

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Geelong — 11 December 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

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Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witnesses

Dr David Fuller, Clinical Director, and

Ms Claire Geldard, Director of Operations, Women's and Children's Directorate, University Hospital Geelong.

The CHAIR — I would like to begin by acknowledging the traditional owners and pay respect to their Elders past and present. Welcome everyone to this public hearing of the Family and Community Development Committee's inquiry into Perinatal Services in Victoria. This is the 11th public hearing held by the Committee for this Inquiry. The Committee has held hearings in Melbourne and in regional Victoria, and has also been conducting community forums to encourage participation from as many people as possible and we are delighted to be here in Geelong today and thank the Geelong City Council.

These proceedings today are covered by parliamentary privilege and as such nothing that is said here today can be the subject of any action by any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted. All mobile telephones should now be turned off.

I would like to introduce myself, I'm Paul Edbrooke, Member for Frankston and Chair of the Family and Community Development Committee. We've got the Deputy Chair.

Ms McLEISH — I'm Cindy McLeish, Member for Eildon.

Ms COUZENS — Christine Couzens, Member for Geelong.

The CHAIR — Maree Edwards, member for Bendigo West, will join us shortly.

Our first witnesses today are Ms Claire Geldard, Director of Operations, Women's and Children's Directorate, and Dr David Fuller, Clinical Director from the University Hospital, Geelong. Thank you for attending here today.

All evidence at this hearing taken by the Committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript.

Basically, we are here today, as you know, to record as much information as we can to inform the inquiry's report to the state government to change where we need to as far as perinatal services across the state and we have a special interest in hearing about what's going on in the Geelong area today. I would like you to invite you to give us a 10 to 15 overview of what you do in the sector and then, if you don't mind, we might have a bit of a discussion and have questions.

Dr FULLER — Sure. I've got some slides as pointers to work us through, and they will be largely summarising what we've put in our written submission.

The CHAIR — Apologies for turning our backs to you.

Dr FULLER — No worries. I thought we would start by talking about who we are, give you that background, and then go into our presentation from there. Barwon Health, as you know, is a large regional health service that operates in Geelong and is not just acute care but a large amount of community care as well. In terms of perinatal care, we're both a level 5 maternity service and a level 5 neonatal service. There are six levels of maternity and neonatal services in the state so on the neonatal side of things the level 6 are the places with neonatal intensive care units. There are four of those in the state: Women's, Mercy, Monash and Children's. Level 5 is one level down and there are criteria about who is eligible for care in level 5 services and what level of staffing and equipment and environment you need with that.

Similarly, in terms of maternity services, level 6 is the highest level and then level 5 is one level down from that, and there are again criteria about who should be in those areas and staffing we need. We are one level down from the top and the highest level that is anywhere within regional or in outer metropolitan. There are a number of other services that are on the same level as us within metropolitan or within regional services.

I am the Clinical Director of the Women's and Children's Directorate of Barwon Health, I'm a paediatrician by background so particularly my clinical expertise will relate to the baby side of things. Claire, who is Co Director of Operations, Women's and Children's is a midwife by background.

Ms GELDARD — I'm a nurse.

Dr FULLER — And a nurse. Just some important issues of principle that I think underpin the areas that we commented on, and I will highlight where they are relevant as we go through. The first is the importance of providing care that is safe but also care that is effective, so providing best evidence care and trying to do that systematically across the system.

The second principle of consumer centred care is recognising that consumers are the best ones at prioritising what are their needs and we need to partner with them and work with them in providing services.

The third principle being that this is about perinatal care, it's not just about pregnancy delivery but it encompasses broader things than that, including feeding support and emotional health.

Lastly, equity is an important principle and that we are aiming to achieve good health outcomes for all and that will sometimes mean that you need to focus services in one area more than another because there are greater needs. I'm sure none of those are new to any of you but I thought I would just outline those before we go into the areas that we will talk about.

The first area we talked about in our written submission was the importance of access to real time data focused on areas that will make a difference to the quality of perinatal care, and that very much sits under safe and effective care. There are a group of indicators called perinatal service performance indicators that are released by the Department each year. It used to be the case that in 2015, for example, we received data from three years previously so we could measure what our performance was three years earlier than now. That's really hard to do in terms of improving performance; we really want to know what is happening right now.

We've just received the 2016 data for us but the report for the state isn't out as yet. That's a big improvement on three years lag time, it's only a year and a bit lag time in terms of getting that data but it still is difficult to actually improve your service if you don't have access to more real time data. At the time we wrote the submission we were just starting on a trial of actually getting access to a number of those indicators in real time because we send our data that is automatically entered to the Department and then get it back. We've tried to replicate that data within our own service and had trouble actually getting anything that correlated closely with what we got back from the Department so Safer Care is actually running a trial we're involved in where we can, for most of the indicators, plug in the date range and it will tell us what happened last month. That's such a crucially important thing to actually monitor how you're performing, work out what areas you're not performing in, put something in place to improve that care and then work out right now has that made a difference rather than waiting another one or two years to find out whether that made a difference. That's only happening in selected sites. Claire has been quite involved in some of the projects but I think critically important that that actually gets rolled out to every health service and the support given to actually then use that data as well.

Ms GELDARD — Yes, particularly for the smaller health services.

Dr FULLER — The second issue which really ties onto that is the resources to actually analyse and monitor those trends, put some changes in place and then measure the response of those interventions. That's particularly around safe and effective care but I've put up equity as an important principle there as well. Claire mentioned that particularly the smaller services, they often don't have the resources to be able to firstly analyse and then monitor and then put in place a project so I think it's not going to be a case of just providing data but actually working out what's important to places that they actually need.

I've put up this slide, which is from the 2015 perinatal services performance indicators. It's the most recently published so it's nearly two years old now but this is the perinatal mortality ratio for babies born at 32 weeks or more, so it includes stillbirths and it includes neonatal deaths and it standardises the rate for around the state to one, so one is the average of the state.

You can see for the level 6 hospitals here they're all tracking pretty much at one or lower. If you look at the level 5 hospitals here, there's a scattering but you can see that the mean for them would be somewhere along here so about 20 per cent higher. There would be multiple reasons for that, but I think one of the reasons for that is that there's been a lot of focus and resource happening at Level 6 centres for some time at looking at safety and quality and looking at projects to improve care, whereas level 4 and 5 services have traditionally been much more about just providing service and there has been less focus on the safety and quality aspect. That's starting to happen but I think that needs to be a continued focus in the level 4 and 5 hospitals to make sure that we are actually providing good, safe effective care across the board.

Djerrowarrj is an outlier that we're all aware of but you will find in general that the level 3 and 2 hospitals actually have much lower rates and that's because in terms of capability they will tend to ship out higher risk women to this group here and so this group are managing this higher risk group, as are the level 6s but the level 4s and 5s are often doing it without the same degree of infrastructure and focus on safety and quality that has been developed over time in level 6s.

The third issue around safe and effective care, the importance of engagement of senior clinical staff in managing perinatal performance. This is something we are very aware of and trying to work on and I know that Safer Care and the department are also very aware of that. You need to have the people who are leading and delivering the care on the ground actually engaged with monitoring what is happening and actually engaging with leading and implementing that. I don't know there's a lot more to be said to that, but I think it's an important issue.

Lastly in terms of safe and effective care, there's been a lot of work done at defining levels of capability so we've got level 6 services, level 5 and level 4 and so on all the way down. What we don't have so much at the moment is such a good coordination between those different levels, so pathways of care and working out when someone should go from level 3 to level 4, or level 4 to level 5. So, there are some general principles but not such well-defined pathways worked out across a range of criteria. That's something that some services like Traralgon and services in the east of the state have actually taken a significant lead with and doing much better coordinated care between services. There's a big push from the department for regions to actually work in a much more coordinated way, but it's a challenge because we are all individual health services. I have no governance responsibility or authority for any other service within the region, we're all independent, so working out how we can actually be integrated and do that better.

Consumer centred and perinatal comes up with this issue around resources, to be able to find the best standard of care to patients and we are highlighting here both lactation support and emotional health. I've put consumer centred there because that for us is one of the areas that our consumers feed back to us regularly, they feel they don't get enough support with. In terms of what is publicly available there is very limited resource available within our region, and it doesn't necessarily have to be provided by us but we are the only provider of public lactation support and we only are able to provide that in a limited way, five days a week. Claire will be able to talk to that in more detail. I don't know if you want to speak to that now.

Ms GELDARD — Currently we only have a five day a week service and that's both for inpatient and outpatient support and obviously it's critical for the ongoing long term health impacts of breast feeding and emotional health. We've just got one FTE that's currently coming in to play. The benefits for the long term health of both mum and babies, we've got limited resources to provide probably best standard of care possible and it's purely provided by Barwon Health currently in a resource capacity. It's not necessarily matched by anything else in the community so we've provided it in its entirety and it's difficult.

Dr FULLER — This last area, I've put emotional health there but I will move onto this here, which was a specific question, the effect of withdrawal of Commonwealth funding on the Perinatal Emotional Health Program. We were very disappointed when that happened because it has always been prior to the PEHP Program, a struggle providing the right supports for women who are having emotional or mental health difficulties around the perinatal period, particularly for those who are less health literate or lower socioeconomic groups, where access to those services might be more difficult, either financially or because of health literacy as well.

The PEHP Program was particularly good because it could do outreach work, actually go and meet the women in their homes. Prior to PEHP, if you were psychotic or had a very severe mental illness there are obviously services available within Barwon Health. There was a limited range of stuff within Barwon Health for issues that were less than that, and so a lot of woman were stuck a little bit stranded in the middle. If you're a high socioeconomic status and very health literate but suffering from emotional health it's still very difficult to get yourself to access the services that you need but you are capable of doing that. If you're less health literate and you've got a lower socioeconomic status it's that much more difficult again. So, the PEHP Program particularly worked well at reaching out to those women.

The Commonwealth withdrew their funding. The State continued their funding but there was a little bit of uncertainty for a period of time about whether that was going to continue or not and the effect of that, unfortunately, most PEHP Programs around the state actually closed. The funding is there and those PEHP programs, I'm not sure what's happening elsewhere but ours is just in the process of starting again, but there has

been a hiatus of 12 months where that program hasn't been provided. What it's meant is we have had to try and push women more to private services within the community and general practice to actually get those needs met.

Have we seen any significant impact in terms of maternal mortality or neonatal mortality? No, we haven't and you wouldn't expect that given that actually those very severe outcomes are very rare. But what we do know is that the environment in which a child grows up in the first two years of life has a critical impact on their long term health and development and multiple outcomes that aren't just health related and so anything we can do to try and support women with their emotional health in that perinatal period is going to have an impact over time. That's all we were going to present but very happy to take questions or explore any of those areas.

The CHAIR — Thank you for your submission and thank you for that presentation. We might start asking some questions if that's okay. Like I said, this is about us finding out the information we need to go forward and write the recommendations. Some of the questions might appear from a bit of a lay perspective at times, we are trying to drill down these out. We are not doctors but we are trying to drill down and find out some facts.

I was actually wondering about workforce capacity in Geelong, within the Geelong region. We've been all across the state. This is our 11th hearing and we've heard about the shortage of midwives and about the ageing workforce there. In Geelong, what are the workforce constraints?

Ms GELDARD — We didn't have a problem about 12 to 18 months ago. I think with the opening of the Epworth we weren't sure of what the impact that would be.

Ms McLEISH — The Epworth has opened in Geelong, has it?

Ms GELDARD — Yes. It opened 12 months ago.

Dr FULLER — Maternity services really started in the last six months.

Ms GELDARD — They recruited staff about six months ago. We didn't have a problem, we actually struggled to give midwife positions and we had midwives that were very unhappy with having temporary positions ongoing. We currently as well, when we went to Level 5, we've implemented an increase in staffing so that we have in charge staffing across special care nursery and birth suites to improve safety and safe care. Even though it's not actually required for the Enterprise Bargaining Agreement with nurses and midwives yet, we felt it was necessary for our level of for our capacity. We've really struggled to recruit that, which we found quite surprising, being in the position, we were in previously where we were finding it difficult to give midwives permanent positions because there's just not the workforce out there. We've had recruitment strategies, we've had nobody applying from alternate areas, even moving down for a change of life style, which we used to find occurred.

The CHAIR — Claire, what were some of those recruitment strategies?

Ms GELDARD — We've worked with the workforce and they've gone to certain sites, we have done Facebook strategies where we've promoted the change of life style. We're about to do it again in the summer holidays because we get people holidaying down here. It's starting to bring in a little bit of extra interest and people applying but we're still not to our full FTE; so, we are relying on our casual workforce currently. We heard at one of the meetings that we had that a lot of other places are struggling with workforce.

The CHAIR — So there's a deficit that doesn't look like it's going to be managed in the future.

Ms GELDARD — We don't necessarily, in maternity services here, have an issue with ageing workforce, we've probably got a little bit more of an issue now with seniority in our workforce.

Dr FULLER — We're probably less impacted than most regional areas, being the largest regional centre, and having things like beaches and Bellarine Peninsula as attractions as well.

Ms GELDARD — That's what we use.

Dr FULLER — If it's an issue for us it's going to be a bigger issue for other places as well.

Ms GELDARD — In the whole time I have worked at Barwon Health, which is 12 years, we've never been in a position like this where we've taken a number of months to recruit; we've usually just recruited the positions straightaway.

The CHAIR — Thank you.

Dr FULLER — Neonatal nurse side of things we are okay so that's less of an issue there. Medical workforce at senior level within paediatrics is not an issue. Within obstetrics and gynaecology it is an issue. We're just okay but it's not like we are flushed with people saying we want to come and work for you. The junior medical staffing level we're probably just okay as well. There are changes that have happened on the paediatric side at a national level in terms of training that have impacted our ability to recruit and we're working to manage that. We are floating but we're not super comfortable.

Ms McLEISH — I just want to get a better understanding about the environment in which you operate. The Epworth is a recent addition?

Dr FULLER — Yes.

Ms McLEISH — Are there other private hospitals where people deliver?

Dr FULLER — Yes. St John of God Hospital has been delivering privately for many years and the Epworth has just opened recently as well.

Ms McLEISH — What are the hospitals that feed to you for the complex deliveries?

Dr FULLER — Particularly Colac would be the main area within our region. If you go further west than that a lot of them will then will feed to Warrnambool so our Barwon southwest region, which is the way the Health Department has sort of divided the state, there are more smaller places closer to Warrnambool. It's mainly Colac plus the western suburbs of Melbourne and a little bit Lorne and Apollo Bay but the numbers aren't large.

Ms GELDARD — It's mainly Colac.

Ms McLEISH — I want to go back to the first point that you raised, which was about the collection of data and the lapse between getting it back from DHHS in a workable form for you and you tried to correlate that with your own data and you couldn't get close. What do DHHS do to the data that makes it difficult for you to be able to draw that same data and use it?

Dr FULLER — I'm not sure and I've asked this question multiple times. I'm not sure what the 11 secret herbs and spices are that they apply to make it. It's partly because what they try and do to try and take bias out of things is it excludes certain cases. For example, with perinatal mortality they will exclude any cases where there has been a congenital anomaly that's the cause of death. Within the other indicators there are other exclusions as well and I'm not quite sure how they do that.

Ms McLEISH — It's not public?

Dr FULLER — I've asked our IT people to liaise with DHHS and as far as I know they haven't been able to.

Ms GELDARD — It's difficult. Some of them are really quite easy - we've managed for a couple of the indicators, but not for the suite of indicators which is what we were trying to replicate.

Ms McLEISH — How many indicators are there?

Dr FULLER — There's 10 indicators but some of them have got subsets so there's 17 in total.

Ms McLEISH — You've worked out three, four, two?

Ms GELDARD — Probably about four, which were the easy indicators to get the data.

Dr FULLER — We've not got access to how many through the trial?

Ms GELDARD — Probably the 17. Nearly 17.

Dr FULLER — Over 10 anyway.

Ms GELDARD — Yes. Some of them are drawn directly from the birthing outcome systems, some is from our inpatient data, admission data.

Dr FULLER — There are two data systems the department uses. One of them operates on calendar year and one of them operates on financial year.

Ms McLEISH — That's the first time we've heard that.

The CHAIR — Sorry to interrupt, Cindy. If you are having trouble with this as a major hospital in a large regional centre in Victoria, how useful are these data sets for other hospitals?

Dr FULLER — They are going to have more difficulty than us. The current trial we are involved in is through — so the system we put data into is called the birthing outcome system. So, the current trial is actually using the data from the birthing outcome system, applying it to DHHS formula and then you just put your date range in and then you can access that data. So, we could go back and look at what was our rate of third and fourth degree perineal tears last month, we could go back and look at that right now, so that's being run, as I understand it, between Safer Care and through the vendors of the birthing outcome system.

Ms GELDARD — And VMIA as well.

Dr FULLER — Victorian Medical Insurance Agencies.

Ms McLEISH — Interesting to think what happens if it takes that long, they've now have been able to get that down to 12 months from three years, what actually was happening in that time. Continuing with DHHS, you mentioned earlier the connections with the people on the ground. Do DHHS connect with you as a medical service to really understand and take your ideas and opinions on board or do they more tell you about what they think the model should be or the way you should be operating?

Dr FULLER — I think it's changed somewhat with the advent of Safer Care so there's a little more collaboration in the way that things happen. I think prior to that it's often been an announcement of this is where we're going; we need you to implement. It's probably been less co operative than what would be ideal. I think that Safer Care is moving more towards that collaborative, cooperative approach would be my experience so far.

Ms GELDARD — I think they've taken on more of a supportive role as well so if they identify a service that might have some issues they will come down and talk it through with a service. I think there's a little bit more sharing of quality improvement in this state as well, like if another service had a significant improvement in a certain area, I think it's perhaps just starting to shift, the shift of sharing, for want of a better word.

Dr FULLER — One example might be the recent meeting we had with level 5 maternity services that was facilitated by DHHS and really they raised the issues for consideration but wanted to hear from different regions as to what they were implementing, and I think that was a really helpful process because it was actually bringing everyone together, it was getting ideas that had been tried in some areas and getting ideas there, so I think that's a shift and a change that hasn't happened and I think that's probably the move that Safe Care has had a significant part in that shift.

Ms McLEISH — I think it's fair to say when we go around the state we've heard different models being operated in different parts of the state and sometimes DHHS are interested in those as well.

Ms COUZENS — Thank you for coming today, we appreciate it; I know how busy you are. I've got a few questions. How are you meeting the challenges of the population growth in Geelong? Obviously, you've got problems with recruiting staff. Have the numbers dropped in terms of demand at Barwon Health with the opening of the Epworth or is it just meeting population demand?

Dr FULLER — The Epworth is providing private care so really what it's doing is dividing the private market. There's been about 1,000 deliveries in private health, that's been a fairly consistent number over at least a decade, although that's probably dropped off to 750 to 800 as people have moved out of private insurance or moved out of using their private health insurance for maternity care because of the out of pocket experiences that come with that. We do see a little bit of an uplift coming from people using the public rather than the private services as well as the population growth. Our birth numbers are steadily increasing.

Ms GELDARD — Steadily, yes. We don't see huge increases but steadily increasing. Between 2,400 and 2,500.

Ms COUZENS — Around the mental health services for pregnant women after delivery, how are you managing that now given the withdrawal of the Commonwealth funding and that sort of getting back up, gearing up again. What has been happening in terms of mental health services?

Dr FULLER — I will speak and then let Claire speak to that as well. It's been very much that we've had to use either — there's a service called the Raphael Centre in Geelong, which is run in partnership with St John of God, and so it's referring women to that. They will take a certain group of women in that you can't be too emotionally unwell and it's really around anxiety and milder depression and obviously that takes a certain degree of organisation and health literacy to get yourself to a service rather than have something come to you. And then trying to engage and get women back to their GPs is the other strategy which, once again, involves a certain degree of health literacy and organisation to get there. If you're severely depressed and sitting at home it's much harder to actually get yourself out the door to do that. So, they have been the main strategies we have been using.

Ms GELDARD — Rafael have felt the impact of the withdrawal of the PEHP service and so they've had to kind of put some limits onto how to access their service so it requires, like David has just said, it required us sending the women back out to the GP and access a GP referral which we understand women who are feeling emotionally unwell just don't do those things.

Ms COUZENS — Have you been able to work with the local GPs around that or is it just business as usual, refer them?

Ms GELDARD — We did initially when PEHP ceased, we had some communication with them about what our referral pathway would be. I think our referral pathway is on the health pathways for them.

Dr FULLER — It keeps on changing the name but the Primary Health Network, as it is now, have a system called Health Pathways which are actually a series of guidelines that actually talk about, and they use what is best standard of care, so this is what is recommended for issue A or issue B, but also what other services are within the region as well, so it's regionalised also. Where the health services have worked in a range of areas with Primary Health Care Network in developing health pathways so that's been an issue that we have been able to work on them with but I think it's an impact on them. A lot of GPs will have out of pocket expenses.

Ms GELDARD — And then for the women that are on the high end of moderate to severe mental health issues in pregnancy and beyond, or in the antenatal phase, we have had access to a referral pathway to our psychiatry services internally which has its challenges to a degree because obviously they've got demands on their service. With the new position coming on, it's less than what was previously, because obviously the funding is not the same, we're only going to have one FTE so it's not going to be necessarily an outreach service again, we're just trying to work out what that service is going to provide to the women. It's really going to be for those moderate to high risk women and ensuring that they are accessing the right pathways and providing education for the midwives because it's not their core business. We think it's really important for this person in this role to actually educate and make midwives confident and have good knowledge about how to engage with woman who are experiencing perinatal emotional health problems and assist them to access the right pathway.

Ms COUZENS — Given the Closing the Gap Report and the vulnerability of our Aboriginal communities, can you explain a bit around the programs that you're running at Barwon Health?

Ms GELDARD — We have the Koori Maternity Service which sits out of Barwon Health but we also have our Aboriginal Health Liaison Officer, which we have identified, a liaison officer that works in co-location with maternity services. Obviously, every woman who identifies as Aboriginal or Torres Strait Islander doesn't

choose to engage with Koori Maternity Services and they're the kind of people that fall between accessing the appropriate services. We have very clear times throughout the patient journey, a women's journey through pregnancy, where we ask women to identify, we ask the question. We do a lot of work with the midwives around being culturally sensitive to that question.

Ms COUZENS — Do they have training? Cultural awareness.

Ms GELDARD — Yes, all Barwon Health staff members go onto mandatory training. We have our own maternity e learning platform for midwives and all the staff, not just for midwives, for all the staff that is providing care to women. We've also got obstetricians now going out fortnightly to provide high risk clinics, actually outreach, because those women historically do not want to attend hospitals so we are actually providing the service out in their own community within the health service out there so our consultants go out and provide services so they don't have to come to the hospital.

Dr FULLER — As part of Barwon Health's Reconciliation Action Plan, each area identifies areas that they are going to work on to improve our care of Aboriginal and Torres Strait Islander women.

Ms GELDARD — One of our birthing units has been kitted out as a culturally safe space and we are going to be painting it and naming the room so that women who are coming in to give birth can go into that room. Obviously, it's free.

Dr FULLER — Not surprisingly if you look at the health outcomes for the perinatal outcomes for Aboriginal and Torres Strait Islanders, in Victoria and Australia there are a range of indicators where their outcomes are much worse than for non-Aboriginal and Torres Strait Islanders. The perinatal mortality for that group in Victoria has actually been falling in recent years. The most recent data for 2016 hasn't been officially published but there's actually some good news within that as well.

Ms COUZENS — I'm very much aware of the work that Barwon Health is doing and I congratulate you because it's probably one of the best I've seen around the state. Thank you.

Ms EDWARDS — Thank you. I apologise for not being here when the introductions were made this morning. Thank you for your submission. I'm interested in the real time data in the trial that you are participating in. Just a little bit of information around that, if you wouldn't mind. When it started, how long it goes for, and how many sites are involved?

Ms GELDARD — We were actually late into the trial so it was a 12-month trial and it is due to finish in April next year. I think we joined in about July, which didn't really matter that we were a late participant because it needed an extra regional site to be included. In total there is in a metropolitan site, two regional sites, there's about five or six sites so they have tried to do a spread of different capability level sites.

Ms EDWARDS — Do you know which other regional site?

Ms GELDARD — Not off the top of my head. I did have a piece of paper in my bag and I've just taken it out. It's Monash.

Ms EDWARDS — That's all right, you can provide the information to our Secretariat if that's okay.

Ms GELDARD — Yes.

Ms EDWARDS — It's funded by the Department of Health and Community Service?

Ms GELDARD — And VMIA.

Dr FULLER — Victorian Medical Insurance Agency.

Ms EDWARDS — The Regional Perinatal Morbidity and Mortality Review committees that you are part of, do you think that they are contributing to improve perinatal outcomes?

Dr FULLER — I think they are. Though still relatively early days, only been going for a couple of years, about a year and a half, but I think they are improving collaboration between the regions. I think they're really highlighting some key mortality and particularly morbidity data that will contribute to mortality. One of the

indicators is the rate of babies with severe growth restrictions, so very small babies who haven't been delivered before 40 weeks of gestation. The reason that that's important is if you're in that very small group, beyond 40 weeks your risk of dying as a baby skyrockets so there is an increased risk all the way through but it particularly becomes significant if you deliver after 40 weeks, so identifying those babies earlier and delivering them earlier is important so that is one of the indicators that gets looked at within the regional perinatal mortality area.

Even just having a focus on it brings everyone's mind to it more. For us it was an indicator that we were performing badly and if you look back at our data from a years ago, in the most recent data we're actually in the best quartile in this state, and that's partly because of some specific implementation but I think it's partly just because it's being talked about and it's on people's consciousness and people are thinking about identifying it earlier and actually acting on that earlier as well.

Ms GELDARD — The fact that we have got real time data now, and we know it's accurate from being involved in this pilot, which has been really beneficial for us as a regional site, having access to accurate data has allowed us to review those cases in particular accurately and put some quality improvements in place so we can revise our guidelines. Even though our performance was better, you can always do things even better, and so we've got staff working on quality improvement work with the performance indicators which particular ones that we look at from that meeting.

Dr FULLER — If you look at what happened in Djerrowarrj, there has been lots of commentary on that, but you had individual health services doing their own monitoring and no actual talking between them, whereas now you've actually got review happening every three months, data being looked at every three months, and I think it just makes that sort of instance much less likely because it's on the agenda and it's being reviewed and bigger services are then thinking about how can we support the smaller services? You're improving the communication between the bigger and smaller services in other centres as well, so I think it will have continued impact and I think it's important that it keeps going.

Ms GELDARD — There are recommendations that come out of that meeting that go to each individual health service that participate and it goes to the CEO so there is an expectation that if you haven't already got something implemented and its effected then you actually look at implementing those recommendations, the outcomes from the meeting. We had a meeting on Friday and they actually talked about - they are going to actually provide the recommendations from all the regions to every region so they are going to be shared recommendations because there has got to be learnings from other regions that don't necessarily get raised at individual regions and obviously there is opportunities there so they're going to share them all.

Ms EDWARDS — Do you have an increase in higher risk pregnancies in this region?

Ms GELDARD — Obviously we get the referrals in so we do get an increased number because we get all high-risk pregnancies that fall outside the capability for work at Colac that get transferred in. And now that we are a level 5 hospital and neonatal unit, we do get some transfers in for that reason so obviously PIPER —

Dr FULLER — Paediatric Infant Perinatal Emergency Retrieval.

Ms EDWARDS — We're aware of it.

Ms GELDARD — Sometimes referring to us, if we've got capacity to admit, so we get some higher risk transfers in there. We've got a demographic of higher risk and a low socio demographic which then creates some high-risk pregnancies within our own demographic as well.

Dr FULLER — I think we've also got some of the growth from outer western suburbs in Melbourne as well, so that's where there has been a big population growth, and a lot of that will go elsewhere but some of that also comes to us.

Ms EDWARDS — Just one last question in relation to breast feeding. What are the rates like for women who are leaving Barwon Health?

Ms GELDARD — About 85 per cent rate.

Ms EDWARDS — Do you have lactation consultants?

Ms GELDARD — Yes, we do. We do have lactation consultants within the hospital and we have an inpatient and an outpatient service.

Ms EDWARDS — How many lactation consultants?

Ms GELDARD — In total working within the service we've got six lactation consultants but there are other lactation consultants who work. There is a couple in the children's ward and there's a couple of lactation consultants who just work in the work force.

Ms EDWARDS — Do they do home visits?

Ms GELDARD — No.

Ms EDWARDS — That's all. Thank you.

The CHAIR — Just a couple of really quick questions to finish up. We just want to know the number of obstetricians you've got at the hospital? If you have got any recruiting issues with obstetricians themselves?

Dr FULLER — We've got a number of obstetricians on smallish fractions. In terms of EFT we've got four and a bit EFT obstetricians. There would be, I think — I should have this on the top of my head — I think it's 12 or 13. But varying amounts of public hospital work within that. Issues with recruiting, yes there have been some issues with recruiting and that goes down to more junior staff as well, so we've had a couple of years in a row where we haven't had a senior obstetric registrar. It is important for our service to have someone at the end of their training providing leadership. We've actually got someone in the position for next year and we went from having no applicants in previous years to having five or six very good applicants so I hope that is a sign of things to come that we will continue to be able to staff that and it might actually flow through to senior obstetric workforce. I think one of the challenges for public obstetrics is that in the private system there is a lot more money to be made and so actually attracting people to work in the public system can be an issue.

Ms EDWARDS — When you've got two private hospitals.

Dr FULLER — That's right.

The CHAIR — Lastly, we have heard in some of the regional areas that obstetricians have a system with a formal or informal or ringing some of the more metro hospitals that operate at high levels and asking for advice before they conduct an operation or a procedure. Is that a system that you're aware of or is there any allowance for that for the obstetricians at Geelong?

Dr FULLER — I'm not aware of any particular system in place for that and I think I would say that within our service we have got the capability and capacity to provide what's needed. It's not to say that you won't consult from time to time on particular issues or particular cases, and certainly within paediatrics that would be the case as well, we will sometimes formally or informally consult and get advice and really say is this something we should be managing here or should we be transferring this to you? And I think that's a healthy thing to have that.

The CHAIR — Absolutely. I guess for regional areas it is different, you consult with each other. We just heard that that happens quite often.

Dr FULLER — I don't think it happens very frequently.

Ms McLEISH — What about for Colac, do you provide any — —

Dr FULLER — Yes.

Ms McLEISH — So that does happen?

Dr FULLER — Yes.

Ms McLEISH — So you're just looking that way, you provide that service down the line?

Dr FULLER — Absolutely, yes.

Ms McLEISH — Is it formalised or informal?

Dr FULLER — In terms of calling, that's informal. We are doing some work with Colac around working with them to tighten up their systems and their referral and their flow and also supporting their medical and midwifery workforce. There probably are some formal things in place.

Ms GELDARD — If a woman presents at the hospital there is a formalised process around the CTG monitoring. If a woman has a CTG we assess that CTG motoring because we need a double-checking process. It's a little bit difficult with Colac because it's GP obstetrician lead, so it relies on the individual GPs following the capability level and referral process as a level 2, which is Colac. But, again, it's talking to what has been discussed at department level of having some formalised referral pathways that are statewide because they won't be much different from rural to regional to regional to metro, those referral pathways standardised.

The CHAIR — Thank you so much, David and Claire. Thank you so much for your contribution this morning.

Ms GELDARD — Thank you.

Dr FULLER — Thank you. Pleasure.

Witnesses withdrew.