Dear Committee,

Ms DONNA DAVIS: This is something to take on notice, but it would be really helpful to get some idea of the types of basic machines that you don't have access to. That really would make life a lot easier and for you to be able to refer patients to other hospitals. We just heard previously about the fact that in Tamworth there is only one MRI and it is privately operated. To what extent would having—

SUSAN SARGENT: We don't even have an MRI.

Ms DONNA DAVIS: No. So to what extent would having access—and I know that that also comes with needing staff, but it would be good if you could take that on notice and have a think, please. Thanks a lot.

Thank you to the Member for Parramatta for the question. I have thought about this over the past week, and I can't specifically name any basic equipment that we lack, that would improve transfers. There are some tests that we don't do, but as a Level 3 service they don't fall within our scope anyway. I sought feedback from my colleagues in the Emergency Department, however none responded, which is unfortunate as they would have had some good insights as they do a lot of transfers and retrievals.

The main issues as I see them remain with staffing and systems. If you will indulge me, I will elaborate on this, as I have some points that align with the question, if not directly answering it. I will focus mainly on maternity as that is my main area of expertise. Some points are relevant to both nursing and midwifery.

Even though CTG for fetal monitoring is not actually supported by research evidence, it is embedded into our policies. CTG monitoring requires a "second check" for interpretation, done by either another midwife or an obstetrician. Presently, as sole clinicians, we have to log in to the Pexip videoconference system for a check, or call in the doctor. If Tamworth wants one done, we have to copy it or send a picture to the registrar via text, or sometimes we don't even send it to them at all, just enter in the eMaternity system that it was done. None of these checking options are really clear in transmission; they are time consuming, and have confidentiality issues. They take the midwife away from the woman. Calling in the doctor is expensive, and adds to his fatigue. These checks also leave the remote clinician at risk as they are checking something secondhand, that is not directly in front of them. I am not always confident of a check using Pexip as the midwife at the other end is holding the paper trace up to a webcam and it's hard to read it accurately. A system that sent the trace directly would be a huge help, and avoid some of the issues when trying to check remotely. Lots of metropolitan hospitals use a central monitoring system in their

birth suites, Fetalink, where the bedside monitor is transmitted to a computer at the staff station. It also transmits the data directly to electronic medical records. It would not be too difficult to set up a similar system where the referral site logs in remotely to view the actual trace. We already have this remote capability with the critical care cameras in our ED, nursery and HDU. NETS use these for unwell babies, as do Tamworth and John Hunter for ED and HDU cases. It really would not be difficult to do, and would be much more secure, as well as more efficient.

Ultrasounds are largely a staffing problem more than an equipment problem as we do have ultrasound on site. However, they are only available during weekdays. If we could upskill our midwives to perform bedside ultrasounds, with a decent machine, we could work more fluidly with Tamworth for those women who suffer complications both antenatal and postnatal, or who might need additional third trimester monitoring. It would also help with those after-hours presentations who end up having to be transferred just to get an ultrasound. A recent case here in Narrabri could have had a better outcome if she could have had an ultrasound here when she first presented, instead of having to go to Tamworth severely unwell. Her life was at risk. We may be able to reduce the need for transfer for some women, and aid decision making for the referral site to accept or not accept, or to offer treatment locally instead of using a lot of resources to transfer. We could offer more timely care for women who aren't in an emergency situation, but still need priority care. A reduction in transfers would certainly be a cost benefit.

Some of our neonatal equipment is broken - like our incubator. It's been waiting on a part for at least a year that I know of. This does limit our capability for emergency neonatal care if we do get a premature birth or an unwell baby. Although I believe we are supposed to be upgrading to new Panda warmers. The nursery feels like a dumping ground for broken, unwanted or surplus equipment when it could be utilised for back transfers of stable babies and take some pressure off Tamworth. On my last visit to the special care nursery (after a premature birth en route between Narrabri and Tamworth), there were 8 babies with one nurse overnight. We do have the skills for stable growing prems, or term babies with some conditions under supervision of paediatricians, although this is limited by availability of appropriately credentialed staff.

I had asked some colleagues from ED for their thoughts as well, but nobody responded, so unfortunately I can't offer further insight from an emergency perspective,

which is a shame. However, with the change to NSWH Pathology we noticed an increased workload on ED staff with all the bedside testing they now have to do. There have also been delays in diagnostic testing that had to be sent away, delaying treatment and care. One episode recently in maternity led to a delayed diagnosis and significant complications for the mother. So having access to a full pathology lab as we did under St Vincents would be very beneficial. I can't really elaborate any further on that as it isn't my area. I believe there have also been issues with the Telestroke service in Moree, but again, that is not my area of expertise so I can't give much detail on that.

As I noted at the hearing, we need IT systems for patient flow that are more user friendly. I know there's a lot of work already going on with our new Single Digital Patient Record coming in, but this is only one piece of the puzzle. SDPR will hopefully be helpful, however my understanding is that this system is for each person's medical history and records, like the 9 different EMR systems in use now, but it doesn't integrate the EPJB for active admissions or bed management, which is what we need for transfers. Don't get me wrong, patient flow unit do an amazing job, but from a clinician perspective it is frustrating. We are still using paper based documentation in HNELHD, which is, quite frankly, archaic! Every transfer needs dozens of pages photocopied, which nurses and midwives have to do because we don't have admin staff. If SDPR works as intended, it will be an improvement that removes some of these issues, but it is still in development, and not expected to be fully rolled out until late 2027. Splitting a district before this happens would be detrimental to efficient and safe care.

Even with streamlined clinical records, we still need to get the person to an appropriate destination. A statewide transfer network would be much more useful than a mish-mash of different ones that don't talk to each other. Having statewide systems without all the layers to get decisions made would just streamline everything. Duplicating patient flow units in a new health district would add more layers of communication to get through. Currently we will book the inter-hospital transfer with patient flow through the patient journey board. They will then liaise with the referral hospital and arrange for medical discussions to take place between the referring and receiving doctors. The receiving doctor doesn't always accept the patient right away if they don't think the problem is urgent enough. After the patient is accepted, patient flow will talk to bed managers to find a bed. Patients are placed on the waiting list and we are frequently waiting days, even weeks sometimes, for a bed. Patient flow unit often tells us they are waiting for return calls from hospitals out of district (usually Sydney, sometimes private hospitals) and can't do any more. If patient flow was

statewide, some of the inefficiencies could be improved. Sometimes when patients return, this system is not even used, especially from other districts and private facilities, although John Hunter are bad for it too. Patients just turn up out of the blue and we know nothing about them, no doctor has accepted their care, and we definitely don't have a bed ready. This was a partial cause of my own workplace injury from a bariatric patient who just turned up at night.

We often feel like we are ignored out here, as our patients often get bumped for an urgent case - I recall an elderly lady waiting many days with a fractured hip because of "more urgent" cases. If she had been in a larger hospital, her treatment would not have been delayed and she wouldn't have laid here in pain, her chances of recovering her mobility and independence slipping away with each passing day that she remained untreated. Maternity transfers also seem to be given low priority and we can wait many hours with a woman in labour because they aren't seen as urgent enough. Postnatal complications are also usually low priority, even when life threatening. A recent story on The Project about women from Kempsey and Narrabri emphasises that.

Then we have to arrange transport for the patient, a system that is also difficult to navigate, difficult to escalate, and seems inefficient. There have been times where crews have come from Tamworth or Inverell just to do a 5-minute nursing home transfer while our local crew is tasked elsewhere. We spend hours chasing up suitable transport sometimes. What a waste of resources!

Now this last point is not strictly equipment related either, but it's been a dream of mine for a long time, to help with the absolutely appalling state of rural maternity services. I will eventually do a PhD around this.

I would LOVE a dedicated, statewide maternal advice and transfer system. Staffed with experienced midwives, who would have the real-time data on who is on bypass at any given time, and who can accept. A central advice line (similar to Health Direct but strictly for maternity) where a woman can call from anywhere and speak to an experienced midwife for advice and referral. An experienced midwife there to listen, understand and coordinate an appropriate care pathway for the woman. A woman wouldn't have to ring around hospitals to find out where she could go. She wouldn't have to speak to a ward nurse with no maternity training because there's no midwife available at her local hospital. She wouldn't have to turn up to Emergency because there's no other option. She wouldn't have to go somewhere just to be turned away.

Ideally I would love every maternity unit staffed and open. But we all know that isn't going to happen any time soon. So this service could have specialised crews available to transfer the women more safely than in a cramped ambulance or in their own cars on rural highways. A bit like NETS, but for women. Ambulances are precious and need to be kept for medical emergencies. Many of our women live with extreme disadvantage and don't have access to long distance transport.

Wouldn't that just be amazing? This system could extend to the postnatal period as well, offering additional support during that important but sorely neglected time.

Please get us rural midwives out of medical wards and enable us to provide the care that women deserve. We aren't there to make up RN numbers and just do maternity if someone turns up. That's what got me injured. That's what is pushing midwives out and why nobody wants to work rural.

Again, thank you for the question, and thank you for your time in reading my response. I welcome any follow-up questions if they arise.

Regards,
Susan Sargent RN/RM