

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Mildura — 9 November 2017

Members

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Witnesses

Dr Kimberley Sleeman, and

Dr Erin Kelly, Mildura O & G Clinic.

The CHAIR — I welcome Dr Kimberley Sleeman from the Mildura O & G Clinic to these public hearings. 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. So we have got Dr Kimberley et al today.

Dr SLEEMAN — Dr Erin Kelly, GP obstetrician, is also with me.

The CHAIR — Thank you. So we would like to ask you some questions, but first we would love if you could tell us what you do and a little bit about how things are run in Mildura.

Dr SLEEMAN — Sure. So I am an O & G specialist. I have been a specialist here for 12 years. I had written a bit of a summary. Did you want me to read that?

The CHAIR — Please go through it. That would be great.

Dr SLEEMAN — My colleague Erin Kelly is a GP obstetrician who has been permanently in Mildura for about two years but has worked here on and off over that time.

The CHAIR — Is that your creation over there?

Dr KELLY — Yes.

The CHAIR — Fantastic.

Dr SLEEMAN — Yes, that is her beautiful son, Finn, also sharing the day.

I guess I am probably best placed to give a good historical overview given that I have been here the longest of anyone still regularly involved. O & G specialists in Mildura provide maternity care to a very large regional centre, which I am sure you have heard about. I am not sure if it has come through in the other presentations, but we also provide specialist services to a much larger distribution area in all directions, including Swan Hill, Broken Hill, Riverland and far-west New South Wales. The patients living in these remote locations might be small in number but they often have very complex medical needs. They often access services here in Mildura because we have permanent specialists here, whereas there are many inconsistencies in those towns which are run on full-time locum-only services.

The biggest challenge in maternity services in our area is the number and retention of staff across all areas, which includes paediatricians, obstetricians and midwives. It is the shortage of midwifery staff that leads to the biggest day-to-day issues in maternity care in the Mildura Base Hospital. This has really been an evolving crisis for about two years, with staff shortages regularly impacting on patient care on an almost daily basis. Due to a shortage of midwives we are unable to fully staff our lovely, renovated, four-bed birthing suite. We have constant limitations on the service we provide. This leads to a very stressful situation of cancelling and rescheduling patients for planned induction of labour or even having to reschedule planned elective caesareans. It also results in constant stresses for doctors, midwives and patients, who worry about the clinical consequences of delaying birth. This scenario has resulted in the worst possible situation of a stillbirth in a patient whose induction was delayed due to resourcing issues.

This situation also frequently results in us having to consider transferring patients to other areas such as Ballarat, Bendigo, Melbourne or Adelaide. Transfers result in significant stresses for families, physically, emotionally and financially. It is also increasingly difficult to arrange said transfers to other locations because of resource limitations across the state. The PIPER system is not really well-equipped to deal with these situations, and bed shortages are a problem everywhere. Cross-border issues are also a problem. Ideally in the past we always transferred patients to Adelaide because it was closer, but due to higher transport costs we are now directed to transfer patients to Melbourne, which is physically further, and a lot of patients from this area find that to be a much more intimidating situation.

Mildura Base Hospital did undertake an internal review of maternity services in May 2016. However, unfortunately despite this, there has not really been any substantial improvement, particularly in staffing. In

recent years there have been changes in medical directors, nursing directors and midwifery managers, which has undermined the ability of the hospital to progress with the recommended changes. In the past five years there have also been five staff specialists and one VMO come and go from Mildura, so there has been a lot of instability in the workforce.

Antenatal services are provided in community-based clinics. There is no public hospital antenatal clinic as there is in the metropolitan areas. Bulk-billed services are provided at the Ramsay clinic. However, that service has been inconsistent over the past few years due to the unstable workforce, with six different staff specialists in the past five years and only one, Dr Patravali, still remaining. There is also the loss of midwives from that clinic to other services. Mildura O & G Clinic, where I work, has provided the most stable service in the past few years. We have a team approach including O & G specialists, GP obstetricians, midwives, perinatal mental health support and a diabetes educator. There are costs associated with this, though, because it is a private clinic. Previous attempts to establish a collaborative approach with Mildura Base Hospital back in 2012 and 2013 were rejected. We have also sought funding through the division of GPs and primary health network but have never been successful. The service at Mildura O & G, despite the costs, has actually consistently seen the majority of patients birthing in Mildura in the past few years. So despite the out-of-pocket costs we are still seeing the majority of patients. As I already mentioned, other aspects of antenatal care in Mildura also incur costs, such as ultrasound services and pathology services such as first trimester screening.

I am sure you have heard this already, but the Mildura region does have a very diverse patient population and includes a number of vulnerable high-risk groups such as our Indigenous population, teenage mothers, refugee groups, migrants with limited English as well as the other issues such as drug and alcohol and mental health problems. There are community-based services targeted specifically at some of these services, such as the Indigenous patients through MDAS. The Robinvale community health clinic provides an excellent midwifery and GP obstetrician service for that very diverse community, and that is particularly why I have invited Erin to join me, if there are questions about that. A new antenatal service has commenced at community health, aiming to provide care to vulnerable women. The Zoe Support group provides support for teenage mothers with a particular focus on continuing engagement in the education system whilst pregnant.

Despite these services there has been a very concerning number of patients who present to the hospital in labour with minimal or no antenatal care. This group often has complex social issues, particularly drug and alcohol, domestic violence and mental health issues or issues related to being a refugee — non-English speaking and no Medicare cover. These patients place a very great strain on the already limited resources in our unit.

I summarised a few really key points. We do very quite often have socially complex patients, and there are often delays in the system coordinating care after birth with the Department of Health and Human Services in terms of at-risk families. These delays lead to significant time in hospital, putting a further stretch on our resources. There is no consistent postnatal follow up. The public clinic no longer provides postnatal follow up.

There are no public family planning services in Mildura, so there can be a problem of poor contraception and future planning, leading to unplanned pregnancies and other implications from that. Bed shortages in the maternity unit and early discharge lead to stresses on families and possibly impacts on our breastfeeding rates. The perinatal emotional wellbeing service based at the hospital has been very unstable and inconsistent in past years, so accessing this service is not always possible and is quite inconsistent. There are issues with communication between services regarding results and outcomes. As all the antenatal care is provided outside of the hospital, this is a frequent challenge for those providing care for the women in hospital.

I guess one of the other things I am concerned about is duplication of services, particularly how we best use the limited resource of public funding. Duplicated services all doing the same thing is an issue that concerns me, and I would like to see a more collaborative approach to working together. So that is my little summary. I am sure you have some questions. I am not sure if you wanted to ask questions or ask Erin to give you a little bit of a spiel about the Robinvale situation.

The CHAIR — If you could keep it short, Erin, but that would be really handy.

Dr KELLY — Thanks for allowing me to speak. I work both in the private sector with Dr Kimberley Sleeman and also in the public sector, with the hospital doing an outreach clinic to Robinvale one day a week. I work closely with the midwife that is there from Monday to Friday. We offer shared care to a very diverse

community which has both its medical and psychosocial complexities but also language barriers, because for a large portion of my patients English is their second language.

I just wanted to reiterate the concerns that Dr Sleeman has that resource shortages are probably the big issue, as well as consistency in maintaining and supporting perinatal emotional support in the outreach clinics and locally here in Mildura.

The CHAIR — Thanks, Erin. I might kick off. You say in your submission — you talked about it then — that one of the biggest challenges in the provision of perinatal services in this community is retention of staff and resourcing, including paediatricians, midwives and obstetricians. It is becoming more and more obvious throughout the day that patient care is being put at risk by this. We heard a small example before. Have you got an example where something did not quite go to plan because of the resourcing issues or lack of communication, I guess?

Dr SLEEMAN — As I said, the worst possible outcome is a stillbirth in a family whose induction was not able to be done because of resource issues, in a patient who had clear high-risk factors.

The CHAIR — So it was avoidable.

Dr SLEEMAN — I feel it was, yes. That is the worst possible outcome from delaying. We have had a mother who died just before Christmas who was a woman of Aboriginal background who had had virtually no antenatal care — maybe no antenatal care at all — but she had a very significant and strong high-risk history and she died of a pulmonary embolism that would have been avoidable if she had chosen to follow the medical advice that was given. Again, a stillbirth and a maternal death are the worst possible outcomes in a maternity service. Both of those things have happened in Mildura in recent times. With that particular lady, this problem particularly of high-risk women not engaging in care I think is terrible and I think that is one of the things, having been here for a long time, that I feel is one of the biggest problems of what is going on right now and one of the problems that I see in the fragmentation of services.

Ten or 12 years ago when I first started here there were four full-time specialists, all the care was provided outside of the hospital. From an equity point of view, I agree that that was an issue, that there was no publicly funded service, but patients belonged to a doctor and they had all of their care in that doctor's clinic. Ten years ago there was a much higher engagement in care than there is now. Since that time, even though there is a bulk-billed antenatal clinic based at Ramsay, there is an increasing number of women presenting with no care or almost no care. I was on call two weekends ago and I think half of the patients had not had appropriate care. It is a huge problem and, like I said in the example of the woman who died, that was a very high-risk woman and that death could have been preventable with appropriate medical care.

This problem, and I guess it worries me a little bit because it seems that to some degree that services keep getting duplicated. Another service starts a service to try to help that service, and then another service does this and there is too much fragmentation. I am worried about that being an issue — rather than all of the services coming together and having one collaborative service that includes all of the things that are needed. I think that is what we really need. Particularly regarding public funding, that is going to be limited, so it seems crazy to have public funding funding this clinic and public funding funding that clinic when it all should be happening together.

Ms COUZENS — Thank you for coming along today. You talk about high-risk women and the case you cited of the young woman that tragically died. What is the solution? We have already clearly identified that the lack of midwives and professional staff is a huge issue. What are the solutions to trying to deal with some of these problems? If women are not choosing for whatever reason — often it is not a choice factor; it is their circumstances why they are not accessing the services that they need — in your view what would be the solutions to deal with some of those issues?

Dr SLEEMAN — As I was saying previously, I think you need to have a very strong collaborative model to try and address the needs of high-risk patients. I do not know how you get around the problem of people not engaging at all, but I guess that is what these various groups like the Hands Up group and community health are trying to target those people. I guess I worry about all of that happening out in the community without engaging with the rest of the services as well and that high-risk patients need specialist involvement as well as midwifery involvement as well as all the additional allied extra support that is needed. Like I said, I think sometimes

everything gets broken up too much. I really do not know how you address people not attending at all, but again through the Hands Up group I have suggested more targeting needs to be done to general practitioners, because almost everybody, even someone who has had no antenatal care, has usually had one or two ultrasounds arranged by a GP. It is another issue that we have four clinics that are sort of fairly stable and then we have other clinics that have a very high turnover, often with very inexperienced doctors who have not worked in Australia before so they are not aware of the system.

Ms COUZENS — So are the stable clinics the private clinics?

Dr SLEEMAN — All GP clinics are private clinics. What I am talking about is that there are four main family practice-style GP clinics and they are the Tristar clinics. Tristar is bulk-billing and patients who might stroll in to access care might go there. They have a very, very high turnover of staff and so even if somebody has had no antenatal care, they have probably had a 20-week scan by a Tristar doctor. We have tried to reach out to them through writing to the clinic, because if someone is pregnant and they have had a scan, they need to book into the hospital. I regularly write letters to these doctors to update them with, ‘Oh, by the way, these are the recommended tests’ or, ‘Here’s an update on how to manage this problem’, which is usually prompted by something that has not been well managed. That is my discreet way of trying to feed that back to them.

Linking in with those sort of first-line healthcare providers to try and move it on to the next step is what we have tried to do, but we are still not always that successful. The other barrier is the refugee patients with no Medicare. As someone else has already said, they do not have a scan because they cannot afford it. They do not have the blood test because they do not have hundreds of dollars to have a blood test. I do not think there is any way around that, apart from the fact that we try to opportunistically do it if they turn up in hospital, because at least we can do the test and have the result and whether someone collects the money later or not, frankly, from a clinical point of view, is irrelevant. If the patient is there, we take the bloods so we know the important information to care for that woman. If a bill gets sent to them and does not get paid, at least we have got the information to care for them.

The DEPUTY CHAIR — I am going to direct a couple of questions to Erin. Erin, you are a GP obstetrician, yes?

Dr KELLY — Yes, correct.

The DEPUTY CHAIR — How many GP obstetricians are there in the area?

Dr KELLY — I believe there is probably about three — just a small handful — and I am the only one that works both the hospital and a private clinic. There is another GP obstetrician who also does anaesthetics with the hospital and then does GP obstetrics with MDAS and community health. So it is probably a small number here in town.

The DEPUTY CHAIR — So you do deliveries as well?

Dr KELLY — I was doing deliveries prior to the birth of my son, but now since returning and working part time I am predominantly doing antenatal clinics.

The DEPUTY CHAIR — Were all the GP obstetricians doing deliveries?

Dr KELLY — No.

The DEPUTY CHAIR — Only you?

Dr KELLY — Yes.

The DEPUTY CHAIR — And has that been a problem within the town and within the hospital, not having a GP obstetrician doing the deliveries?

Dr KELLY — In regards to patients accepting services from our GP obstetrician, no, I think the community is just happy to —

The DEPUTY CHAIR — Only for the hospital staff?

Dr KELLY — No, just as long as, I think, there is a collaborative approach and options and also me supporting the team when there are limited resources available then there are more hands and the ability to provide community care is well received.

The DEPUTY CHAIR — Do you think there is a greater role for a GP obstetricians in this state, in the rural areas?

Dr KELLY — I definitely believe there is a role, but it should be a collaborative role because here in rural and regional Australia there is quite an increase in the high-risk portion of antenates. For me what I see as the most important key is a collaborative team approach with good resources, probably communication and improved communication between all the services. Private communication of confidential patient details but just something that is easily accessible in the wee hours of the night when a patient presents to the hospital or when they are back out in their community antenatal clinic and they have been to the hospital and the antenatal providers are not aware of that presentation. Then probably education, not just for the patients about the services that are available but also, as Dr Sleeman was saying, the GPs that are needing refreshers or updates of what antenatal services are available in the community and what antenatal investigations are the recommendations.

The DEPUTY CHAIR — Where else can people birth in the region?

Dr SLEEMAN — Bendigo, Adelaide.

The DEPUTY CHAIR — But lower risk?

Dr SLEEMAN — Swan Hill have GP obstetric services with locum support, but that is low-risk patients and more than 37 weeks I think.

Dr KELLY — Yes, more than 37 weeks, low-risk antenates, and then if they become high-risk, they are transferred onto Bendigo or Melbourne. Then Broken Hill has a similar very low-risk service, but then if people become high-risk, they are either transferred to us or to Adelaide.

Dr SLEEMAN — I guess that was my point about the bigger area that we have. I grew up in Melbourne so it astounds me that someone will drive 5 hours along a dirt road to come for a half-hour visit to see me every four weeks, then every two weeks, then every week for her whole pregnancy. This is one of those unique political challenges too, because it is cross-border, tri-state. If you have a 400-kilometre radius, that is the nearest specialist services to us — so Melbourne and Adelaide — but if you go up into New South Wales, the nearest service would be Wagga I think. It is a very long way, so for someone who lives on a station in the middle of western New South Wales they are going to have to travel many hours in any direction to access a specialist service. Some of my most challenging patients in the last 12 years have been women with high-risk pregnancy history who live somewhere where they cannot get out if it rains. Trying to manage a pregnancy like that is fascinating. It is a privilege to look after these women because it is incredible the lengths that they have to go to, and they are kind of the unseen minority because there are not that many of them.

Swan Hill has had mainly GP obstetricians with some specialist locum backup. Broken Hill for many years has been a locum-only service, and the permanent specialist in the Riverland retired about five years ago, making the Riverland a sort of locum-only intermittent service as well. So in all of those regions, particularly if someone knows they have a high-risk pregnancy and needs specialist involvement, a lot of them do come here.

The DEPUTY CHAIR — You may have also mentioned a support group for teenage mothers. Did you say it was Zoe's?

Dr SLEEMAN — Yes, Zoe Support, and Anne is here. I am sure she would love to tell you more about her work.

The DEPUTY CHAIR — Terrific, I was interested to find out too.

Dr CARLING-JENKINS — Thank you very much for coming in. I have been fascinated with your presentation and your evidence so far. I like the point that you have made around duplication of services, which to me is about streamlining and better use of limited resources. That is what I am hearing, and it is beyond collaborating, isn't it? It is about doing the best for the area rather than the best for the individual services. That is what you are looking for.

I just wanted to pick up on one point around the socially complex patients that you described and the difficulties you are having with the department in that area or the delays. I am wondering if you can unpack that a little bit more for us and maybe comment on why you think this might be. Is DHHS under-resourced? Do they simply not understand the area and the rural issues? Do they simply not work well with the socially complex patients? What is the reasoning behind the delays?

Dr SLEEMAN — I think the biggest example, the group that leads to significant delays, are the people who have not engaged in any services during their pregnancy. Essentially the person that ends up dealing with this on a day-to-day basis is the midwife in charge. Someone will come in in labour and have their baby, and then obviously it will become apparent that they have not engaged in any antenatal services, they have been involved in DHHS before. There may be a combination of all of those factors — social, domestic violence, mental health, drug and alcohol. Often it is multifactorial issues, and if they have not engaged in any antenatal care during the pregnancy, they have not booked into the hospital, they turn up and have their baby, and then it becomes apparent that it is not safe to send this baby home and because there has not been any planning, because often people may choose to disengage with services because they are worried about what is going to happen —

Dr CARLING-JENKINS — They have fallen through the gaps.

Dr SLEEMAN — Yes, and then of course it always happens on a weekend, so you have to at least wait until Monday before DHHS answers the phone, and then — honestly Sandra probably can answer this better — it often takes the whole week to get through to DHHS. That would be fair. It takes a whole week for DHHS to come up with a plan for this family. In the meantime we have quite possibly had to cancel an induction or a caesarean because there was not a bed because that person was taking up a bed in our limited beds.

Dr CARLING-JENKINS — You cannot discharge them.

Dr SLEEMAN — Yes, and no-one feels safe to discharge them because there is no plan. If someone has had care in the pregnancy, then an unborn notification is done and there is some kind of system and links in place already with the system, and it takes less time if it is done beforehand. It only takes five days if they have done it beforehand. As I said, this essentially becomes the problem of the midwife in charge of the shift, who is the one who has to keep ringing up DHHS again and again and again and again and again.

Dr CARLING-JENKINS — It becomes a problem for the whole system, though, doesn't it, because it becomes a problem for you?

Dr SLEEMAN — This is why I mentioned it, and this is why this particular group —

Dr CARLING-JENKINS — You have got an induction plan, then you have to put that off and your whole —

Dr SLEEMAN — So that particular group of patients who have had limited care take up a massive amount of the resources beyond what should be reasonably expected, which leads to flow-on effects to the rest of the system because our system at the moment is so stretched, predominantly by the lack of midwifery resources on a day-to-day basis.

Dr CARLING-JENKINS — Is part of the disengagement of these women the lack of public antenatal services as well? Would that fill part of that gap, or is it just a unique —

Dr SLEEMAN — I think part of the problem, as I kind of alluded to, is that the services provided at Ramsey have been inconsistent because of the multiple changes over time. At least that is my impression from what other people tell me, so because that service has been inconsistent GPs do not always refer patients to that service because they are not sure what service they are going to get. As I said before, some people themselves are not engaging with services for a variety of complex social reasons.

The CHAIR — Thank you so much for coming in today, doctors. We appreciate your time, and it has been a very valuable contribution, so thank you so much.

Dr SLEEMAN — Thank you.

Witnesses withdrew.