LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES

(Reference: Inquiry into maternity services in the ACT)

Members:

MS B CODY (Chair)
MRS V DUNNE (Deputy Chair)
MS C LE COUTEUR

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 6 AUGUST 2019

Secretary to the committee:
Mr A Snedden (Ph: 620 50199)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 1.03 pm.

TOOHEY, MS KAREN, Discrimination, Health Services, Disability and Community Services Commissioner, ACT Human Rights Commission

THE CHAIR: Good afternoon and welcome. I declare open the third public hearing of the Standing Committee on Health, Ageing and Community Services inquiry into maternity services in the ACT. Before we proceed, I would like to take a moment to acknowledge that we meet on the lands of the Ngunnawal people. I pay my respects to elders past, present and emerging, and the continuing contribution of their culture to this city and this region.

Today the committee will be hearing from two witnesses: one from the ACT Human Rights Commission and the other from ACT Health. On behalf of the committee, I would like to thank all witnesses for making the time to appear today. I remind witnesses that proceedings are being recorded by Hansard for transcription purposes, and will be webstreamed and broadcast live?

Ms Toohey, thank you for appearing today and for your written submission to the inquiry. I remind you of the protections and obligation afforded by parliamentary privilege and draw your attention to the pink privilege statement that is on the table. Could you please confirm for the record that you understand the implications of the statement?

Ms Toohey: I do.

THE CHAIR: Before we proceed to questions from the committee, I note that the committee has decided not to disclose the names of medical officers, including midwives and doctors. Witnesses need to refrain from identifying medical officers when giving evidence. Ms Toohey, would you like to make an opening statement?

Ms Toohey: I was not proposing to, if that is okay.

THE CHAIR: That is fabulous.

Ms Toohey: It is a very short submission.

MRS DUNNE: Thank you for coming today, Ms Toohey. In your submission you have talked about the sorts of complaints that you have dealt with in the maternity space. I go to the issue of staffing and beds, probably together, because they are the two resource issues that are highlighted in your submission. You say in your submission that women have advised that they do not feel appropriately supported in the postpartum period. Is it mainly in the postpartum period that this is an issue or is it generally across the board?

Ms Toohey: I flag that the way we highlighted the issues in the submission is that obviously they come out of complaints that we get. What we endeavoured to do was not report on anything that we had heard but only report on matters that we had received.

MRS DUNNE: Okay.

Ms Toohey: So that was the nature of the complaints we received. Certainly there were issues. I think it was on the public record that there were concerns raised about the utilisation of the beds in maternity services, particularly at the Canberra Hospital. The staffing issues in that space that were raised with us primarily related to postpartum particularly, I guess, because of that notion of people attending to the next person coming in.

We also had some issues that were raised with us, particularly in that phase, around communication and that notion that there were assumptions made about what people knew about the process, what would happen, and how long they would be there, those sorts of things. We have generally described that as not feeling supported in that period.

MRS DUNNE: Do you have a feeling for what sorts of categories these fall into? Are these people who are supported through their pregnancy by the midwifery service or people who see an obstetrician, or does it not matter; there is still a sort of lack of communication about what to expect afterwards?

Ms Toohey: I think we would say that based on the matters that we have received, sometimes it is the issue about an obstetrician providing the service up until that point. Certainly, in our experience sometimes people are better informed if they have a midwife attending to them throughout the process, because there is a number of pathways, as you are well aware, into maternity services. There are certainly gaps in people's understanding about what will happen, what their expectations are.

As you know, people will often plan for a perfect process. That does not always occur. So we certainly find in the matters that are brought to our attention that communication around those issues is not always that clear. We would certainly also say—I think I make this very clear in the submission—that the matters we deal with are the matters where people were unhappy with an element of the service delivery. But it is a small number of matters relative to the overall service being provided by maternity services in the ACT.

I again want to acknowledge, as we do in the submission, that the ACT is blessed with excellent staff, very professional staff, and that that is most people's experience. The matters that come to us are unfortunately the matters generally where something has not gone according to plan.

MRS DUNNE: You have said that you receive about 500 healthcare complaints. What proportion of that would be maternity services?

Ms Toohey: Unfortunately, we are not blessed with a very good database. What we have worked out is that in 2017-18 we got about 600 complaints. About 150 of those related to Canberra Health Services. We think about 20 of those related in some way to maternity services. So it is a small number—

THE CHAIR: So it is very small.

MRS DUNNE: A very small number.

Ms Toohey: Yes. Again, it is people, as you know, who either had a very difficult experience or for whom something has gone wrong and it is a reaction to what has occurred. So sometimes at the early end of things something has gone wrong and they have contact us very quickly, or it has been a very difficult experience. They have tried to resolve it. That has not worked. So they have come to us as an external body.

MS LE COUTEUR: I was most interested in what you were talking about regarding complaints handling. I thought it was great that you provided some possible solutions. First off you talked about where the complaint has a financial implication but it involves a small amount of money, and what we have at present does not actually work. You said that the ACT civil law wrongs legislation specifically acknowledges that claims can be conciliated under the HRCA. Can you talk more about that? I gather that that is not happening, having regard to how you have written this. How could it be improved?

Ms Toohey: One of the issues we encounter is that people will come to us because we are the health complaints entity. We provide a free and very accessible conciliation service. People come to us hoping to resolve their complaint, often having already used the internal mechanism available to them through the hospital or through the service.

One of the elements, often, in a complaint is a financial element. That can be for a whole range of reasons. It might be reimbursement of costs; it might be reimbursement for medical issues that have arisen as a result of an adverse outcome; it might be for pain and distress, those sorts of things. The legal services directions in the ACT provide very limited flexibility for ACT agencies to resolve matters with a financial component without the Government Solicitor signing off on that outcome. For matters that we describe as low-end matters, where there may be—

MS LE COUTEUR: What sort of money would low-end matters involve?

Ms Toohey: I am trying not to generalise but I will need to. For example, we have certainly had advice from medical insurers that for them to take a claim it has to be at the high end, very large amounts, to justify them taking it on to court. That would be half a million dollars and up.

MS LE COUTEUR: It is really a lot of money.

Ms Toohey: Yes, it is a lot of money.

MS LE COUTEUR: Less than half a million is not—

Ms Toohey: Yes, so what we—

MS LE COUTEUR: For most people that is—

Ms Toohey: Yes, so we might be looking—

THE CHAIR: It is a lot of money.

Ms Toohey: If I compare it to discrimination claims, for example, we might settle matters for pain and distress in the $5,000 to $10,000 range. We have very limited room to move at a conciliation level. That is what I mean about the low-end matters, because unless there is a legal liability, as I understand it, the agencies have very little flexibility to resolve those claims. We end up with a complainant who has potentially had a bad experience. It might not be because of negligence or anything like that. They have had a bad experience; they have included a financial component as part of the resolution that they are looking for and the agency is not able to provide that financial resolution because they certainly will not go against legal advice that they have received.

There is a range of matters where we would hope that there might be more flexibility from providers—in this case I am speaking specifically about CHS—in that space where someone has asked for a financial component, but they do not have that flexibility to settle those matters. They come to a conciliation and they have a very helpful discussion. I have to say that the people we deal with in conciliation processes are always very generous with their time and very helpful. But there is a level of frustration that the person has, in that they go away without what they see as a component of a resolution that is very important to them.

MS LE COUTEUR: If there is a financial component and the people dealing with it are not in a position to move on it, does that mean that other things which could potentially make the situation better are not done because the government will say, "No, we can't deal with this because of the money"?

Ms Toohey: It very much depends on the matter. There are some matters, obviously, where we will be able to resolve it, for other components of a resolution proposal. Certainly, there are matters where people go away very frustrated at what they think is a very reasonable solution and they are not able to achieve that. So they do not want to walk away with just part of an outcome.

I appreciate that the government has a very strong commitment to ensuring that it only spends money appropriately. Certainly, across my other areas of jurisdiction, we do see financial settlements. I will not say that they are as a matter of course, but they are certainly not irregular, if I can put it that way. In these sorts of matters, unfortunately, it can mean that either the person does not get an outcome or the message is to take it to court. And that is not a process that any of us want to put people through.

MS LE COUTEUR: No. I would assume that maternity services are not in any way unusual as far as health complaints—

Ms Toohey: No.

MS LE COUTEUR: As far as this part of it goes. It would not matter what your complaint was; it would involve the same issues?

Ms Toohey: Yes. Part of the reason for including it in the submission was because it

has been relevant to a number of matters arising out of maternity services. I think there is a broader issue that it would be helpful for the committee to consider.

THE CHAIR: I know you are talking right now about Canberra Health Services, but do you receive complaints about other maternity services in the ACT?

Ms Toohey: I can take complaints against any health service in the ACT: the health services, the hospitals and individual practitioners. They all fall within our remit.

THE CHAIR: Private?

MRS DUNNE: And the private hospitals.

Ms Toohey: And the private hospitals, yes. Obviously, the complaints are usually proportionate to numbers. The smaller the service, the less likely we are to get a complaint.

THE CHAIR: Granted. I was making sure that it was across the board.

Ms Toohey: That is why I need to be mindful that we are talking about service providers, not necessarily just Canberra Hospital.

THE CHAIR: As a general rule, are complaints about maternity services in the ACT of a smaller number than health complaints more generally?

Ms Toohey: Yes, they are a smaller component.

THE CHAIR: I know we have been talking about Canberra Health Services, but I wanted to get a holistic view.

Ms Toohey: Again we get about 600 health complaints a year. About 150 of those—rough numbers—relate to Canberra health services. That is across all of the Canberra health services—

THE CHAIR: I thought you were talking about Canberra Health Services as in the—

Ms Toohey: No.

THE CHAIR: directorate.

Ms Toohey: Canberra Health Services, yes, is 150 of the 600 that we get.

MRS DUNNE: Where do the others come from?

Ms Toohey: We get a lot about individual practitioners. Again we co-regulate in the ACT with APRA, so all of the matters to do with dentists, doctors and everybody else also come through us.

THE CHAIR: Going back to your submission, you also talk about the interpreters. There was some concern around interpreter services.

Ms Toohey: Yes.

THE CHAIR: Including Auslan interpreters?

Ms Toohey: Yes.

THE CHAIR: That was all related to maternity health services?

Ms Toohey: Yes.

THE CHAIR: Can you just expand on that.

Ms Toohey: We have had a number of matters where women have presented and family members have been used as an interpreter, which, as we both know, is not appropriate, irrespective of the circumstance. We are generally unclear as to what the obstacle is. Certainly the Health Directorate has done a lot of work in that space, encouraging people to use interpreters, but we still view that as an ongoing issue.

Particularly in circumstances where women are often feeling very vulnerable, it is an issue that continues to be of concern to us. It is one where we try and work with the community to ensure that women understand what their rights in that space are. We appreciate that sometimes it is time dependent, but, equally, often it is not. Sometimes there might be an emergency, but equally there are other mechanisms available to get interpreters involved in that space. Certainly the use of family members, children, is, as we see it, completely inappropriate. And they are the sorts of matters that we get.

THE CHAIR: These are people complaining that they have not been given interpreter services?

MRS DUNNE: Or inappropriate services?

Ms Toohey: Yes.

MRS DUNNE: In the context of maternity services, I suspect that there would be a class of people who would consider that if the interpreter who turned up was a man it may be challenging?

Ms Toohey: Yes.

MRS DUNNE: Are there particular languages which are more difficult to source interpreters for?

Ms Toohey: My experience in the ACT is that there are difficulties with some small language groups. You can use a phone interpreter. We get that that is not ideal, but, as you say, sometimes—yes.

MRS DUNNE: "Push", yes.

Ms Toohey: Facetime for Auslan has been one of the resolutions that has been

reached because of the lack of availability in the ACT. Also, because it is a small community, there are conflicts that occur with respect to who knows whom. We understand some of those difficulties.

Equally—there are a number of matters that spring to mind—we are aware that it has been a scheduled appointment and it has still not been arranged. You can make those arrangements. Whether there are assumptions about the importance of an interpreter providing accurate information or it is just the difficulty in organising it, we know that interpreters are actively used but the matters that have been brought to our attention lead to downstream problems. That is, again, the reason we put so much emphasis on the need for interpreters up front.

THE CHAIR: I am just thinking of the logistics. There would be many occasions where you would have to have an interpreter during the whole labour process?

Ms Toohey: Not necessarily. Often you are talking through what may happen as opposed to having to be in the room minute by minute: having someone available as opposed to being in a birthing suite continuously. But it is at least that awareness. We have particularly seen it in a couple of matters around emergencies where they are using family members to try to explain and clearly the information was not conveyed appropriately or the family member elected not to convey all the information because they did not want to frighten someone. But that means that then that person is not aware.

In our experience, the practitioners are used to working with interpreters in these spaces. As I said, in our experience, they do not need to be in the room consistently, but they need to be available.

THE CHAIR: It must be difficult, and I can only imagine it, for people where English is a second language when you are in a situation that you may not be fully in control of. It is difficult anyway. To have someone who may be not be able to explain it as fully and as comprehensively as possible must be awful.

MRS DUNNE: That also leads to my next substantive question, which is about consent.

Ms Toohey: Yes.

MRS DUNNE: I think that we have real issues with people who are not properly informed and therefore not properly giving consent. If someone's husband is doing the interpreting and goes, "I do not want to talk about that," and therefore does not tell his spouse that this or this may happen, but she has to consent, that is a substantial problem.

Ms Toohey: Consent is an issue. As we have seen on the public record, there have been some issues raised about consent in these processes.

MRS DUNNE: Which is where I was going.

Ms Toohey: In some of the matters we see, it is reflected as a communication issue.

Our view would be that if it is a communication issue then it is a consent issue. The two go together. We understand that Canberra Health Services are doing substantial work in that area and we are working with them in that space.

MRS DUNNE: On the subject of consent more generally, as you said there have been issues raised about consent in submissions to this inquiry. I have two questions. From the Human Rights Commission's point of view, do you want to give us a view about what informed consent looks like? Also, have you come across issues of incomplete consent or inappropriate consent in the maternity matters you have looked at?

Ms Toohey: I think certainly the professional codes identify that consent must be obtained ongoing for each procedure. I think that the code for midwives and clinical practitioners makes clear what informed consent looks like. It has been raised in a number of matters that we have dealt with. More recently, we were asked to go back and have a look at a number of matters that were, I guess, in the public domain. I think, as I just said, it is identified as a communication issue. Our view would be that if it is a communication issue, then it is a consent issue.

I do not think that in our experience we have seen any examples where procedures have been undertaken without consent. There may be; certainly the way some people have expressed it is that because of the pressure of the particular circumstance, they felt a level of lack of choice, if I can put it that way. Sometimes in the matters that we have seen it is that issue around it being an emergency situation or there is a critical issue emerging, particularly with a baby, and there is a push to get the consent to do particular things, sometimes without necessarily providing all the possible options in those circumstances.

As for the matters that were brought to our attention, we were contacted, for example, by a number of people after the last hearings were reported. Their matters had been investigated. They had had a sit-down meeting with the service provider. They were satisfied that the issue had been addressed but they wanted to bring it to our attention at, I guess, a more systemic level. They are discussions that we are having on an ongoing basis, particularly with Canberra Health Services, about that consent. What is the framework? What are the instructions? What is the messaging that is going to staff around those issues?

MRS DUNNE: The issue that we became aware of was, I think, dealt with quite effectively by the clinicians in that there was an email chain very quickly—

Ms Toohey: Yes.

MRS DUNNE: Within an hour or so, an appropriately senior decision-maker had actually sent out an email saying, "I just bring this to your attention. These are the things that you need to do."

Ms Toohey: Yes.

MRS DUNNE: I think that that was quite an appropriate response to what was a difficult circumstance to actually identify who the complainant was. But I suppose that one of the issues is that if you have continuity of care, then you should be able to

sort of have a discussion beforehand. In the best of all possible worlds, births are on 85 per cent of occasions routine things—

Ms Toohey: Go to plan.

MRS DUNNE: They go to plan. But there is always the 20 per cent of stuff that does not go to plan. So how much do you say to someone about the things that can go wrong so that if something does go wrong, you have a proper system of continuity of care? You can say, "This is the thing that we were talking about. This is where you need to make this decision or this decision or this decision." It is easier to have that conversation under tension if you have already flagged it previously.

Ms Toohey: Yes.

MRS DUNNE: But that requires a high level of contact and trust between the patient and the care provider over a long period of time to sort of obviate that sort of high tension where, "Gosh, I was not given all the information," because you probably would have been given it weeks before.

Ms Toohey: Yes, some time before.

MRS DUNNE: When you are dealing with these issues, what sort of advice are you giving about how to minimise these circumstances where someone might say, "I do not think I was given all the information," or "In different circumstances, I may not have gone down that path. Perhaps I was not fully informed."

Ms Toohey: I think, as you say, the continuity of care model is really important. I think also—it is one of the things we have seen in a number of services—that because there have been both changes in senior staff but also a churn of staff, there are different understandings of what informed consent looks like and how that should be developed over the course of care.

We have not finalised the matter yet, but we will be making some recommendations around how to ensure that that is sustainable, that base level understanding of what informed consent looks like. Again, I think, reflecting on the professional codes particularly for nurses and midwives, it is very clear in there what informed consent looks like. We are very confident that the staff are aware of that and that they act in accordance with their professional codes.

I think there is some new focus on what maternity services in the ACT look like. The information provision process seems to be more robust now than perhaps it was when I came to the ACT a couple of years ago. We are very aware that CHS is doing a lot of work in that space at the moment.

MRS DUNNE: But you said that in a sense it sort of depended on the senior staff to some extent, that there were different interpretations of what informed consent meant?

Ms Toohey: Yes, as you would be aware, as staff changes there are assumptions made about who knows what, and who knows what the policies are and what the processes are. I think, particularly when you have people who may have been seeing a

private obstetrician coming into the public system, people's expectations are quite different around what the service delivery will look like. As I understand it from what we have seen of the information provision around maternity services, some of those issues are being directly addressed now through the new model of care.

THE CHAIR: I note the time. However, I have a quick question for you, Ms Toohey. In your submission, you talk about Calvary Public Hospital and the concerns being raised about the limitations on information provided to women about contraception, abortion and other related services. In 30 seconds—

MRS DUNNE: Twenty-five words or less.

THE CHAIR: Yes, can you wrap that in a nice bow for me?

Ms Toohey: Certainly, people have raised with us concerns about going to Calvary because of the particular model of care, that there are limitations on information that is being provided. People are not always aware of that. It is a discussion that we have had with Calvary about publicly available information on their website or other sources that make it clear to people trying to access those services what the limitations are.

It is certainly not always clear to us, and we have had people raise it with us. Again, the reason it is in the submission is just to draw it to the committee's attention. Particularly given the public-private model, it would be helpful, certainly from the people who come to our service, if there were some very clear information about what those limitations are so that people do not find themselves having to either change service—

THE CHAIR: Again, it is about informed choice.

Ms Toohey: Yes.

THE CHAIR: Thank you very much for appearing today, Ms Toohey. I think we have probably got hundreds more questions. When available, a proof transcript will be forwarded to you to provide an opportunity to check the transcript and suggest any corrections. I do not remember your taking any questions on notice.

MRS DUNNE: No.

THE CHAIR: On behalf of the committee, I thank you for appearing today.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children, Youth and Families, Minister for Disability, Minister for Employment and Workplace Safety, Minister for Health, Minister for Urban Renewal

McDONALD, MS BERNADETTE, Chief Executive Officer, Canberra Health Services

BRACHER, MS KATRINA, Executive Director, Women, Youth and Children, Canberra Health Services

LIM, ASSOCIATE PROFESSOR BOON, Clinical Director, Obstetrics and Gynaecology, Canberra Health Services

PEFFER, MR DAVE, Deputy Director-General, Health Systems, Policy and Research Group, Health Directorate

THE CHAIR: We will now move to our next witnesses appearing today, from ACT Health and Canberra Health Services. I particularly welcome the Minister for Health, Minister Stephen-Smith, and officials. Thank you for appearing today, and for your written submission to the inquiry. I remind you of the protections and obligations afforded by parliamentary privilege, and draw your attention to the pink-coloured privilege statement that is on the table. Could you confirm for the record that you understand the implications of the statement?

Ms Stephen-Smith: I have read the privilege statement and I understand it.

Ms McDonald: I have the read the privilege statement, and agree.

Mr Peffer: I have read the privilege statement.

THE CHAIR: Before we proceed to questions, I would like to note that the committee has decided not to disclose the names of medical officers, including midwives and doctors. Witnesses need to refrain from identifying medical officers whilst giving evidence. Minister, do you have a brief opening statement?

Ms Stephen-Smith: I do. Before we start taking questions, I would like to make a short opening statement. On behalf of the government, I would like to take this opportunity to acknowledge and thank all those who have come forward to provide submissions and to share their personal experiences as part of this inquiry.

I want also to acknowledge the dedicated and hardworking health professionals who work in maternity services across the ACT, and who care for women and families during one of the most significant times of their lives. Every day, our hospitals and clinical staff strive to provide the best possible birthing services and to do this in a compassionate and supportive way.

While the feedback in relation to patients' experience of treatment in the ACT's public maternity system is overwhelmingly positive, what we have heard through this inquiry is that this is not everyone's experience. We acknowledge that there is further work to do to ensure consistent access to the best care and support for women and families.

I want to put on record that the government welcomes this inquiry and the

conversation that is happening in the community about potential improvements to our maternity services for families in the Canberra region. As minister, I also want Canberra women to know that I hear them and that we are working hard to make it easier for families to access information and services during pregnancy, birthing and the important first months after their baby is born. This includes initiatives like the ACT's new maternity access strategy, which has provided more than $2 million in funding in the 2019-20 budget; the $2.9 million expansion of services for childhood and gestational diabetes, also funded in this year's budget; the $49 million expansion of the Centenary Hospital for Women and Children that is underway; development of additional models of care like the current homebirth trial; the $2.6 million upgrade of the maternity ward at Calvary Public Hospital, Bruce, completed last year; and development of the new children's health services plan.

I am grateful to all the women who have taken the time to share their experiences. The ACT government has participated and will continue to actively participate in this inquiry. We look forward to seeing the recommendations and the continuing work that will follow to improve our maternity services.

On that note, Madam Chair, I will hand over to Dave Peffer, Deputy Director-General of Health Systems, Policy and Research at the Health Directorate, to provide more detailed advice on work taking place across the territory to improve maternity services in the ACT; then we will be very happy to take questions.

Mr Peffer: Thank you, Madam Chair, and thank you, minister. For many years women in the ACT have been choosing the public maternity system for the birth of their children. Over the past five years more than 30,000 births have taken place here in Canberra, adding to our local population and that of the surrounding region, and more than 20,000 of those have occurred in the public system.

Demand on the public system has steadily increased since the completion of the Centenary hospital at a rate of 4.5 per cent annually. Feedback on our public system is overwhelmingly positive. However, as the minister said, there is always room for improvement.

As has been mentioned there is a lot of work taking place across the system to improve public maternity services in the ACT. The ACT's new maternity access strategy has been under development over the past 18 months and has involved extensive consultation with health sector stakeholders, consumers and the broader Canberra community. It will see the establishment of a single territory-wide intake phone line for maternity services across the Centenary hospital and Calvary Public Hospital, as well as a community-based early pregnancy and parenting service.

These services will support access to models of maternity care which match each woman's individual needs and promote service choices closer to home where this is safe and suitable for new mothers. The services will see families connected to midwives earlier in their pregnancy, providing them with information and guidance from a midwife sooner. We expect that the new intake line will commence later this year.

In addition to the maternity access strategy, another important piece of work taking

place over the next 12 months is the development of a new child and adolescent health plan. One of the focuses of this plan will be developing nation-leading services and supports for new parents. This will include consideration of both universally accessible services in areas such as breastfeeding support, perinatal mental health and early parenting support, and services targeted at families with more complex needs. As part of this we will work across the health system, including with Tresillian, the new provider of services at QEII, to examine the services available.

Throughout that process we will also be working with families of children who are being, or have needed to be, cared for by other major city hospitals. This work will allow us to learn from parents' own experiences, including how they can be better supported. There will be a focus on how we grow specialist paediatric services and how we better support families to improve care coordination and access to the health services they need in Canberra when they are also receiving specialist support from interstate.

The ACT government also supports work being undertaken at a national level to improve maternity services, including the proposed development of a national stillbirth action and implementation plan, in response to the recent Senate Select Committee on Stillbirth Research and Education report. We also support the recently released Australian national breastfeeding strategy 2019 and beyond, released last weekend, the national strategic approach to maternity services, and work underway on professional indemnity insurance for privately practising midwives. The ACT government is committed to reviewing the recommendations made in these strategies to further improve our own public maternity system.

THE CHAIR: Thank you. I have a couple of quick questions before we move to the rest of the committee. Mr Peffer, your submission talks about the maternity assessment unit and the early pregnancy assessment unit. These are two areas that could address some of the concerns that have been raised by witnesses so far. I was wondering if you could expand on those and also tell me if that does incorporate the maternity access strategy and how those two are working.

Ms McDonald: Ms Cody, I might take that question if that is okay.

THE CHAIR: Yes.

Ms McDonald: We are happy to expand on the maternity access strategy and the different components of that. I might call on Katrina Bracher, who is our executive director for women, youth and children. She can give us more detailed insights into the question that you have asked.

Ms Bracher: There are a couple of parts to your question.

THE CHAIR: There are; sorry.

Ms Bracher: One is about the maternity assessment unit? Is that correct?

THE CHAIR: Yes.

Ms Bracher: The maternity assessment unit is an area in the Centenary Hospital for Women and Children that currently exists. They have about four or five spaces where women who are booked to have their babies at the hospital can come for an assessment antenatally if they are worried. That is a service that is significantly under pressure. In the expansion of the centenary hospital we are expanding that facility and that model of care to being more hours per day. We are going to a 24/7 service so that women can access through there, and we are bringing the gestational age at which women can access that service to earlier in their pregnancy as well.

THE CHAIR: What is the current gestational age?

Ms Bracher: If the woman is high risk and is part of our service, they can come at whatever age, but there is a bit of a triaging that goes through in terms of demand. If a woman has not yet reached 20 weeks, currently they might be encouraged to go to the emergency department. We want to acknowledge that that is not our preference, and we are certainly working towards having those women who are booked into our service coming directly, for a maternity assessment, into the maternity assessment unit.

That area will change its location in the expansion of the centenary hospital, too, to be right next to the birthing suite so that we can bring women into the maternity assessment unit antenatally; start inductions in that space if that is clinically appropriate for the woman; and then move the woman into the birthing suite just for the birth of the baby.

What was part 2?

THE CHAIR: The early pregnancy assessment unit. I think it links in with what you were just talking about.

Ms Bracher: It certainly does. We have our outpatient clinics that do early pregnancy assessment, right through from normal pregnancies to very high risk pregnancies. We often have significant intervention for those women. That is part of the expansion. It is bringing that model of care together for women so that they can come in at whatever point in their pregnancy. If they are booked to have the baby and we are aware of them, they can come in at whatever point; have their pregnancy and maternity assessments done in that space; and then move into the birth suite if that is what they need to do.

THE CHAIR: We have had some evidence raised with us—and you, yourself, have just stated it—that if you have issues with a pregnancy prior to 20 weeks gestation, you are generally sent through to the emergency department. We have heard evidence of women having to deliver their stillborn babies in emergency.

Ms Bracher: It is less than ideal.

THE CHAIR: Some of the evidence we have heard is that an antenatal or a postnatal suite may also not be the right place because there are all these happy babies being born. Is that something that Canberra Health Services is looking at as part of this early pregnancy assessment and the maternity access strategy?

Ms Bracher: The maternity access strategy is separate. That is an access and a referral type place. I can talk to that.

THE CHAIR: Yes.

Ms Bracher: For a woman who is worried or is in fact miscarrying it is a real challenge to find the right place for the woman. We agree, and we believe that the emergency department is less than ideal for that. Emergency department staff are uncomfortable about that as well. We feel that sometimes bringing a woman into a birth suite where other babies are being born at that point in time might also be not right for that particular woman.

THE CHAIR: Yes.

Ms Bracher: We acknowledge and understand that sometimes an outpatient clinic space also might not be the right place for her. We want to move towards a model where we can manage those women in our maternity service, not in the emergency department, unless there is another physical health issue. We want to have those women managed compassionately in our maternity service and try to be flexible about what that particular woman and her family need at that point in time.

MRS DUNNE: I get a lot of feedback from people who have had miscarriages and then are going back for assessments. They say how inappropriate and confronting it is to be in an outpatient clinic with all these obviously pregnant women when they are in the process of very recently dealing with a miscarriage. I understand that it is difficult, but it is a very common item of feedback that I receive that these things need to be dealt with more sensitively.

That leads me to my question. What is the timetable for the expansion of the Centenary hospital?

Ms Bracher: The expansion will happen over three phases. Because it is a currently operating hospital, we cannot just close it and do it. It is not a greenfield hospital where we can build it over there and then move in. It will happen in three stages. The expansion will be completed in 2022. The tender evaluation process is underway, and the process of appointing a consultant to do the design with us is being finalised.

MRS DUNNE: So there is not a design yet?

Ms Bracher: There are concepts; there is a concept design. There are plans for the location of, for example, the new maternity assessment unit and the other components of the expansion. As for the detailed design, where the clinicians actually get involved and say they need a therapy bed that is such and such a height and they need handwashing facilities in this space and that space, that sort of detailed design is what we do with health service architects who are really competent and able to help us with the design and the flow to meet the model of care. We do that in a staged process after an appropriation to construct. We do not do that beforehand because it is part of a costly exercise.

MRS DUNNE: When was this appropriated?

Ms Bracher: The budget was appropriated in 2019-20.

MRS DUNNE: The full $49 million was appropriated in 2019-20. It was budgeted for in 2017-18. The appropriation has gone up and down, and we understand the reasons for that. But the final appropriation was this year; is that right?

Ms Bracher: That is my understanding.

Ms Stephen-Smith: The 2018-19 budget.

MRS DUNNE: 2018-19, not 2019-20?

Ms McDonald: 2019-20, I think.

Ms Bracher: The business case for the capital went into the 2019-20 budget. There were smaller amounts in previous budget years that related to concept design and testing what the demand needs actually were, to inform the business case.

MRS DUNNE: This was an election promise for completion in 2019-20? It was supposed to be completed in this term?

Ms McDonald: I am not sure. I would have to check that, in terms of data—

Ms Stephen-Smith: I would have to go back to the statements that were made during that time.

Ms McDonald: Mrs Dunne, can I add one thing? The question was about what is going to happen and the completion. The point of doing the expansion, changing the maternity assessment unit and redesigning is about changing models of care to improve the services for our women as they come in.

There are things we are doing in the meantime to look at where the most appropriate place is, if you are miscarrying, and it is such a traumatic time. Can we not wait for when we have done all of the actual capital works? Are there things we can do right now to change the experience for those women who are having that experience? You mentioned the experience of women who are coming back for outpatient appointments and specialist appointments post a miscarriage. What else can we do from that perspective?

There are a lot of things that we can do in the meantime until the capital works are actually completed. That is something that we are actively looking at as well.

MRS DUNNE: Thank you, Ms McDonald. Could I go back to what Ms Bracher said about the maternity assessment unit, that it does not operate 24/7?

Ms Bracher: Currently, no.

MRS DUNNE: What are its hours of operation?

Ms Bracher: We have a morning and an evening shift, until about 9 o'clock at night.

MRS DUNNE: What happens after 9 o'clock at night, if somebody is there?

Ms Bracher: If they are already in the unit and they still need care, they would be transferred into our birthing suite or to the antenatal ward. If they present at 2 o'clock in the morning, currently, the advice to those women is that they present to the emergency department. Our registrar goes to the emergency department to see them there.

THE CHAIR: And assess them?

Ms Bracher: Yes.

MRS DUNNE: At what time does the maternity assessment unit open in the morning?

Ms Bracher: Seven, 7.30.

MRS DUNNE: But it does operate seven days a week on that time frame?

Ms Bracher: Yes.

MS LE COUTEUR: I am wondering where the homebirth trial fits in to all of this. On page 6 of your submission, "private homebirth" is shown at the top of one column. Is that the homebirth trial? I did not think it was private. If not, where is it?

Ms McDonald: Ms Bracher can give you an update on that.

Ms Bracher: Private homebirths currently happen in the ACT with a private midwife. That is outside what we do in the public health system.

MS LE COUTEUR: That is what I thought.

MRS DUNNE: That is 2017.

MS LE COUTEUR: It is 2017.

MRS DUNNE: Yes, that is right. The pilot started—

MS LE COUTEUR: I thought it had started by 2017. Where, if at all, do homebirths fit in to your models?

Ms Bracher: We currently have a homebirth trial underway. It started in about 2017. It is a trial that is currently underway. It is anticipated to have somewhere between 30 and 40 women who birth at home before we do a full external and independent evaluation of that trial. That is likely to happen towards the end of this year. Baby No 30 was born late last week. We are very pleased and proud, as I am sure their families are.

That homebirth trial started in a very limited way as a new initiative within the ACT. My understanding is that it deliberately had very tight boundaries around it, based on what the territory's insurer would insure ACT Health at the time, and now Canberra Health Services, to deliver. That includes geographical boundaries. That is about being a safe distance from a tertiary hospital should the woman or the baby get into trouble and require assistance.

It also has some parameters around the clinical picture of the particular woman; quite limited or quite tight, if you like. There has been some concern; and some of the submissions, in fact, have asked whether they could be expanded, based on what happens in other jurisdictions. We are silent on our view on that. We have to be, because the insurer has insisted that this is the way that our homebirth trial will be rolled out. Once there is an independent external evaluation that is provided to the minister and to the insurer, decisions about expanding the homebirth trial can be taken at that point. We are not in a place to make that decision at this point.

MS LE COUTEUR: The insurer, in fact, is the decision-maker on this, not ACT Health? I am trying to simplify what I think you have said.

Ms Bracher: The insurer will provide government with advice as to whether they are prepared to insure Canberra Health Services to do a homebirth trial. The government will then need to make a decision about whether that insurance, or lack thereof, is a community risk that the government chooses to take.

MS LE COUTEUR: Surely, the government can self-insure. The ACT government is a reasonably large—

MRS DUNNE: It does self-insure.

THE CHAIR: It does self-insure.

MS LE COUTEUR: If these people are correct and we self-insure, whom are you getting the advice from?

Mr Peffer: I can probably illuminate the situation a little more, Ms Le Couteur. This is a nationwide issue that COAG Health Council has been looking at for some time. In the territory there is the trial that is underway; that will be reviewed and evaluated shortly. There are also a number of privately practising midwives offering a similar service.

Health ministers since 2010 have been grappling with the issue of how to insure a homebirthing service, whether that is provided through a public health system or whether that is provided privately. To date there has been an exemption offered for insurance for privately practising midwives. I understand that in the territory at this point we have two that are operating.

At this point health ministers are considering four options for how to progress this issue, recognising that across the nation around 1,000 homebirths occur each year. The four options currently being considered are to allow the current exemption to expire, which, in reality, may close down the private delivery of home birthing

services; to permanently embed that exemption for privately practising midwives under the national law, so that they can continue on; to allow the exemption to expire and for public health systems to then deliver the services on an ongoing basis, which is the trial that is currently underway here in the territory, and there are other jurisdictions doing similar things; and to remove the exemption and have governments across the nation effectively underwrite or provide the insurance.

Even if governments were to undertake the activity without their own insurance, we always have a mechanism for reinsurance at an aggregate level. Treasury, through ACTIA, will then source reinsurance for its full range of risks, whether that be home-based births or any other activity that the territory currently undertakes. Treasury will go through a process to attempt to offset that risk through a reinsurance process.

MS LE COUTEUR: I am still confused about what part of the government is basically the decision-maker. Is it going to be for the health ministers Australia-wide? Are we going to sign up to what everyone else says? Is it ACTIA that is going to make the decision on an insurance basis?

Ms Stephen-Smith: ACTIA would not be making a decision. The ACT government would be making a decision about what services are provided in the ACT. But that decision would be informed by the insurance position that is available to us. As Mr Peffer said, in terms of the way ACTIA manages that insurance, yes, we self-insure to an extent. But we do reinsure for medical indemnity. So we would need to make a decision about the services we provide on the basis of both what is best for a clinical service provision for Canberra women and an understanding of what our insurance position would be in terms of being able to get that reinsurance.

MS LE COUTEUR: So it would be Health, not ACTIA, making the decision?

Ms Stephen-Smith: Yes, it would be the government making the decision about what risk we—

MS LE COUTEUR: Yes, but what part? Obviously, different parts of—

MRS DUNNE: Presumably the cabinet would make that decision.

MS LE COUTEUR: the government have different priorities. I assume that Health—

Ms Stephen-Smith: Sorry, Mrs Dunne?

MRS DUNNE: I presume that the cabinet would make that sort of decision?

Ms Stephen-Smith: I would expect that, yes.

MRS DUNNE: Yes. I seek some clarification. In the submission, which was admittedly published in May, it is stated in the second paragraph:

> The ACT government continues to make maternity services in the ACT a priority. Over the next three years the ACT government has committed

> $65.5 million to the expansion of the Centenary Hospital for Women and Children to provide additional capacity and support for maternity and paediatric services.

Can you clarify that number? My understanding is that that is not the appropriated number, nor is it the number that I got in an answer to a question on notice recently, which is different from the appropriated number.

Ms McDonald: Sorry, I missed the first part of your question.

MRS DUNNE: $65.5 million is the amount in the submission for the expansion of the hospital for women and children. Some of that was taken out because the neonatal intensive care unit is not—

Ms McDonald: The paediatric intensive care unit.

MRS DUNNE: Sorry, paediatric intensive care is going somewhere else. I understand that. So 65 is not the number now. Also, I got an answer to a question on notice recently. I stand to be corrected, but I think it was $51 million. On notice, can we clarify how much money and can we clarify the timetable?

Ms Stephen-Smith: Yes.

Ms McDonald: We can take that on notice, yes.

THE CHAIR: I want to have a quick chat about the refurbishment of the Calvary Public Hospital maternity services. The submission was received a little while ago. Can you give me an updated version of what is happening there?

Mr Peffer: So what we have seen through the refurbishment is a considerable increase in the standard of amenity. I am aware that Calvary had received some feedback through patients experiencing the wards there about the level of amenity and the standard that was provided for. Through the refurbishment, that standard has been considerably increased.

I think that Calvary has heard from mothers going through about that better experience. An amount of $2.6 million has been spent to refurbish that ward. It has provided increased access the single bed rooms, which was a particular piece of feedback that was received from mothers going through Calvary. It also provides facilities for partners to stay overnight, a new family lounge room and also much more contemporary birth suite rooms as part of the refurbishment.

MRS DUNNE: Were the birth suites remodelled as well?

Mr Peffer: That was part of it, yes.

THE CHAIR: Are they similar to those at the Centenary Hospital for Women and Children?

Mr Peffer: My understanding is that the design of those would have been the

contemporary practice at the time.

THE CHAIR: We heard evidence a few months ago about some concerns that had been raised with the Human Rights Commission in relation to health complaints and the limitations of information provided to women about contraception, abortion and other related services at the Calvary Public Hospital. There was a view to maybe making the informed choice more available. Have those concerns been raised with you, minister, or with Canberra Health Services?

Ms Stephen-Smith: Yes.

THE CHAIR: Sorry, I am not sure whom to direct that to.

Ms Stephen-Smith: Yes, I have actually just received a letter in relation to one of those matters, particularly around the availability of contraception and contraceptive advice postpartum. I understand that that is an issue that Minister Fitzharris had previously discussed with Calvary. I am getting some more advice in relation to that.

Of course, Calvary operates under the code of practice—I do not have the full name of it in front of me—in relation the way Catholic hospitals and health services operate across the country. I think it would be fairly common understanding that Calvary does not provide abortion services and that there are limits to some of the services that they would provide. My understanding is that that is made very clear to women in that context. I do not know if Mr Peffer has more to add.

Mr Peffer: The name of the code is the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia. It governs the operations at Calvary. Calvary does refer people back to their GP if they are seeking further information as required on family planning needs.

THE CHAIR: Is it usually just back to their GP?

MRS DUNNE: That is pretty standard practice and has been since Calvary was Calvary.

THE CHAIR: I am sure that sometimes a family GP may not be the most appropriate source for a woman to seek contraceptive advice from.

Ms Stephen-Smith: I think the issue that I am going to seek some further clarity on is in relation to advice as opposed to service provision. Obviously, we are not expecting Calvary to provide contraceptives but potentially what is that in relation to advice?

MRS DUNNE: I want to go back to the expansion. What is the thinking about the amount of staff that will be needed to fully staff the expanded maternity services in the 2023 hospital?

Ms McDonald: I might start off talking about that. We are currently reviewing our staffing numbers. We have just approved increases in our maternity staffing in our birth suite, adding an extra team leader on every shift, as well as increasing our maternity staffing for our postnatal wards. We have looked at our staffing levels and

listened to our staff, and we just recently increased those staffing levels.

MRS DUNNE: Could you provide information to the committee, on notice, about what it was and what it is becoming?

Ms McDonald: Absolutely; we will do that. We are also looking at our registrar staffing levels. This is all in light of the increased demand that we have had for our services and wanting to provide a comprehensive, responsive service. We have looked at that. I am happy to provide that information on notice.

In terms of any expansion that we do throughout the organisation as part of the expansion process and the planning process, it is about looking at what our numbers go up to, what is the change to our bed numbers, and then what is the required staffing that goes with that. That is in the planning phase at the moment. We will actively plan that so we can recruit and then revise our recruitment strategy for our midwifery staff in particular. I will ask if Katrina would like to add anything to that.

Ms Bracher: We are in the process of developing a workforce strategy for our whole service, midwifery included. We are mindful of the growth that is going to be required over the next three years. Some of the growth is in midwifery; some of it is in neonatal nursing, for example—it is a highly specialised area—and some of it is in medicine.

Our director of nursing midwifery is currently working very closely with the tertiary institutions here not only to look at the undergraduate programs or the graduate entry programs but also to encourage re-entry programs for midwives who might have left the workforce and want to come back. There are some programs for staff who are working in nursing who might want to specialise in or cross-train into midwifery; we are looking at specific programs around that. We are also looking at a number of retention strategies in that space, acknowledging that highly skilled, experienced midwives are valuable and scarce. They are a scarce commodity.

And we want to try to make it possible for experienced midwives to stay in the workforce in a more flexible way rather than feeling the need to resign or retire when they get to that point. They have a wealth of information to share with our new graduate midwives, from a mentoring, coaching and experience perspective, and also for the women who are benefiting from the care at that point in time. So we are working on that, both for our current workforce but also for the growth that we know that we will need into the next few years.

MRS DUNNE: Ms McDonald, I am not sure that I understood your answer. You said that you have decided to up the number. Are those staff on the ground or is that in a recruitment phase?

Ms McDonald: We have been actively recruiting. I think we have recruited something like 15.4 FTEs in the past 12 months or so.

Ms Bracher: Fifteen, yes.

Ms McDonald: We continually to actively recruit. Those numbers we will hope to

staff as soon as possible. But it is the balance. If we do not have the FTEs and the base on the ground, you do not want people working overtime and those sorts of things in order to staff up. We will do a gradual increase, but we are quite confident that it will make a big difference to the workload levels and make it a better place to work, and that will be more attractive for people, along with all the recruitment strategies that we have to get people and to get those numbers in place as soon as possible.

MS LE COUTEUR: I want to go to the bottom of page 8, your section about consumer feedback and the complaints process. Obviously the vast majority of individual submissions we have are from people who would be complainants, I would imagine, at some point. We hear a lot more than you do. But I was surprised at how little attention you have given to this. It says:

> Where a complaint is received, both maternity units provide women and their families the opportunity to meet with senior staff to discuss their concerns.

Is that all you do: discuss concerns? And is this usually all that is required?

Ms McDonald: No. Just to clarify, you are referring to when—

MS LE COUTEUR: I am referring to your submission, page 8, at the bottom.

Ms McDonald: When we receive a complaint, whether it is in maternity or anywhere in the organisation at Canberra Health Services, it comes into our feedback team. That feedback team will make contact with the person as quickly as possible, usually within three days, to acknowledge the receipt of the complaint and have an early discussion about what people would like to happen. It is then referred to whichever area. In maternity services, it goes through to our maternity services to review. Then, depending on the nature of the complaint—what is involved in the complaint—often there is a clinical component to it where we need to understand what actually happens. Different people, different clinicians, may be questioned about what happened and their recollection. The medical history will be looked at from what has been documented and recorded. We also then will talk to the individual about their experience.

There is quite a lengthy and extensive process that goes on with any complaint investigation. And absolutely, primarily, for maternity services it is involving the woman and whoever else they would like involved in those discussions. We always make it possible for people to come in and have a discussion. Boon Lim, our director of obstetrics, is involved in those discussions more often than not. Senior clinicians, midwives or obstetricians are always involved in those discussions with families and the woman involved.

It might look like just a simple sentence, but in actual fact it is an extensive process to follow up. With most complaints it is quite dependent on what the nature of the complaint is. If it is something that we can resolve quite quickly and simply, we will seek to do that. If it involves multiple conversations, we will take multiple conversations to resolve that with the woman and the family from a maternity perspective.

Sometimes we cannot. Sometimes people are not happy with what the outcome is. From our perspective—I think you had Ms Toohey here just recently—sometimes we will get the health commissioner involved so that they can work with us, and the family and the individual, to resolve the issue that the complaint was about.

MS LE COUTEUR: One of the things that Ms Toohey touched on was that if there is money involved, the ACT government had to get the Government Solicitor's advice before it could go anywhere, regardless of how significant the amount of money might be. This seemed to be an obstacle in some of the smaller cases. If you have a large maternity case, obviously that makes sense, but have you thought of any ways of being more flexible down the bottom end of the scale?

Ms McDonald: We are bound by the Government Solicitor's advice, basically. You would have to ask the government solicitors if they could think of more flexible ways to respond to these issues. As part of the ACT government, and as a directorate, we are bound by the advice that we receive from GSO.

Ms Stephen-Smith: Just to add to that, Ms Le Couteur, that is in the context of the Financial Management Act, which public servants are bound by. In terms of the expenditure of any public money on anything that might be related to compensation or that type of expenditure, they would be bound to receive legal advice in relation to that in order to be able to determine whether they are spending taxpayers' money in accordance with the Financial Management Act.

I did see some of Ms Toohey's evidence, and I do understand that that can be very difficult, but it is also part of fiduciary responsibility under the Financial Management Act.

MS LE COUTEUR: Yes, it is expenditure of money, but the people who are asking for money possibly may have other issues at the same time. If you have a situation where the Government Solicitor says, "No, we do not think you are liable. You should not pay," for whatever reason, would that mean that if the person was complaining about other things you would have to say no to the lot because you cannot say yes to the dollars.

Ms McDonald: No, absolutely not. We absolutely work through that process that I just described with the individuals involved. Often it does end up in conciliation. I have staff members who will go along to conciliation with the health commissioner's staff. We try to resolve as many of the issues as we possibly can. But sometimes you do get to the point where the individual would like a payment and that is what they are seeking; everything has been resolved but there is that last issue left. We absolutely try to resolve as many issues as possible, but sometimes it does end up with that as the final outcome.

MS LE COUTEUR: Do you get more complaints comparatively from maternity services compared to the rest of the hospital?

Ms McDonald: I would have to go back to my numbers and get that broken down. I can take that on notice if you like the in terms of percentage.

MS LE COUTEUR: Okay.

Ms McDonald: It does not stand out to me.

MS LE COUTEUR: Okay. It is not something where you think, "It is a complaint and therefore it must be maternity"?

Ms McDonald: No.

THE CHAIR: The committee is looking into maternity services across the ACT, but is there a national approach to maternity services that the ACT is part of or follows?

Ms McDonald: Not a national approach as such. I am not sure what you mean by a national approach, but I can give you some information on what we do participate in nationally. Dave can do that, too. From our perspective, from a benchmarking perspective we do participate in maternity, in women's health, WHA. It is a benchmarking group with our peer hospitals around Australia, our level 6 hospitals. That is a fantastic national thing for us to participate in because it does allow us to benchmark against our peers and see how we are performing from a quality and safety perspective. That is one national approach that we are involved in. Dave might want to add something from a broader perspective.

Mr Peffer: Yes. That is what is happening within LHDs. Departments of health around the country are also collaborating to develop a women-centred care strategy for maternity services. The strategy will be put through the COAG Health Council—health ministers—within the next 12 months. A draft is currently being prepared. It looks at some principles and values to underpin the care, and at a range of initiatives that could be rolled out in a flexible way within each jurisdiction, to be reflected in their own maternity access strategies and service planning.

In terms of the principles that health departments around the country are looking at, there are four main principles. The first is the right to be treated with dignity and respect, and to privacy and confidentiality. The second is the right to equitable health care and the highest attainable level of health. The third is the right to informed consent and refusal, and respect for choices and preferences. This is really about ensuring that there is a level of control in decision-making. There is also the right to equity and to be free from discrimination, harm and coercion. Underpinning that are the values upon which services should be designed—safety, respect, access and choice.

As part of that strategy, there are four main areas of work that health departments have committed to. The first is ensuring that design is based on an evidence-based approach. That is already being taken up through the maternity access strategy and other initiatives that are underway in the territory. The second is individualised care: recognising that everyone coming through the system has their own circumstances and preferences, and ensuring that the care is culturally appropriate. The third is having a workforce that is skilled and aware of the latest evidence and able to apply that in practice. The fourth is care that is holistic, not looking just at physical health but at physical, emotional, psychosocial, spiritual and cultural.

That work is being progressed. At the moment it is still a draft, but there is an expectation that it will be put to health ministers for adoption within the next 12 months.

THE CHAIR: Does that interact with the announcement this week, I think, by the Prime Minister about the national breastfeeding strategy? Did he call it something like that?

MRS DUNNE: There was one announced on the weekend.

THE CHAIR: On the weekend, was it? Sorry; my days blur.

Mr Peffer: It was over the weekend.

Ms Stephen-Smith: Yes, there is a separate national breastfeeding strategy.

THE CHAIR: That is separate from this strategy?

Mr Peffer: That is right. A national breastfeeding strategy was released over the weekend. That strategy was developed collaboratively between the states and territories and it had been endorsed by the COAG Health Council.

In terms of the objective of that strategy, it is to drive an increase in breastfeeding. I think the target is up to 50 per cent by 2025 of babies breastfed exclusively to around six months of age; 40 per cent by 2022, which is quite an improvement. It has a number of objectives to position mothers to understand the importance of breastfeeding and the evidence behind that and, more broadly, to educate the community on the importance of breastfeeding, with a view that that would lead to more inclusive and accepting workplaces and more public spaces where breastfeeding is acceptable. Those sorts of things can all contribute to a mother's willingness to breastfeed their child.

THE CHAIR: I was really lucky; I was able to breastfeed, and found it remarkably easy. Other women do not have that luxury and are completely unable to breastfeed. Will there be adequate supports for those women as well, and those children?

Mr Peffer: Yes. Under the strategy there is an intention to almost strengthen the supports that are currently available. Certainly, within the ACT we have a range of supports offered by a number of organisations—perhaps the principal among them is QEII—that do provide that ongoing support. We have commenced a project to examine and review the service options provided by Tresillian, through that facility, with a view to looking at what might be expanded in the future to better cover the care that is required.

MRS DUNNE: I was very taken by the evidence given in the previous hearing a couple of weeks ago by Safe Motherhood for All. I perused the submission and I cannot put my finger precisely on the figures. The figures reported by Safe Motherhood for All for midwife-led, non-medicalised confinements, for want of a better word, in other countries are much higher than in Australia and the ACT. They talked about Sweden and the Scandi countries. Also New Zealand has a much higher

non-medicalised, non-hospitalised, birth-centre-operated system. How is it that the ACT, and more generally the Australian, model of care is a much more medicalised process than we see in other countries?

Prof Lim: We actually have quite a good mix of midwife-led models of care compared to medical models of care. In fact 30 per cent of women who come to our service go through a continuity model. That is evidenced by the relatively low intervention rates compared to the other units.

Bernadette mentioned that we are part of the Women's Healthcare Australasia benchmarking process, which looks at 51 hospitals. When we look at the outcomes that we have, compared to the tertiary level units, level 6 units, we have one of the highest unassisted vaginal birth rates compared to the other level 6 units. Seventy-one per cent of our women who have vaginal births have unassisted vaginal births, compared to the average of about 66 per cent across the Women's Healthcare Australasia hospitals. That is 51 hospitals across Australia—69 per cent across Australia and 66 per cent across all level 6 hospitals. Our actual models of care, the variety of models of care, essentially are very good, compared to other units across—

MRS DUNNE: Actually, my question was not so much about how the ACT compares with others, but about why our model of care seems to be more medicalised than, say, our neighbours across the ditch. My recollection—I cannot verify it at the moment—was that something like 80 per cent of women would start in a CACH-type system, a midwife led process. It was also said to us by Safe Motherhood for All that we have not made advances in reducing maternal mortality in the last 20-odd years. We have not made the advances that some other countries have made. Would you like to comment on that?

THE CHAIR: "We" as in Australia, or "we" as in the ACT?

MRS DUNNE: In Australia. I do not think that you could possibly talk about ACT mortality figures because the numbers are so small.

Prof Lim: As far as I know, in New Zealand—and I have worked there in the past—the funding arrangement is different. The midwives are the primary fundholders. When a woman books into maternity care, they book with a midwife, and the midwife will access services where appropriate with the funding they are given. That is how the model of care is different. In Australia, admittedly, it has always traditionally been a very medicalised model. I think there is beginning to be a shift in models of care towards midwifery-type models of care. I think that will change in time.

As far as maternal mortality is concerned, Australia has one of the lowest maternal mortality rates. There has been improvement. Maybe, for instance, stillbirth rates are fairly static—the perinatal mortality rate. That is why there has been a parliamentary inquiry into stillbirths, to try to improve the stillbirth rates. That has been static, and that has been recognised. But Australia actually has one of the lowest maternal mortality rates in the world.

MRS DUNNE: What you are saying, Professor Lim, is that maybe it is the funding model that points towards a more medicalised model. Is part of the issue how the

Medicare schedule is constructed?

Prof Lim: Traditionally, in Australia, it has been a very medical model in the past. I think there is a shift; especially in the public services, there is a recognition that midwifery-continuity models of care result in good outcomes.

THE CHAIR: I note our time has come to an end today. I would like to thank all of the witnesses for appearing today. When available, a copy of the proof transcript will be forwarded, to provide an opportunity to check the transcript and suggest any corrections. Ms McDonald, you took a couple of questions on notice. Although the committee has not set a deadline for receipt of responses, answers to these questions would be appreciated as soon as possible.

MRS DUNNE: Sooner rather than later.

Ms McDonald: Sure.

THE CHAIR: Thank you, on behalf of the committee, for appearing today. That concludes our hearing.

The committee adjourned at 2.35 pm.