

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Wangaratta — 25 October 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witness

Ms Julie Wright, operational director of women's and children's services, Albury Wodonga Health.

The DEPUTY CHAIR — I welcome to these public hearings Ms Julie Wright, operational director of women's and children's services from Albury Wodonga Health. Thank you for attending to today, Julie.

Ms WRIGHT — Thank you for the opportunity to speak at the inquiry.

The DEPUTY CHAIR — 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 are recorded, and you will be sent a proof copy of the transcript. Julie, I invite you to make a 15 to 20-minute statement, and it will be followed by questions from us.

Ms WRIGHT — Thank you. As mentioned, I am Julie Wright, the operational director of women's and children's services at Albury Wodonga Health. I welcome the opportunity to speak today partly in my role as the operational director, but also I have been a midwife in Victoria for 31 years and have worked fairly consistently in that profession, although I do also have a background in vocational education and training and have done some teaching and academic work. I have also been heavily involved — well, I should not say heavily involved, but I have been involved — with the Australian Nursing and Midwifery Accreditation Council reviewing and accrediting a number of bachelor of midwifery courses at universities across Victoria. This has given me a broader insight and perspective into maternity services, the midwifery profession and the education of midwives. A little bit of background also on myself. Certainly I hear about Yea — and sorry, Roma; you mentioned where you were from — to a long way away.

Ms BRITNELL — Warrnambool.

Ms WRIGHT — I spent the first five years of my career in Melbourne as a nurse and midwife. I then as a newly married woman moved to a rural town in New South Wales with 450 people. It was 50 minutes from where I actually worked but also 50 minutes from lots of my friends, who were birthing at Wodonga hospital, where I worked. The only thing really in between us were a lot of paddocks, a freeway for the last 10 minutes of the drive and the hope that you might never deliver on the side of the road. I think it gave me a better understanding of some of the issues faced by women who live a distance from town.

I do not really want to talk about myself, but along with 31 years of experience in midwifery I have had three pregnancies myself: one in the 80s, one in the 90s — I like the three different decades — and twins in the year 2002. I was very glad that I actually had moved from Culcairn closer to Albury, only 20 minutes from my workplace, by the time I had the twins, because they would have been born on the side of the road, I can assure you. However, this is not about me; this is about us as maternity care providers being responsive and ensuring that our women do get safe, quality of care.

I do not want to go over or labour the point of certainly what Leo, Libby and John said. I also recognise many of the aspects that Liz and Rebecca have referred to. What has come across from listening to them today and also from reading a number of transcripts, particularly Professor Michael Permezel's, is that there are very common themes, particularly in relation to workforce issues — I think the changing nature of the women we deal with, the increasing complexities that we are dealing with, the access to appropriate perinatal emotional and mental health services and also the resources when we talk about assessment clinics. Pardon me up front — I will touch on some of those things, but I will try not to go over them, because I think they have articulated them very well, as has Professor Permezel, and I will focus on things where I think maybe I can add either further information or something that has not come to light.

Just to give you a little bit of background on Albury Wodonga Health. Albury Wodonga Health and Wodonga hospital maternity services provide care to women across seven local government areas across both north-east Victoria and southern New South Wales. For some it is a 2-hour drive to the hospital if you consider the hills up near Corryong or to Falls Creek. Albury Wodonga Health is actually a Victorian public health service that provides public and private care to women in the area. There are two components of our hospital: one sits in Albury on New South Wales soil, where paediatrics is, which I oversee; the other part, where maternity is, is in Wodonga. Navigating some cross-border issues is very normal for us but is not without complexity, I can assure you. However, there occasionally has been some real benefits.

Albury Wodonga Health has a number of models of care. We run a very good midwife care program where the women see the doctor for two visits during their pregnancy at 28 and 36 weeks, and then also if they are overdue. That is really well accessed, and we see about 250 to 300 patients a year on that program. It runs five days a week, and we have a satellite clinic in Albury. I say 250 to 300 because some women will be referred off during the program. We top it up a bit because we know women will drop off because they will have a risk factor. We work under the Australian Nursing and Midwifery Council guidelines for referral and consultation, and that provides a really strong framework. We also have GP care. We also have obstetrician private models of care, and there are shared care entities.

Leo certainly alluded to the fact that there are GPs with some obstetrics training, but what we have seen with the rise of some bulk bill clinics, particularly around some of our more regional towns, is that not every GP has an adequate level of training. But women actually do not understand that, and it is how you get that information out to them. Having recently met with some consumers on Monday, that was one of the key things, particularly in their first pregnancy, that they mentioned. It was that when you are first pregnant, you actually really do not know. What are the models? What do they mean? Who do I go to? What is good? What does that doctor do? Why can my GP where I live or where I normally go not provide my care?

In our maternity service we are classified as a level 5 maternity service and a level 4 special care nursery under the respective capability frameworks in Victoria. We have six obstetricians and 12 GP obstetricians, although there are additional GP obstetricians who practice within the area but actually do not work on our roster. There are paediatricians, registrars, doctors in training, anaesthetists, a range of physicians including a specialist, an obstetric physician and social workers, as well as a strong midwifery nursing workforce. We provide a high level of care to women from 32 weeks of pregnancy onward. Women under that gestation would be referred to Melbourne, which is 3½ hours down the road.

We are very lucky at this point in time to have a full complement of midwives. That has taken a lot of work. Nine years ago, when I first came into the role of nurse unit manager, there was a 10 EFT shortfall. I will talk a bit more about the workforce and some of our approaches later. Again, I will just reiterate the key things around what Michael Permezel had spoken about earlier, in September when he presented, and what Leo mentioned today — they are, the concerns around PIPER and the lack of sometimes understanding. We always feel we have got a good relationship with them, but there is that lack of understanding and that timeliness with needing a bed, and the shortage of NICU cots is one of the constant challenges.

Around the regional workforce and particularly the medical workforce we have, as I mentioned, six obstetricians. Three of those obstetricians actually did come back to us; having done some registrar training time with us, they then returned. I think that growing your own, or that exposure, in a rural or regional area is really beneficial. One of those now obstetricians was the registrar 18 years ago. He is now our director of obs and gynae.

One of the other things I would just like to point out in relation to transfers that at Albury Wodonga Health we have probably tried to understand a little bit more of is, 'If we were not so far from Melbourne, would it cost as much?'. The average transfer for a baby or a mother from Albury-Wodonga is around \$5000, and just depending on the nature of the transfer — occasionally it is twins — it could be up to \$7500, \$8000. It is a significant amount of money. Most of our mothers and babies would be retrieved by air. Again, we need to always factor in that we are probably 5 hours away. There have been times when we have been able to notify them ahead — if someone comes in in imminent labour — and on occasions we have actually had them there in the birth suite ready to accept a baby. So it can work exceptionally well.

We transfer out 25 babies on average each year and about the same number of mothers with baby in utero. So I cannot stress enough the importance of having really good relationships and access to beds when you need them. Another thing, which I know Professor Michael Permezel did address in his submission to the inquiry, is around the accessibility of genetic services, not only for screening but appropriate counselling and appropriate care after a diagnosis to support women in the choices that they may make, including about access to termination of pregnancy. Medicare item numbers are not available for genetic counselling.

We recently had a situation in Albury-Wodonga where the Victorian Clinical Genetics Services was offering a program, and that was accessible for women. We had a consultant obstetrician and gynaecologist who also had expert training in providing ultrasound screening. Unfortunately that person passed away unexpectedly last year and subsequently, following that — and maybe not aligned to it — the VCGS, the service, was withdrawn, they

state, for a number of reasons. They now provide a quarterly clinic in the paediatric rooms out of Albury. We find this is not appropriate. Women cannot wait for the next quarter. The alternative is to travel to Melbourne. Travelling to Melbourne and leaving your family at a very vulnerable time to access counselling and appropriate genetic testing is also not tenable for many of these women.

There is access to telemedicine five days a week. However, you need to also factor in, if you have got a woman sitting there getting a diagnosis or finding out something has been determined on ultrasound and who needs further testing or counselling, that telemedicine is not, you know, at the flick of a button someone will be there able to address your unique need. It does take some navigating.

We recently had a lady set up here. She is a trained genetic counsellor. She was previously contracted by VCGS and they did offer her, I believe, a position in Melbourne. She was unable to. She has a small family and she did not want to move there. She has now set up a private clinic in Albury-Wodonga, which is a fantastic support. However, because there is no Medicare item number when patients see her, or are referred to her — and she is increasingly seeing more patients, which is fantastic — there is a full fee because there is no rebate or no item number. However, the fee that she is charging is much cheaper than travelling to Melbourne. Sometimes women and families have had to wait a lot longer than three months to get an appropriate appointment in Melbourne.

Again, I will just touch on the regional maternity meetings, which have been, as Leo said, very well supported and provide excellent clinical review and discussion. These meetings, which have brought a lot to the regional centres — and great discussion, great support, for our rural counterparts — do take a lot of time, investment and review, and having that centrally coordinated party in Melbourne cannot be underestimated. The funding does go through to 30 June 2018, and at this point there is no funding beyond that. We have been informed it needs to remain sustainable. However, to do anything well — and this does need to be done well; it is about understanding the histories, and I am quite involved in this at the Albury Wodonga Health end — it does need time and investment.

I am not going to talk much about perinatal emotional and mental health because I know Jenny Ahrens will follow me. Jenny is from Albury Wodonga Health and is heavily involved in the perinatal emotional health program. Suffice it to say in Jenny's written submission I made a statement which outlines — and I cannot emphasise enough — the integral need for well-resourced perinatal emotional and mental health services that support women and their families. As stated in my testimonial in Jenny's submission, mental ill health during pregnancy and early motherhood is a serious public health concern with potentially serious consequences for women's lifelong mental health and also for the wellbeing of their children and families.

Albury Wodonga Health is quite fortunate to have a well-established perinatal emotional health service as well as the Albury-Wodonga Tresillian parents and babies service. The parents and babies service closed in Albury under Mercy Health four years ago. Albury Wodonga Health put their hand up and said, 'We'll take it on' — a huge learning curve for me. Late in October 2013 it moved across to Albury Wodonga Health, under a slightly different model, into a little old house down the end of the street. We were very fortunate to gain a grant from the Victorian government at the time, and we built a purpose-built house. We have been in that now for two years. The service is funded partly via NSW Health funding, which is passed on to the Victorian government and down to Albury Wodonga Health, and two years ago Tresillian came into, we call it, an alliance, not a partnership, with us. They provide services and provide similar funding.

We have now been able to enhance the services we offer, and we have four clinicians working there — two working 0.8 and two working 0.6 — and they provide a range of services. There is lactation. Most of them are day-stay or half-day programs; they provide circle of security; parent-child interaction; perinatal emotional health assessment; referral pathways, if someone presents; or if there are housing issues, they will liaise with those services. There are strong linkages with PEHP, the parents and babies service, and also with GPs in the area, our social workers and our paediatricians. It is a very strong model, and we are very fortunate to have it, as are the families in the area. We have monthly complex care meetings, and players or people represent each of those organisations, including DoCS, VACS, and the Aboriginal health services that are in our area.

Another point which I would like to raise, and I know which has been raised, is the access to lactation services. Breastfeeding rates continue to decline across Victoria. There needs to be more appropriate funding for lactation consultants, and they need to be accessible for all women across the state regardless of where they live. Most maternity services are not in the position due to budgetary limitations to fund full-time lactation services, and it

is not unique to regional or rural areas; I have done a little bit of research around Melbourne. Where there are services, they often only run for two or three days a week. We fortunately run ours at four. So it may be of value to consider further funding of these services.

On a practical level, there are a couple of suggestions I would like to put forward. One is, and someone mentioned it earlier — I think Cindy or Roma, you may have raised this as a question — that we know King Eddy hospital only too well, like Leo does, where we would defer to access their policies and procedures. South Australia, New South Wales and also Queensland have a central repository of guidelines and drug protocols for their maternity services. That is something that has not been developed well in Victoria. Again, Libby and counterparts from Northeast Health Wangaratta have raised the fact that many health services are developing their own, and it takes a lot. You need to have a level of expertise and to be able to provide the time and the people to do it well. To reduce duplication it would make sense to have a central repository.

Recently after developing something like I think about 27 neonatal drug protocols, we decided that was enough and we did some research. South Australia and King Eddy could have provided us with what we wanted. We tried to access something similar in Victoria and hit quite a number of blockers, which I will not go into here. What we have chosen to do is go with NeoMed, which is a New South Wales-based system. So we use NeoMed for all our drug protocols, and they are very comprehensive. But then in the case of a neonatal resuscitation we use the PIPER neonatal drug calculator worksheet, because we know if PIPER come and retrieve the babies they will want to know that we have used similar protocols to what they would do. However, they do not have a range of detailed protocols. So you do the worksheet — it will give you a formula about the amount of drugs and the certain drugs to deliver, and we do it that way. So they are some of the issues that we have to deal with.

With other resources I would like to point out, sometimes it is the basic things. CTG machines is one thing. Once upon a time CTGs were done on a certain group of women. They were a criteria. Those criteria continue to increase. Whereby in the past four or five CTG machines may have been appropriate for monitoring the women that came through Albury Wodonga Health, now we would be looking at seven or eight. However, we do not have that number, and what we do is we tend to juggle workloads or try and schedule when women turn up. We know with increasing vigilance on decreased fetal movement that women are required to present in a very timely manner and will often come in a frequent number of times for fetal monitoring. As the criteria continue to improve and the number of women come through the door, for things as basic as CTG machines — which are not cheap — we need to be able to have adequate access to them in a timely manner. Also, something that has been raised at a number of our regional meetings is having a portable CTG machine that we can take from the birth suite to the theatre and continue monitoring, whereas we have got very bulky machines and you have to sort of wheel them alongside the bed. It is not necessarily easy to navigate when you have got drip poles and everything.

The other thing — I know that Leo has mentioned it, and it is coming up across a number of centres and with other nurse unit managers I have spoken to in the state — are the resources required to ensure the timely assessment of women. We see approximately 300 women come through our door every month, on average 10 a day, to have an assessment of some kind. It might be fetal monitoring, it could be that they are unwell, ruptured membranes or premature labour. Bleeding is another common one. Sometimes it is for their anti-D. This number continues to increase. There are no resources and nothing in the safe patient care act to meet the needs. We have actually, like Wangaratta, put somebody on 9-to-5 to support that service, but that is in addition to anything that is recognised in the safe patient care act or funding.

Another very basic thing — it would be a wonderful thing to see — is what in New South Wales is called the Good Egg Pack. We were very lucky to receive a Good Egg Pack about three or four years ago, but they were rolled out across New South Wales about 10 years ago and funded by the Humpty Dumpty Foundation. Essentially it is like a big backpack and it has got everything you would need for a neonatal resuscitation, should you need it, including an oximeter and a Neopuff to help breathing support. We were lucky to come by one because we had a woman who went into premature labour in Culcairn, which was 45 minutes from our hospital. She was 28 weeks — or 27 weeks — pregnant with twins. She birthed one: went to the local hospital which has aged-care beds and the very elderly doctor popped across and delivered the first twin there. He did an admirable job. Next New South Wales got a call from him. They rang us in Wodonga and said, 'Can you send a paediatrician out?'. Gathering some supplies, the paediatrician took a registrar with him and they arrived there. The helicopter was dispatched from New South Wales, did not quite realise how far Culcairn was and had to

stop in Wagga for fuel. Meanwhile we still had a baby in-utero. They asked, 'Have you got the Good Egg Pack? You are in New South Wales'. 'No, we are actually a Victorian health service'. Anyway, long story short, we were provided with one. They used the fact that paediatrics sat in New South Wales, so we qualified. That has been a fantastic thing. It has only been used once or twice in that three or four years, but when we see more and more rural health services and the tyranny of distance, as we say, I think these would be a wonderful asset to the transport incubators that were rolled out across Victoria some years ago.

Workforce — this is probably one of the burning issues across the state. We are very lucky that we have got 113 permanent midwives plus 20 nurses who are not midwives on staff. On top of that we have a pool of casual midwives and nurses, although that seems to be depleting. Each permanent staff member works on average about 5.4 EFT. Only 10 now work full-time. Of the 113 midwives, 50 per cent of our midwives are graduates of what we call our grow our own program. It is a paid model, whereby they work three days a week in the health service. They do their birth suite day non-paid as a placement day and they attend university. We have a partnership with La Trobe and Charles Sturt, although more recently we are using La Trobe because they have a more flexible model. Charles Sturt have a very fixed model. Interestingly not all universities offer exactly the same program, although they essentially have to meet the same requirements under ANMAC.

So over the past 20 years we have had in excess of 100 midwives graduating as a registered midwife through our graduate diploma in midwifery grow your own program. A number of the midwives who move on often go for career things. The Royal Flying Doctor Service in rural and remote Australia seems to be very attractive to some. Others obviously seek out new opportunities or move out of the area. But this has been integral to us maintaining a workforce. Double degree graduates — we have had I think approximately 10 pass through our ward — yes, 10 — over the past six years. We have only been able to retain two. What we find is that the graduates that come in, due to the selection process, have often come from and grown up in the city and they have been to university in the city. Unfortunately they do not access a graduate program there because they were not matched in the matching process, and the place they will get will be Albury-Wodonga. They are bound to that. They will come, and they will return to the city.

What we have done for next year — our key criteria and the first thing we would ask them or look for was where did they grow up? — is we have taken five double degree graduates. They will start in late February. All of them went to school in Albury-Wodonga; I think one is just out of Albury-Wodonga. We also want to ensure that they have done well academically and they have got good references, but we are hoping that we will be able to retain some of these graduates because they are very high quality, you invest the time in them as graduates and you do not want them leaving and going back to Melbourne.

Of the two we currently have in our workforce, one was actually from Warrnambool, so it was a regional area. She moved to the area, brought her husband and they are well-settled. The other one was an Albury-Wodonga girl originally. So we are fortunate — but I can never say never — to have a full complement of midwives. We do not seem to have the same issues at this point in time when we advertise getting suitable applicants. But I will never say never, and certainly going back nine years it was different. I think again our pool of midwives that we have been able to grow through the graduate diploma program have been what has made our workforce what it is today.

The other component of the workforce, particularly for us at Albury Wodonga Health — and I would imagine Wangaratta may have similar concerns, although I did not hear them mentioned today — is ensuring our special care nursery nurses and midwives have adequate skills and training. As we see more complex babies come through our nurseries, we are struggling to ensure that we have got the right skill mix of nurses and midwives in there. Again, cost is prohibitive. Them needing to go to Melbourne to do a 12-month program is often out of the picture, because they have got families or they are established, and merely just because of the cost of going down. Funding and support for a course that would be developed in line with level 4 nurseries or special care nurseries that are not metro and that are not neonatal intensive care would be fabulous. Some years ago there was what they called a level 2 program: they went down, did three months in Melbourne, came back and continued to work and do some study within their local service, and we had a number of staff that did that. But that program has actually dropped off. That is the one thing that we are struggling with at the moment, because it does require another level of expertise as well as a level of confidence.

The DEPUTY CHAIR — Julie, can I just ask you to pause for a moment. I am just very conscious of time. We have probably only got 15 minutes left. Have you got much that you want to —

Ms WRIGHT — I am nearly done.

The DEPUTY CHAIR — You are nearly done?

Ms WRIGHT — Yes, a couple of points. The Maternity Connect Program has also provided a great conduit for nurses and midwives in the very rural areas to come down to Wodonga or Wangaratta and upskill. Similarly we can have a midwife or someone from our special care nursery go to a tertiary centre if they would like to get some experience, but that is a two-week funded program, and that funding tends to be dependent. They go 12 months by 12 months, so we are never quite sure it will be ongoing.

I think just the last two points I would like to raise are around the different models of care that women can have access to. Women seem to be very happy — having met with some the other day — that there is choice, but it is understanding that choice. They certainly want to be involved and they want to be informed about their care, but they often do not know the difference, as I said, between midwife care and an eligible midwife. We do have a couple of eligible midwives practising in Albury-Wodonga.

The last point I would just like to point out before closing — certainly in my role and what I am seeing — is the increasing vulnerability of the workforce to the different factors that they are exposed to today. We are seeing increased complexities in our patients, increased drug use amongst clients and aggressive patients. I think the fear of litigation on the back of Bacchus Marsh and the media around that, we are finding midwives are more and more challenged and very vulnerable. They will clearly identify it with, ‘Some days I just don’t feel I can face another day’. Yes, we have a busy work environment, but there is actually more to it when I unpack it with them. They will state it themselves, and also around the increasing professional development requirements, which they are happy to undertake, but it is another layer on top of that.

They are probably the key points I would like to outline. Again, we continue to try and improve services, and I think everyone is very aware of maintaining a high-quality level of care, but it needs to be responsive to new evidence and best practice initiatives. With the increasing spotlight on governance in maternity services, it is forevermore keeping us on our toes. Thank you.

The DEPUTY CHAIR — Thank you. That indeed was extremely comprehensive, and it was really good to hear your opening to understand that you get the tyranny of distance, and it is something that Roma and I as country members see all the time — it offers particular challenges. Given that we have not got much time, I have just got a couple of questions that I will —

Ms WRIGHT — Sorry.

The DEPUTY CHAIR — Look, you have answered a lot of our questions just through your commentary. Do you know how many people would access the private facility at the hospital for birthing?

Ms WRIGHT — For a private obstetrician or eligible midwife? There is an eligible midwife practising now in Wodonga. I think she would see about 40 women a year, so it is a very small number. She is on her own. She does antenatal and postnatal care up to six weeks, but currently under the Victorian arrangements you need to have an agreement in place. We do not have that. I think there is only one health service up north that has gone down that path at this point. But it has dropped off a little bit. The number of private patients who would go to an obstetrician as a private patient or to a GP-obstetrician as a private patient was in the past about 32 or 33 per cent. It has dropped off. I think it is probably down in the low 20s now.

The DEPUTY CHAIR — And do people come from Wangaratta?

Ms WRIGHT — Probably not so much from Wangaratta. You will get the odd person. Occasionally we will have a referral because of gestation, but certainly from places like all of Deniliquin in New South Wales and Yarrowonga. There is often a split, and I think it is aligned to families or because they might work in a town, so they will tend to align that way. So we will have women who come from Yarrowonga, Myrtleford, Mount Beauty, Corryong or Tallangatta. They will come down to us.

The DEPUTY CHAIR — I was very interested in the Good Egg packs.

Ms WRIGHT — Yes, they are fabulous. I was so excited. I would not try and climb Everest with it on my back, but it is absolutely wonderful.

The DEPUTY CHAIR — That is heavy.

Ms WRIGHT — It is really heavy, and it is also being used for training purposes. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists had their provincial meeting in Albury-Wodonga in April or May. I took it across, and one of our paediatricians just went through it because it is really good for rural clinicians or rural GPs to see what they might need. Interestingly on the day when our paediatrician went out to Culcairn, he grabbed everything and thought he had done really well. The one thing that was probably imperative was the laryngoscope. A neonatal laryngoscope for a tiny prem is so small, and it was the one thing he forgot. They actually managed very well and still managed to intubate that baby, but he said, ‘That should have been the first thing I grabbed’. So they are excellent.

The DEPUTY CHAIR — So is the Good Egg pack a New South Wales tool?

Ms WRIGHT — It is a New South Wales entity.

The DEPUTY CHAIR — And you have got one because the paediatric is in New South Wales?

Ms WRIGHT — Yes, but we house it in Wodonga, and we house it near our transport cot. And they know. Michael Stewart — not Michael Stewart, Michael Stewart is a PIPER in Victoria — I have forgotten the chap’s name, but I certainly have his contact.

The DEPUTY CHAIR — How much are they?

Ms WRIGHT — Good question. I would have to get that information back to you. I am very happy to.

The DEPUTY CHAIR — I would appreciate that, yes.

Ms WRIGHT — Yes, absolutely. I do not think we are looking at thousands upon thousands.

The DEPUTY CHAIR — Where would you have them located?

Ms WRIGHT — In a special care nursery.

The DEPUTY CHAIR — Sorry, I mean in the state.

Ms WRIGHT — What they do is they locate them in their regional centres mainly or larger rural centres. They can go to their website or database in New South Wales, and if they get a call from Culcairn, Holbrook or Deniliquin, they say, ‘Okay, I know the Good Egg pack is in the special care nursery feeding room. Can you go and get it?’. We actually deliberately house it next to our transport cot so they can take them together. And there are drugs. We have a box of drugs that is in the cupboard and it has got ‘Do not forget the drugs’ on it. They are wonderful.

The DEPUTY CHAIR — That is quite impressive.

Ms WRIGHT — I can put you in touch with New South Wales.

The DEPUTY CHAIR — Thanks.

Ms BRITNELL — I just want to drill down a little bit more on the training. You have highlighted the importance of taking people from the rural areas who understand rural living. Do you have the university in Albury that does nursing as an undergraduate as well?

Ms WRIGHT — There is Charles Sturt in Albury and Latrobe in Wodonga. Both do an undergraduate nursing course. For the girls who are doing midwifery — the graduate diploma of midwifery — they can do it through Charles Sturt, but they have to go to Wagga for their study blocks or days. They do some online, and then they do their practical component with us. For the Latrobe model they have to go, currently, to Bendigo. Our students or prospective students are informed of that, but again, for the Latrobe model at Bendigo they tend to block their blocks really well and it is a short time frame that they need to be down there. They can go down and link up at Latrobe and do lectures by linking up or online. So it works well, and their program can be done in nine months, whereas Charles Sturt have a very fixed and rigid 12-month program.

Ms BRITNELL — Most of the midwives that have done their postgraduate or their double degree, are they locally grown and have done their undergraduate here usually as well?

Ms WRIGHT — Yes, 50 per cent of our current workforce have done —

Ms BRITNELL — Both?

Ms WRIGHT — Sorry. Yes, absolutely. They would be, and we have just interviewed this week 12 prospective people to do mid-next year, and most of them are working in the Albury-Wodonga area.

Ms BRITNELL — So what would a loss of the university in a rural or regional city look like for the workforce of health?

Ms WRIGHT — I think it would be massive. Not everyone would go locally. We recently had an inquiry from someone. She had done the five years in Melbourne — a bit like me — and wanted to go back to the country and go back to a regional area. They know that we have a really good health service. Well, I believe we do, and that is why they are contacting us. But what you do not have if you do not have one locally is, not only does it reduce access, but it also reduces, I think, the relationship with the universities.

Ms BRITNELL — The relationship between the university and hospital institution?

Ms WRIGHT — And the hospital, yes. You have a much closer relationship, they will tend to listen, and you can develop and work together, we think. And as I said just for the midwives to go down and do a lecture —

Ms BRITNELL — Is that way your university here has that flexibility around block training rather than what you would see in Melbourne? It has actually developed because of that relationship?

Ms WRIGHT — Yes, absolutely. Recently I provided some feedback to Latrobe Bendigo because the girls were saying when they had to go down they would often go the night before and it was three days away and they had to pay. So Latrobe Bendigo have just titrated their lectures to fall more succinctly within a day. They said, ‘I would much prefer to do a longer day than to do it over three days.’ That is good. Latrobe are very responsive, and that is what we need — that understanding of what works for people who do have to travel or are not accessing study in their home town.

Ms BRITNELL — Thank you.

The DEPUTY CHAIR — Are you able to comment on the percentage of women in the north-east that have high-risk pregnancies requiring a level 6 service?

Ms WRIGHT — I probably could not give you the percentage, and I love figures, but what I can say is we certainly are seeing an increased level of — and Leo mentioned you have got your GDM, your obesity — I think what we are seeing more is the social complexity that is growing: the at-risk and the vulnerable children. That is where our parents and babies service is fantastic. The number of women that would have to be referred antenatally to a high-risk service is very low unless they come in in threatened prem labour, and then we would try and get the baby in utero to Melbourne rather than birth them here if that is under 32 weeks.

But we have an obstetrics physician — this is one of the conversations we had with the department last year around the capability framework when they were talking about referring women down to a level 6 if they had certain risk factors. When you have an obstetric physician that is actually in town — he came from the Mater in Brisbane — the women get referred there, which is fantastic. And even if you did say, ‘You probably need to go to Melbourne because this is the capability framework we are trying to encourage’, if they know they can go to Albury, they will go. You can tell someone, ‘Look, it would be great for you to see a doctor in Melbourne in relation to this, or even make an appointment’. It does not actually mean they will attend. We even see that sometimes locally, where a woman has not gone and seen the obstetrician. To them, if they do not understand the importance — if it is not well explained and even when sometimes it is — women have their own reasons: they are busy, they live too far out of town or ‘I went to my doctor, I thought that would be okay’.

The DEPUTY CHAIR — You may have heard the presenters prior to you mention the mother baby unit?

Ms WRIGHT — Yes.

The DEPUTY CHAIR — What are your thoughts?

Ms WRIGHT — Fantastic, and that is where we are lucky, because we have got the Albury-Wodonga health one, and we have developed the alliance with Tresillian. I would go as far as to say that I think every regional area in Victoria should have one. It is very low cost. I did a lot of exploring — I travelled to Sydney and Melbourne and across to Bendigo and looked at the Raphael Centre over there. The funding is around \$240 000 and we managed to employ 1.6 EFT of clinical staff, and we have got a clerk and then we have got enough to run the service and programs and a bit left over. We could probably increase the staffing a little bit if we needed to, but because we went into the alliance with Tresillian they provided two clinical staff as well. They have employed a manager — we do not pay for the manager, they do.

It is a fantastic relationship, and again that took a bit of exploring. It was when I was visiting the centres that the conversation arose; they asked what we were doing and it evolved over time. They were fairly keen, and then we had another service contact us — Karitane — about whether they also would be interested in joining us or we would be interested in partnering with them, so we actually put out an expression of interest. Again, as Rebecca stated, you cannot wait to access somewhere in Melbourne like Tweddle or Queen Elizabeth; it is often a very long waiting list, and having families separated is not conducive to good outcomes.

The DEPUTY CHAIR — Fabulous. Just finally, would you say that there is a good working relationship between the hospitals — the larger and small ones — in the north-east?

Ms WRIGHT — Absolutely. I think we have really good relationships. We all seem to know one another and we have no issue picking up the phone. We have tried to establish some pathways and very respectful relationships.

One last thing, Cindy, I am involved in the subcommittee for the maternity e-handbook which is maternity guidance as they call it, or guidelines in old language to me, that are currently being developed. As Leo mentioned there are five rolled out and the next five are about to come out. They certainly have been developed in line with rural, metro and tertiary centres. We will then develop another probably 10 across next year, so a central repository is there. They are a bit clunky more in their format rather than the interpretation, but I suppose it depends when you are reading them how quickly you want to get that information. If it is an emergency, anything can be a bit harder to decipher. But they are there, and I think we will become more familiar with those. There is some really good work. But the drug protocols — you would save us a world of pain.

The DEPUTY CHAIR — Thank you Julie. Thank you so much. Forty-five minutes goes very quickly.

Ms WRIGHT — Yes, it does.

The DEPUTY CHAIR — We really appreciate your time

Witnesses withdrew.