T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 5 February 2018

Members

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Ms Cindy McLeish — Deputy Chair
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Witness

Ms Jodie Ashworth, General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing Officer, Northern Health.

The CHAIR — It is my pleasure to welcome our next witness, Ms Jodie Ashworth, chief nursing and midwifery officer and general manager of perioperative services, ICU, emergency services and cardiology. I welcome to these public hearings Jodie Ashworth. Thank you for coming here today and spending the time with us. 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 also a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript to have a look over.

Ms ASHWORTH — Thank you, Paul, and thank you for the opportunity to present.

The CHAIR — I invite you to give us a 10-minute brief of your involvement in the perinatal services sector and where you think we should be focusing, and then we might ask some questions if that is all right with you.

Visual presentation.

Ms ASHWORTH — Just while I am waiting for my presentation to come up, it is probably worthwhile giving you a little bit of background on myself. I trained for midwifery at Cairns Base Hospital as a hospital-trained nurse many, many years ago now. I have worked across three states and one territory of Australia in midwifery practice. I have actually worked from rural to metro in Victoria and also had eight years at Bendigo Health as the maternity services manager, where I introduced case load to that particular hospital. In my current role I oversee just under 3000 nurses and midwives in the northern corridor for Northern Health.

My presentation partly focuses on workforce, and mainly maternity workforce, and how that links to perinatal indicators and certainly perinatal mortality. 'Facing the challenges of maternity service growth with success' — it would be pertinent to outline and define what success looks like for us at Northern Health in this space. Basically it is improvement in the department of health perinatal indicators, it is lower perinatal mortality, it is a waitlist for employment for midwifery staff and it is improved staff and community satisfaction with maternity services.

Ms McLEISH — Are they internal KPIs or department —

Ms ASHWORTH — They are internal for us. Just a little bit about our catchment: it includes the three growth corridors of Mitchell south; Hume, which is Craigieburn and Broadmeadows; and Whittlesea. The Northern Health catchment is expected to grow by 47 per cent between 2011 and 2026. We have high rates of family and humanitarian settlement, and the graph shows the distribution of age, which shows, I suppose, an indication of the young families that we have coming through the catchment. There is a higher percentage of households with children, and this is particularly related to the new estates that are forming through the Craigieburn region. We have higher fertility rates — out to 2.8 per cent in some areas against the state average of 1.8 per cent — and we have a higher proportion of couples with children.

We have higher rates of family violence. In some areas the proportion of couples or households with children is actually 10 per cent to 12 per cent above the state average. We have higher rates of obesity, and our gestational rate of diabetes is one in six women, compared to the national average of one in 16. We have higher rates of socio-economic disadvantage, and 75 per cent of the community accessing our health service have English as a second language. We have had a 52 per cent — nearly 53 per cent — increase in births in the past seven years. We plateaued out for the 16–17 financial year, but if you look at the year-to-date comparison with what we are currently doing, we are now expecting another 10 per cent increase in growth on our current numbers.

Our mortality ratio for 2014: some people find these indicators difficult to interpret. Can I just say it is a combination of perinatal mortality and a number of indicators, and the best way to describe it is the smaller the dot and the more you are to the left and the lower part of the screen, the better. In 2014–15 you can see we were sitting alongside Werribee Mercy. We are the purple dot under that. In 2013–14 we had a worse perinatal mortality ratio, and that could have been reflective of the 2012–13 growth rates where we can see an increase of both 12 per cent and 14 per cent growth in those particular years.

Our midwifery staffing profile from 2014–17: the number of births increased by 31 per cent, and our vacancy rate was decreased from 11.3 per cent to 0.9 per cent, so we managed to get something right in the current years and climate. We currently have 153 EFT midwives in our service. In 2014 it was in November that we probably

hit our worst deficit of 23 EFT maternity staff. What did we do about it? We established some strategy objectives. We decided that we were going to stop trying to pull in agency and overseas nurses and perhaps be competitive in the local market. Sixty-five per cent of our staffing population actually live in our corridor, so we decided to make a real effort to attract and retain the workforce from the northern corridor community. We decided to support and build a high-performing workforce, build on our midwifery identity and safety culture, develop a plan for the future workforce that started at an undergraduate stage and went right through to private practice midwifery, and strengthen our collaborative approaches to practice with our obstetric colleagues.

What actions did we take around this? We identified and aligned with university partnerships to local student cohorts, and we introduced the paid model of employment for postgraduate midwifery. In 2014 we had one postgraduate student from RMIT. For the last three years we averaged between nine and 10 from Latrobe University, Bundoora, which is who we have partnered with. We increased our clinical support and education to combat the junior workforce that we were trying to grow, and we aligned with best practice programs of PROMPT, FSEP and PIPER. We also expanded rotations across the continuity of care for midwifery. We decided it was time to celebrate midwifery as a profession, and we separated midwifery from nursing. We developed our strengths and promoted them.

It must be noted that we sit in a triangle between the two largest maternity hospitals in the state, being the Mercy and the Royal Women's. It is really hard to compete in a market when the tertiaries have so much to offer for professional development, so we really needed to find our niche in the market and work out what we were going to do to create our own identity rather than compete and try and pull staff from the tertiaries. We reached into the far ends of practice and introduced registered undergraduate students of nursing and private practice models, and we developed a more collaborative approach to models of care. Our obstetricians and midwives work together, learn together and play together. Certainly in the space of education PROMPT has been really good, but our neonatal training is also multidisciplinary and our student midwives and our medical students also do PROMPT, our neonatal training and FSEP.

What are the outcomes? We have consolidated our university partnerships to the local student cohorts, and we have increased the placement and enrolment offers through both La Trobe and ACU. At one particular time, I think it was back in 2013, we were chasing, I suppose, the student fee placement model. Students from interstate and students from Deakin at Warrnambool were actually placed at the Northern Hospital. While this was good for student professional development, it was not growing our own local workforce. Consolidating back with our two universities, especially those in our catchment, has really been beneficial. It was the local campus at Bundoora that we aligned with for the postgraduate diploma program, and we continue to support our students in the employment model and consolidation of practice.

I think the paid employment model is the way forward for Victoria. It is exceptionally difficult to go to university — to fund a $20 000 course as well as supporting a family, which a lot of these young girls who are entering the midwifery workforce are doing. They are gen Y. They are trying to buy a house if they are not still living at home with mum and dad. It is very unattractive to do a double workload, let alone to try and understand and comprehend the amount of double shift work and the safety concerns that come with supporting an unpaid model.

We have increased capacity and success in attracting and retaining our midwifery workforce through our computer match. We fully match all our positions, and a high percentage of our graduate midwives stay and transition into re-employment. We commenced a midwifery pool. What we try to do is give all of our graduate midwives a little bit of EFT. It may mean that they have to join our pool and have 0.4 somewhere else in the organisation for a little while until a position becomes available, but we do currently have a waitlist at Northern Health for people to work in our service. It really is about growing and supporting your own.

We improved access to training and monitoring of practice from engagement at the best practice programs. In 2014 we actually used to charge to do fetal surveillance, so we did not really have it as a mandatory competency. We charged $50 for our midwives and doctors to do the program. We have since removed that charge, and we offer that free of charge. We have made it a mandatory competency and have aligned with the state's best practice policy in regard to fetal surveillance. We do the same for our neonatal resuscitation training.

We have re-employed and retained our midwives across a continuum of care in the establishment of the midwifery pool I have spoken about, and we actually had an incredibly large improvement in our People Matter survey last year in regard to staff satisfaction.

You can see we have pulled back our perinatal mortality ratio for 2015–16. Our dot is smaller and we are further on the left, and we are actually one of the better performing hospitals now in the state.

Just a brief mention of our Koori maternity service at Northern Health: we do offer individualised care and a continuity program for our Torres Strait Islander and Aboriginal families. Hume and Whittlesea sit within the top 10 for absolute numbers of Aboriginal and Torres Strait Islander residents, and Mitchell is also high, giving us one of the highest population counts in metro Melbourne. This particular model has been exceptionally successful in attracting our Koori families to deliver back on country and come into Northern Health, and we are now pulling families from as far away as Werribee that are coming because they have heard from the mob this is the place to be. So we quite often are now accepting women out of catchment as well. So 116 women received pregnancy care through our Koori maternity service in 2017, and you can see that significantly more women in the KMS program are considered to be high risk — 42 per cent — in comparison to 12 per cent for all other women. So they are, as the perinatal mortality outcomes suggest, a high-risk population.

For those that birthed in the program 73 per cent had a vaginal birth, but between 85 per cent and 90 per cent had more than two postnatal visits and domiciliary care from the midwife in their home, wherever that may have been at the time — sometimes that varied. We do have quite a tight process around our antenatal care as well, and at Northern Health we do have a car that has been funded by the organisation. At times we realise that we do have to pick our women up, and quite often the elders in the community — their aunties — are the ones that find our younger girls because they are not always at the address that they have registered with us.

On 17 February 2017 we opened up our birthing room. The art was commissioned by a local Aboriginal artist. Interestingly enough we also had the same picture in earth colours, and I would have thought that the elders would have chosen the earth colour painting, but they did not. This was their choice. They went with the colour, and it has been widely used and, I suppose, appreciated not just by the mob and the Aboriginal community and their families but also by our other CALD families, who have quite often asked to go into this room because of the connection that they feel. It got a mixed review. It was interesting. We had a phenomenal amount of hits on our website when the ABC and SBS televised this room being officially opened. It was interesting that we got a fair bit of feedback — 'Well, where are the rooms for normal women, Caucasian women?', to which the health service promptly replied, 'We have eight rooms like that out of our nine birth rooms'. We did make it quite clear that all of our rooms are open at all times. We never move family. If one of our Hindu families are using this particular room — and they tend to like it — then we certainly do not move them out when we have a Koori woman coming to deliver. It was the winner of the 2017 public health service award for improving Indigenous health.

The Northern Health and private midwife collaborative model of care: I am not going to go into too much detail because I know you have already heard from the private practice midwives — other than to say this was our opportunity to promote midwifery care. It was a good challenge for us to develop the potential of our profession, and again it worked in fitting in with our strategy to establish a midwifery identity, so it was very much linked to a strategic process.

The collaborative model at Northern Health: we received funding to implement the pilot in 2015. We established a multidisciplinary committee to engage the key stakeholders, and probably the only comment I would like to make around this — and I know Andrea has spoken about it — is around credentialing. We do have the same process for our private practice midwives as we do for our medical staff. We made it very clear to the group at the beginning that it was going to be virtually our way or the highway, that we expected them to abide by our own policies and procedures, and that their credentialing was dependent upon that. That gave the medical staff something of substance, I think, that they could hang their hat on, that this pilot could be collaborative and work without the fear, rightly or wrongly, that the private practice midwives would veer off into a scope of practice that would be outside what they felt comfortable with. I suppose I am familiar with homebirths practising outside the scope of practice. I sit on the AHPRA disciplinary panel for hearings, and I have heard a number of cases there. I also was a witness in the Supreme Court for AHPRA around a homebirth case. Senior leadership went in very much aware of, I suppose, the bias, the myth and the perception of obstetric and midwifery models, and we managed to break down those barriers and push ahead.

There are a number of things that are key to a successful implementation. People say, 'Why have Northern Health been able to do it and it hasn't kicked off anywhere else?'. One of the things was we did have the lack of other continuity models. So we did not have case load, and we have a very small cohort of privately practising

obstetricians. There was no real feeling of a cross of boundary and, 'These midwives are going to take away a portion of our customers'. I think that was helpful. We had incredible support from our CE and from our board. We decided that we were going to put aside our fears of the private practice group only being a group of three and, 'What are they going to do if they grow and can't manage the workload?' and work towards just supporting integrating them into the health service.

The outcomes I am sure Andrea would have spoken about, but there they are: reduced length of stays, reduced caesarean section rates, reduced use of epidurals, reduced number of episiotomies and reduced number of tears pretty much across primips and multips.

The benefits to us as an organisation, again, as I said, we have been able to establish an identity and work with a new continuity of midwifery model for our region. We have got improved satisfaction from both our patients and our staff because they have helped reduce the workload of some of our employed midwives. We have been able to attract a new workforce to Northern Health. The midwives also sit on our books, so we call on them casually when we are short and things get tight. It has had a positive impact on midwifery care for all patients. As I said, it just creates an extra resource for us to use at times. We have had reduced demand, even though it is a very small portion, this time on antenatal and postnatal services.

Just a comment about this particular case. This is Lara, Onur and Emilia. They were delivered two and a half weeks ago with the private practice midwifery group. Lara was a first-time mother. She had a low-risk pregnancy, and she very much wanted a homebirth in her own home. She met up with Andrea and Hannah and decided to go with the practice and with the collaborative program. It just so happened that at delivery there was a severe shoulder dystocia. We had the head delivered for 3 minutes and could not deliver the body. Then a number of midwives and medical staff — both private practice, our own staff and the medical staff — did a number of manoeuvres before we finally managed to link a catheter around the anterior shoulder and deliver the baby. We did fracture the clavicle in trying to get this baby out.

It came out and required full resuscitation — CPR — and our paediatricians and the full team were there to provide that. I suppose my concern would be that this would have been your typical homebirth of a first-time mother with a low-risk pregnancy, but faced with that scenario in the home I am not sure that the outcome would have been the same because the access to immediate emergency care and support would not have been there. This is 4 hours post birth, and they are doing well at home now. So it is a true example of when collaboration can create a safe outcome.

That just shows you the diversity of some of our midwives who are currently working in the service. It is interesting. We had these lanyards made as part of promoting our breastfeeding. It is such a simple thing, but, again, it helps establish an identity and gives them a sense.

If I had to deliver one or two key messages, they would be around building midwifery identity and leadership for Victoria at all levels. We have a chief nurse. We do not have a chief midwife. We are not on our own. Certainly the New South Wales chief nurse is also not a midwife. We have got very established processes for nurses at executive tables now and at the board table, but, to be quite honest, you see only what you look for and you recognise only what you know. Still there is that gap and as to building midwifery as a profession, there is still the lag, I feel, not just for Victoria but for the country. We have hospitals in this state that are doing 4000 deliveries and do not even have a midwife at the executive table. So the director or the EDON is not also a midwife, which is fine, but then the next level should have a midwife representative. It is no disrespect, I am also a nurse, but, again, they are two separate professions.

I think we need to look at postgraduate scholarship support. That goes right to the undergraduate. I know that the state is looking at doing a registered undergraduate student of midwifery pilot. I think that is a good way to go. I think it is a better model even in the rural and regional areas than some of the established models where we are training and doing six-week courses for ENs. I believe in perhaps scholarships for private practice midwives going forward. We do it for nurse practitioners, but we are yet to see any scholarships go into the private practice midwife space.

Like our colleagues interstate, after being based in the regional areas for quite some time, there is going to need to be some rural incentive for midwives to work in the rural areas. I mean, you get it in Queensland, you get it in New South Wales, but you do not get it in Victoria. I know that many people say it is only an hour away to the next biggest region. It is a long way for an obstetric emergency still, so we really need to develop those models.

I think the work that Safer Care Victoria is doing in partnering rurals to metro is absolutely essential. It is a great piece of work. We are very fortunate to have Euan Wallace involved in that. We are working on the governance side at the moment of linking those partnerships. We also need to work on the workforce side, so what those shared models for collaborative midwifery and obstetric practice look like between somewhere like Northern and Kilmore.

The CHAIR — Thanks for the presentation, Jodie. Do you mind if we ask you some questions now?

Ms ASHWORTH — Sure.

Ms EDWARDS — First of all, congratulations on the work that you are doing there. It is absolutely outstanding. We have heard so much about the Koori maternity birthing room and how wonderful it is. Just a question about the CALD communities that you have at present and the structural and language services that you provide. Perhaps if you could talk a little bit, very briefly, about that particular side of the service.

Ms ASHWORTH — It is difficult. We service people from 185 countries that speak 106 different languages and practise 90 different religions, so our CALD community is diverse, and delivering patient-centred care to such a diverse community can be difficult. We struggle with health literacy and having our families informed. We do have our own in-house interpreter service at Northern Health. In addition in maternity services alone we are still spending around $300 000 a year on outside phone call and other interpreter services. It is a challenge that we think we are managing, but, as I said, it is still a challenge and it is difficult to provide patient-centred care to such a diverse community. Social isolation is difficult. Our failure-to-attend rates for antenatal care, surprisingly, are quite low, but for other services, our gynaecology services — terrible, 37- 40 per cent. Again, I think part of that is socio-economic disadvantage — public transport into the Northern is not simple — and part of it is health literacy.

Ms EDWARDS — So you bring in the interpreters. You have to contract that out.

Ms ASHWORTH — Yes.

Ms EDWARDS — Are any of your midwives trained in other languages, other cultures, or do you just rely entirely on that?

Ms ASHWORTH — There are quite strict policies and procedures around who can interpret for medical decision-making. We will find that with some of the midwives who are up here, we might grab a midwife to say, 'Can you ask if her feeding was okay overnight or if she slept?'. But when it comes to urgent clinical, medical decision-making, they cannot ask those questions purely because of the procedures around medical decision-making. So yes, we do on a daily basis, and it is not unusual for us to even get the environmental service Indian lady to go and speak Punjabi and ask, 'When's your husband coming to pick you up?', but medical decision-making is still where it gets difficult at times because we have to rely on a straight interpreter service.

Our family violence rates are challenging. Having those conversations with women not in the presence of their husband with some of our communities is difficult because first you do not get that opportunity, and when you do get that opportunity you find that their English is so poor that it is difficult to truly understand what is going on in the home.

Ms EDWARDS — Do you think there is a solution?

Ms ASHWORTH — I think if you are talking about family violence —

Ms EDWARDS — I am talking about just generally how to better support these women and families.

Ms ASHWORTH — We are doing a trial at the moment with mothers groups from particular communities. We have a group of Punjabi women that come together to share stories and try and build supportive relationships. I am not sure. We have just settled 2000 Syrian refugees in the northern corridor, as you are probably aware, and we are starting to see some of the challenges with that come through the door now. It is just part of investment in CALD communities and what we are going to do to, I suppose, assist and help build a healthy lifestyle for those Australians. I am not sure that we have nailed that yet and I am not sure the resources are there for us to be truly successful in the northern corridor just yet.

Ms BRITNELL — You talked about the funding. You have subsidised the course that you now charge $50 for — the two courses. How are you actually managing the funding around delivering that course? How are you subsidising that?

Ms ASHWORTH — Organisational. It is just coming straight out of our bottom-line budget.

Ms BRITNELL — You also talked about midwifery being more affordable. I am just thinking, if we have only midwives, that might suit Melbourne quite well, but it does restrict the regional and rural area, which you have obviously worked in, if you have got not too many mids on that day and you need to put someone in a surgical ward. How do you —

Ms ASHWORTH — Absolutely. The cream of the crop are the double-degree students who are coming out, and we certainly try to retain all of those. But that is the model for regional and rural Victoria — developing scholarships for those double-degree students. Direct entry midwives, even in a tertiary situation, can be challenging because if we have a slow day and we want to redeploy that staff member to a medical-surgical ward, it is not an option. But in the rural and regional areas where you have only three or four people on a shift, you really do need the double degrees. I absolutely agree with you; it is the double-degree students.

Ms BRITNELL — It sounds like an easy option but it is creating a longer term problem — like a short-term solution to a longer term problem. Surely we can train the skill set together rather than ditching part of the skill set.

Ms ASHWORTH — There are two separate professions. That is like saying we can train an OT to be a physio. They really are two separate professions now. Rightly or wrongly, whether I agree with that or whatever my personal opinion is, that is the way that the country has gone with AHPRA in separating registration. I think we need to understand that there is a niche in the market for both of those professions, and maybe for direct entry it will be the development of a private practice model that we see in New Zealand, but we are a long way from that and I absolutely concede that for an employment model in the regional areas you need double-degree students.

Dr CARLING-JENKINS — When I was preparing for our hearing today I had questions around the workforce strategy and questions around the advantages of having admitting rights for private midwives, but you have covered all of those very comprehensively in your presentation, so I guess really I would just like a copy of your presentation, if we can retain that. I want to congratulate you on that proactive approach to staffing because obviously that has really turned around your entire service. I also want to congratulate you on your award last year because obviously that is well deserved. It sounds to me like you do practise best practice in Indigenous health, and that is very well done.

The CHAIR — Thanks, Rachel. I concur.

Ms McLEISH — Thank you, Jodie, for coming in and giving us such a comprehensive presentation. Northern Hospital is one that I am very familiar with, and I find it amazing that one year on, the Koori birthing suites have had such great success. I certainly congratulate you for that. I was also very impressed to hear about your strategy to grow the local workforce, and we have heard in country areas how important that is — to recruit locally and keep them local — and looking at that in that outer area, that growth area, and hearing of your experience as you are leading the team is also terrific.

Earlier today we had a presentation from PIPER, and I understand that the Northern is a level 5 hospital. What is your experience with transfers to and from level 6?

Ms ASHWORTH — We have just pushed with funding to 18 cots and, as you said, are at level 5 capability now. We have a good relationship with the network and with PIPER. We find that they give us efficient and expert service when we require help in an emergency to transfer out. What we are struggling with at the moment, I suppose, again is establishing our reputation, our credibility and our identity in pulling our babies back into the corridor in Northern Health and what we call 'bringing them home' once they have finished care in a NICU, particularly from Mercy.

Quite often our babies will be at the Mercy hospital and would be appropriate to transfer back to Northern, but every nursery is staffed to a certain level and everyone is trying to keep their occupancy up. Sometimes we feel

we are not utilised to our full capability, but that is just about us. As I said, we have recently employed a number of new neonatologists. We do have neonatologists on call 24 hours now. We have not always been like that. It is just about building the trust and rapport with the tertiaries and, I suppose, letting the frozen moment happen and letting our babies come home because we have the capability to manage them that then frees them up to do the work that tertiaries should be doing best, which is NICU and level 6 work.

Ms McLEISH — Thank you. Can you just explain to the inquiry the relationship between the Northern and Kilmore?

Ms ASHWORTH — Northern provide governance support to Kilmore hospital. Our clinical director sits on their perinatal meetings, and we are pretty much the sounding board for any case audits that they do. In addition to that we are also the default fallback hospital for them for support in that the capability of Kilmore is still patchy. On average we would probably get three notifications a week saying that they do not have capability, either with an obstetrician or anaesthetics, to be able to run a full service. So the women of that northern corridor then flow down into the Northern. Our relationship is so tight now that often they will not call PIPER first. They will just call and say, 'Can you take our women?', and we do.

By the same token they often will help us out when we are bed blocked and we have too many women, too many babies and not enough beds. We will say, 'These women are from your postcode. Can we please transfer them back postnatally now that they have delivered safely?'. They also offer us a service. It would be good, as I said, to see tighter workforce links with Kilmore going forward. They have struggled to build an obstetric workforce, and it appears those challenges are going to continue.

Mr FINN — Jodie, you made reference to the growth that is happening in the area around Northern — and I know that very well, being not far from where I live. Do you have the sort of resources that you need to cope with that growth? If not, what resources do you need to keep with the game?

Ms ASHWORTH — We have been fortunate in receiving the funding — about 162 or 163; do not hold me to that 1 million — from the government to build the new tower, which will allow us at Northern Health to move some of our services, particularly ICU and some surgical wards, across into a new building. What that does is it gives us a space to futureproof for maternity services and look at extending our space and, I suppose, our print, our maternity service print, in the organisation. I feel we are going to need to do that. We do not have funding for that extension and development of the maternity service as yet, so that would be beneficial going forward. Certainly we have sat now at 28 beds, I think, for the last four or five years. We have not increased our bed numbers despite the increased number of births, and that is purely because we are currently landlocked and partly because we felt we have got one of the best length of stays in the state, but we worked and we have tipped incredible resources into our antenatal, our day assessment service and our domiciliary services.

It would be remiss of me not to mention that we have one of the worst breastfeeding rates in the state. It is terrible. We are trying, and we are working really hard with that. We have our women for 2.4 days in hospital, so the establishment of a lactation service and lactation support post discharge for us is pivotal — absolutely pivotal — and at the moment we still have no funding source to provide that support, which we would actually like to give in the home.

Also for us and our community it gives us another look into the home and our families and an assessment of family violence. Like I said, we have run the busiest emergency department in the state, at 92 000 admissions a year and 250 paediatric presentations a week — up to 320 presentations in winter — so that service is growing phenomenally and many of our young infants and signs of family issues are coming back through the emergency department. Certainly lactation support would help us fix the problem. And it is multifactorial, our breastfeeding rates —

Mr FINN — I was just going to ask: is there a particular reason that you have such poor —

Ms ASHWORTH — There is a cultural component to it. There is a socio-economic side to it. There is a support side to it. There is the reduced length of stay in that breastfeeding is not really even established in the 2.4 days before they leave. They then have two domiciliary visits, sometimes three if they are a really young mum, but there is very little funding opportunity or scope at the moment to provide a post-lactation service before families are handed over at the six-week mark to maternal and child health. So from day two to the six-week mark there is nothing. There is a gap. By six weeks they are done. They are tired. They are exhausted.

They are looking for a perinatal emotional health bed by that stage because the sleep settle is imbalanced, and we have got a whole new problem.

The CHAIR — Jodie, thank you for coming in today and spending time with us, and thank you for your honesty. It certainly goes a long way, and you answered a lot of our questions. You have given us a lot of food for thought, too. Congratulations on being the last witness at this inquiry as well.

Ms ASHWORTH — I would just like to make one more comment, and it is about our relationship with Mercy. It is just for noting that the Mercy hospital and Northern have a unique partnership and relationship that we very much value but that part of that relationship is that the Northern Hospital does all the second and third-term terminations for Mercy hospital because, for obvious reasons around religion and ethics at Mercy, they cannot induce a labour unless there has been a fetal death. That gives my midwives and obstetric group, if you consider that we are already challenged with our own high-risk women, an additional load of anguish and trauma because they manage well over and above their own organisation's tragic and sad stories because we also do Mercy's.

Mr FINN — So Mercy doctors are referring terminations to the Northern?

Ms ASHWORTH — Severe abnormalities — babies that have got an outcome that is not viable with life and babies who have severe congenital abnormalities cannot be induced and delivered at the Mercy hospital.

Ms BRITNELL — Over how many weeks?

Ms ASHWORTH — They do not do any terminations at any level. We offer an early pregnancy social termination service at Northern Health, but anything for, as I said, severe abnormality — that is, not conducive to life — needs to come to the Northern.

Ms BRITNELL — So your staff are getting a double whammy of the psychological effects that that trauma has on them.

Ms ASHWORTH — Yes. We do over and above, so that has been difficult to manage. The other thing is there is very little resource to manage that counselling-perinatal role between the sick —

Ms BRITNELL — The staff and patients.

Ms ASHWORTH — The staff and patients.

The CHAIR — Thanks for bringing that to our attention, Jodie.

Ms ASHWORTH — It is tricky.

The CHAIR — Thank you so much for coming in.

Mr FINN — Thank you. That is very interesting.

Ms ASHWORTH — Thank you for your time.

Committee adjourned.