

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bendigo — 24 October 2017

Members

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Witnesses

Ms Fiona Faulks, deputy director of nursing, women's and children's services,

Dr Nicola Yuen, director of obstetrics and gynaecology, and

Ms Amanda Hewett, Mamta coordinator, Bendigo Health.

The DEPUTY CHAIR — I would like to welcome everybody to this public hearing of the Family and Community Development Committee's inquiry into perinatal services in Victoria. This is the fifth hearing to be held by the committee for this inquiry in a series of hearings that will be conducted in Melbourne and in regional Victoria over the next few months. The committee is delighted to be here in Bendigo today and looks forward to hearing from the local community. Tomorrow the committee will hold a further hearing in Wangaratta. If you are interested in that, look at our website. That will have details of other upcoming hearings as well.

These proceedings today are covered by parliamentary privilege and as such nothing that is said here today can be the subject of any action by any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted. Today we also have the Parliament's broadcast team here filming the hearing. They may do some interviews during the morning. All telephones should now be turned to silent.

I welcome to these public hearings Ms Fiona Faulks, deputy director of nursing, women's and children's services; Dr Nicola Yuen, director of obstetrics and gynaecology; and Ms Amanda Hewett, Mamta coordinator, from Bendigo Health. Thank you for attending here today. All evidence taken at this hearing 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, and 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.

We have scheduled 45 minutes for your hearing. I would like you to spend the first 10 minutes or 15 minutes making a submission to us, and then we will ask questions if that is okay.

Ms FAULKES — Sure. I am happy to begin really by just putting some context around Bendigo Health itself and our services. As a level 5 maternity service and level 4 newborn service, we support the Loddon Mallee broadly all the way up to Mildura and then down to Kyneton and Sunbury. We provide antenatal intrapartum and postnatal care and neonatal care for neonates older than 32 weeks. We care for women at 32 weeks gestation and beyond. Beyond that, our transfer or referral pathways are down to the metropolitan services in Melbourne.

We have the capability to look after reasonably unstable neonates needing neonatal CPAP and short-term ventilation prior to transfer. We provide a number of different models within our service for women accessing antenatal care and then intrapartum and postnatal, including low-risk midwifery-led care, high-risk obstetric care, GP shared care and a continuity-of-care model with our midwives. Our obstetrics and midwifery teams work together to ensure that women receive the most appropriate care based on their history and coexisting health issues.

Most recently we have noticed, like all health services have, an escalation in the number of women who are experiencing gestational diabetes or who are perhaps obese or morbidly obese, which changes their risk profile throughout the pregnancy. We have certainly noticed that impacting on our services.

We work closely with our rural partners in the Loddon Mallee and the GP obstetricians that provide care to women who are low risk and appropriate for that model of care but have noticed that the referrals to us are increasing based on those risk profiles that are considered inappropriate now for rural services. That is impacting on us and also on those women of course.

I have with me today the Mamta coordinator. Mamta is our continuity model of care for women, which means they have small teams of midwives — usually two, sometimes three — caring for a woman antenatally and caring for her then throughout her labour and birth and also postnatally, which is a very popular model of care. I will pass over to our director of O and G to talk about the high-risk obstetric models.

Dr YUEN — In terms of the high-risk obstetric models we have a team of consultant obstetricians, including three full-time staff specialists. The acuity of patients has changed quite dramatically over the last 12 to 18 months in terms of some of the things that Fiona has already touched on.

Just as an indication, we remodelled our range of care around normal and high-risk pregnancy for the beginning of this year, moving into our new facility. We are expecting approximately a 50-50 mix between normal and

high risk. In fact on review of those statistics it seems we are more like 70 per cent high risk and 30 per cent low risk, so there is a significant increased acuity that we are seeing. Obviously those women require more visits during pregnancy and are also more at risk of poor perinatal outcomes, so we are obviously trying to deliver the best model of care that we can to them.

Along with that we have had to focus on really making sure that we deliver appropriate intrapartum care to these women as well. To that end we actually now roster a consultant dedicated to the birth suite Monday to Friday, 7.30 a.m. to 5.30 p.m., who has no responsibilities other than to care for women in labour and to provide that support and expert advice.

Just following on from what Fiona has already said, the impact of the maternity capability framework has had quite a significant effect on the services that we deliver. The capability framework has had an effect on the smaller hospitals, meaning that they are seeking advice and support from the regional referral centre — this being Bendigo — around patients that exceed their capability. We are collaborating quite extensively with the smaller referral centres to ensure that we are supporting them to meet their capability, therefore ensuring that women receive at least some of their care closer to home, reducing the travel for some of them.

Ms FAULKES — In terms of the challenges we face, as a regional centre I guess we are very different to metropolitan services in terms of how we access our workforce, replenish our workforce and support it. Our options for growing our own are really reliant upon the postgraduate workforce employment model of training of midwives. We have for many, many years now utilised that postgraduate model of training to replenish our workforce every year, and that has been very successful. We would not like to see that replaced by an undergraduate model only. It is important that that postgraduate model remains an option for nurses who are trained in nursing but wish to move into the midwifery field.

Currently we have options for a bachelor of midwifery or a bachelor of nursing/bachelor of midwifery, and then there is also the postgraduate training model, which is critical to rural and regional workforce sustainability.

I think there is an opportunity for us to continue to build our capability within Bendigo and to continue to build our capacity to support the smaller rural services around us. It is important to us, as it is to the rural services, that low-risk women can remain in their own communities and birth where appropriate. I think they are some threats to our current service model.

Dr YUEN — Following on, just talking about recruitment and retention, obviously the issues that we have with recruitment and retention of rural specialists are not dissimilar to other areas of medicine. We have very much the same philosophy as Fiona, where from an obstetric point of view we would like to grow our own, and that really answers to two things. The first is around growing a cohort of regional obstetricians that are trained regionally and tend to work regionally. There is a program beginning out of the college of obstetricians and gynaecologists around rural funded training positions, for which we have been approved at Bendigo Health but that we are yet to achieve funding for. So obviously our ideal would be to be able to grow our own obstetricians that are going to work within our community.

Further to that we have got two procedural GP registrar positions, which are really designed to train GPs who are going to do rural obstetrics and really support the Loddon Mallee region at large. We train two each year with that, who leave the program at Bendigo after a year with an advanced diploma, which allows them to practice GP obstetrics within the region. I think that is probably our commitment to the region in terms of continuing to strengthen and support the smaller regional hospitals with an adequately trained medical workforce, and obviously Fiona has touched on some of the midwifery as well.

Ms FAULKES — I think the other very important aspect of quality and safety within maternity care is clinical leadership, and one of the challenges we face is that neither the Safe Patient Care Act nor the EBA before that provided for supernumerary clinical leadership within the birth suite and the special care nursery space. Although we endeavour to ensure that occurs at Bendigo Health, I think from a statewide perspective we should be really looking at how we ensure that clinical leadership is provided within all birth suites and neonatal services. That coordination role and escalation role and supportive role to both junior and senior staff is critical.

The DEPUTY CHAIR — Would you like to just explain a little bit about the Mamta?

Ms HEWETT — Yes, the Mamta program is a continuity-of-care midwifery program run through Bendigo Health. We have eight midwives who work within our teams. We usually work in teams of two or three. We are a low-risk model, so we recruit women who are low risk at the beginning of their pregnancy, but we retain the women if they become high risk throughout their pregnancy. It is a very popular program within the community. Our application process is that women apply for the program and then they are recruited at about 20 weeks. Currently we are able to recruit about half of the women who apply. We see these women throughout the antenatal period, and then we are on call for their births. We see them throughout their postnatal period, and then we do their home care.

Ms FAULKS — In terms of being oversubscribed, I guess, one of the challenges in the continuity model is the prevention of burnout in the midwives that work in that model, because they are on call 24 hours a day. It is a hard balance to maintain, and we find that we support the midwives moving in and out of the mainstream midwifery cohort to allow them to have a break from time to time from the on-call. For those who want to there is the ability to move back into our mainstream workforce, come off call for a while and kind of re-energise, if you like, and then move back into the model. Our model has been operating for 10 years now, and we have not had an issue with the recruitment or sustainability of that workforce.

The DEPUTY CHAIR — Okay. Are you ready for some questions from us? I will start. First of all, can you tell me what other smaller centres nearby people can birth at?

Dr YUEN — Geographically, and I have got to get this right being relatively new to Bendigo, Castlemaine is probably our closest regional centre. Castlemaine is a level 2 within the maternity capability framework. Beyond that, Kerang has recently closed its services.

The DEPUTY CHAIR — Closed?

Dr YUEN — Closed, yes — closed last year. Cohuna and Echuca would be the next closest. Echuca is a level 3, Cohuna is functioning as a level 2, and Swan Hill is also delivering and they are also a level 3.

Ms FAULKS — There are some antenatal services in Robinvale, but not birthing services, and then Mildura is a level 4.

The DEPUTY CHAIR — So you capture the more complex ones from those.

Ms FAULKS — Yes, correct.

Dr YUEN — We also capture quite a significant amount from Deniliquin as well, so we are getting steady traffic coming down from New South Wales.

Ms FAULKS — And then also a lot of women from Boort and that area, which is kind of over to the west.

The DEPUTY CHAIR — Regarding the choices for people close by — not even close by, a little bit further — they just really come to Bendigo. How far would the average person travel?

Ms FAULKS — It is difficult to say. We have a lot of women coming from Kerang, and that is an hour and a half for them to travel. We have high-risk women coming from Swan Hill, which is over 2 hours, and then we have women coming from Mildura, which is over four. Sometimes women will come from Mildura, but sometimes they will also be referred to Adelaide. You can imagine how challenging it is for them. The higher risk women will be transferred from Mildura down to one of the metro centres. In some ways they are displaced at a very critical time of their lives when they are at extremely high risk of social and emotional disadvantage, and being removed from their social networks and their support networks is challenging for them.

The DEPUTY CHAIR — You mentioned you have got three obstetricians.

Dr YUEN — We have got eight obstetricians on staff. Three are full-time and the rest are part-time.

The DEPUTY CHAIR — How many of those are country people?

Dr YUEN — All of them live in Bendigo now. Whether we started in Bendigo, I would have to say probably half of them started in Bendigo, but we do not have a fly-in fly-out workforce, so it is a Bendigo-located workforce.

Ms EDWARDS — Thanks for your submission. It was really pleasing to see Bendigo Health put in such a comprehensive submission to our inquiry. I have just a couple of questions in relation to the transfer model. Can you perhaps tell us how well the PIPER transfer system works in these regional areas?

Ms FAULKES — There are two elements of PIPER for us to rely upon, and then there are the elements that our rural partners rely upon. For us there is a neonatal element to it and also a maternal element. At times we have trouble moving women out when we need to, due to a lack of beds in the metro services. Sometimes we will make a referral to PIPER, recognising that a woman is beyond our capability and needing to move her to a metro service. Sometimes that can be either not possible or very slow. Usually that is related to the bed status in the metro services.

There is a similar problem with the neonates in the sense that, really for us, by the time we have an unstable neonate within our neonatal service or an unstable woman, we can be between 2 and 6 hours away from having a specialist team arrive to assist us. So really, certainly in the initial phases, we need to be able to be self-sufficient for a period of time, and that is not always easy. I know that our rural partners have similar problems in that they approach PIPER to assist with a transfer and there is a long period of time often that they need to wait until that assistance arrives.

Ms EDWARDS — Just in relation to the Mamta program, how many women would you see per year?

Ms HEWETT — There are about just under 250 births per year.

Ms EDWARDS — How many midwives work in that program?

Ms HEWETT — Eight.

Ms EDWARDS — That is a big case load, isn't it?

Ms HEWETT — Yes, it is approximately about three women per month per midwife.

Ms EDWARDS — How many women apply per annum? You said about half get accepted, so obviously it is extremely popular.

Ms HEWETT — About double would apply, but of the people who would apply, not all of those people would be eligible with the low-risk recruitment model.

Ms EDWARDS — And how many of those women would be first-time pregnancies?

Ms HEWETT — That we actually recruit or that we —

Ms EDWARDS — The women that enter the program.

Ms HEWETT — About 60 per cent. That is our aim.

Dr YUEN — Just to comment on that, we have set up a profile for Mamta in terms of what recruitment should look like in terms of the proportion of first-time mothers returning — returning clients. Obviously there are people who have had a good experience before who would like to return to the program, but we also want to make it available to as many women as possible as well. We also talk about women who have had a previous caesarean section, and they are eligible for Mamta as well. So that is the profile that each Mamta midwife holds in terms of recruitment. It is not just about the numbers; it is also about the spectrum of care we are able to provide for those women.

Ms EDWARDS — Can you just tell us how women are referred to the program?

Dr YUEN — In terms of the process, all women referred to Bendigo Health maternity care have a booking-in visit with a midwife, who completes a review of their medical issues, their obstetric care to date and their investigations to date. Out of that, they are then screened by an obstetric consultant in terms of denoting

them with a risk. Sometimes that is very easy. Patients are definitely deemed normal risk — there are no issues — or they are high risk because of their issues. Sometimes it is that we need to see them to have a further conversation with them to determine that. Once women are screened to be normal risk, then they are eligible for recruitment by Mamta.

Ms EDWARDS — Just in relation to Aboriginal and Torres Strait Islander women, the support you provide, I presume, is through the on-site Aboriginal health liaison officer —

Ms HEWETT — Correct.

Ms EDWARDS — and you have a memorandum of understanding with the Bendigo and District Aboriginal Cooperative.

Ms HEWETT — Correct.

Ms EDWARDS — What percentage of women would be coming to Bendigo Health who are Aboriginal —

Ms HEWETT — Who are identifying as Aboriginal and Torres Strait Islander in terms of pregnancy care?

Ms EDWARDS — Yes.

Ms HEWETT — About 2.5 per cent.

Ms EDWARDS — Would you say anecdotally that that would mean that those women would be at higher risk than other women?

Ms HEWETT — Yes.

Dr YUEN — A significant amount of that 2.5 per cent are coming from regional centres referred to us because of their risk profile and they have been identified as having a higher risk pregnancy.

Ms HEWETT — Particularly from Echuca or Swan Hill or Mildura, they are referred down to us.

I just wanted to go back a point, Maree, if I may, around Mamta. I think one of things that is critical with the Mamta model or the continuity model is that although women go in as low risk, if their risk profile changes throughout their pregnancy and they become high risk, which we know can happen at any stage, women are not removed from the program based on that. They are retained. There are two things that are important about that. Because the women are at a time when they critically need support because they have become high risk, they still maintain that relationship with their midwifery team. The other thing is that the midwives working in the Mamta program remain skilled in working with high-risk clients, so I think there are two elements to why that is important.

Ms BRITNELL — Thank you very much for taking the time to present here today and share with us the challenges and opportunities, I think, as well for this region. I was actually quite surprised at the dramatic increase I think you were articulating in the increased levels of obesity that were putting people in the high-risk category. My question is around health promotion and the awareness of obesity and high risk in pregnancy. Do you think that has been keeping up?

Dr YUEN — I think the impact of obesity in pregnancy is still very much a developing area for obstetrics. I am currently involved in the development of guidelines around obesity management in pregnancy with Safer Care Victoria in the maternity handbook. Talking to my colleagues, it is still very much an area where the evidence is still being discovered. I think out of that we are gaining a little bit more focus on those issues around health promotion and health management prior to pregnancy. It is obviously a difficult field for us because by the time they get to us they are already pregnant.

It is obviously something which we are very keen to manage. It is certainly something which we promote within our gynaecology clinics with women seeking fertility treatment or investigations for subfertility, but I think it is something that will probably garner a little bit more traction over the next couple of years as we begin to understand a little bit more about the risk of obesity in pregnancy.

There is some data that has come out recently around the increased risk of perinatal mortality and how that directly correlates to BMI at the beginning of pregnancy, so we are beginning to see that. We at Bendigo have done some research around the risk of postpartum haemorrhage and obesity, and we are beginning to see some results from that.

Once we are able to give women more information about what risk they are actually facing, I think we will be in a better position then to some help support them prior to pregnancy to achieve a healthy weight before pregnancy.

Ms FAULKES — I agree with you, though, that I think really by the time women are pregnant the horse has bolted. I think it is a public health issue that we need to be addressing. I think, as Nicola said, once we are aware of what impact that can have on the woman and her baby, we might be able to gain some traction with women understanding how a change in lifestyle might impact positively on them or their baby.

Ms BRITNELL — I just wanted to clarify: you said that there was a 70 per cent increase in the last 12 to 18 months of people in that risk category from obesity.

Dr YUEN — No. What we have said is that we expected to have a profile of normal risk to high risk of 50-50. In fact what we have found is normal to high risk is 30-70 in favour of high risk being our predominant cohort. Of that, the main contributor to the high risk is BMI and diabetes. So it is not a growth; it is just that we guessed our risk profile and got it a little bit wrong.

That has also been the perfect sort of storm of maternity capability kicking in as well. BMI has been one of the major restrictive factors for some of the smaller hospitals to care for women. Certainly the smaller hospitals within our region do not deliver women with BMIs over 40, so that is a group that we are now seeing moving towards us in bigger numbers than perhaps we did two years ago.

Ms BRITNELL — You also talked in your presentation just now around developing guidelines and getting them obviously from research. That makes me think about one of the presentations we had in another inquiry, where they talked about the difficulty of IT and having that smooth transition between institutions such as pathology, such as between units in Melbourne and country or private practice and public health services. Is that a challenge that you guys are familiar with as well?

Ms FAULKES — Definitely.

Ms BRITNELL — Is there some way we should be streamlining that with support from the Department of Health and Human Services?

Dr YUEN — It has been a challenge. It has actually been discussed quite extensively at the regional perinatal morbidity and mortality meetings, which have been now established for almost 18 months. Having tertiary or Melbourne metropolitan representation at those meetings has been important for us to understand what the issues are. The issue of communication between the services, I think, is what we are talking about. It is very difficult. We are not all on the same computer system, we cannot all see each other's records and certainly that is not the way that care is currently established.

We are very, very heavily dependent on the handheld Victorian maternity record: the VMR. We use that as the only reliable form of communication. That is given to all patients at the beginning of the pregnancy, and they are expected to bring it to every visit, and we emphasise that with the tertiary centres as well. In fact it has been agreed with the tertiary centres that at the moment the only reliable form of communication is the handheld record.

Ms BRITNELL — What is the percentage, in your gut feeling probably, of who turns up without that? Is it 30 per cent, 10 per cent or —

Dr YUEN — I would say certainly the patients that I see in obstetric clinics would be pretty low. I would say most of them would have it with them, at least nine out of 10 women would have it with them.

Ms FAULKES — That was a major problem for us. We received some feedback from both GPs and rural services that the communication between us and them was not really working around pregnancy care, so we introduced an education program for our midwives to make sure that as soon as they hand over that VMR, right

at the start of her pregnancy, that they educate her about the importance of that document — that it is not just a document that is an option to them but is actually required to provide safe pregnancy care to them. All women have them, and we encourage and have taught our midwives and medical staff to ask for it at every visit, and then we update it with the BOS summary that we generate at the end of that visit.

It is critical. For example, if a woman was pregnant and was receiving care from Bendigo Health, but went to Mildura for the weekend and ruptured her membranes or became unwell, that transfer of information is slowed down significantly. If she has her handheld record with her, all of the pregnancy details are there. If you are asking whether it would be wonderful to have a statewide database, yes. A statewide database for GPs, hospitals and midwives to have access to? Yes, yes, yes.

Ms BRITNELL — Are we getting duplication and wasted funds such as tests being reordered and that sort of thing? Is there an opportunity for savings by doing exactly that — having a streamlined communication system that is accessible by all people who are trained in confidentiality?

Dr YUEN — Potentially. We do quite a bit of work at the beginning of pregnancy to ensure that we are not duplicating unnecessary tests for patients. There is a lot of manual chasing down of results from GPs to ensure that we are not ordering tests that are unnecessary, and that is all part of rational ordering.

In terms of allowing that very clear communication plan from one facility to another, acknowledging the fact that at the moment one of the things we have talked about today quite extensively is the increasing movement of women between services, I think having something that would allow that to be on record at the time of consultation would be fantastic.

Ms BRITNELL — I wanted to ask you also: what in your opinion is the best model for creating pathways to midwifery?

Ms FAULKS — Sorry, I do not understand the question.

Ms BRITNELL — You talked earlier about the fact that you have got some real challenges around retention and having enough midwives. You also talked about postgraduate and some midwives nowadays coming in without their general nursing first. Which, in your opinion, is the best way to actually have a midwife available and trained to the capacity to meet rural needs?

Ms FAULKS — I think there is a difference between regional and rural in this space. I think within our staff group we have bachelor of midwifery midwives who have just studied midwifery. We have bachelor of nursing and bachelor of midwifery midwives, who have done both.

Ms BRITNELL — Double degree?

Ms FAULKS — Double degree, correct. Then we have the postgraduate students who become midwives. They all can work within our service reasonably seamlessly without much difference noted from us.

Within a rural service a midwife is required to be often across a number of different sections of that facility. So I have myself worked rurally, and I was expected to look after the maternity unit as well as the emergency department as well as some surgical beds. I understand the rural challenges in that space.

Certainly for us now in Bendigo, once upon a time we had trouble sustaining bachelor of midwifery students because we had such a high rate of gynaecology surgery as well as other patients that did not sit within the midwifery scope, and that was problematic, but now our unit is big enough and busy enough for us to employ bachelor of midwifery midwives successfully, and certainly their training is on par.

Ms BRITNELL — So yes, from a health systems perspective they are really very suited to a very specialist, larger institution.

Ms FAULKS — Correct, yes.

The DEPUTY CHAIR — I have got some questions now about GPs and the role of GP obstetricians and GP shared care. Can you please talk a little bit about that?

Dr YUEN — Yes. The GP shared care is a model that has existed for a very long time. Its profile within Bendigo probably was not as high as it needed to be, and certainly there is a little bit of work going on around encouraging that practice of maternity shared care with their local GP. In terms of the numbers at the moment, those that engage with shared care is small. That is partly to do with the risk profile that we have just talked about — the women who are suitable for shared care are the normal-risk women, not the high-risk women. We are already identifying what is the minority in our cohort at the moment that would be eligible for shared care.

In terms of GP obstetricians, there are no GP obstetricians practising within Bendigo, but we certainly know that to sustain the rural workforce outside of Bendigo within the region GP obstetricians are incredibly important for us to support, and that is where we see our role — as really around ensuring that the training that they can receive at Bendigo with their procedural skills year is adequate to set them up for that practice.

The DEPUTY CHAIR — I do recall a number of years ago that there was a fear that the GP obstetricians would be becoming less because of the insurance and liability. Is that something that you feel or you hear or you experience?

Dr YUEN — Certainly my experience in the last 12 months of recruiting is that the position at Bendigo for the GP registrar to gain that advanced diploma in obstetrics is very popular. Certainly we are trying to identify registrars who are wanting to stay within the region, and in fact both of our current GP registrars are intending to stay within the Loddon Mallee region and to actually use their skills. I think we have probably gone the other way from that point to actually accepting the fact that we are not going to be able to provide obstetricians to every rural hospital within the region, and therefore GP obstetricians are absolutely critical to us supporting maternity care at the smaller hospitals.

The DEPUTY CHAIR — And that is the model that is in the smaller hospitals now?

Dr YUEN — Yes. The bulk of the care that is provided by the obstetric workforce, acknowledging the work by the midwifery, outside of Bendigo is provided by GP obstetricians, not by obstetrician gynaecologists.

The DEPUTY CHAIR — I have just got one other question about the maternal and child health program. You spoke about postnatal care. I was wondering how that fits with the role of the maternal and child health nurse.

Ms HEWETT — We see our women on the ward while they are an inpatient within the hospital, and then we see them in the home. We do a couple of visits at home, and then we hand over to maternal and child health — so they take over from us.

The DEPUTY CHAIR — Okay, yes. That is a formal process?

Ms HEWETT — Yes. We send an email when we have discharged them from our care. Maternal and child health get a notification of births so they know that a woman in their area has had their baby. Maternal and child health have usually contacted the women before we have actually handed over.

The DEPUTY CHAIR — I have just got one more question about the high risk of gestational diabetes and even with obesity. Can you tell me what sort of additional services somebody in that high-risk category may get?

Dr YUEN — Antenatally women that are identified as having gestational diabetes enter a multidisciplinary care model at Bendigo Health, and that involves a dietician, a diabetes educator and an endocrinologist as well as an obstetrician. So they enter quite a broad team of care. What we also know is that this is a group of women who need additional midwifery support through the last part of their pregnancy. We know that one of the risks for babies born to mothers with diabetes is hypoglycaemia in the first hours to days. One of the critical factors for us to mitigate that risk is to actually get them expressing antenatally for colostrum. Obviously that is something where we try to engage with midwifery support for that and lactation consultant support early to help reduce the risk for those neonates when they are born.

So the care model antenatally is very multidisciplinary to try and target all aspects of that. When they are in labour these women are cared for obviously under the high-risk model with midwifery support. Postnatally these women will receive ongoing follow-up in terms of the fact that they will be referred to their GP with a

request for a six-week glucose tolerance test to ensure that their diabetes is not ongoing beyond pregnancy. Part of that is that they receive counselling in hospital after their baby about the high risk of their future pregnancies.

Ms FAULKES — The other sequelae of diabetes in pregnancy is in the neonate. We see a high number of neonates being admitted to our special care nursery with hypoglycaemia and needing care and monitoring in that space. There is a whole lot of things that start to happen. There is a cascade of intervention, if you like, both for mum and the baby.

Ms EDWARDS — We have both Monash and La Trobe here as our rural medical schools. How many staff are you able to gain from there? Are they being trained through that program or are they coming from outside of the region?

Ms FAULKES — All of our postgraduate employment model students come from La Trobe. They have just introduced, this year, the bachelor of nursing-bachelor of midwifery, based in Bendigo, which is of huge benefit to us. Because we are growing, the employment model was not going to be able to sustain us long-term. We now have 20 students in every year of the bachelor of nursing-bachelor of midwifery. It is really key for regional services to have local people trained in midwifery, because then they stay in our unit. When we have students or graduates from interstate or even from Melbourne come to us, they often leave in time to move back to be with their family. So for us it is critical to have local people trained who we know have a vested interest in our community and the health service and will stay with us, and that has been our experience — if they are local, they stay with us.

Ms EDWARDS — Are you aware of any scholarships that are available through either of those tertiary institutions for those bachelor degrees?

Ms FAULKES — Yes. There are scholarships available for their tuition. The round has just been released. I think it is \$4000 to \$6000 per successful applicant. But in terms of the funding for the health services to have them, the T and D grants from the Department of Health and Human Services is what is provided to support them in terms of clinical support. We could probably improve in that space, particularly with the employment model. With the bachelor of nursing-bachelor of midwifery students, they are always supernumerary, so they come into the service and they work alongside a midwife. With our postgraduate employment model students, they are part of our workforce, so to provide support for them to be in the birth suite they need additional clinical support, because they obviously cannot be in there independently. So it would benefit them enormously to have more funding supporting them for us to be able to allow them to spend more time in the birth suites as supernumerary students.

Ms EDWARDS — I just wondered in terms of lactation consultants; do you have specialist lactation consultants or is that part of midwifery?

Ms FAULKES — No. We have a breastfeeding support service, which is a team of lactation consultants who look after women. They do classes antenatally, particularly in the gestational diabetic group, to get them expressing early so we can hopefully avoid that hypoglycaemia and admission of their babies to special care. They do general antenatal breastfeeding classes. They do inpatient breastfeeding clinics, where they are available to inpatient women to come in and spend a couple of hours with them and breastfeed in a group with the other women who are inpatients, and then they do some postnatal education as well as parenting education generally. So we rely upon them very heavily. They come into the unit for women with breastfeeding problems and write breastfeeding plans for them — lactation plans — that allow the midwives then to support those more complex breastfeeding problems.

Ms EDWARDS — Does that tie in with a broader education program that you run — antenatal programs across the hospital?

Ms FAULKES — Yes.

Ms EDWARDS — Could you perhaps tell us a little bit about what those education programs entail?

Ms FAULKES — In terms of the childbirth education? The childbirth education program is mostly picked up just by primigravida women — women in their first pregnancy. We are currently looking at developing some innovative delivery models such as YouTube and apps. We have almost got an app finished for our clients,

because we find that women can choose to engage in that education. Some women for whatever reason, whether it is geographical because they actually live in Swan Hill, cannot make it to childbirth education classes or whatever. We want all women to have access to that education. So we are looking at innovative platforms, but currently it is still a face-to-face class that they do. They do them on Sundays and then they also do them Wednesday nights — I think it is Wednesday night or Thursday night. So there is still the traditional delivery of childbirth education, but we are keen to make sure we can make it an option for all women.

The DEPUTY CHAIR — I am mindful of the time. Roma has just got one more.

Ms BRITNELL — I had three more but just want a quick clarification. Obesity is the rationale behind gestational diabetes; is there a direct link or not necessarily?

Dr YUEN — Not necessarily. There is a group of women with obesity. One of the risks of obesity is an increased risk of developing gestational diabetes, but it is not that all of our gestational diabetes women are obese and it is not that all obese women would.

Ms BRITNELL — But the reason we are seeing a dramatic increase, is that directly because of the obesity element?

Dr YUEN — Yes, and also because it breaches the capability of some of the smaller hospitals. So once they are diagnosed with diabetes, then they are coming to us here.

Ms BRITNELL — Yes, so they are referring — understood. I do not know if you saw the appointment of the rural health commissioner — a federal appointment — last week, and I just wanted to address that. No? You did not see that.

Ms FAULKS — No.

Ms BRITNELL — I wanted to address workforce issues specifically in rural areas, and I just wondered whether that is something that Bendigo would be interested in engaging with and taking the opportunity to look at the opportunities?

Ms FAULKS — Very much so.

Dr YUEN — Definitely. I think we have identified both midwifery and obstetric and GP obstetrician workforce issues today, and I think an opportunity to develop that further would be fantastic.

Ms BRITNELL — One last question: lactation team — is that an initiative of the hospital and how is that funded?

Ms FAULKS — It is an initiative of the hospital, and it is funded through WIES because we choose to fund it.

Ms BRITNELL — Right, so it is from your global budget?

Ms FAULKS — Yes, because we believe in the importance of it. We believe in breastfeeding as the best outcome for the babies and the mothers, and so it is one of those things we choose to fund.

The DEPUTY CHAIR — Thank you very much. We greatly appreciate you coming in and giving your time for a very enlightening discussion with us.

Ms FAULKS — Thank you. Should you have any other questions that arise throughout the course of today or at any stage we would be very happy to respond.

The DEPUTY CHAIR — Thank you. We will.

Witnesses withdrew.