FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bairnsdale — 7 December 2017

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Ms Meryn Pease, CEO, Orbost Regional Health.
The CHAIR — I welcome to these public hearings Ms Meryn Pease, CEO from Orbost Regional Health. Thank you for attending here today. 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. As I have said to other people today, we are here to get the most information we can out of the people who are working at the coalface in this sector. We are certainly not here to judge or bite. If we can hear from you for about 10 to 15 minutes, then we might just have a conversation and ask you some questions, if that is okay.

Ms PEASE — Certainly. I will give you a little bit of background, if I can, for a start for context.

The CHAIR — That would be great.

Ms PEASE — Orbost Regional Health is a multipurpose service. It is located in far East Gippsland. It is a 5-hour trip to Melbourne and over an hour’s trip to Bairnsdale, which is the nearest health service. We are the only health service between Bairnsdale and the New South Wales-Victorian border, just to give you a little bit of context.

The health service has a catchment of about 1 million hectares of land, and it is based on small communities, mostly along the Snowy. They are in very isolated areas like Goongerah, Bendoc, Bonang, Cann River and those sorts of areas. They are geographically isolated but also socially disadvantaged.

Prior to April 2017 we operated a maternity service at level 2 capability, providing a low-risk maternity service, an antepartum service, a birthing service, postpartum services and neonatal care, with excellent outcomes for mothers and babies. The service was staffed by a sole GP with a specialty in obstetrics and five qualified, competent and highly experienced midwives. The team provided 24/7, on-call service for birthing women. This was a midwifery-led model of care with GP obstetric support, which worked really well for the women and their families, the GPs and the midwives. The continuity of care was excellent, as one of the midwives was also the maternal and child health nurse. Another is the women’s health nurse, who was doing the six-week postnatal checks. In small communities and small health services, you will find that staff will wear multiple hats and have different skills.

In January 2016 — I started there in November 2015 — I had an independent external review done of maternity services, given all of the Djerrriwarrh issues that had emerged at the time. Maternity services are renowned for being high-risk services, so I wanted to make sure it was a safe service and that we were working within our service capability framework. Djerrriwarrh was an example of creep; they crept beyond what was their capability. I wanted to be really sure that we were providing a safe service.

That external review was commissioned. The report delivered a finding that ORH maternity service is a safe, quality service that is conservatively screening women to assess their level of low risk, which meets our safe maternity framework criteria. There are clear referral pathways for women assessed as high risk, and an independent external obstetric case review process is in place; however, the number of low-risk births was small, with an average of 22 to 24 a year. This saw the GP with obstetrics seeking additional placements at hospitals that had a high number of births. He had a partnership with Western Health, but when Djerrriwarrh emerged, Western Health withdrew their support for him to continue to do extra cases and gain experience with birthing at Western.

Ms McLEISH — Did he go for a month or two weeks at a time? How many times a year?

Ms PEASE — He would go down every three months and do four days or five days. That meant that he then had to look elsewhere for placement, so he was doing the locum relief program. He went up to Logan, which is outside of Brisbane and has large maternity services, to complement his experience at Orbost. That only lasted for so long. In April of this year he moved on to another rural health service. They were birthing more babies — so about 100 births a year at that service. That meant that we could no longer sustain our level 2 service with excellent outcomes. We then stepped down to a level 1 service, which was providing antenatal, postnatal and neonatal care, and entered into an MOU with Bairnsdale regional health to provide the birthing component.
So as part of the antenatal care we have an agreement with one of the local GP obstetricians in Bairnsdale, and she comes up one day every four weeks. She will do the screenings and checks for the antenatal women, and then for the rest of the day she will do women’s health. It has been an advantage in that way for us, but as you can understand, the midwives and the community are sorely sad to see the loss of the birthing service.

The areas of particular concern for us at Orbost Regional Health are around the availability, quality and safety delivered to mothers and babies. As I said, we have stepped down from a comprehensive, safe and high-quality maternity service to providing a level 1 service. Our women are not just Orbost women; they are women from up at Bonang and Goongerah — you know, 100 kilometres north of us. Their trip for birthing now is a 2-hour or 2.5-hour trip.

Since April we have had one unplanned birth at the hospital. That was a lady who had a multiple birth, presented to us late in labour and was not safe to transfer. She had a nice, healthy baby. Mother and baby are fine. The midwives did the delivery, and then the support services came from Bairnsdale. We have only had one, so that is really good. It is showing us that our model is working and that we have got the support of our community, but there is that risk that we are not birthing compared to the risk of women having to travel, to pick up when they are in labour and to work out whether they have got enough time to get that extra hour’s distance down to Bairnsdale.

Ms McLEISH — What was the reason for the unplanned birth?

Ms PEASE — Being multiple pregnancy —

Ms BRITNELL — It happens quicker later.

Ms PEASE — This was baby number seven. Each labour gets a bit shorter.

The CHAIR — She would have been telling you what to do, wouldn’t she?

Ms PEASE — Just about.

The decision to suspend birthing was very emotive for the health service and for our community, as it had been a core of our health service since 1930. It has been a long-established service, even before then, I think, back to when they had tents and it was very much the booming timber industry.

The requirement to travel — we have talked about that. Regarding the financial burdens, there are other risks involved in this for these women and their families. The requirement to travel the extra 100 kilometres is daunting for expectant parents in our community, as is the financial burden of accommodation, petrol, child care, meals and so on in being away from home. We are talking about socially disadvantaged, low-income communities. This burden increases the likelihood of poor antenatal attendance and unplanned birth at our health service, which now does not have midwives on all shifts or obstetric medical care.

The midwives at Orbost Regional Health are frustrated and disheartened to have trained for many years and now find themselves in a health service without the full scope of maternity care. These midwives are local and well-respected within our community. There is a risk that they could leave to practice midwifery elsewhere, which would significantly deplete the highly trained nursing workforce that the health service has worked hard to develop and support. That is the first issue.

The second one is about access to and provision of an appropriately qualified workforce. Orbost Regional Health has invested significantly in the maternity workforce over many years to be able to provide a safe and sustainable maternity service to our community. Attracting and retaining a GP obstetric workforce in the current risk-averse climate is an insurmountable challenge that has meant that ORH is no longer able to safely offer birthing services.

The consideration of incentives and requirements to encourage GP obstetricians to work in rural areas would go some way to ensuring that women are able to safely birth as close to home as possible. High-risk, low-volume discussions about maternity birthing services have led to the departure of highly trained staff and have therefore increased the risk for women in rural and remote communities.
Low volume does not necessarily mean low quality. Many rural and remote birthing services have performance data that is envied by larger services. ORH underwent an external review of the safety of our low-risk birthing service, and not surprisingly the review was very positive.

Women are screened appropriately and referred to large centres where required. We refer on to Sale, then on to Traralgon and then on to Melbourne if we need to — so that is the graded capability — and the birthing outcomes for mothers and babies have been excellent. I have got some data, but I do not really think we need to talk about data.

Out of the statewide reports on perinatal services, of all the indicators, there is only one, which is getting women to stop smoking antenatally in early pregnancy — that is our main challenge. Our midwives are highly skilled, and I guess what I come back to is that if there were any incentives to have GP obstetricians working in more rural communities, one of our biggest challenges is how we are classified by the commonwealth: you know, we are 2 hours from the border, so we are classified as rural — we are not classified as remote. We are in the mix with Kilmore and Heathcote — services that are an hour from Melbourne. It does not make any sense.

Ms McLEISH — Can I ask about that? Why is that the case? I would have thought that you would have been remote.

Ms PEASE — The commonwealth rejigged the ratings.

Ms BRITNELL — Is that because you are close to Bega?

Ms PEASE — I guess if you look at us as compared to the Northern Territory or far west Queensland, yes, we are not isolated; we are rural.

Ms McLEISH — It depends on your comparison, doesn’t it? Within Victoria or within Australia.

Ms PEASE — That is exactly right.

Ms McLEISH — So Swifts Creek would be remote?

Ms PEASE — Rural as well. Absolutely.

Ms BRITNELL — So where in Victoria is remote?

Ms PEASE — Nowhere. There is nowhere.

Ms BRITNELL — I thought Portland was remote. It must be rural.

The CHAIR — Would you mind taking some questions, Meryn?

Ms PEASE — Certainly.

The CHAIR — Can I acknowledge Tim Bull, MP, in the room — a great local member. I have just got one question. I wonder if you can clarify something you said earlier. Obviously in these areas you have people who wear multiple hats — you know they are multiskilled. We have heard that in other regional areas there is the same demand and the same issues so people wear multiple hats, but you talked about the fact that there is no creep. We have actually heard that in other areas — and I think it concerned the rest of the committee as well — you have got people being asked to do things that they have not got the competency or the proficiency to do. They do not have any certification to do it, and that was seen as something that they just had to do to get by. I am wondering how you can stop that.

Ms PEASE — I have not seen it in Orbost in the two years that I have been there as CEO. We have got a very safe maternity framework. The midwives are very clear about their scope of practice. The obstetrician was very supportive of the midwifery model. Maybe if it was a medical model — if it was flipped the other way, where it was a medical model — then the midwives might have perhaps felt some creep. That is not going to be the best outcome for the family, the woman, the baby or the clinicians involved. It is not. We have a really strong, safe model. The other reason I know it is safe is because we have got clear criteria, and every case is assessed against those criteria. We have a tool called [inaudible]. The independent reviewer provided us with a
copy of that. So every birth was assessed against that to provide a risk rating of that birth and the outcomes of that birth.

We have a process of peer reviews. So in any of our cases where the midwives think, ‘Oh, that was a third-degree tear or close to a third-degree tear, or that labour was a bit long’, based on their experience and knowledge, they are referred off to an obstetrician in Warragul. That process has been in place for many, many years. He will provide a review; he will do a case review of that whole case and come back with some recommendations — he will come back and say, ‘No, the care was appropriate’ et cetera.

The CHAIR — It sounds like it is managed very well.

Ms PEASE — Yes.

Ms BRITNELL — Are you comfortable that Orbost will now be managed appropriately, or are you disappointed that the services are not to be offered to mums and babies?

Ms PEASE — I am absolutely disappointed, because we had a really strong, safe service. I realise we had one GP obstetrician, and in small communities you do not have four or five GP obstetricians sitting there, just for that number of births. I understand Djerrriwarrh and all the recommendations that have come out of that. But I think the one thing I would stress to the committee is that rural communities have a role in birthing. They can provide safe services. We just need some incentives to be able to have the GP obstetrician backup. We cannot have the GP obstetrician backup an hour away — that is not safe for the midwives and it is not safe for the mother and family. But to have a GP obstetrician working in our community with some incentives to keep them there — New South Wales have got a process whereby if the GP stays with them for X number of years, they pay off half their HECS debt or, you know, the same with their graduates. Could Victoria look at something like that for those rural and isolated communities in Victoria — maybe not in Australia but for those ones?

The CHAIR — Or your Medicare number or something like that.

Ms PEASE — Yes.

Ms BRITNELL — So do you think that now the service is currently unavailable the risk of unsafe births has been removed?

Ms PEASE — No. There is a balance.

Ms COUZENS — Thank you for your contribution today. We appreciate it. Have you been or are you working with any Aboriginal women in the perinatal services?

Ms PEASE — No. We had a plan that, in six months time, we were going to set up antenatal clinics at Lake Tyers, and we were going to attract the women from Lake Tyers, because we were under the understanding that perhaps coming our way was more supportive for the women than for them to travel in another direction. So that was our plan until our GP decided that, no, the risk was too great for his qualifications.

Ms COUZENS — So are you looking at getting another GP back to re-establish the service — is that the plan?

Ms PEASE — We have since 1 April. We have had advertisements out with nine recruitment agencies across Australia for a GP with obstetric specialty. We cannot get them. We have also been looking for another GP without obstetrics. We cannot get them. We are in the mix. I think in Gippsland there were about 69 vacant GP positions. So look at Gippsland, look from Warragul, the end of the line, to Orbost. We have tried. We have applied to get a GP registrar — that is not going to give us the obstetric skills — but again it is the same thing. We need to be able to tie them somehow. We need to attract them and tie them somehow to the community for five years or eight years, and financially support them somehow.

Ms COUZENS — So what is currently the role of the midwives, then? What are they doing?
Ms PEASE — They support the GP obstetrician from Bairnsdale. They do the clinics on the alternate weeks for the women. If they cannot all get in to see the GP obstetrician on that day that she is here every four weeks, our midwives will do the antenatal screening. They do the postnatal support, so they will do the domiciliary home visits and they do the neonatal checks. Then our women’s health nurse will also do the six-week postnatal mother’s check.

Ms COUZENS — And they have been provided with training around the family violence and mental health areas?

Ms PEASE — Family violence training, yes, they have. They are screening for that as well. And with the postnatal depression and those screening tools — yes. I guess the other statement would be that although we are 5 hours from Melbourne, we are absolutely contemporary with what is best practice that is coming out to ensure that we have a safe maternity service.

Ms McLEISH — Thank you, Meryn. It has been really quite interesting listening to you talk about this situation and how challenging it has been for you. I took great pleasure in being in Orbost recently and quite enjoyed the town. I thought it was a really lovely little spot, and it is a pity that maybe a lot of other people do not realise how great it is and what a good spot it might be to work. Are 457 visas still an option for doctors?

Ms PEASE — Not so much, because we need a GP who is registered as a medical practitioner, not someone who is gaining their medical practitioner —

Ms McLEISH — But that does not need to be the case though. You could still —

Ms PEASE — We need them because we have also got the hospital. I did not talk about aged care. We have got 50 beds as well, which is acute and aged care beds, so we need them to be able to provide urgent care, so they have got to do the on call for urgent care as well.

Ms McLEISH — As well the obstetrics?

Ms PEASE — Yes.

Ms McLEISH — You mentioned that with the GP that was there how every three months he would go to Western Health, essentially, for the four days. Now, with the midwives being left without that service, is there any option for them to do something similar — to go somewhere every three months or six months for a week?

Ms PEASE — Absolutely. Out of the Royal Women’s there is a program where they can elect to go to a higher level maternity service and work there for a week, whatever, and have their learning objectives and fulfil that. One of our midwives has taken up that option. A couple of them are getting closer to retirement age, so they are not really wanting to do that. But yes, absolutely. And we are well connected within Gippsland to Bairnsdale, Sale, Traralgon and also to the Royal Women’s, so the network support and collaboration is there.

Ms McLEISH — Thank you.

The CHAIR — I have just one last one. What is the outlook for the birthing unit at Orbost at the moment as far as you are concerned?

Ms PEASE — We have promised the community that we would look for 12 months to find a GP with obstetrics. In all reality, come April next year we will most likely be saying to our community we will have to stay as a level 1 service.

The CHAIR — Sounds like it is a shame.

Ms PEASE — Yes, absolutely. If we were not having excellent outcomes, I would say, ‘Yep, okay. We’ll put our hand up and we’ll stay level 1’, but because of the excellent skills of our midwives it is just a shame.

Ms COUZENS — So you are not optimistic at all that you are going to find somebody between now and April?

Ms PEASE — We cannot get a GP who does not have obstetrics. If there was a training pathway for a GP with obstetrics and we could bond them —
The CHAIR — All right. Thank you so much, Meryn. It is really obvious that you are proud of your service and your team. Thank you for coming in today and sharing your time with us.

Ms PEASE — That is all right. Thank you very much for inviting me.

The CHAIR — Cheers.

Witness withdrew.