FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bairnsdale — 7 December 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

Witness

Ms Heather Daly, midwife.
The CHAIR — I welcome Heather, who is a midwife. 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 comment you make outside this 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. I understand, Heather, you are a midwife that works at Bairnsdale Regional Health Service, but you are not representing BRHS today. You are representing yourself.

Ms DALY — That is right.

The CHAIR — We would love to hear from you for about 10 to 15 minutes. Tell us your story, and then we might ask questions if that is okay.

Ms DALY — Okay. That is fine.

The CHAIR — Thanks so much, and thanks for your patience today, too.

Ms DALY — I have not actually got copies of my blurb for you, but I can supply them afterwards. Yes, I am a registered nurse and midwife. While I am currently employed as a midwife and community health nurse at Bairnsdale Regional Health Service, I am speaking as an individual and not officially representing the service, as you said. However, my comments are not aimed at criticising the health service, but as possible suggestions for most rural maternity services. The criteria I wish to address are regarding the availability, quality and safety of services, the methods to reduce the incidence of maternal and infant mortality and premature births, and access to and provision of an appropriately qualified workforce.

I have been working in maternity services in this region for the most part of 25 years, having moved to pursue a country lifestyle from Melbourne where I trained at the Royal Women’s Hospital. I was born in Omeo and I was thinking that maybe your mother was possibly the midwife when I was born.

Ms BRITNELL — Probably.

Ms DALY — At the time it was actually difficult to secure a permanent job in maternity at Bairnsdale regional health. Midwives had to wait until a position became available. Over time the availability of midwives has fluctuated and frequently there have been periods when recruitment has been difficult. That has been fairly constant really in the last 10 or more years. Since then I have seen several changes in the delivery of perinatal services, and following a period of working as the school nurse I returned to work as a midwife when a collaborative team model was introduced.

Women in East Gippsland have limited choice as to the type of birthing services they access. For those living in remote areas, the time, cost and logistics of travelling to access any service can be difficult, especially for those on low incomes, as Sue has covered. Closure of maternity services such as at Orbost, albeit temporarily, has increased the difficulty for those living in that area and beyond, leading in some cases to intervention in the birth process, such as induction of labour which was not perhaps planned beforehand. Solutions to the situation may be to ensure provision of support and incentives to attract suitably qualified medical staff and also ongoing education and support to midwives at a local level, as well as to provide incentives to aid recruitment. But I do not see that as being an easy pathway. Another option is funding existing services for the provision of outreach care, including postnatal care if it can be adequately staffed.

BRHS used to provide a midwifery outreach service to areas such as Omeo, Swifts Creek, Dargo, Lakes Entrance and Lake Tyers Aboriginal Trust/ Bung Yarnda, for around 10 years before it ceased in 2010. I personally feel this type of service could once again be valuable, especially when there are issues of poor antenatal attendance.

When rural women and their families are required to travel to a tertiary centre due to neonatal prematurity, complex medical conditions or maternal complications, these services need funding to provide adequate access to accommodation and postnatal services for the families when they get down to Melbourne. As was mentioned, separation can be a problem. We sometimes cannot transfer the women until the next day because there are not the facilities available in the tertiary centre. It should also include access to emergency financial support for
families to assist with travel expenses, as those on low incomes are often at greater risk of complications such as premature birth, and just travelling to Melbourne is a really difficult expense for them.

Telemedicine, if offered by tertiary centres, could also prevent women having to travel long distances to access specialist antenatal care for complex conditions. It might not replace it 100 per cent but just reduce the times they have to travel.

In terms of providing a qualified workforce, it is important that access to scholarships and paid postgraduate midwifery training at smaller regional hospitals continues. General nurses who have settled in the local area really find it difficult to move away to metropolitan or large regional centres for ongoing education, particularly if they have young families. Midwives who do not have to move away are more likely to continue working in local maternity services, and this will hopefully ensure there are younger midwives coming through to replace the many who will be retiring in the next five to 10 years.

I also feel access to grants for programs such as Maternity Connect are important, as is the provision of ongoing local education opportunities to maintain skills and currency and knowledge of evidence-based practice. The cost and time commitment associated with metropolitan-based education workshops can be prohibitive. At present Bairnsdale offers team maternity care, which provides continuity of care during the antenatal period with a known GP obstetrician and a small team of midwives, with the aim of having a known midwife during labour. Ward-based postnatal care is provided by a core midwife and labour care is provided by a team midwife. This model has been an improvement both for women and midwives from the past when there was a choice of either limited midwife antenatal care for most or a continuity-of-care model for some. Women can also choose to see their GP obstetrician only if they wish.

I feel a combination of models, including team, outreach and continuity of care or case load is most optimal and sustainable, suiting both women and midwives. Not all midwives have the flexibility or desire to provide an on-call service, especially those with young families. Some women and their families want a closer relationship with a known midwife throughout the antenatal, intrapartum and postpartum period, whilst again others are happy with just seeing their GP obstetrician for most of their antenatal visits.

A recruitment issue for rural units such as Bairnsdale is that some midwives choose not to work in small maternity services because of their desire to work specifically in postnatal or neonatal nurseries or no longer wish to work in the more intense environment of birth rooms. This is usually not possible in small units, where midwives are required to be able to work competently in all areas of maternity care. Others are used to working quite independently of GP obstetricians and involve them only if indications for referral and consultation are present, which again is not always an option in small rural units. So they choose to work elsewhere or are happy to work in environments, like where Sue is working, and are quite independent.

Some midwives and particularly new graduates find the experience of often working alone, as in at Bairnsdale, quite stressful. Therefore it is important that the provision of ongoing education and support is maintained and backup is available from a bank of midwives in times of busy periods and sick leave. The availability of some rotating positions between general nursing and maternity care helps to sustain a midwifery workforce to enable midwives to maintain competence and currency of practice, while having the opportunity to work in their other areas of interest as well. That used to be quite common at Bairnsdale. There were a few positions where midwives could rotate through and then back to the general wards. Since that has been abandoned, I think we have less midwives available than then. It may not be totally responsible but it is an issue.

My role in community health is primarily in sexual and reproductive health. I am a nurse cervical screening provider — previously a pap test nurse — and the role gives me the opportunity to provide pre-pregnancy health advice to young women. With the national cervical screening program changing to commencement at 25 years and then five-yearly rather than two-yearly, I think the opportunity for health promotion will be reduced. I am also concerned that subsequent funding for women’s health services will be decreased.

I believe that instead the funding and time available could be used for specific public health promotion activities around pre-pregnancy help, with the aim of reducing risk factors such as obesity, poor diet, diabetes, smoking, alcohol and drug use. As mentioned earlier, East Gippsland has a higher than the state average teenage pregnancy rate, and staff resources could be used at schools, TAFEs and educational settings for disengaged young people to provide pre-conception health promotion and general sexual health information, with the aim of reducing future poor perinatal outcomes. Thanks for the opportunity to speak at this inquiry.
The CHAIR — Thank you so much, Heather. Do you mind if we ask you some questions now?

Ms DALY — No, that is fine.

The CHAIR — You have probably been sitting there hearing us refer to workforce pressures time and time again. I would like to ask you as a midwife, like I have asked most people today, how can we attract people to regional areas? We heard from Bernadette that in your hospital there are scholarships, but apart from that what do you think attracts people to come from the city, after having done their courses there, to the country and, some would argue, to a better lifestyle and stay here?

Ms DALY — On attracting people, it is often the families based here that generate the workforce — you know, people growing up, going to school here and being able to access education easily without having to move away, or doing the postgraduate midwifery certificate locally.

The CHAIR — We recently heard from a provider in a regional area, and they were targeting secondary colleges. They were pretty much giving students options of what they could do and getting them interested so they could set them on a pathway. Is that something that you think should be considered here — getting local kids qualified for jobs that are coming up in a local area?

Ms DALY — Definitely, yes. Targeting locals and offering pathways that are not difficult is important. As a past school nurse, I know they have career days and work on that, and that is really important.

Ms McLEISH — Thank you very much for coming and sitting here and listening for most of the day. You would have a really good understanding of what everyone is bringing to us. It has been really valuable. You mentioned at your hospital that there was a rotation in the general wards and people had come into the maternity ward. That has changed, and you think perhaps there is less maternity skills now because of that. We have heard previously that sometimes in some of the smaller areas that they have done a rotation, whether it is the doctors or the midwives, into busy hospitals — not necessarily in the city but in the larger areas with a higher capability — making sure they kept their numbers up. They might go out for a couple of weeks and deliver lots of babies or be involved in a lot, so that they remain highly skilled rather than only doing so many babies. What do you think of that?

Ms DALY — It is certainly an option. I know that one or two of the Orbost midwives have tried to do that. But I guess with family pressures and commitments, it is still difficult to move away.

Ms McLEISH — What would the barriers be? Is it at the level of the individual or is it perhaps within the hospital or the health network system that it is difficult to open the doors in another bigger hospital and say, ‘Can we pop someone down there for a couple of weeks or two weeks twice a year or something like that?’

Ms DALY — I know I did a similar program quite some time ago now, but, yes, I went and worked at William Angliss because they had team-shared care maternity. I was well supported by my partner, but that could be an issue — just being able to leave home for a week or two weeks. Another issue would be the rostering at the hospital. I should not speak for Orbost all the time, but I know that midwives have had the opportunity to come down to Bairnsdale from Orbost, but with their rostering commitments at Orbost it makes it difficult for them to leave. Yes, there are quite a few complex issues. I realise I left out a little paragraph in relation to that rotating. Yes, some staff would benefit or would be happy with rotating from general to maternity, but on the other hand many midwives prefer not to have to work in general or with general patients. In smaller hospitals combined maternity and midwifery units are often a barrier to midwives moving to the area.

Ms COUZENS — Thanks for coming along today. I appreciate your input. How well do you think midwives are trained in mental health, family violence, cultural training — those sorts of areas? Do you think there is a demand for more?

Ms DALY — It is improving. Recently some of us have had family violence training, and we are working on the tools to do our assessments antenatally. I think they can be improved across the state. We use a Victorian maternity handheld record, which is sort of a guideline for our assessment, and I think that could be improved to improve skills of midwives that are making assessments of family violence.
Mental health — again, we are working on that. We have the support of our perinatal emotional wellbeing mental health nurse, who has spoken at meetings and talked about how we can assess and help women through. So yes, reasonably well.

Ms COUZENS — You mentioned Aboriginal people and the numbers attending the antenatal clinics. What is a solution to providing those services? We know the Closing the Gap report is not great, and unless we start doing something it will be 1000 years before we close the gap. Have you got any ideas around how that gap could be closed and we start somehow engaging those women to come into the clinics, or do you think having an outreach service is a better option?

Ms DALY — I am not sure whether Narelle or the representative from GEGAC will speak on that, but at the moment we have our Koori midwifery service. It works primarily with the women antenatally, but it introduces them to our service, to the midwives who will be allocated to them. We are working on building those relationships. We have not done it quite successfully yet because of our staffing issues, but I know Narelle has organised an afternoon tea where the Aboriginal clients can meet the midwives, so get to know us before they come into birth at the hospital.

Ms COUZENS — The area you are working in, though, has that already got an established working relationship with the Aboriginal service, or is that in train? I am not really clear.

Ms DALY — It is separate, but we work closely together. The Aboriginal women need to book in — we need to know they are coming — but we know that their antenatal care is being managed by the Koori midwife. We communicate regularly, any issues we discuss, and some of those women are raised at the vulnerable families meeting as well. So we have a fairly close relationship. But, look, it probably can be improved. We have talked about that in terms of just building up women’s familiarity with the service and feeling comfortable coming into our service.

Ms COUZENS — And in terms of the scholarships that were mentioned earlier, do you think they are adequate and are promoted enough within the profession to attract people?

Ms DALY — I am probably not up with the amounts and that to be able to comment, but I think that perhaps could be promoted more. We really need to work on recruiting midwives because that is one of the biggest issues we face.

Ms COUZENS — It is a big issue right across the state, so it is how we actually promote those scholarships and perhaps improve them. It would be interesting to know what attracts people to those scholarships and whether they think they are adequate for what is on offer or whether that needs to be expanded, because I think they are really important key areas in recruitment.

Ms DALY — Yes, definitely.

Ms BRITNELL — You mentioned the closure of Orbost, be it temporary — is that what you said?

Ms DALY — Yes.

Ms BRITNELL — How confident is the region around that being a temporary situation?

Ms DALY — Well, not very confident that they will recruit because of the low numbers of birthing women. For a GP obstetrician to maintain their skills and work in that environment, it is difficult to recruit for someone to be independent — and I probably should not comment on what would make it more attractive for GP obstetricians. And that is similar for the midwives there; with the low numbers it is hard to maintain skills. I know for a time when I was school nursing I had left for a little while but then came back and worked one day in maternity. I found that challenging; working one day in maternity, anything could crop up. It was difficult to maintain my skills. So I made the decision, especially when they introduced the midwifery team, to come back and work more hours, because otherwise I would have left, I think, completely. It is very hard to just keep your skills up.

Ms BRITNELL — So do you think there is a role to play with AHPRA and perhaps government to work harder at mentoring support systems, giving flexible opportunities for people, like you say, who may or may not have families that cannot go for a whole two-week block but might want to do a one-day block and supporting
people? Otherwise we will lose this regional service and skillset or not develop the skillset that we need into the future?

**Ms DALY** — Yes, it needs to be continued. I think it has improved in recent years having local educational opportunities like PROMPT coming down and having our educator coordinate that. It saves a lot of the staff having to go off to Melbourne, and that is challenging. I think that has improved, and it needs to continue.

**Ms BRITNELL** — Do you as a nurse working in the field see or are you exposed to scholarships? I just do not remember seeing too many scholarships. Maybe I just never saw the advertisements. Do you see that often — the encouragement for scholarships to go on and do more study, say, for midwives?

**Ms DALY** — More so than in the past. I think it has improved. I certainly accessed a scholarship to do my sexual and reproductive health course and found that really helpful. If I had not accessed it, I probably would not have done the course. So yes, having that access, and as long as it is not too onerous to apply. And not having the guidelines too strict. The scholarship should cover accommodation because that is a big thing, going to Melbourne, and if you have not got somewhere to stay, you are paying for accommodation. So the scholarship needs to be fairly broad to allow for that sort of access.

**Ms BRITNELL** — You mentioned poor antenatal attendance. We have heard at our other hearings about the handheld record and how even though people might not go to the same place all the time, or might move, it is actually working really well. But are you suggesting that there is a high incidence of non-regular attendance?

**Ms DALY** — Look, I have not got data, but fairly frequently we do have a certain number of poor attenders, and they are often the ones with higher risks, or we do not pick up their risks if they are not attending. I think having access to outreach where we can say, ‘Well, I’m going to see this person’ — whether it be someone in Omeo and meeting them at the health service there might help. I know in the past when we did do this outreach service those women were often the ones that benefited from the outreach service, because to travel down that hour and a half, 2 hours from Omeo for an antenatal appointment, plus do all the shopping and do other things often means antenatal care might be a low priority.

**Ms BRITNELL** — Are you suggesting that in this part of the world that distance and isolation is the reason causing the non-attendance?

**Ms DALY** — In some aspects. Even to Lakes Entrance we often have poor attenders. Again, I guess it is the generational poverty and just spending money on coming in to access services when they have not got that money. In the past we had our outreach service to Lakes Entrance and that perhaps could benefit.

**Ms BRITNELL** — Can I just clarify: do you mean the cost of travel or the cost of the service?

**Ms DALY** — Sorry, the cost of travel for the women, yes.

**The CHAIR** — Thank you, Heather. There is nothing the committee loves more than hearing from people who actually work at the coalface. It is interesting that today through all levels of the sector we have heard roughly the same thing. Everyone seems to be on the same page about what the demands are and how we need to meet them. Thank you so much for your time today.

**Ms DALY** — Thank you.

Witness withdrew.