Royal Commission
into Family Violence

WITNESS STATEMENT OF LISA ANNE DUNLOP

I, Lisa Anne Dunlop, Executive Director Clinical Operations, The Royal Women's Hospital of 20 Flemington Road, Parkville, in the State of Victoria, say as follows:

1. I am authorised by The Royal Women's Hospital **(the Women's)** to make this statement on its behalf.

2. I refer to and adopt the Women's submission to the Royal Commission into Family Violence dated 28 May 2015. A copy of the submission is attached to this statement and marked "**LD-1**".

3. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

4. I am currently the Executive Director Clinical Operations at the Women's. I have held this position since May 2009.

5. As part of my role as Executive Director Clinical Operations, I have executive responsibility for the leadership and management of the clinical services at the Women's to ensure effective, efficient and integrated high quality clinical services are delivered, consistent with the Women's strategic and annual operational plans. These services include maternity, gynaecology, reproductive services, women's cancer and newborn services as well as the associated clinical support services such as emergency, perioperative services and allied health etc.

Background and qualifications

6. I have over 35 years' experience working in public hospitals in both clinical and managerial roles.

7. Prior to commencing as Executive Director Clinical Operations, I was Director Redevelopment at the Women's from January 2003 until May 2009. In this role I

was responsible for the project management of the new Royal Women's Hospital building in Parkville on behalf of the Hospital. It was my responsibility to ensure that the hospital was designed and built to meet the clinical needs of the organisation and to prepare the hospital for its relocation and to become operational. Prior to this role, I had worked as Unit Manger in both Birth Suite and Pregnancy Day Care Centre at the Women's for a number of years.

8. I began my career as a nurse and worked at the Royal Children's Hospital for 4 and a half years, followed by 30 years at the Women's as a midwife.

9. I hold the following qualifications:

   9.1. Masters of Health Administration from Latrobe University (2001);

   9.2. Bachelor of Applied Science (Adv. Nursing) from Phillip Institute of Technology (1990);

   9.3. Registered Midwife at Royal Women's Hospital (1985);

   9.4. Registered Nurse at Royal Children's Hospital (1982).

Family violence partnerships at the Women's

10. The Women's is currently involved in three project partnerships aimed at preventing and responding to family violence:

    10.1. Sexual Assault Prevention Program in Secondary Schools (known as SAPPSS) is a comprehensive primary prevention program for young people. The program was originally developed by CASA House (a department of the Royal Women's Hospital) in 2004 and uses the whole school community to model and educate young people about gender equity and respectful relationships. SAPPSS is now delivered by Centres Against Sexual Assault in Melbourne and Geelong, and CASA House supports its delivery in 10 secondary schools in north-west Melbourne. In addition to providing respectful relationships education at secondary schools, I believe that we should also be looking to expand these programs into primary schools. It can be too late by the time a student reaches secondary school to change behaviour. It is important that we start early.

10.2. Acting on the Warning Signs is a partnership between Inner Melbourne Community Legal and the Women's which provides a co-located legal clinic to patients at the Women's and through the provision of training for clinicians in family violence prevention, sensitive inquiry, integrates legal assistance into health care and social support at the Women's. Training is delivered by a multidisciplinary team including police, lawyers and health professionals, so clinicians understand their role in the broader response system. The project has been funded from philanthropic and pro bono sources.

10.3. Strengthening Hospital Responses to Family Violence (the 'Strengthening Hospitals project') is a partnership with Bendigo Health and Our Watch that is developing, implementing and evaluating training, protocols and resources to improve health care and social support for patients experiencing or at risk of experiencing family violence. In June 2014, the Office for Women within the Department of Human Services provided 12 months funding for a pilot project, with Our Watch conducting the evaluation. The project is developing a transferable model and methodology for embedding knowledge, skills and capacity for other hospitals across the State to better identify and respond to family violence. The project has since received some additional funding from the Department of Health and Human Services (DHHS).

Data collection

11. One of the issues that has been highlighted through the Strengthening Hospital's project is the complexity and gaps in data collection for family violence. There is currently no agreed, comprehensive framework for health services to respond to family violence

12. There is a need to establish best practice standards: standardised care pathways; standards of practice in hospitals; minimum standards relating to data definitions, data collection and reporting.

13. In Australia, while there have been a number of efforts by past governments to improve health information, we have not yet moved to a central health information record keeping system. That is so, even within Victoria. Each hospital and health service has its own record in relation to a patient. There is no streamlined sharing of information between hospitals and/or general practitioners and this is usually reliant on written correspondence such as referrals and discharge summaries and

episodic sharing would only occur if a patient's care were transferred. There is also no single or consistent method for recording and collecting health information. Some hospitals have moved to fully electronic systems, while others, such as the Women's are still using a paper based system. Those hospitals that have fully electronic medical records will not necessarily have the same software system.

14. However, while there are considerable differences in how health information may be recorded and collected, there is some consistency about what information is recorded. The reasons for collecting information apply across the health system, namely::

14.1. The need to record a patient's health information for the benefit of the patient's treatment, so that all medical and other staff dealing with the patient are able to know what the patient's needs are, what has been done and what needs to be done. This is important both for the patient's immediate health, but also for effective long term health and treatment.

14.2. The coding of conditions and treatments in order to receive funding. Much of health funding works on the basis of the patient's primary diagnosis and treatment. For example, a complex pregnancy will receive higher funding than a straightforward pregnancy. The cost weights and allocation of funding are determined by the Department of Health and Human Services and updated annually.

14.3. The collection of data for public health purposes, including to monitor and track the prevalence of diseases (e.g. diabetes, heart disease, cancers, infectious diseases) and other health conditions (e.g. obesity) or social factors that may have a significant impact upon health (e.g. smoking). This information is mandated by the Department of Health and Human Services and/or the Commonwealth.

15. Hospitals generally collect and submit data in three different information management sources/streams:

15.1. Emergency department data (Victorian Emergency Minimum Dataset);

15.2. Inpatient data (Victorian Admitted Episode Dataset); and

15.3. Outpatient data systems (Victorian Integrated Non-Admitted Dataset).

16. Each hospital may use different brands of software, but the minimum information collected and required to be submitted to the Department of Health and Human Services by the three systems is the same, they collect the minimum information required by the relative dataset. The inpatient data is the most comprehensive patient information data set. Where the information is captured and whether it is consistently captured will be affected by whether the Department of Health and Human Services has identified the information as relevant for funding purposes, or has mandated its collection for public health purposes.

17. Currently, the Department does not mandate hospitals or health services to capture and/or report family violence data, nor is there a unified evidence based data set. This needs to occur and then funding be made available to modify the current data collection systems to be able to record and report family violence. Currently family violence issues are not required to be recorded nor is there a mechanism to retrieve and analyse the associated data. This means that:

17.1. family violence is not easily identified in the documentation as an important issue causing, contributing and impacting upon a woman's health;

17.2. the documentation does not serve to prompt or remind clinicians to consider asking about family violence in order to better diagnose and treat;

17.3. there is no easy or consistent way for subsequent staff and clinicians to know that there are known family violence issues (let alone multiple hospitals the same patient may present to). Even though a clinician might have asked and identified family violence as an issue in a previous attendance at the hospital, when the patient attends subsequent appointments or other hospitals and health services staff and clinicians will be unaware that family violence is a potential issue unless and until they read the full clinical paper history and this could be paper based, electronically based or both;

17.4. there is nowhere consistent in the Victorian healthcare system that flags family violence as an issue for the patient, so that steps can be taken from the minute she walks in the door (potentially with her violent partner) to ensure care is delivered in the safest and most appropriate way;

17.5. There is no way to report on the prevalence and impact of family violence as having caused or complicated a patient's health, the subsequent care

provided by a hospital and therefore the impact on the health care system, all of which is a preventable.

17.6. there is no easy way to evaluate the effectiveness of various interventions and training, on a patients long term health.

18. Family violence is also not identified as a factor that affects hospital funding, yet we know that it is the biggest contributor of ill health and premature death to women aged 14 - 44 in Victoria and that the impacts on a women's health will begin before age 14 and proceed beyond the age of 44. Diagnostic based funding will only capture those forms of violence that have resulted in a physical injury and subsequent diagnosis, requiring treatment. A fracture, for example will be funded in the same way whether someone falls down the stairs or is pushed down the stairs, but we know the psychological impact and need for further provision of care will be more extensive in the case where someone was pushed down the stairs. Although antenatal funding can be different for a 'complex pregnancy', it is predominantly associated with medical co-morbidities and does not specifically include family violence. Family violence has not been identified as a factor that would make a pregnancy 'complex'. This makes family violence related presentations invisible in hospitals. There is no incentive in the funding model for hospitals to identify or address family violence.

19. Onsite legal services are not currently recognised as part of the multidisciplinary team caring for a patient and therefore are not funded. Other support services such as allied health professionals (e.g. social workers) are recognised in their own right as part of the healthcare team.

20. Policy development across a range of areas is a priority in establishing hospital responses to family violence. Health services require a suite of policies and guidelines that enable all staff to respond effectively to presentations and/or disclosures including:

20.1. A definition of family violence that is agreed and understood by staff at all levels.

20.2. Identification of points of entry to health services including, emergency departments, inpatient and ambulatory care settings

20.3. Establishment of minimum response requirements that empower clients to self-manage through education, support and referral processes

20.4. Identification of client pathways interfacing with Family Violence support services

21. Health services developing a best practice family violence response model should consider the organisational culture and support of their own staff, many of whom may be survivors, current victims, or personally affected by family violence themselves.

Lisa Anne Dunlop

Dated: 10th August 2015