

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Mildura — 9 November 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

Dr Nikhil Patravali, director, obstetrics and gynaecology,

Ms Janet Hicks, director of nursing, and

Ms Sandra Doyle, nurse unit manager, maternity services, Mildura Base Hospital.

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

Welcome. I have been through the legal stuff. We are here today to hear as much information from you as possible so we can actually put recommendations to the state government to improve the perinatal services sector. If we can just begin with a 10 to 15-minute presentation from you, then we will ask some questions if that is okay.

By the way, you will need to speak into this microphone as well. It records it for the Hansard staff. The microphone you are holding, the free microphone, is so everyone else can hear you.

Dr PATRAVALI — Thank you very much for having us here. I will introduce myself again. I am Nikhil Patravali. I am the clinical director and consultant staff specialist at Mildura Base Hospital. I am the only staff specialist working at the hospital at the moment, and I work with two visiting medical officers. I have got Sandra with me on my right, who is a midwifery unit manager. I have got Janet Hicks, who is the director of nursing, on my left. Also with us today we have our chief executive, Julia Morgan, who is at the back.

The CHAIR — Welcome.

Dr PATRAVALI — First of all, I would like to thank the committee for having us over. I would like to take this opportunity to demonstrate our hard work for the region — what the hospital and we as a department are doing for the region — the challenges that we face on a very daily basis and what strategies we have in mind and perhaps are already following to address all of the challenges and resource issues.

We would perhaps like to start off with where we stand in the grand scheme of things, looking into the population demographics. Mildura as a city is around 60 000 to 70 000 in population, and we cater not only to the city but also to the whole of the Sunraysia region. We are very geographically located where we border with South Australia and New South Wales, and we do get lots of patients from all over these areas birthing in our unit and utilising our services. We have a very diverse multicultural community. Almost 67 countries are represented, and that in itself brings up a lot of challenges not only with the medical side of risks and demographic changes but also with cultural beliefs and expectations from services as well. That itself is a very big ongoing issue for us that we address on a daily basis.

With Aboriginal and Torres Strait Islanders, we have around 1.9 per cent to 2 per cent of the population around the region classified as this, as per the 2016 Australian census. From this population around 7 per cent of all our births are from Aboriginal and Torres Strait Islanders.

Visual presentation

Dr PATRAVALI — This represents perhaps the whole regional demographic. The purple is our main, primary area of catchment. The supplementary area is in light pink, and our secondary area of catchment is in light blue. It is a very big geographical distribution that we have.

With regard to Mildura Base Hospital, as an entity we are the only hospital with a birthing suite facility. That is our biggest challenge, with all of the resources from the rest of the antenatal services all the women deliver only at the base hospital. Our primary clinic is Ramsay Specialist Clinic, which is linked with the hospital in a separate building. But we do have all the other women availing themselves of antenatal facilities from Robinvale health services, MDAS, Mildura O & G, which is a private enterprise, Dareton, which is part of the Coomealla health Aboriginal service in New South Wales, and the Sunraysia community health centre. We also have a midwife-led home birthing private service where the midwife would then refer patients to us. We also get less than 1 per cent of patients who are not registered with any of these services delivering with our birthing suite.

Our base hospital has a capacity of 165, and in the Victorian maternity services framework we are a level 4 service, which means we take mild to moderate-risk patients. We are perhaps bordering on level 5. Level 6 is a

tertiary level — the Royal Women's and so on. We do accept level 5 work perhaps sometimes because of the geographical issues, timing of deliveries and so on.

From a neonatal service point of view, we are at level 3, so we do not deliver babies less than 34 weeks at the moment, but there is a lot of discussion being generated around how we can improve that in this area so we then can perhaps deliver from 32 weeks onwards so there are less women getting transported elsewhere.

The CHAIR — Where are they sent at the moment?

Dr PATRAVALI — I will perhaps come to that. They are sent to a lot of other regional areas — so Bendigo, Melbourne and Adelaide at the moment.

What do we have as a maternity service in our hospital? We are a mixture of an antenatal and postnatal ward which has a capacity of up to 12 beds. At the moment we are resourced for up to eight beds. But we pull in resources from the community and that goes up and down depending on the needs during particular months. For example, September and October are busy months from an obstetrics point of view — all the Christmas babies will come out then. We then try to pull in resources and help with the department.

Our birth suite itself has got four birthing venues or birth suites but it is only staffed for three at the moment. Our special nursery has a total of six cots but we have staffing only for four cots at the moment. This is manned by nurses and midwives who are trained up.

From a medical staffing point of view, we have three consultant obstetricians of which one is a staff specialist — that is me. We have got two visiting medical officers who work for Mildura O & G and they birth their women up in our facility. The work is perhaps for four or five consultants, and the fourth place is supplemented with locums at the moment. We have two registrars in the unit — one is an accredited registrar who is being trained at the Royal College of Obstetricians and Gynaecologists — who rotate through our department, and we have funding to that effect.

The other one is an unaccredited registrar, and these middle-grade resources are very important for running services as they are the people on the floor with experience but not as much as a consultant. We have a very junior RMOs who work on the floor. We have four of them who have some interest in obstetrics and gynaecology and want to learn a bit more about them. They are the workers at the grassroots level. We perhaps have capacity for more junior doctors, and that is perhaps part of the strategy. I will come to that in a minute.

Ramsay Specialist Clinic is the only clinic which is linked with the Mildura Base Hospital as a public enterprise. It is perhaps the only consultant-led bulk-billed clinic. It has an antenatal clinic. Because of all the other issues and challenges we have, we are unable to do all the postnatal care for most of the women who we look after, and we only do select postnatal care back in that clinic. Most of these patients would go back to the GPs or to the midwives, and we use domiciliary midwives to supplement that service. We also through that clinic provide a lot of termination of pregnancy and general gynaecology, so a lot of my time is utilised not just for perinatal and antenatal but also for other women's health needs at the moment.

From the antenatal clinic point of view, we do a clinic once a week, but we see almost 40 to 50 patients in that clinic. The way we have developed this clinic is through a lot of meetings and working out what model works really well for us, and it is in partnership with midwives. It is a joint clinic where there is a midwife, a consultant and a registrar. They been able to provide another midwife now, so we see through a lot of patients in one day. We recognised very early on that the population we were seeing had a lot of high risk in them for whatever reason, especially with increases in body mass index and medical issues. One of the bigger problems was diabetes in these young women. We have been able to provide, again a very joint, diabetic clinic with a diabetic educator on board and a Skype consultation with the endocrinologist at almost a very tertiary hospital level of care for these women. So we have developed this antenatal clinic to provide services that otherwise women would have had to go and see three people for but they get to see them in one go.

As I have mentioned before, we have a memorandum of understanding with all the other services so that if they have high-risk women — say, for example, MDAS has a high risk in the Aboriginal community — they will then refer these women to us, and if shared care were required, we would then see those women part in part or they would just be completely taken over by a consultant at that service. We also cater to outreach clinics as well, which again is part of Mildura Base Hospital. Like Robinvale, the clinic is an antenatal, postnatal and

gynaecology clinic. It is, again, held every Wednesday. A GP obstetrician goes to that clinic. It is again a midwife and doctor-led joint clinic that provides excellent service to that area, but then again all the high-risk patients get referred perhaps to Ramsay Specialist Clinic as well. At Dareton women who are under the care of CHAC, again, get service from our accredited registrar, and it is again a registrar and midwife-led model. So basically the base hospital has a primary clinic at Ramsay Specialist Clinic and two other supplementary clinics — one in Dareton and one at Robinvale — and we take all the other high-risk patients from other clinics.

So what do we do, what are our statistics with births at the hospital? We have almost 900 deliveries — this figure has been consistent for a few years — of which we have 453 vaginal births. This is just a split up of all emergency caesarean sections, elective caesarean sections, instrumental deliveries and vaginal deliveries. Again I have just made it a bit simple. If you look at total births, almost 62 per cent are vaginal births, and this includes vaginal deliveries and instrumental deliveries. The rest, 38 per cent, are emergency caesarean sections and elective caesarean sections. The caesarean section rates are slightly higher than the national average. It is an ongoing issue, perhaps to do with the health demographics of women as well. We have a very high-risk medical population, high BMI population, and we know that such women have almost a 50 per cent chance of not achieving a vaginal birth. Hence the numbers are slightly higher than average.

This graph perhaps reflects on our 2016–17. It is a fairly consistent graph with what happens, because one of the other issues that we always try to look for is if there were any bias for particular months or with a particular service provider that had either the vaginal birth or caesarean sections going up and down. Perhaps it is a very consistent figure the whole year round, which perhaps tells us that it is not a very service provider-based bias.

So what challenges do we have? I think one of the biggest challenges we have is midwifery staffing, and this perhaps comes up with every health service provider where recruitment and, more importantly, retention has been a very big issue. It is especially for experienced midwives. We are anyway understaffed for what capacity we have, and on top of that if retention and recruitment is a problem, it then impacts on patient care when patients are needing to be transferred out because the ratios are just not safe to carry on with any birthing or follow-up for these patients.

Medical structure also does impact. We are very thin on the ground from a junior doctor point of view. We are in the process of recruiting this middle-grade tier which then allows an almost 24-hour service, which is much safer for women. But it is not just with obstetrics; it is to do with neonatology and paediatrics as well — they are looking at how to develop that service as well so we can take in younger babies and women delivering for whatever reason early and keep them in the region to improve the services.

We have a very, very high-risk population, and it is very different to perhaps some other areas. But we do have a high-risk population particularly from a BMI point of view. More than 30 per cent of women who birth here are obese or morbidly obese. One of the other challenges we find, being the only unit which has a birthing facility, is patient expectation not really marrying up with capability requirements in terms of the resources that we have. So it is almost never guaranteed a woman will walk in and will get a place whether she is high risk or not, because if there are staffing issues, they get transported for various reasons outside. That has always been a very consistent problem for us in the department.

What does that mean in real terms? It really impacts a lot of things that we do. It means, again, we are needing to send mothers and babies, sometimes after delivery, to tertiary centres. We recognised very early on that high BMI was a very big issue. Early this year we had to send a memorandum to the community saying that for any woman above 50 BMI we just do not have the capability to deliver here, and we have then spoken to lots of tertiary units that have now accepted that any woman above 50 BMI would then get transferred out, which perhaps does not go down very well, as you can imagine, with patients. It is slightly discriminatory, but I think looking at risk stratification you have to do what is safe for people. That has always been an issue.

We are so far out that actually the nearest hospital is 400 kilometres away, which is Bendigo and Adelaide, and then Melbourne, which is our primary tertiary hospital, is even further away at 600 kilometres. There are a lot of financial and social impacts on women and families for this very reason. Where we identify risks in the antenatal period we try to prime them that this could happen, but we are not in a society which is very affluent, and despite giving a lot of warning, some women tend to get disengaged with services, which is even worse. So this does impact not only the hospital but families as well financially. There is very limited financial support for these women who would be deemed medically not safe to deliver here. They do not get full funding for this sort of transport, although it perhaps is technically a medical decision for not delivering at the base hospital, but they

get very limited funding and not all the cost is covered. That has been a sore point for patients in the past and is ongoing.

We had a very beautiful, midwifery-led pregnancy and partnership program where all the low-risk women with no risk factors could just see a midwife in their antenatal care and on two occasions be referred to a consultant just to make sure the whole plan was in order. We had to suspend that program almost forcefully in May of this year because of an inability to staff the main birth suite, so these midwives got pulled from antenatal clinics to be on birth suites helping their colleagues, which definitely then has had an impact on all the services, including the antenatal clinics. As a consultant, perhaps I am seeing more high-risk patients. Seeing low-risk and high-risk patients impacts on care; you actually cannot refuse care to anybody in that circumstance. Hence this is the area that really is lacking and perhaps needs to be resourced with funding or with personnel.

All of this, all in all, has impacted staff morale and satisfaction at work, and there is an increasing demand. I have, time and again every other day, seen midwives working over and above the time that they are contracted for just to mind the floor, so there is a lot of hard work, although there is a lot of camaraderie going on. We are a beautiful team. It only takes you so far when you are flogged time and again.

So what strategies do we have? The hospital in particular and the department have sat together, we have thought of lots of different models and, as from the chief executive, we have had a lot of targeted campaigns from the UK and from New Zealand to recruit people. We have done a three-month offer for travel and accommodation and provided flexible, short contracts. Perhaps a postgraduate midwifery training and graduate program is offered. It is still underway. It is still early days. We have not seen a lot of effect from it. Of what I know — perhaps Janet could set us right — we have not had a lot of interest generated, but we do have some promising results maybe. I will let Janet speak on that.

What we do is we sit every month looking at all our high-risk patients, looking at all the morbidity that has occurred in women and babies, and see where we as a service can improve. It is a full multidisciplinary meeting where midwives, doctors, junior doctors, the paediatric team and anaesthetists sit through and discuss all of these cases. We also are linked with a regional morbidity and mortality meeting. We are recognised as a regional isolated centre, so it is important for us to get that message out to all the other centres like Bendigo, Melbourne and so on of where we stand and why we refer patients. These regional morbidity and mortality meetings that have been going on this year have been a great success for all of us getting together as the whole Loddon Mallee region and supporting each other.

We do a lot of in-house training for midwives and doctors alike, because I think that is really important from a safety point of view. PROMPT is one example of this training. We also do a lot of CTG, which is cardiotocographic monitoring. It is the trace of the baby — that is, in labour — and it has been recognised that not finding things early on and not training your eyes to recognise problems actually causes a lot of trouble, and hence we have implemented CTG training.

We are very diligent with logging all of our risks in this software called Riskman, and we then discuss all the near misses and adverse events that have happened, learn from them and have strategies in place so that they do not occur in the future. Our risk manager looks at all the complaints and compliments, and I think in particular compliments are very important when you are very flogged. The hospital itself has its own strategy to integrate staff; they have what is called ‘employee of the month’ where they recognise good work by people, and that keeps people going.

We are endeavouring to link lots of other services like MDAS and all the other services around with the hospital, and we will be having strategies early next year to link with these to see where we can do something cumulative and have some streamlined pathways so we are all talking to each other. We are well aware that, as the only hospital for births that takes in all of these patients, we need to be aware of what their challenges are, but they need to be aware of what challenges we have so they then inform the patients at the grassroots level so that the expectations meet up with the reality for patients, and that is very important.

We are hoping to do open forums like today for patients, educating people for antenatal and postnatal care and what is available out there in the community, because I think if it goes down at the grassroots level, perhaps it is more a success story with what limited resources we have. And that is it. Thank you.

The CHAIR — Thank you. Do you mind if we ask some questions?

Dr PATRAVALI — Sure.

The CHAIR — Has Janet ever got employee of the month? In all seriousness from me, just one general but quite complex question I guess in a way: from a state government perspective, what recommendations could we put forward to provide you with support to ensure that you have the staffing and resources that you need in this area? So it is a simple question and a very complex answer, I think.

Dr PATRAVALI — Yes. I think it is a very multifactorial thing where I think the biggest challenge is recruitment — at all levels. It really is. We have advertised time and again for midwives and doctors; it is just the way the region is.

The CHAIR — The ones you have got here, though — how have they been attracted here and what has been successful? Is it a lifestyle? I see you laughing up the back. Is it a lifestyle? Is it people's family that draws them back?

Ms HICKS — Certainly where we get most of our staff is through having a connection to the community, so it is through marriage, it is through family. It is people who grew up here or in the region who went away for study and had children, and that has then been a trigger to come home to be closer to family, and those of the most common applicants that we get. We are getting more applicants now, though, who are younger, who are unable to secure work in their city first-preference hospitals, who are going to the regional areas, and we do offer a lot of support with travel and accommodation and those sorts of things that actually brings those staff to the region.

We are actually quite different to most other regional hospitals that I have spoken to when you look at the profile of our nursing staff in particular. Fifty-three per cent of our nursing staff across the hospital have less than five years experience, so we have actually got a very junior workforce compared to most hospitals that have an ageing workforce. We seem to have that band at the top who are close to retirement, and then we have this band at the bottom. It is the middle grade — you know, the medium to high level of experience — that is really missing from the workforce, most often because that is when they have their families. They take a break from working and they reduce their hours.

We do have a very young workforce, so I certainly think a key for us is in the training sector. We offer a postgraduate midwifery program within the unit, and we take two or three students per year. Then we also offer a graduate year as well after that, and they are always subscribed. That is not enough for us, though, to continue to keep enough workforce in place, because the numbers going off on maternity leave are much higher than that, because again we have that young workforce that are taking those breaks. So training is certainly a key issue.

The CHAIR — You mentioned the staff are going above and beyond to keep the feet on the floor and to care for people. Maybe Sandra can tell us how you negate the effects of people being burnt out and how you keep people's morale up. I know that they have got a lot of training to do.

Ms DOYLE — That is a really good question, isn't it, because the majority of the staff pick up more shifts than they are contracted to work. Staff often work double shifts, including me.

The CHAIR — How many hours are we talking about, Sandra, if you do back-to-back shifts?

Ms DOYLE — Me in particular?

The CHAIR — Yes, how many hours would that be?

Ms DOYLE — Once a fortnight I would do a double shift.

The CHAIR — And how many hours is each shift, both together?

Ms DOYLE — They are 8-hour shifts.

The CHAIR — So 16 hours straight.

Ms DOYLE — Yes. And that is not an uncommon thing per week, not for me but for someone. Keeping the morale up is a really difficult thing, but we try and be quite personable and team orientated, and go out and have a drink and come back to work again.

Dr PATRAVALI — Coffee helps, buying a coffee.

The CHAIR — Yes, I am not doubting the passion and commitment from your staff. Just working 16 hours straight is quite a commitment in itself.

Ms EDWARDS — I did 26 hours as Deputy Speaker the other week, so I feel for you.

The CHAIR — You did phenomenally. You were not grumpy at all.

Ms EDWARDS — You mentioned telehealth that you are utilising for endocrinologists and diabetes. What is the potential to utilise telehealth in terms of antenatal care and postnatal care for your service?

Dr PATRAVALI — The trouble is time and personnel. If you imagine — and I can only speak for my own clinic, I am the only consultant staff specialist and I am providing all of these other services as well, not just the perinatal — it is well and good to have it. It is possible. We have got the technology. I just do not have the time, so it means we are actively recruiting another consultant, and if it comes through to fruition, you have another consultant on board and you then are doubling the time and resources. So I think it boils down to people as opposed to technology.

Ms EDWARDS — That is interesting to know because we are all very conscious of the fact that there is a shortage of midwives across the state and maternal and child health nurses as well. Does your service offer pregnancy and birth education classes?

Ms DOYLE — Yes, we offer a full range of antenatal classes that have been going for many, many, many years, because I have been doing them for many years — I do not now — a full range of classes, which we are revamping next year to make them more exciting.

Ms EDWARDS — How many numbers would you have at those and is there a limited capacity?

Ms DOYLE — No. That is our problem. We do not limit anyone. We take everyone that wants to come, and we do have too many for the size of the room and that sort of stuff at the moment. They are often twice weekly, so breastfeeding and parenting is weekly, and pregnancy, labour and birth is weekly as well. In particular at the pregnancy, labour and birth classes you would get 16, 18, sometimes 20 couples altogether, so that is a lot of people all at once, and those classes would go for a three-week period and then repeat.

Ms EDWARDS — And do you have lactation consultants at the hospital?

Ms DOYLE — Yes, we do. We have got a lactation service, so that person works five days a week.

Ms EDWARDS — So you have one lactation consultant?

Ms DOYLE — Other midwives are lactation consultants, but one person works in that service. It is a five-day-a-week service, and it is available for education prior, so any type of breastfeeding education prior, whether it be one-on-one or as a class thing. Then also an unlimited amount of visits after the baby is born depending on what the woman needs.

Ms EDWARDS — So they are part of the domiciliary midwifery team?

Ms DOYLE — Yes.

Ms EDWARDS — You mentioned that you had 165 maternity —

Dr PATRAVALI — No, not maternity. The whole hospital has got —

Ms EDWARDS — I was going to say that is an awful lot.

Dr PATRAVALI — I wish I had 165.

The CHAIR — I take back my question about resourcing!

Ms EDWARDS — Do you operate as a public-private hospital?

Dr PATRAVALI — The maternity and perinatal is public is what I would say, because Ramsay is a private enterprise with the Department of Health. It has got that service level agreement, but perinatal services is completely bulk-billed.

Ms EDWARDS — That is good to know. You also mentioned the mortality and morbidity rates that you meet regularly to discuss. I just wondered how your service compares to other services in terms of those particular issues around mortality and morbidity.

Dr PATRAVALI — I think if I were to compare like for like, we are very comparable. I can say that for sure because of our regional Mallee Loddon district. Before we started those regional morbidity to mortality meetings we were quite unsure. You do not know where you stand, and that meeting in particular has helped. In fact it has helped us improve and learn from our mistakes, so we are at least starting to do better now with our morbidity and mortality.

Ms EDWARDS — Would that have something to do with the fact that you can now send women to Bendigo or Adelaide, particularly if they are very high risk?

Dr PATRAVALI — I would perhaps say we were always sending them. It has become more of a formal process and the acceptability has increased. The streamlining of that process has occurred, so I think that has actually helped with improving patient care. There is no phoning a lot around and you are trying to explain your situation. People know exactly where you stand, and cutting down on that time has actually improved the outcomes.

Ms EDWARDS — On the question around high risk — you mentioned obesity as a big issue across the region, and it is a long time since I had my four children — I just wondered what the other risks are that you are seeing regularly around women who are pregnant, apart from obesity, or is it just that there is a determination made by specialists in that respect?

Dr PATRAVALI — Obesity is just one thing that then brings up all the other challenges as well with diabetes, blood pressure issues. The younger mums with first pregnancies have a high risk of blood pressure. Nutrition has been an issue because we are not really in an affluent population, so low haemoglobins, and hence it then stems down to when they deliver they lose a lot of blood, and if you have not started with good haemoglobin, that has its own impact with morbidity and growth of fetus. So it is a bit more complex than saying these are the four high-risk factors, but as we all know from demographic anecdotal evidence all around the world low socio-economic people have higher problems, and we do have a lot of low socio-economic lack of support, and hence all of these other services are doing a great job I think in supporting these women.

Ms EDWARDS — I just had one question and you might have already answered it, but how many midwives do you actually have?

Dr PATRAVALI — Forty-five.

Ms EDWARDS — Full-time?

Ms DOYLE — No, there would be three maybe that are full-time.

Ms EDWARDS — Three full-time?

Ms DOYLE — Everyone is part-time virtually.

The DEPUTY CHAIR — What about EFT?

Ms DOYLE — Currently this month and next month — this is not EFT — we cannot even fill the base roster. So we are 10 to 14 shifts down per week just on the base roster. So everyone picks up to fill up the base roster. Then you have the problems of sick leave and family leave. I think we are eight EFT down.

The DEPUTY CHAIR — Thank you very much for coming in. It is always really good to talk to country hospitals and find out the challenges and what works well. You mentioned earlier that you are a level 4 hospital but that out of necessity at times you have to do some level 5 procedures. What are they?

Dr PATRAVALI — Delivery of very high-risk women who should really be cardiac problems with very complicated diabetes on board, people with again very, very big BMIs who do not want to go. We do take everyone. Although we say, ‘You need to get delivered elsewhere’, we would support a woman, and we get a lot of unregistered people as well who come through. So I think with uncontrolled medical conditions they are deemed fit to deliver in a tertiary hospital, and sometimes these medical conditions are just so complex they do not have one but two or three medical conditions, and that makes them very complex. In fact if you are delivering someone with these sorts of big BMIs, you need two midwives per patient, and we just do not have that sort of capacity.

The DEPUTY CHAIR — But you said you do some of them, so which ones do you do of the level 5?

Dr PATRAVALI — The ones which perhaps we are unable to transfer, the extreme premature births who are imminently delivering and we do not have the time, or a few months ago the airport was shut at night and we just could not transfer people out.

Ms DOYLE — They were redoing the runway.

Dr PATRAVALI — So we do include the whole — whatever resource we have within the ICU —

The DEPUTY CHAIR — So you have the capability within the staff to do that?

Dr PATRAVALI — Yes. We have got an ICU as well — intensive care unit. The neonatologists are very experienced as people; it is just that from a resource point of view we do not.

Ms HICKS — Could I just add to that. I think that is really one of our key challenges — our geographical location. Ultimately if a woman walks in the door in labour, she is staying with us; we do not have an opportunity to actually transfer her. If she has threatened labour we may have a window of time when we call PIPER for a retrieval. It is going to be a minimum of 4 hours for them to get a plane in the air, come up here, stabilise someone and actually transfer them. We will call PIPER. We will have that conversation. They may often just fly up here and support us and be here for those very high-risk women, but that is a really key challenge for us in ensuring that our staff are well-trained to be able to actually deal with whatever walks in the door. We can be classed as a level 4 maternity service, but we actually have to have the capability to respond to whatever walks in the door, because we are not a 20-minute ambulance ride up the road to the next level 5 facility.

The DEPUTY CHAIR — So was there ever talk of increasing that to become a level 5 maternity hospital?

Dr PATRAVALI — We are endeavouring, by increasing consulting numbers and registrar numbers. I had a meeting with the clinical director for paediatrics and neonatology. They are certainly endeavouring to improve their own service so that we can then take more high-risk people. But again it boils down to midwifery staff. It is a bit of a catch 22.

The DEPUTY CHAIR — What was the number of obese women that you saw?

Dr PATRAVALI — More than 30 per cent would be obese or moderately obese.

The DEPUTY CHAIR — I just want to ask about your accreditation and the accreditation process that you use.

Dr PATRAVALI — For whom are you talking about?

The DEPUTY CHAIR — For your processes with maternity. Do you use ISO or do you use the Australian qualification one?

Ms HICKS — National standards, which we have just gone through in the last four weeks.

The DEPUTY CHAIR — Thank you. For some reason I had the feeling that you were one of the hospitals that had the ISO. Could you tell me the downsides of telehealth?

Dr PATRAVALI — I perhaps think it is to do with continuity of care. When patients see the same person all the time, it is useful. Sometimes with telehealth they do not get to see the same person; it is a team of people who come and go. You cannot examine the patient as well, so I think you would only go by symptoms — what patients are telling you — and what parameters are there. You cannot really examine people. Maternity in particular is a very challenging specialty. It is very different from anything else. You have a baby and a mum, and everything that the disease process does it does to the baby, and the pregnancy itself changes the disease process. So I think for a select population, which is perhaps low risk, it may work, but for a very high-risk population — it is that end that we are more worried for from a risk point of view — it perhaps may not work completely in its entirety. Some aspects you can perhaps use telehealth for, like monitoring diabetes, where you are just looking at what the numbers are — blood sugars — and then you say to increase your dose or reduce your dose. But as an obstetrician, to know if I am hearing a fetal heart, measuring and so on perhaps it may not work. So some aspects you could use it for, not in its entirety.

Dr CARLING-JENKINS — Thank you so much for coming in. I am conscious of the time, so I will make my questions brief. You have made that easy for me, unfortunately, because I was going to ask a lot of questions about the community midwife program, because I have read about it on your website, and then I found out it was suspended, which is a tragedy really because it sounded fantastic. So you are saying about 900 babies are being born. What percentage of those babies would have come under that midwife program when it was up and running at full steam?

Ms DOYLE — Ten per cent. It was not running at full capacity; it was started at half capacity.

Dr CARLING-JENKINS — So at full capacity would that mean it would cover 20 per cent?

Dr PATRAVALI — Twenty per cent, perhaps.

Dr CARLING-JENKINS — That is quite significant.

Dr PATRAVALI — Yes.

Dr CARLING-JENKINS — Right, interesting. Do you have any idea when you be able to restart that? Is that ‘How long is a piece of string?’ when —

Dr PATRAVALI — I think our biggest challenge is recruiting midwives to man the birth suite. I think that is the key area. What I am hoping — and I was having a chat with Sandra — is that we devise some new strategies, look at our own resource, perhaps pull in advice from those we have so they can come through and rotate through clinics and see those low-risk people, but just use what we have, really. We are going to sit a bit more formally within the next forthcoming few months and decide on what we can do with what we have. Perhaps that is the only way. We will not be able to pluck a midwife in the near future to just set up a whole service, because you do not need one; you need a cohort of people, accounting for leave and all the other factors that come through. That perhaps is not sustainable for the way we are at the moment.

Dr CARLING-JENKINS — It is a very comprehensive service, so how you are accommodating that 20 per cent — perhaps they are staying longer in the hospital; they have to see someone — has flow-on effects all through your system.

Dr PATRAVALI — And actually looking at experience, where you need experienced midwives for running an off-and-on service. That is the biggest challenge. Because all the people are low-risk, recognising the deviation from low-risk — and only an experienced person can do that — is the key to running these services. As a matter of fact we need experienced midwives on the floor, so it really would never —

Dr CARLING-JENKINS — You need both. So is that the problem you were describing, Janet, with missing that middle layer?

Ms HICKS — Yes.

Ms DOYLE — With a midwifery group practice the midwives are on call a lot, and those in the middle range of midwives are the ones with the babies and young children who —

Dr CARLING-JENKINS — Who cannot commit to that kind of roster.

Ms DOYLE — are not really keen to do that job, and that has been our difficulty here. It is not that people do not agree with it — the midwives all agree with it — but it is a matter of who actually wants to do the job.

Dr CARLING-JENKINS — Or who has the capacity — who can do it.

Ms DOYLE — Yes, that is right.

Dr CARLING-JENKINS — Fair enough. Just one more quick question, and it is around the exposure of incidents of infant mortality closer to Melbourne. We have heard during hearings to date about changes in practice as a result of that. What changes has your hospital made because of those incidents in the last 12 to 18 months?

Dr PATRAVALI — I suppose we have engaged very diligently with these morbidity and mortality meetings and educated ourselves — we have invested a lot into education and training. We have revamped our PROMPT course — it is done a bit differently; it is very hands-on, drill based — so everyone is equipped to manage an emergency. Also we have now started rotating midwives through antenatal and so on. So it is more about education that has fallen in place.

I think the effects we would perhaps see in the next forthcoming years with both the education and training. There is always a bit of a lag to that effect, but we are hopeful; the morale and the feedback have gone well. We have also invested in a lot of research — I have done four research studies involving women looking at other practices with vaginal births, caesarean sections, nutrition, contraception choices for the future — just looking at that overall thing. We presented all the four studies at the annual RANZCOG conference this year in Auckland. We are trying our best to understand what we are doing and learn from what we are doing. I think the effects we will see perhaps in the next forthcoming years.

Ms DOYLE — We also have a daily multidisciplinary team meeting where we discuss the day's activities, and tomorrow and the next day and the next day in relation to inductions of labour, who really needs to be done, who else is coming in that might need to step in and who needs to be put back a day — all that sort of thing. This is so that people are not being missed; they do not disappear and then turn up and nothing has happened and no plan has been made — that sort of thing. So that is a daily thing. We also have a monthly one as well where we discuss our high-risk patients, but that daily one is a very important one.

The DEPUTY CHAIR — Just earlier, I know you were in the room when Jacinta from MDAS talked about the transferring to a tertiary hospital and how it would be great if that hospital had a KMS. Is there any way you can influence that?

Dr PATRAVALI — I think it is very difficult for us because you have a very small window of opportunity speaking with PIPER. You are so bound by just trying to get a bed in that situation rather than looking at it a bit more holistically. We do not very consciously look for that because it is always a challenge, because tertiary hospitals as well are very busy and not all hospitals have beds when we pick up that phone, so it is just the first available and the patient is sent out. We try our best, though, if a patient was identified in the antenatal period and if she were an Aboriginal and so on then we ask for a preference from the woman — for them to choose a tertiary hospital that they would like to go to or if they have had an experience with their relatives and so on. But in an emergency it is almost impossible.

The DEPUTY CHAIR — Fabulous. Thank you.

Ms COUZENS — Thank you for your presentation. I think you do an amazing job under the circumstances. I am interested in your views. I think the challenge is that we do not have enough midwives and recruitment is the key as well. If there are enough midwives to do the job and you retain them, then a lot of the problems are solved, I think is what you are saying. I was interested in whether you have an Aboriginal clinic within the hospital?

Dr PATRAVALI — No. I think we are very reliant on all the other services, and they are doing such a fantastic job. What we have done is we have had a memorandum of understanding with them where if they identify a high risk, they then link the patient to Ramsay Specialist Clinic and then we look after the patient with the shared role. The midwives as well come in when the patient is delivering, perhaps not as a delivering midwife, but to be a support person.

Ms COUZENS — Is that the Aboriginal midwives?

Dr PATRAVALI — Aboriginal midwives, yes. They would then come in with the patient as well and be in a supportive role. That sort of model perhaps works better for us than all of us providing the same service in all the areas of service provision.

Ms COUZENS — Do you have cultural training within the hospital?

Ms HICKS — Yes, we do. Our manager of our Aboriginal health service provides cultural awareness training and orientation for all staff coming into the hospital, including the rotational medical staff that turn over every 12 to 13 weeks, so everyone has some level of cultural awareness training.

Ms COUZENS — That is Aboriginal and CALD people?

Ms HICKS — This one is predominantly Aboriginal and Torres Strait Islander training. We are just actually entering into an agreement with our local SMECC, which is Sunraysia Mallee Ethnic Communities Council, who is going to come and deliver multicultural awareness training to our staff as well. We are starting that in the emergency department and then hoping to roll that out across the hospital.

Ms COUZENS — That is great.

Ms DOYLE — Can I just say that the MDAS girls will come and give us short sessions on all different cultural subjects as well as far as the midwives go. Jacinta mentioned before that we have just recently had the big two-day culturally aware emergency training. That was new for us. But on an ad hoc basis they do come and give us training.

Ms COUZENS — With the cultural training, do you think that has engaged Aboriginal women more and that support within the Ramsay clinic? Have you seen evidence of that?

Dr PATRAVALI — Definitely. Just to give you an idea, when I started I had 10 antenatal patients that swelled to 50 per week. That number of registrants is going up. I have certainly gone and met with, for example, Sunraysia community and so on myself, so I have had that sort of link. We have done some memorandum of understanding as well. We are in the process of linking all the services. I think the women recognise that is the only birth place anyway, but I am also aware that it should not be out of force, that they like the place, because that is the only place they deliver. Hence we are trying our best. Apart from all the work that we do, we find time and link with the other services so that they are aware that we are on board, as it were.

Ms DOYLE — Certainly the midwives have a very good rapport with the workers at MDAS and the other various areas, mostly because we have all worked together. We all know each other quite well, so we understand and it is very easy to communicate difficulties or anything.

Ms COUZENS — I am not sure who mentioned before that middle part of the staff experience going. Have you looked at, and I am sure you probably have, incentives to return to work after they have given birth and those sorts of things?

Ms HICKS — It is a really difficult thing to combat because it is a lifestyle choice and you certainly understand why women want to stay home with their own families in that time. We certainly offer flexible shifts, short shifts, casual work — we have a large pool of staff who are casual — and we rely on those staff obviously to pick up a lot of shortfalls and they are a very flexible workforce. I commend them every day for the work they do because of their flexibility. It creates a lot of management time in having to call every day — those constant text messages and phone calls out to our small pool of staff asking, ‘Can you work today? Can you work this afternoon? Can you work night duty? Can you work tomorrow?’. It is just a constant stream of requests until someone responds, and thankfully usually someone does.

Ms COUZENS — The only other question I had was around mental health and the perinatal services that you provide. How do you go about identifying the mental health issues for the women that you see? Is there something in place?

Dr PATRAVALI — Yes. It is part of the antenatal care anyway, and then we link to the perinatal emotional service. That service was also shelved for a bit, and that has now just started again, so we can link them to the whole perinatal mental health program. We are also privileged to have a mental health department as well for the very high-risk ones. You would then get a psychiatric liaison nurse or a consultant. But then if it is beyond that, they need to go to tertiary centres and so on. I think as an antenatal service it is easier, because you see the patient for nine months and you can identify things; things come up. Lots of issues are raised by the service providers like MDAS and so on. They would tell us that this is going on socially for the patient and we can then link them to the right people. There are systems in place. It is not a perfect system, but we are trying our best.

The CHAIR — We had better let you get back to delivering babies. I am surprised your pager has not gone off while you have been here. I just want to say we appreciate your time. We feel privileged to have had you here today. The passion obviously shines through and if you could pass on our thanks to your staff that would be good. It is great to hear you speaking so highly of your team. It speaks wonders to us without your actually having to say it. Thank you so much for spending time with us today.

Witnesses withdrew.