FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 18 September 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

Witnesses

Ms Lisa Fitzpatrick, Branch Secretary,
Ms Julianne Barclay, Maternity Services Officer, and
Ms Maree Burgess, Maternal and Child Health Nurse, Branch President, Australian Nursing and Midwifery Federation (Victorian Branch).
The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee’s inquiry into perinatal services in Victoria. This is the second public hearing held by the committee for this inquiry. The committee will hold further hearings in Melbourne and in regional Victoria, and we will be conducting community forums to encourage participation from as many people as possible. Our first regional hearing will be held in Warrnambool on 11 October. Please see our website for details of the upcoming hearings.

Under the terms of reference for this inquiry the committee will examine the quality and safety of health services delivered to women and their babies during the perinatal period; the provision of an appropriately qualified workforce; the disparity in outcomes between regional and metropolitan locations; and perinatal mental health services for women. We will also consider the quality and safety of current methods to reduce the incidence of maternal and infant mortality.

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. If you have any special needs today, please see the committee staff, who will assist you. We have got Greg and Rachel over there. 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 to silent, please.

I now wish to call our first witnesses, Julianne Barclay and Lisa Fitzpatrick from the Australian Nursing & Midwifery Federation. Welcome, Julianne, welcome, Lisa.

Ms FITZPATRICK — Also can I introduce to you Maree Burgess. Maree Burgess is a maternal and child health nurse with some 30 years experience in that field. We know that some discussion and some presentations to the inquiry have focused on or mentioned maternal and child health nurses.

The CHAIR — We take it that we will be taking evidence from Lisa and Julianne —

Ms FITZPATRICK — And Maree Burgess.

The CHAIR — 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. I now invite you to make a 10 to 15-minute statement, and we will follow up with questions if that is okay.

Ms FITZPATRICK — Sure. Thank you. The Australian Nursing & Midwifery Federation, Victorian branch, of which I am the Branch Secretary, has approximately 7000 members who are working in the field of midwifery and maternal and child health. We cover members who do provide the full continuum of care during pregnancy, birth and then after birth as well.

We have obviously presented a submission with a large number of recommendations, but in essence our submission goes to a number of important issues. Particularly we focus on existing services and where we see that those existing services could be improved. We also refer to issues around workforce. We think that there are significant issues related to retaining and growing the workforce for both midwifery and then ultimately maternal and child health nurses into the future. The education associated with that workforce is the main focus of our submissions. In addition we want to emphasise really integrating better mental health services for pregnant women and their families.

What I might start doing is talking about where we are in relation to workforce matters at the moment and what the current government is doing. We have in the public sector ratios for midwives who work in the birthing suite, in postnatal and also in neonatal services. The current government is at this stage finalising recommendations from an independent panel in relation to both improvement of those existing ratios but also extension of those ratios into other areas, such as assessment units and also postnatal care outside the home. I think it is absolutely critical when we are talking about postnatal care — given that women, after they have birthed in the public sector, are being discharged 6, 8, 12, 24 hours post birth — that we also do look at what services we are providing in the community in relation to postnatal care and particularly how those services integrate with the maternal and child health nurse service.
The Australian Nursing & Midwifery Federation has sought improvements in the ratios that we currently have in legislation as well as the introduction of ratios into new areas such as assessment units and also the domiciliary postnatal care area. What we do advocate for is one-to-one care for a mother during birthing when they are in the birthing suite, and that is one of the things that we are seeking. We currently have two midwives to three birthing suites, but given the pressure on birthing suite numbers we know that those birthing suites are well utilised. In fact we have women birthing in public hospitals outside of those birthing suites, including in the assessment units, and it is critical that we have one-to-one midwifery for those women. The word ‘midwife’ means ‘with woman’, and that is a critical thing.

We also know that we have assessment units that have started up in Victoria over the last 10 to 15 years. These units really are in lieu of women who are pregnant presenting to emergency departments, and so it is critical that we have those units well staffed with midwives as well. And the postnatal units: we now have, of course, what is called ‘rooming in’, and so babies room in with their mother in the postnatal unit. Once upon a time many of those babies would have been in the special care nursery. The special care nursery is now dealing with more intensely unwell babies, and babies that are unwell are now rooming in with their parents. This of course increases the workload of midwives to do all that they have to do in that postnatal period, particularly intensified as a result of earlier discharge than what we have had in the past.

The neonatal services also are mentioned, and there are recommendations in relation to what we are seeing happening in our neonatal services with an increase in presentations of babies — not unwell babies but babies who have been discharged with the mother — coming back into neonatal services. I think the percentages of those babies in Victoria sit around 4 per cent to 4.5 per cent. We are wanting to see, as I said, the improvement of ratios so that women can get better care and so that their babies can get better, timely care in hospital whilst they are there and also more domiciliary services so that women who are going home actually are being seen by a midwife outside of the hospital. Then of course those visits streamline nicely into the visits from maternal and child health nurses, who see mother and baby within the first seven days after discharge.

In relation to education, we think it is absolutely critical that the government implement increased scholarships, particularly for those nurses who wish to undertake midwifery studies. There are three ways that you study to be a midwife in Victoria. You can do the direct-entry bachelor of midwifery; you can undertake postgraduate studies, once you are a nurse, in midwifery; or you can do an undergraduate double degree where you do nursing and midwifery. Particularly for regional Victoria there is a strong preference by regional Victorian facilities that employment is there for those who are registered both as nurses and as midwives, because of, I guess, the flexibility in relation to employment, and we think that is important.

The cost associated with doing those, particularly the postgraduate studies: the postgraduate studies sit around $20 000 to $23 000. If you are doing an unpaid model, then of course those studies are full-time and you do not have an opportunity to work outside of your studies, so you really have to take a break from the workforce in order to undertake those studies. There is an alternate model in Victoria as well, but unfortunately at this stage only around 60 midwifery students are being educated through the second model. That is what is called a paid model of employment. This is where midwives study part-time but also work part-time in a facility. We have a number of regional Victorian hospitals which are undertaking this model; in addition we have some metropolitan, but they are in small numbers.

For example, this year Northern Hospital has around eight student midwives who are undertaking their qualification in the paid employment model. Bendigo Hospital has around four students. Those numbers are small predominantly because of the funding arrangements that are in place for hospitals to employ these postgraduate students whilst they are doing their midwifery. Northern Hospital advised that per student — and that is their eight students — they are in the red in relation to about $33 000 per student, and we think that is, in the overall scheme of things, a relatively small amount of money to provide a hospital with to ensure that they are undertaking the employment model. Particularly importantly, I know that the director of nursing at Northern Hospital spoke to me about a single mum who had travelled from Geelong each day to be in the paid employment model so that she could undertake midwifery studies. She was a single mum and would not have been able to undertake midwifery had she not been able to access a place in the paid employment model.

The midwifery workforce in 2013 in Victoria was working approximately 25 hours on average per week. In 2016 it is down to 22 hours per week. I have a gentleman here with us today. His name is Mr Ian Kenny. He is a midwife at Sunshine Hospital. There is a headcount of around 203 midwives at Sunshine Hospital and twenty-
two are full-time midwives in that workforce. So importantly we have to look at why are midwives either leaving the workforce or certainly reducing their hours, and the ANMF is confident that because of the numbers —

**The CHAIR** — Could you just repeat those numbers?

**Ms FITZPATRICK** — For Sunshine Hospital? Yes. So Ian Kenny, who is with us here today — 203 midwives on the roster, and he is one of twenty two that are full-time employees. Some overseas midwives that are coming in are required to be full-time, but the bulk of a very, very large percentage of that workforce are part-time and we do know that the reported hours are down from 24.9 to 22 over a three-year period.

One of the things we desperately have to do is work out how to retain that wonderful specialist experienced midwifery workforce and then of course grow the workforce into the future. In the first quarter of last year we had, I think, 123 midwives graduate from their courses. We do not believe that there is a reluctance of either nurses or students to undertake midwifery; there is an interest, and people want to do it. It is about making sure that they get employment after it, and that is something that we have been working on with the current health minister. We certainly have raised these issues in relation to the employment model being funded so that we can provide more places where student midwives do not have to give up their employment to undertake the courses.

Before I stop I would say that in relation to maternal and child health nurses in Victoria we are very fortunate. We have the most well-educated maternal and child health nurses in the country. They are registered nurses. They have also completed their midwifery postgraduate studies, and they have also done postgraduate studies in maternal and child health. They are well equipped and are doing much more work, particularly now, in the area of domestic violence.

We have had in this year’s budget a record $81.1 million announced for the improvement and scholarships for nurses to undertake maternal and child health nursing as well as continuing professional development around family violence. These are critical, but once again, if we do not retain our midwives in the system, then that reduces the pool of midwives who go on to do their maternal and child health nurse studies. So it is really critical that we do address and continue to work to improve the numbers in our midwifery workforce and I guess the conditions that they work in in relation to being able to provide that continuum of care to mother and baby.

**The CHAIR** — Thanks so much, Lisa, and thank you for coming today. We might start with some questions. Your submission noted that there is a trend towards more complex births. Can you elaborate on that for us?

**Ms BARCLAY** — Thanks for the question. Yes, there are a number of factors that have contributed to increasing complexity. The number of normal births is reducing year on year. Maternal comorbidities, such as obesity, diabetes and other maternal conditions, contribute to women perhaps needing to be birthed earlier. Secondly, there has been a recent focus on stillbirth and a focus on decreased foetal movements being a significant indicator that perhaps all is not well with the baby, so there has been a re-emphasis on foetal growth and more babies are being induced because they are being picked up earlier as having slower than expected growth. So all of those things contribute — plus the age of women, plus the multicultural diversity. All of these factors have increased over time, and they contribute to the complexity of the pregnancy, the labour and the birth.

**The CHAIR** — Thanks, Julianne. We have also heard quite a bit about the implementation at Northern Health of private midwives. I am just wondering if you could tell me about the federation’s involvement in that.

**Ms BARCLAY** — There was a consultation process to develop the guidelines around these programs. It is called a collaborative arrangement between a private midwife and a public hospital, and that was finalised perhaps three years ago. There were to be two hospitals taking up that option, but only one did. That was the Northern Hospital. So we were involved in the consultation process for drafting those guidelines, and then Northern Health invited us to be involved at every step along the way as they developed documentation and processes around how they were going to run that program.
We have been involved subsequently just with a catch-up meeting and regular reviews, so we are comfortable that that program is running well. It is well governed by the regulations, firstly, from the department and, secondly, within the hospital, and we know that midwives who are working in that program are happy. We also know that the midwives in the hospital who interface with those midwives are also working collaboratively, so there do not appear to be any major issues of conflict, which we have heard about in other programs. So the medical staff, the private midwifery staff and the hospital midwifery staff all appear to be working collaboratively to meet the needs of these women. My understanding is — and I think they presented to you — their clinical outcomes are really good as well.

**Ms McLEISH** — Thank you for coming in. Can I just clarify: you talked about normal births and you talked about being induced. Is that a normal birth?

**Ms BARCLAY** — Is an induction a normal birth? It might still be a normal birth. A normal birth is usually described as a vaginal birth. You may have an induced labour, and we would say that that is not a normal process. A normal process is when a woman goes into spontaneous labour. The rate of spontaneous labour has dropped significantly over the last five years. A woman may go on post induction and have a vaginal birth, and that is the aim, but a woman may also go on and have an instrumental birth, which would not be a normal birth, or a caesarean section, which would not be classified as a normal birth.

**Ms McLEISH** — Is episiotomy a normal birth?

**Ms BARCLAY** — Yes.

**Ms McLEISH** — Sorry; I was just trying to clarify the language.

**Ms BARCLAY** — Episiotomy facilitates a normal birth.

**Ms McLEISH** — You mentioned earlier you have some 70 000 members. How many of those are in country Victoria?

**Ms FITZPATRICK** — The federation has almost 80 000 members —

**Ms McLEISH** — Sorry; I wrote 70 000.

**Ms FITZPATRICK** — in total, but of the workforce that we are talking about in relation to midwifery and maternal and child health nurses, we have around 7000 of that 80 000.

**Ms McLEISH** — Seven?

**Ms FITZPATRICK** — Seventy — sorry — 7000. Otherwise we would not be here, would we! There would not be any problem at all in relation to workforce. Around about 35 per cent of our membership are in regional Victoria.

**Ms McLEISH** — And do the members in regional Victoria highlight any specific issues?

**Ms FITZPATRICK** — Other than the ones that we have spoken about, no. Distances can be an issue. Workforce retention can be an issue, particularly in the workforces that we are talking about in relation to midwifery and maternal and child health nursing. I think it is really about ensuring and growing the workforce in regional Victoria. One of the things that we are adamant about and really work hard on doing is ensuring that our regional campuses of universities remain open, so the threat of Deakin University in Warrnambool closing its midwifery and nursing programs was really significant because we do rely on those regional campuses, being Bendigo, Warrnambool and other places, around ensuring that we actually do have a regional workforce.

**Ms McLEISH** — I just wanted to look at some of the numbers that you have mentioned. Before you said that there were 150 midwives on the roster at Sunshine, for example. Has the number of midwives in the state grown over the last decade?

**Ms FITZPATRICK** — Yes, it has grown.

**Ms McLEISH** — Are more people choosing to work part-time?
Ms FITZPATRICK — Yes.

Ms McLEISH — So is the retention issue around full-time work, or is it that less people are choosing to do part-time work as well?

Ms FITZPATRICK — I think more people choosing to do part-time work and reducing their hours from full-time is the problem.

Ms McLEISH — And how is that a problem?

Ms FITZPATRICK — Because in essence the less shifts, the less hours that people work, the more gaps we have in our rosters, and what that does is it feeds into those people who are there feeling disenchanted not being able to provide it.

Ms McLEISH — So you would rather full-time workers than part-time workers?

Ms FITZPATRICK — No. Ideally we would hope that the part-time workers would be able to work more than 20 hours a week because we want to grow the workforce and grow the hours. When we improve the ratios for staff we actually need more midwives to fill those hours. So no, we are not against a part-time workforce, but we are concerned that the ratio between full-time and part-time, if Sunshine was any example, is quite extraordinary. And it is certainly not one that we see in the registered nurse working force, where the average number of hours in Victoria is 32 hours. So we do have an issue where we have got registered midwives working on average 12 hours less per week than their nursing counterparts.

Ms McLEISH — I just have one more question about telehealth. How would you think that would work for maternity services?

Ms FITZPATRICK — I think it would be wonderful. I think it would really be a positive contribution. I know that there is work being done by the department, and Julianne might be able to speak more about that, but we are making steps in relation to telehealth, and particularly for regional Victoria services it is a very positive step forward.

Ms McLEISH — What are the pros and the cons of that?

Ms BARCLAY — After we wrote that submission last week the department have requested expressions of interest from CEOs who want to set up telehealth. I think that the cons sometimes talked about may be related to a woman not having the relationship with the provider. But the way telehealth is supposed to be set up, one example of the pro might be Wangaratta hospital. The woman sees the midwife, the midwife is with the woman and they have a consultation with an obstetrician who is at the Royal Women’s Hospital. So the woman does have a known professional with her and that person can actually have further conversations after the consultation, but we also have the opportunity to have that expert advice from the Women’s hospital about some complicated matter. It may also be that the GP is with the woman and they have the consultation with the consultant in Melbourne. It may not totally reduce the need for women to travel, but it could massively reduce the need for women to travel. So you might have your first appointment in Melbourne with the specialist, but you might be able to have subsequent appointments by telehealth.

But the system is not well set up for this in Victoria at the moment. What I think needs to occur is that those big level 6 hospitals would have, for example, a clinic that ran and women would make appointments with their GP or with their local midwife and they would have their appointments via telehealth. It is funded by Medicare; there is a Medicare item number for telehealth. It is not the woman sitting at home having a consultation with a health professional who is somewhere else. It would ordinarily be in association with another health professional. I think it is a real benefit in terms of improving access.

You were asking before about the issues for rural populations. That is one — women having to travel long distances to access specialist care. The other is related to transport. For rural services to remain viable there needs to be a robust system of retrieval and transfer, and there are occasions when rural services have to wait quite some time to transfer a mother and/or her baby to a more acute facility. I believe that you are hearing from that service down the track. I just want to raise that as a concern because if a midwife and a GP, for example, are in a small facility with a sick baby, it is incredibly stressful and it is quite worrying to be having to wait a considerable amount of time before the retrieval service can arrive. But once again, with really good telehealth
facilities people can be looking at what is happening with the baby from a more acute facility and can be providing advice. All of those things provide great reassurance, I think, in case they cannot be physically present.

**Ms Edwards** — Thanks for coming in this morning, and thank you for your submission. I just wanted to follow up on a question that Cindy asked in relation to the part-time workforce. Can you perhaps give us some idea of what the impact of that is on a woman in labour?

**Ms Barclay** — The part-time workforce?

**Ms Edwards** — The part-time midwives, the shortage in the rosters — what is the actual impact on a woman in labour?

**The Chair** — Can I extend on that question too? If someone came in today and they were pregnant, if you have got 150 mostly part-time midwives, how many midwives would that person see, and what would the continuity of care be?

**Ms Barclay** — Can we say there are two separate points? One is that you are talking about continuity, and maybe we could have a whole discussion about continuity — and I am happy to. The second point is about when a woman is in labour how many people she is going to see. The part-time workforce will not necessarily impact on the woman in labour on a shift because the issues there are not related to the part-time workforce. Somebody will be rostered; however, the issue is that there are not enough midwives rostered on a shift in the birth suite for one midwife to be allocated to care for one woman in labour for the entire shift.

Leaving a discussion about continuity to one side, ideally one midwife would be available to care for one woman for the whole shift that that midwife works. If the woman is in labour for two shifts or three shifts, she might have two midwives or three midwives care for her. The issues in birth suites are related to the fact that when a baby is born we need at least two people in the room — two midwives — or if something actually goes wrong with that birth or after the birth, we might need two or three midwives in that room to cater for the emergency scenario. When we have a situation where we only have two midwives rostered to three birth rooms, you can see that a woman can spend a lot of time in her labour without a midwife with her. So that is the issue about the numbers.

**Ms Fitzpatrick** — And we do know that we have midwives in order to fill the vacancies or the gaps in the roster who are working double shifts, and we do not think that that is a safe practice. Our enterprise agreement refers to what happens when you do work double shifts. It is not uncommon, sadly. So that could potentially have a detrimental effect on a mother and a baby when you have got a midwife who has been working 16 hours continuously.

**Ms Edwards** — I have a question around how many midwives would be from Aboriginal or CALD backgrounds.

**Ms Barclay** — I do not have that information.

**Ms Fitzpatrick** — I do not know.

**Ms Edwards** — I also have a question relating to your submission around the shortage of lactation consultants. You mentioned incentives for midwives to train. What do you think is needed to encourage more lactation consultants to be trained?

**Ms Fitzpatrick** — I think Maree might be able to help with this as well, particularly as it is her speciality area.

**Ms Burgess** — Certainly it leads itself into maternal and child health. Of course the basic aspect is that we are all midwives. We do breastfeeding as part of our training to support women in the early postnatal phase and of course moving on into the community. Yes, we absolutely support women as they move into our community facilities and also when we do the first home visit. As far as additional people training as lactation consultants goes, local government is actually really supportive of people who want to go on and do an additional specialty. They do support them, because some of that education is really expensive. That has seen the growth of maternal and child health nurses with that specialty, and that has learnt itself to them setting up
lactation clinics where parents, in addition to their drop-in visits they have with the universal service nurses, can actually drop in to, say, the City of Melbourne. They have three lactation clinics every week spread over the week that women can drop in to at no cost. They can stay there for up to 3 hours and have that additional support.

I have to say that I work in the City of Banyule, and it was a great loss to us when the Mercy did not maintain their funding for a day-stay lactation clinic. It was really good. You often find that those tired mothers, when they get home they have breastfeeding problems. They were able to go down to a day-stay facility. There were four mothers that would stay, supported by three lactation consultants, and they would view that feeding over the day. By the time those women left they were in a different place altogether. They had really grasped it, so I think it is really critical to see some community facilities supported. Obviously the hospitals have got their lactation clinics as well. Again, because it is reduced funding, the concept of staying there for the day has been diminished, so you really go in for a one-off, 2-hour consult, and then you go home again.

Ms EDWARDS — You are in Banyule?

Ms BURGESS — Yes.

Ms BURGESS — I have a case load of families of about 600 across the nought to four-year age range. You see them more intensively in the first year when we have 10 key ages and stages visits, but Banyule has, along with a lot of other councils, open sessions now. Again, talking about supporting lactation and early maternal health, they are able to come in to open sessions every week. They can just drop in. They do not have to make an appointment. They could come to 52 open sessions a year if they wanted to. They can get support with their general health and wellbeing and support with feeding.

I also work in one of the new community hubs. We are located with the early years services. That has worked extremely well — the whole-community sense and the idea of a hub. We have multiple language group playgroups for the diverse community that we have. We have got a feeding space so that when women come in, if in the consult they express a concern about their feeding, we will head down, they will do a feed and we will do an observation to check to see how they are going and what the attachment is like. It is this all-encompassing service while working alongside the early years educators as well.

Ms EDWARDS — I just have one last question in relation to the integrated health services model that you referred to. Can you perhaps talk through what you think that will look like?

Ms FITZPATRICK — I think I am really picking up on some of Maree’s issues in relation to the community hubs. What we are not wanting to do is to set up more services; we have existing services that we think are underfunded. For example, community health centres are a wonderful resource that we have here in Victoria, but they spend their time applying for grants — 12-month grants or 18-month grants — with very little ongoing funding. What we would like to see is a strengthening of the out-of-hospital funding for perinatal services.

Importantly, and we have not touched on it a lot, is that mental health wellbeing for mothers and families in particular. We know that it is the most vulnerable time around family violence with pregnant women, and so we would like to, I guess, see things to make sure that they are streamlined, that people are aware of the services that are available and that whether it is the Bendigo community or the Warmambool community we have got a range of services that can touch on maternal and child health, nursing, family violence, lactation issues and all of the other things in postnatal and antenatal services. It is really just making sure that those services are as integrated as possible so that we have got the local acute hospital — actually that birthing suite — in touch with those other services so that they know where to refer and that there is capacity to refer the service.

Ms BRITNELL — Can you describe to me the assessment units, and are they available in the far reaches of the state or mainly in the city areas?

Ms FITZPATRICK — They are mostly metropolitan. They operate in different ways, so some of them we know that birthing commences — labour commences — in the assessment units. We do know that because a shortage of birthing suites some babies are born in assessment units. We know that there are other hospitals
where inductions might start in the assessment unit or that they are a replacement for emergency departments at hospitals as well, so very few emergency departments in the state will actually see pregnant women coming in and that they actually refer them through to the assessment units. Julianne, you might like to —

Ms BARCLAY — Yes, so in some places the assessment unit is a real physical separate area, and in some places the service is run within the birth suite. But due to capacity issues in metropolitan areas, particularly the growth areas, these assessment units grew to being very large and quite complex in the work that they were doing there. The staffing in those areas is less again than what it is in birth suites, so you can imagine that it is not a great experience for a woman to be in one of these areas and to find that she is in labour and then actually subsequently have her baby there. That does sometimes happen, so we are looking to see these assessment areas being staffed the same as birth suites or at least staffed better than they are now to recognise the complexity of the work that is occurring in those areas.

You may be familiar with the Warrnambool service, and Wangaratta also. At those hospitals, a woman who has a query in the community about her labour or thinking that she might be coming into labour or having perhaps ruptured her membranes will always ring the birth suite. So those birth suites operate as a triage service. They operate as an information service. Then if the woman needs to be checked out, or the latest of course is the reduced foetal movements — a lot of women are ringing because they concerned about reduced foetal movements — if there is no assessment area as such, those women present to the birth suite and have care administered by a midwife. They will be admitted if they need to be admitted, or they will be monitored and reassured and go on their way home. So in some cases their separate areas are quite big separate areas where the capacity has been outstripped by the demand for birth suite beds, and in other areas the birth suite actually delivers that service.

Ms BRITNELL — Have they developed as a reaction to the service being overcommitted to? So is it better to, rather than staff them, actually improve the whole of the approach that we used to deliver in the birthing suite and fairly still do in Wangaratta and Warrnambool?

Ms BARCLAY — I think the priority for every health service would be that a woman would birth in a birth suite. It is not normal to be birthing in these other areas.

Ms BRITNELL — It is like a pre-op sort of concept — pre-op care?

Ms BARCLAY — It started off as a clinic. We could do a few more things in the clinic before we bring women into the birth suite and we can start the induction in the assessment area before we bring her to the birth suite, and then, ‘Oh goodness — three or four other people have come in and now there are no beds in the birth suite but we have already started this induction in the assessment area’. So that is sort of how it operates.

Ms FITZPATRICK — I think it is also a preference to have women, instead of presenting to the emergency department, actually making sure that they can access a skilled midwife.

Ms BRITNELL — The other question I have that I am still not sure about is what your point is around the part-time. I can understand you saying that it is going from 25 hours EFT to 22. We used to have policies around not being able to work less than 0.5, and that became impractical in the hospitals I worked in. You could not work less than 0.5 — two shifts one week, three shifts the next. People found that onerous, so it was reduced because it accommodated the majority of the workforce, which was women who were going off and having families and balancing family and work. But if you are there for the shift and if you are there part-time two days a week, one day a week, the continuity of care for someone in a birthing suite for the 8 hours that you are there on the shift does not change. I am not sure why increasing part-time, except when you are trying to do the roster, which is very, very challenging —

Ms FITZPATRICK — It is simply about the roster. We are not talking about continuity and saying that part-time members cannot deliver continuity. It is simply about the roster, and when you have got Victoria with a growing birthrate and increasing demand and then the workforce reducing in hours, that is sort of heading for a collision.

Ms BRITNELL — So that is the point. I thought you said we had more midwives than we did but they are working less hours. Are we actually not meeting the demand?
Ms FITZPATRICK — No, we are not meeting the demand.

Ms BRITNELL — So that takes me to the next question: you are in hospital, training.

Ms FITZPATRICK — Yes.

Ms BRITNELL — Is that for registered nurses who have done their general and then going on to do post?

Ms FITZPATRICK — Yes, it is called the postgraduate employment model.

Ms BRITNELL — Yes. So is it simply budget that is precluding some hospitals? I do not believe it is in Warrnambool Base Hospital — is that correct?

Ms BARCLAY — It was, yes. They did have two —

Ms FITZPATRICK — Paid places.

Ms BARCLAY — a couple of years ago, and now they have a fully supernumerary.

Ms BRITNELL — Okay. Is it budget only or is it the supernumerary — the fact that you have got to have someone supervised, so your rostering capacity is also challenging because you cannot have too many on that have not got the capacity to actually deliver the service?

Ms FITZPATRICK — It would be both. We do not want to flood the places with it, but I think the problem is we have got about 60 training this year, and without additional funding those facilities that are undertaking that program are saying that they cannot. The example that I gave is the Northern saying that of their eight students they are around $33 000 per student short to continue that program into the future.

Ms BRITNELL — But the Northern Hospital could not take 16, and Warrnambool could not take four — or could they double what they could take to get midwives up to 120 rather than 60 per annum?

Ms FITZPATRICK — I think we would have to ask the hospitals. I am not sure of their capacity. I think what we are mostly concerned about is that we are about to lose the eight, so that would be a very backward step.

Ms BRITNELL — And the cost of doing midwifery, as you say, is around that $20 000. Do you think that is prohibitive for students? Have we seen a decrease since that was introduced — which is probably, what, 15 or 20 years ago when that was introduced — or have we seen no alteration to people taking on that challenge?

Ms FITZPATRICK — I am not across the growth. I could not tell you in relation to whether we are seeing more or less. I do know there are commonwealth-supported places, which is quite critical. That means that the fees then are around about the $12 000 mark, but I am not sure about how universities go about applying. It is really up to the university, as I understand it, and how they allocate their commonwealth-supported places, and we think that they are quite limited when it comes to midwifery, although that almost halves the cost of the course.

Ms BRITNELL — The other question: you mentioned that a person who goes just to midwifery and does not have their general behind them as well is harder to utilise in the rostering system. Is that because they cannot be shifted off to surgical to cover a shift in that ward or is it because they do not have the ability to operate across the whole spectrum on the mid floor?

Ms FITZPATRICK — In regional Victoria it is around the flexibility to work in other areas of the hospital other than in maternity, the birthing suite or postnatal. But we are not against bachelors of midwifery, let me assure you. We are just, I guess —

Ms BRITNELL — Most midwives cannot work anywhere else; most surgical nurses cannot work anywhere else either.

Ms FITZPATRICK — I think regional Victoria is a little bit different in some areas.
Ms BRITNELL — Try and move a midwife, and you will not be happy as a supervisor. That is probably enough, thank you.

Ms FITZPATRICK — We certainly can supply the figures in relation to the growth of midwifery workforce registered. We can go back and do that work. They are there with the AHPRA or any of those figures — they will be there.

The CHAIR — Thank you, Lisa, Maree and Julianne. I understand how busy you must be as Secretary in Victoria as well, and we very much appreciate your submission and your time at the hearing this morning. Thank you so much.

Ms FITZPATRICK — Thank you. We particularly want to thank the Committee. We think it is extraordinary and very important work, and we congratulate you for the interest and for the work that you will be doing as part of that inquiry.

Witnesses withdrew.