closed that and we took it on at the hospital and set up the clinic there. We see around 800 women a year, so up to 8000 appointments a year for women that are pregnant. That includes the women who come through from Hamilton, Portland and the surrounding areas that do not actually deliver with us but get reviewed by our doctors to ensure that they are getting the right care.

The statewide universal protocols come into this as well. We had to set up our own protocols, which we base on the bigger hospitals, but the fact that we have to do it I think is an issue. I had to sit down and look at all these protocols and decide what we would do at Warrnambool. I think we should be doing exactly what the bigger centres are doing. We do, but it just means that every person in my position in all these hospitals has to spend time managing these protocols, and every year we have to look at them again. It is just time and energy and money that we probably could be spending elsewhere.

In relation to the database, we all use our own systems, and as Julianne said before, Centricity is fantastic for monitoring in labour, but at the moment we do enter data. It takes a long time. A lot of our midwives in clinic spend a lot of their time collecting and collating data to put into a system, which then can be found in four different places. It is an issue, and it comes back to quality assurance again. We present to the perinatal morbidity and mortality forum, which Julianne touched on. That has come out of Bacchus Marsh as well in ensuring that everyone is providing adequate care and that our performance indicators are being met. But in saying that, I am the one who gets the data together to present to Geelong and our region, and because we have a different system to Geelong, Terang and Portland, it is up to me to find which cases need to be presented and to present them to Geelong. If I individually miss something out of our database, there is no-one else independently monitoring what we are presenting. So it just comes down to honesty that we present the cases that are not meeting the indicators, because no-one else can access our data.

Ms FACEY — Would that not be the same in the other hospitals, though, Rach?

Ms LEE — It is exactly the same everywhere. If we all had the same database that could be accessed independently, to me that is a good way to make sure that we are all meeting our targets and not inadvertently not presenting cases that need to be presented.

For us one of the other major issues is with PEHP. Since the introduction of that service the midwives have had a wonderful opportunity to refer lots of women to that service in order to gain the support that they need. We have about 10–20 minutes with each appointment as midwives, and in that time we have to cover their assessment for their pregnancy. There are just so many other issues that need to be covered, and we can now refer on to that service. They are almost always full, are they not?

Ms FACEY — Yes.

Ms LEE — There is a waitlist for women to be able to see —

Ms FACEY — The funding for PEHP certainly is an issue, and I know that Nicholas is going to elaborate on that, but it has been a fantastic initiative over the past — I am not sure how many years. It must be four or five years. And the support that is given to the women is incredible, as is the feedback from the women when they come in to have their babies. They have the support in the antenatal and postnatal periods.

Ms LEE — The Healthy Mothers, Healthy Babies initiative, which has just been rolled out as well, complements that service. We tend to use that as a triaging opportunity, and they can then direct the women to the services they need.

Ms FACEY — I think Julianne alluded to the fact that we do deal with a cohort of vulnerable women and families, so all of these supports in the community are really crucial to us providing that extra —

Ms LEE — It allows us to provide the medical care that they need from midwives, and then that extra support is given by these other services. I think it is increasing, because one of the things we pointed out before is our intervention rates are going up. We cannot underestimate the psychological effects that has on women. Yes, we are getting better outcomes and we are losing less babies, but the psychological effects of intervention on women is something that is not always looked at. We see it when they re-present for their second and third babies. There is often trauma and there are things that have not been recognised as a part of this intervention cascade that we are seeing.

Ms FACEY — That might be a long-term thing that will become more obvious to us.

Ms LEE — I think in 20 years time —

Ms FACEY — Probably even 10 years.

Ms LEE — we will realise there are a lot of women out there with post-traumatic stress related to what happened.

Ms FACEY — To even just the induction of their labour.

The CHAIR — Janene, have you got anything to add before we ask some questions?

Ms FACEY — Rach is sort of with the antenatal clinic. I will leave that side of the business to her. Julianne covered our service very well with her presentation. We did have a bit of a chat beforehand, and my list of issues and challenges is very similar to Julianne's presentation. The main one for us certainly in our department on a day-to-day basis is the amount of presentations — outpatient assessments — that we receive. I actually looked at some of the other submissions, and I see that other hospitals around Victoria have that issue too. I think this has probably come about due to that closer surveillance of pregnancies and the education of women to, if they have decreased fetal movements, present to the ward for assessment. This is all done outside our ratios. We are having 1800 presentations over a 12-month period.

Ms LEE — They are not accounted for in staff.

Ms FACEY — That is 50 a week, I think I worked out last night, so that actually has a huge impact on the care the midwives can actually give to the other patients in the department, whether it be in birth suites, the special care nursery or postnatal. So that is one huge issue for myself, and I am caring for my staff and my patients in bringing that to your attention. Whether or not it is something that can be built into ratios, I am not too sure. It does have unpredictability, because you never know when someone is going to call and say they have had bleeding or that their baby is not moving.

Our special care nursery is staffed from our ward ratios, so there are no governing ratios for our special care nursery. It becomes an issue when we have got babies with extra special needs, like CPAP, and that is where we get a little bit of pressure from Melbourne. Last week, for example, we had six babies in our nursery, which is our capacity, and we had one on CPAP. We had the pressure from PIPER to take another baby back to Warrnambool. We just did not have the resources. There have been a couple of phone calls on a couple of occasions from PIPER just inquiring as to why we would have a resource issue. We had a resource issue on this particular day for these particular reasons. It does not happen all the time — it is pretty rare — but I suppose it is about just having that respect for the regional hospitals when they say they are at capacity and cannot do a transfer back.

The transfers we spoke about with AV, I am not sure what the solution is there. There are also issues with AV with the transport cot for neonates. Quite often we will get a call from Portland to bring a baby across or from Hamilton to bring a baby down to us for ongoing care. There is one transport cot that sits at Portland hospital, and I am not too sure how they get it to Hamilton if they need to transfer a baby immediately to Warrnambool. That is an issue, and I think that is an issue around the state. You may have heard that from other regional centres. I am not too sure. That is an incubator that the babies need to be transported in.

Julianne talked a bit about the governance with Terang and the other outlying hospitals, and that probably goes back to education being a crucial part of our business, because we want to support the smaller hospitals so that they can sustain their services. That is why we feel that education is a crucial part of that process. Do you have any questions?

The CHAIR — Thank you. It has been very informative so far. Rachel, would you like to start?

Dr CARLING-JENKINS — Yes, I might just follow up on the questions I asked earlier. I thank you for expanding on the increase in interventions. My understanding from what you have been saying is that it is about risk management and erring on the side of more caution.

Ms LEE — Mostly, yes. It is a bit of a Big Brother effect, where everyone is quite aware of the fact that we want the outcomes to be good. There has been a lot of education, and the department has obviously looked into what happened in some of the other services in Victoria. We are now much more accountable for our outcomes, and I think the women too see it in the news and in the papers.

The education surrounding what to look out for to avoid a stillbirth has meant that with the interaction between the patients and ourselves in clinic alone we have seen a tenfold increase in phone calls from women worrying about foetal movements. For us that is something we have to act on, so that increases the outpatient assessments. It means that women are more nervous. If someone complains that their baby's movements have decreased or they have got any concerns, there is less room for movement in allowing women to continue their pregnancy past term. I think we are just accepting that. The outcomes after induction do not change with our statistics, so the vaginal birth and caesar rate are exactly the same. It is hard then to argue that by not inducing women we are doing any harm or good.

Dr CARLING-JENKINS — That was going to be my next question around the rates of caesareans. So that has not changed?

Ms FACEY — No.

Dr CARLING-JENKINS — That is interesting.

Ms LEE — No, it is exactly the same. We actually have a really good vaginal birth rate here; it is around 60 per cent.

Dr CARLING-JENKINS — Excellent. Then the other one that I was just going to follow up on was around the perinatal palliative care.

Ms FACEY — To be honest that is something that I have not had to deal with in my leadership role. But as Julianne said, paediatrics have been innovative, and I am sure that if the occasion occurred, we would be able to provide the resources.

Ms LEE — They tend to be in Melbourne, do they not?

Ms FACEY — Yes, they do. But if the occasion arose that a family wanted to transfer back to Warrnambool from Melbourne for whatever reason or a baby was born that we knew was going to be palliative prior to birth, we could provide that service and those resources.

Ms BRITNELL — Rachael, on the database issue, when you set it up did you actively approach the department of health and ask them what sort of assistance they could offer or whether they were able to take on much of the responsibility?

Ms LEE — No. What seems to happen is that individual services look at software packages and pick which one suits them the best. For us when we set up the women's clinic, the program we chose, the software, is one that is being used by other consultants already, so we knew that it did what we needed it to do. But unfortunately there does not seem to be one package that does everything. That is why it happens. For example, TrakCare, which we use as inpatient software, does not provide outpatient services.

Ms BRITNELL — But your performance indicators must be set by the department?

Ms FACEY — Yes, they are.

Ms LEE — What do you mean, sorry?

Ms BRITNELL — When you say that you are establishing protocols, those protocols would be around those performance indicators.

Ms LEE — The protocols and the databases are probably two separate issues.

Ms FACEY — Yes, they are.

Ms LEE — The databases are the software that we choose to put everything into and therefore we can pull certain data out of them — but, say, Geelong cannot access ours.

Ms BRITNELL — But to pull that data out, you have got to give information to the department to prove that you are a reasonable business.

Ms LEE — Yes.

Ms FACEY — Yes, we monthly have to supply our data.

Ms LEE — They all do that. It is just that we all use different programs.

Ms BRITNELL — With the protocols, was there any active interaction with the department?

Ms LEE — The department does not have protocols that we have to follow. Yes, we do have to —

Ms BRITNELL — Criteria but not protocols.

Ms LEE — That is right.

Ms BRITNELL — Meet those criteria through helping develop the protocol to meet that criteria.

Ms LEE — Yes. As Dr Uren said, there was the 3centres committee, which was the big centres that got together with, I guess, the aim of coming out with universal guidelines. But there was no consensus, and the government did not enforce a decision.

Ms BRITNELL — The waiting lists for the perinatal emotional health program — I suppose I should wait for Nicholas actually on that one. Can you tell me other than anecdotally — like you keep on getting the feedback, you are saying, from people looking like they are feeling more supported — have we got any data to support the fact that it is actually working, having that support?

Ms FACEY — I think Nicholas will have some data. I have seen some data from Ballarat.

Ms BRITNELL — The patient ratio model. I just wanted to clarify: you are actually saying that with the patient ratio model that the hospital has to stick to, it actually does not work in maternity because of the nature of the changing assessment requirements that were not there 20 years ago — they would go to their GP to be reassured — whereas they are coming up to you to get reassured more.

Ms FACEY — They do work. But with the impact of the inpatients, that has just added another workload that has not been recognised. This has all changed dramatically.

Ms BRITNELL — Yes, so the patient ratios do not apply to you. That is what I mean.

Ms FACEY — Yes. Unfortunately they are classified as outpatients, but that does not reflect on my staffing at all.

Ms LEE — The ratios definitely do apply to maternity, and they are adhered to

Ms BRITNELL — Sorry, that is not what I meant to imply. Because you have increased assessments, that is not factored in.

Ms FACEY — Yes, it is not being factored in, so that is something that is an issue.

Ms LEE — So for your person in charge, instead of having no patients — the person in charge of the unit on a daily basis should have no patients — we might have five women ring up in a morning who all need to be seen. Therefore for those patients who have to be seen by somebody, if we cannot account for it in clinic, which we try to, they end up on the ward. Over 20 weeks, they are sent straight to the ward, so it is essentially like an emergency department. After 20 weeks they have to account for these assessments.

Ms FACEY — Ours is in hours and out of hours. Other hospitals do have that facility, like a day assessment unit. We cannot sustain that because we do not have enough births.

Ms LEE — We just do not quite have the number.

Ms BRITNELL — Is Warrnambool moving into that transition phase where we need to reconsider?

Ms LEE — We do not have enough births, really. The problem is, as you saw, the trend is that one day you will have zero assessments and the next day you will have 10, so it is very hard to staff. When you look at the data, really you need around 1000 to 1500 births to easily staff a day stay unit. What we do is we pick up the slack in the antenatal clinic and then the leftovers go to the ward. The clinic is only Monday to Friday, and we are also fully booked with patients.

Ms FACEY — The impact comes back to the unit.

Ms BRITNELL — So you cannot see a solution?

Ms FACEY — Other than asking people to work extra hours. We need to deal with it. Obviously they are classified as outpatients, but there is no recognition.

Ms LEE — And I think historically the GPs have picked up a lot of the slack. The GPs stopped their delivery rights and the service moved to the hospital. I guess generally the rural areas are not being funded to provide this full antenatal service. Really it has been something that has always been done with GPs.

Ms FACEY — The impact would be right across Victoria with these extra outpatients.

Mr FINN — On the issue of education, which has been emphasised and re-emphasised a couple of times this morning, is that education directed at other local hospitals or is it directed at the patients?

Ms FACEY — I am talking about our midwives and our staff. For our long-term sustainability we need to have a good team of well-educated midwives and medical staff, which we do within our unit very well. The amount of education has sort of ramped up a little because of the expectations that have come out of Bacchus Marsh and Barwon. There is always something else to add to it. We see ourselves, because we are a regional hospital, as being able to actually facilitate possibly other hospitals and support their midwives in sustaining their services too. The education issues are certainly within South West Healthcare. I could have a full-time educator in the unit to support so there is some division with supporting student midwives, midwives and medical staff — the list just goes on, and the expectations keep going up.

Mr FINN — Indeed. I noted earlier that one of you — I cannot remember which one, sorry — mentioned that one time recently you had a full quotient, if you like, of beds taken in the neonatal special care nursery. Would it be feasible or even desirable to expand that nursery?

Ms LEE — It can be empty for a week, and then it could be —

Ms FACEY — There are peaks and troughs. We probably run generally at about three babies, which is one staff member for our ratios. But once we get up to six babies, we actually need two staff members. It comes down to that resource issue too. Quite often when there is a baby that needs less attention or that maybe spends time with its mum out on the ward, the midwife will devote her time to another patient on the ward plus the nursery.

Ms LEE — It is one of the trickiest things, the fluctuating nature of the service.

Ms FACEY — Yes, it is the nature of our service, and it is something that is unpredictable, as maternity services are.

Mr FINN — If the size of the nursery were to expand, would the staffing be the main issue in coping with that expansion? Say if you were able to cope with nine, for example.

Ms FACEY — A lot of the time we would not have babies. We would still only have our three babies, so it is just that justification. There probably is not a justification there at this stage and until our births go up.

The CHAIR — Thank you for your time. It has been very obvious in this inquiry that everyone that comes in and makes a submission is very passionate about the job, and certainly we have seen that today from the representatives from the South West Healthcare organisations. Thank you so much for your time today.

Witnesses withdrew.