



National Audit of Early Pregnancy Assessment Services (EPAS) Clinics

Australian Department of Health, Disability and Ageing

Final Report

September 2025

Acknowledgements

Patient Experiences

This report contains perspectives from patients who experienced early pregnancy complications and accessed early pregnancy assessment services. This report acknowledges and appreciates the valuable contribution of these women who have shared their personal experiences.

Key Stakeholders

Deloitte would like to thank all individuals and organisations who participated in stakeholder consultations and contributed to this report. This report recognises the collective effort of multiple government and non-government organisations over many years to directly or indirectly improve the experiences of women who experience early pregnancy complications.

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Glossary

Acronym	Full name
ACT	Australian Capital Territory
CALD	Culturally and Linguistically Diverse
D&C	Dilation and Curettage
ED	Emergency Department
EPAS	Early Pregnancy Assessment Services
EPC	Early Pregnancy Centre
DHDA	Department of Health, Disability and Ageing
GP	General Practitioner
GPO	General Practitioner Obstetrician
hCG	Human Chorionic Gonadotropin
ILSS	Infant Loss Support Service
IVF	In-Vitro Fertilisation
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual+
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	Non-Government Organisation
NHSD	National Health Service Directory
NICE	National Institute for Health and Care Excellence
NSW	New South Wales
NT	Northern Territory
OBGYN	Obstetrician Gynaecologist
PHN	Primary Health Network
PICF	Patient Information and Consent Form
Qld	Queensland
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SA	South Australia
SA2	Statistical Area Level 2
Tas	Tasmania
UK NICE	United Kingdom National Institute for Health and Care Excellence
Vic	Victoria
WA	Western Australia
WAS	Women's Assessment Service

Definitions

Term	Definition
Acute pain	Sudden, sharp or intense pain.
Antenatal care	A planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy.
Anti-D immunoglobulin	A blood product (plasma) treatment for Rhesus D, typically delivered as an injection.
Continuity of care	Ongoing and consistent management of a patient's needs within and around the same episode of care during the delivery of early pregnancy assessment services. The episode of care includes assigning a healthcare professional, initial EPAS appointment, follow-up care, and referrals to additional services (such as psychosocial supports).
Dilation and curettage	A surgical procedure involving dilatation of the cervix and curettage of the uterus, commonly performed after a miscarriage, or for the removal of cysts or tumours.
Ectopic pregnancy	A pregnancy that occurs outside of the uterus, usually in a fallopian tube, ovary, abdomen or cervix.
Empathetic care	The delivery of respectful, compassionate, holistic and culturally sensitive care from health professional to patients.
EPAS (Early Pregnancy Assessment Service) clinic	A designated outpatient clinic that specialises in providing assessment, diagnostics, care and referrals for patients experiencing complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation.
EPAS provider	Any healthcare service or setting that can provide assessment, diagnostics, care and referrals for patients experiencing complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation. The term 'EPAS providers' refers to both EPAS clinics and EPAS in alternative health settings.
EPAS in alternative health settings	A generalist healthcare setting that can provide assessment, diagnostics, care and referrals for patients experiencing early pregnancy complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation. Examples include an emergency department, a general practitioner, or a maternity, obstetrics, or antenatal hospital unit.
EPAS journey	The complete patient experience through an episode of accessing EPAS. This includes the initial recognitions of symptoms or concerns in early pregnancy, assessment, diagnosis, management, follow-up care and discharge.

Episode of care	A continuous period of healthcare delivery for a specific medical issue, condition, or treatment need - from the initial presentation or referral to the completion of treatment or discharge.
First trimester	The initial stage of pregnancy, covering the period from conception to 12 weeks gestation.
Gestation	The period between conception and birth.
Haemodynamic stability	The medical term used to describe stable blood flow.
Human chorionic gonadotrophin (hCG)	A hormone produced by certain cells of the placenta during pregnancy.
Miscarriage	A miscarriage is the unexpected loss of a pregnancy before 20 weeks. Miscarriage is a naturally occurring event, unlike abortion procedures.
Methotrexate	Methotrexate is a medication that interferes with the body's ability to use folic acid, which is essential for cell division. It is classified as a folate antagonist and is commonly used in cancer treatment, autoimmune diseases, and certain pregnancy-related conditions.
Misoprostol	A medication that causes the uterus to contract and the cervix to soften, commonly used as part of a medical abortion or to manage miscarriage.
Molar pregnancy	A rare complication of pregnancy caused by an abnormal fertilization of the egg, leading to the growth of abnormal placental tissue instead of a normal embryo.
MS 2 Step	A medical abortion medicine that can be used for termination of pregnancy up to 63 days after your last menstrual period.
Non-viable pregnancy	A non-viable pregnancy refers to a pregnancy in which the embryo or fetus is no longer developing or has no potential to result in a live birth
Priority cohorts	Priority cohorts for this national audit refers to First Nations people / communities, those who identify as LGBTQIA+, those who are culturally and linguistically diverse (CALD) and recent migrants including refugees.
Progesterone	A hormone that supports menstruation and maintaining a pregnancy.
Psychosocial supports	While there is currently no consistent definition for psychosocial supports in an early pregnancy context, the term refers to non-clinical and recovery-oriented services delivered in the community and tailored to individual needs following pregnancy complications and/or loss. ¹ Psychosocial supports addresses both the mental health and social well-being of a person.
Retained product of conception	Refers to placental and/or foetal tissue that remains in the uterus after miscarriage, planned pregnancy termination or preterm/term delivery.

Rhesus D negative (Rh(D))	A blood type where, during pregnancy, antibodies in the parent's blood can destroy the baby's red blood cells if their blood types are incompatible (i.e., the parent is Rh(D) negative and the baby is Rh(D) positive).
Transvaginal ultrasound	A common imaging procedure used to visualise and examine female reproductive organ, where the transducer used to create the images is inserted vaginally.

Executive summary.

1.1 Introduction and project approach

Early pregnancy is a critical period for both the parent and the baby. People may require early pregnancy assessment services (EPAS) due to complications that can occur in the early stages of their pregnancy. Examples of complications include bleeding in early pregnancy, miscarriage, and ectopic pregnancies. People can access EPAS at outpatient clinics (EPAS clinics) or through alternative health settings, such as general practitioners (GPs), emergency departments (EDs), and/or maternity wards. This national audit adopts the following definitions for EPAS clinics and alternative health settings (see Figure i).

Figure i: Defining EPAS clinics, EPAS in alternative health settings, and EPAS providers



- An EPAS clinic** refers to a designated outpatient clinic that specialises in providing assessment, diagnostics, care and referrals for patients experiencing complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation.
- EPAS in alternative health settings** refer to other more generalist settings, such as EDs, GP obstetricians or maternity wards, who provide assessment, diagnostics, care and referrals for patients experiencing complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation.
- EPAS providers** is used to refer to both EPAS clinics and EPAS in alternative health settings collectively.

Purpose of this report

Deloitte was commissioned by the Department of Health, Disability and Ageing (DHDA, or the Department) to undertake a national audit of EPAS clinics. The purpose of this national audit is to obtain a better understanding of how EPAS clinics in Australia operate and the current EPAS service landscape in Australia. Findings from this audit aim to inform the development of strategies and programs that may improve care and outcomes for clients accessing EPAS clinics and for people who have experienced a miscarriage. This final report summarises key findings and recommendations from this national audit. The key data sources for this national audit include desktop research, consultations with relevant stakeholder groups (non-government organisations (NGOs), professional bodies, federal and state/territory government agencies, and health providers who deliver EPAS) and surveys to EPAS providers and patients who accessed EPAS in the most recent two years.

Summary of national audit findings

EPAS clinics were identified through three methods: (1) an online desktop review of publicly available information, (2) a provider survey and (3) through consultation with health providers. Through this process, this audit has identified 84 EPAS clinics in Australia. EPAS clinics are typically located in metropolitan areas and attached to tertiary hospitals.

There are significant variations across multiple dimensions of the service delivery model of EPAS clinics. The models of care adopted by EPAS clinics are contingent upon the type of provider, available resources and jurisdiction-specific or hospital-specific protocols. Examples of these variations include:

- **Inconsistencies in service scope.** At a minimum, EPAS clinics typically deliver and/or facilitate pregnancy assessment and management. The inclusion criteria vary by individual clinic but generally excludes urgent cases and includes women with a maximum gestation period of between 14 – 20 weeks. The services delivered by EPAS clinics vary across the following dimensions: (1) the availability of medical and surgical management of miscarriage, (2) access to follow-up care, including approaches to follow up care (including referrals to psychosocial supports), and (3) access to remote and out-of-hours supports. These variations exist because the service scope of individual EPAS clinics is often determined at a service provider level.
- **Differences in collaboration and referral pathways in and out of EPAS clinics.** The absence of consistent referral protocols has contributed to observed variations in referral practices. The extent to which GPs refer to EPAS clinics varies due to differences in awareness levels of EPAS clinics as a service among GPs. GPs often refer patients who experience pregnancy complications to hospital EDs, as opposed to EPAS clinics. Similarly, low community awareness of EPAS means that patients often do not request for a referral to an EPAS clinic, and instead present directly to the ED. Another contributing factor is the fact that most EPAS clinics that were consulted were not aware of and therefore have not registered their service on the National Health Services Directory (NHSD) or Provider Connect Australia. Low awareness of EPAS clinics among key referrers such as GPs may impact timely access to EPAS, as most EPAS clinics require appointments and do not accept self-referrals. Inconsistencies are also observed in terms of referrals out of EPAS clinics. EPAS clinic providers acknowledged that there is currently no clear, universally followed process for making referrals, leading to variation in how different EPAS healthcare professionals handle similar EPAS-related cases.
- **Differences in governance and staffing structures.** EPAS clinics are typically staffed by junior doctors, nurses and/or midwives, and supported by a supervising consultant; however, the staffing structures among individual EPAS clinics exhibit variations due to differences in available resourcing to support service delivery.
- **Inconsistencies in existing education and training mechanisms for health professionals who deliver EPAS.** EPAS clinics are typically staffed by more junior healthcare professionals. This, together with the lack of formal education and training on EPAS, has meant that many healthcare professionals' first exposure to early pregnancy complications would occur during their initial rotation into an EPAS clinic or an EPAS clinic in alternative health settings such as emergency departments. Similarly, most midwives received minimal education about early pregnancy complications and do not experience practice placements in EPAS clinics during their medicine, midwifery and nursing studies.¹ The quality of healthcare practitioners' 'on-the-job' learning is dependent on the capacity and willingness of experienced staff (e.g., consultants, senior nurses and midwives) to facilitate learning opportunities. Such opportunities are typically delivered informally and can differ substantially between EPAS clinics.

¹ Freeman N et al., 2024, Midwives' and registered nurses' role and scope of practice in acute early pregnancy care settings in Australia: A qualitative descriptive study, *37 Women and Birth*

- **Variations in patient volume.** EPAS clinics – particularly those that are attached to large tertiary hospitals – typically experience higher patient volumes (~29 patients per week) compared to EPAS providers who operate in alternative health settings (~16 patients per week). These figures are however likely an underestimation of actual need due to low awareness of EPAS more broadly. Survey respondents who recently accessed EPAS are often in their 30s and living in metropolitan areas; however, this pattern appears to be driven more by service distribution (the physical location and accessibility of EPAS providers) rather than the full spectrum of need for these services. More data is required to understand the demographic characteristics of patients who experience early pregnancy complications.

The lack of standardised service delivery models has introduced variation in patient experience.

The services offered by EPAS providers (both in clinics and alternative health settings) broadly meet the medical needs of patients. However, inconsistent referral protocols mean that psychosocial supports (particularly those which relate to mental health supports) are not consistently provided to EPAS patients. There is also scope for the delivery of EPAS to be more tailored to the needs of priority population cohorts such as First Nations peoples, people from migrant and refugee backgrounds, and patients who identify as LGBTQIA+. While many EPAS providers acknowledge the potential need for tailored services to priority cohorts, their ability to do so is hampered by resourcing constraints and limited understanding of the needs of different population cohorts. Another key limitation is the lack of comprehensive training and resources to address the wide spectrum of cultural, linguistic, gender, and socioeconomic differences among patients. As a result, the current delivery of EPAS may not fully account for the varying needs, beliefs, preferences or health literacy levels of patients, leading to generalised guidance and supports that may not support individual needs.

Notwithstanding these differences, **EPAS clinics remains perceived by both patients and providers as a vital health service.** This reflects the number of people who experience early pregnancy complications, and the associated medical and psychological risks. Most stakeholders who participated in this audit reaffirmed the view that EPAS clinics in particular play an essential role and are the desired setting to receive high-quality non-urgent pregnancy care. This national audit has also identified pockets of excellence in some healthcare settings. Some EPAS clinics have proactively developed guidance, processes, induction and training resources to elevate the quality of support. This presents an opportunity for these resources to be shared more broadly across the sector.

The system underpinning the delivery of EPAS should ideally be designed with the patient at the centre. Patients identified five key factors which influence patient experience and enable the effective delivery of EPAS:

1. **Rapid access to EPAS.** The timeliness and accessibility of EPAS is important for patients who experience early pregnancy complications. This is currently a challenge as EPAS clinics typically have restricted operating hours and offer limited support outside of these times. People experiencing pregnancy complications, particularly over the weekend, are often required to visit the ED or wait for care. A virtual model of care is broadly perceived to be beneficial as it increases the accessibility of EPAS, especially for those who are required to travel long distances to attend an in-person appointment.
2. **Empathetic communication skills.** Empathy and the feeling of “being heard” are among the most critical aspects of care for patients accessing EPAS. Patients noted that it is important for

healthcare professionals to acknowledge and validate the physical and emotional impact of early pregnancy loss or complications.

3. **More consistent approaches in the delivery of or referral to psychosocial supports.** Stakeholders also highlighted the importance for EPAS health professionals to either provide or facilitate access to high quality psychosocial supports – particularly those which relate to mental health. The potential need for these supports should be assessed during initial and follow up appointments.
4. **Continuity of care.** Stakeholders noted that assigning a health professional (e.g., a midwife or a nurse) to provide continuous care during an episode of care is the preferred staffing model. Stakeholders also noted that EDs may not be an appropriate space to deliver EPAS due to the lack of privacy and the disruptive environment.
5. **Appropriate physical infrastructure, with discrete waiting rooms and distinct physical separation between early pregnancy and maternity services in hospitals.** Discrete waiting rooms and a clear physical separation between an EPAS clinic and maternity services are especially important for patient experience.

Recommendations

This national audit has identified eight recommendations to improve the quality of EPAS. The recommendations, along with the EPAS provider type that they are related to, are summarised in the table below.

Table ii: Summary of recommendations

No.	Recommendations	Relevance of recommendation by EPAS provider type
1	Build on Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and state governments' guidelines to establish guidelines for the provision of EPAS in clinics and alternative health settings.	EPAS clinics and EPAS in alternative health settings
2	Collaborate with community representatives to develop more standardised and context-specific resources, supports and guidelines for healthcare professionals who deliver EPAS to patients from priority populations.	EPAS clinics
3	Expand resourcing to ensure appropriate staffing and infrastructure (e.g., ultrasound machines) to deliver high quality EPAS.	EPAS clinics
4	Develop standardised education, training and induction resources on trauma-informed early pregnancy complication care and provide dedicated funding to support uptake of training.	EPAS clinics
5	Investigate and expand alternative service models that increase accessibility and enable continuity of care within an episode of care.	EPAS clinics and EPAS in alternative health settings

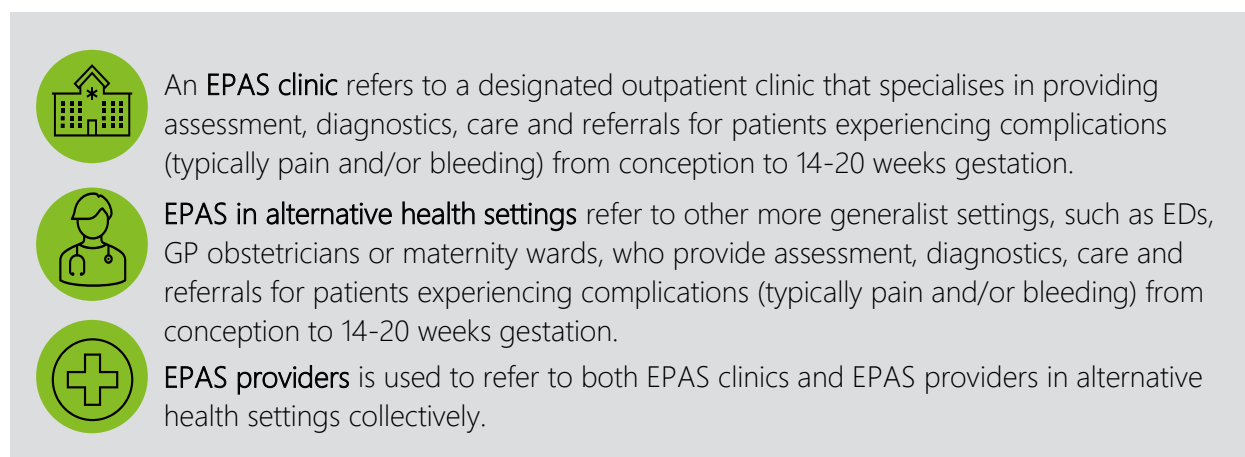
This could include consideration of telehealth (e.g., 24-hour hotlines), virtual and midwifery-led delivery models.

6	Develop standardised informational resources for EPAS patients, covering the medical and psychosocial aspects of care and ensure patients consistently provided these resources.	EPAS clinics and EPAS in alternative health settings
7	Improve community and health system awareness of early pregnancy complications and EPAS – this could involve a community awareness campaign, outreach activities to GPs and a review of health system protocols	EPAS clinics and EPAS in alternative health settings
8	Introduce structured data collection and reporting mechanisms (including patient feedback) to strengthen the evidence base on EPAS.	EPAS clinics

1. Introduction.

This chapter provides a high-level summary of the context underpinning the national audit of Early Pregnancy Assessment Services (EPAS) clinics. Figure 1.1 provides a definition of EPAS clinics and EPAS in alternative health settings, which are used for this project.

Figure 1.1: Defining EPAS clinics, EPAS in alternative health settings, and EPAS providers



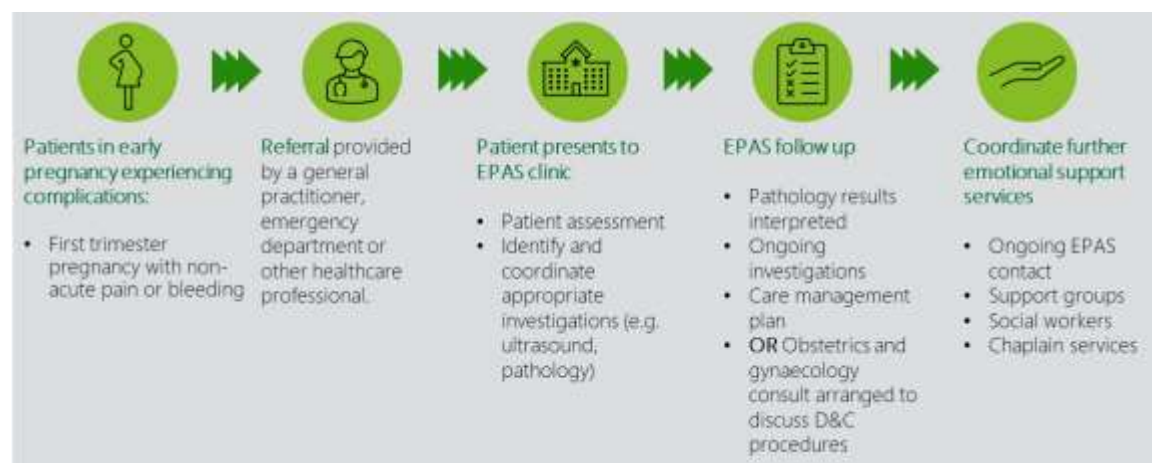
1.2 Early pregnancy

Early pregnancy is a critical period for both mother and baby. There are multiple definitions of early pregnancy care, but the most common definition relates to care provided to people from conception to the first trimester of pregnancy. Early pregnancy assessment services (EPAS) may be required if complications occur in early pregnancy. Complications includes: bleeding in early pregnancy, miscarriage, ectopic pregnancy, and hydatidiform mole.

1.3 EPAS clinics

An EPAS clinic refers to a designated outpatient clinic that specialises in providing assessment, diagnostics, care and referrals for patients experiencing complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation. Figure 1.2 provides an overview of a typical EPAS clinic pathway.

Figure 1.2: Overview of EPAS clinic pathway



Source: Adapted from Queensland Clinical Guidelines: Early Pregnancy loss.²

Research has found that there are several benefits that EPAS clinics provide compared to care sought for early pregnancy complications received in alternative settings. These include^{3,4}:

1. Faster diagnosis – EPAS clinics can help identify the location of a pregnancy and confirm its viability – this includes identifying ectopic pregnancies which can be life-threatening. Early diagnosis also allows for better decision making regarding non-surgical options for managing early pregnancy complications.
2. Improved patient care – EPAS clinics provide services including clinical assessment, ultrasounds, laboratory investigations, management planning, counselling and support.
3. Education – EPAS clinics provide information and education regarding medications, foods and procedures which should be avoided during pregnancy.
4. Social and emotional well-being – EPAS clinics provide additional support to reduce the mental health impacts associated with early pregnancy complications.

For more information on early pregnancy assessment, complications and services, please refer to Appendix A.

1.4 The Australian Government's response to support those experiencing early pregnancy complications

People who experience a miscarriage commonly report a lack of information, poor access to follow-up care and limited referral to counselling or other services.⁵ They often also experience stigma and a feeling of shame that is compounded by a medical system that doesn't meet their needs.^{6,7} In May 2024, the Australian Government announced a funding package to help meet the needs of people who have experienced miscarriage.⁸ Equating to \$9.5 million, the funding package will include bereavement support for people and families who suffer through the physical and emotional impact of miscarriage, as well as addressing the data gaps in our understanding of miscarriage.

The initiatives funded include:

- \$5.5 million for grants for bereavement support services,
- \$1.5 million for education and awareness activities,
- \$1 million in funding delivered to the Australian Institute of Health and Welfare to improve data on miscarriage, and
- \$1.5 million to facilitate a national audit of Early Pregnancy Assessment Service (EPAS) clinics.

The national audit of EPAS clinics (this project) aims to inform the development of strategies and programs that may improve care and outcomes for clients accessing EPAS clinics and for people who have experienced a miscarriage. This will help ensure that the shame, stigma and isolation commonly experienced following miscarriage are mitigated.

1.5 Project scope and purpose

Deloitte was commissioned by the Department of Health, Disability and Ageing (DHDA, or the Department) to undertake a national audit of EPAS clinics. The purpose of the audit is to obtain a better understanding of how EPAS clinics in Australia operate. This audit aims to:

- inform the development of strategies and programs that may improve care and outcomes for clients accessing EPAS clinics and for people who have experienced a miscarriage,

- encourage EPAS clinic operators to register on the National Health Service Directory and Provider Connect Australia. This will enable other health professionals to refer clients to EPAS clinics and ensure the general public can access information on these services. Provider Connect Australia registration will help EPAS clinic operators to ensure their information is consistently maintained and up to date.

The scope of this project includes:

- identifying the number of EPAS clinics operating,
- identifying the location and hours of operation of each EPAS clinic,
- describing how each EPAS clinic operates in relation to, and links with other health services, including referral pathways from the EPAS clinic if services beyond the scope of the EPAS clinics are required,
- describing governance and staffing structures of EPAS clinics, including any specialised training (e.g., psychosocial training) provided to staff,
- identifying inclusion and exclusion criteria (both clinical and non-clinical) for clients accessing each EPAS clinic,
- describing the accessibility of EPAS clinics (including how they accommodate people with disability and their level of inclusiveness for LGBTIQ+ patients),
- outlining the services provided by each EPAS clinic,
- providing an indication of the number of patients seen by each clinic each calendar year,
- assessing the cultural safety and suitability of EPAS clinic for clients from First Nations, migrant and refugee backgrounds,
- collecting data on patient experiences and satisfaction with EPAS clinics including psychosocial support and referrals to support services,
- identifying what is working well in EPAS clinics and outlining any changes that could be made to improve the EPAS clinics (particularly in relation to supporting national consistency),
- identifying how clients who have used the EPAS clinics became aware of the service, and
- increasing the profile of EPAS clinics by encouraging them to register their service on the National Health Services Directory and Provider Connect Australia.

1.6 Purpose of the report

The purpose of this report is to provide an overview of the findings and recommendations informed by stakeholder consultation, patient case studies, and a survey of patients and providers.

1.7 Structure of this report

This report is structured to comprise the following section:

- **Chapter 1 – Introduction** (this section).
- **Chapter 2 – Methodology.** This section provides an overview of the national audit's methodology, including data collection approaches through surveys, semi-structured interviews/focus groups and case studies.
- **Chapter 3 – EPAS characteristics.** This section describes the current state of EPAS, including the number of EPAS clinics, the location of EPAS clinics, clinic operating hours, and the number of EPAS providers registered on the National Health Service Directory.
- **Chapter 4 – Service scope.** This section provides an overview of the types of services that are delivered in EPAS clinics,

- **Chapter 5 – Governance and staffing.** This section outlines findings on governance, staffing composition and approaches to staff training across services that deliver EPAS.
- **Chapter 6 – Patient characteristics and experience.** This section details findings on patient awareness, satisfaction with services, the availability of tailored supports for priority population cohorts and the key success factors which enable the effective delivery of EPAS.
- **Chapter 7 – Patient journey map.** This section provides in-depth detail of eight selected case study participants to demonstrate their experiences as patients when interacting with different health services upon experiencing early pregnancy complications. These case studies are intended to provide real-life examples of strengths and gaps of the current service system that delivers EPAS.
- **Chapter 8 – Recommendations and next steps.** This section provides a series of recommendations and suggested next steps to improve the delivery of EPAS in Australia.

2. Methodology.

This section provides an overview of the national audit's methodology and analytical approach.

2.1 Methodology overview

Figure 2.1: Project methodology

	PHASE 1: MOBILISE & PHASE 2: PROJECT PLAN September-October 2024	PHASE 3: DESKTOP RESEARCH October 2024-November 2024	PHASE 4: CONSULTATION January to June 2025	PHASE 5: DRAFT REPORT & PHASE 6: FINAL REPORT July-August 2025
ACTIVITIES	- Project Inception meeting - Planning workshop - Project Plan	- Desktop research and initial consultation - Consultation plan - Ethics approval	- Workforce survey distribution - Patient survey distribution - Stakeholder interviews - Case studies (patient journey maps)	- Preliminary Findings Workshop - Draft and final report
DELIVERABLES / OUTPUTS	- Draft Project Plan - Final Project Plan	- Desktop Research Summary Report - Consultation plan (incl. interview guides and stakeholder surveys) - Ethics application and supporting documents	Consultation Outcomes Summary Report	- Draft Report - Final Report

The methodology for this national audit comprised four key phases and is outlined in Figure 2.1:

Phase 1: Planning. In this phase, Deloitte worked with the Department to agree on a shared understanding of the project's objectives, milestones, planned meetings, scope, nature of the project and expectations and governance of the project. Deloitte delivered a Project Plan that outlined the methodology for the audit and stakeholder engagement, milestones, roles and responsibilities, and provided a high-level summary of key activities.

Phase 2: Desktop research. Deloitte conducted a broad scan of publicly available information, academic and grey literature on EPAS. Generative AI was leveraged to scan through online sources to extract relevant information on EPAS. Deloitte delivered a desktop research report that summarised best practice guidelines for the delivery of EPAS and provided a snapshot of identified EPAS clinics across Australia. Informed by the insights obtained from the desktop research report, Deloitte developed a consultation plan that contained data collection tools, including survey and interview guides and outlined the method of engaging stakeholders.

Phase 3: Ethics application. Deloitte developed a stakeholder engagement protocol, including consultation guides and participation information consent forms. This protocol received human research ethics approval from Bellberry Human Research Ethics Committee (HREC) on April 22, 2025 (ethics approval number: 2025-01-088). The data collection tools were distributed to all state / territory government agencies and selected NGOs prior to dissemination to the broader sector for input and feedback. Further detail on stakeholder consultation activities is provided in the next phase.

Phase 4: Consultation. Deloitte distributed the patient and provider survey to NGOs, and state/territory government agencies to distribute. A series of stakeholder consultations with patients, EPAS providers, state/ territory health departments, and NGOs was completed.

Phase 5: Analysis and reporting. Desktop research and primary data collected in previous phases were synthesised to develop key findings aligned with the audit's key research questions. As part of this phase, Deloitte ran a workshop with key stakeholders from the Department to test and validate key findings from the desktop review and primary data collection and to facilitate knowledge sharing. Feedback collected from the workshop was integrated into the report.

2.2 Data sources

The findings and recommendations in this report have been developed based on evidence drawn from both primary data (through semi-structured interviews, case studies and surveys) as well as a review of relevant secondary data.

Secondary data sources

Secondary data on EPAS clinics was shared by SA Health (South Australia), WA Health (Western Australia), the Tasmanian Department of Health and NSW Health (New South Wales).

Primary data sources

This audit adopted a phased approach towards data collection:

Phase 1: Initial consultations.

The first phase of data collection was conducted between March 2025 to April 2025 and involved consultation of stakeholders that did not require ethics approval, including NGOs, professional bodies, government agencies and health providers.

Deloitte received a list of stakeholders directly from the Department (45 stakeholders, of which 31 opted in to participate). State and territory departments also provided the contact details of EPAS providers, health professionals and researchers in their respective jurisdictions (21 stakeholders, of which nine opted in to participate). Additionally, NGOs and professional bodies provided the contact details of other health professionals. In total, 48 (53%) stakeholders opted-in to participate in consultations. See Table 2.1 below for an overview of the number of stakeholders consulted.

Deloitte directly contacted stakeholders via email to invite them to participate in a short consultation. Stakeholders who did not respond were sent a reminder email. Consultations were scheduled for 30 minutes to one hour, with one to four participants present on call, and hosted virtually using Microsoft Teams. Consultations took place between March to April of 2025. A member of the Deloitte project team facilitated the consultation with an additional team member present to take notes. The consultation questions were aligned with the research questions outlined in Section 2.3 (See Appendix B.1 for the full list of consultation questions and Appendix C for the full list of organisations consulted).

Table 2.1: Stakeholder participation in consultation process for the National Audit of EPAS Clinics in phase 1

Stakeholder group	Contacted	Declined	Completed and completion rate
NGOs	20	2	15 (75%)
Maternity Consumer Groups	2	0	2 (100%)
Professional bodies	10	2	5 (50%)
Government	23	9	6 (26%)
EPAS provider	39	0	20 (51%)
Total	94	13	48 (51%)

Source: Deloitte Access Economics.

Phase 2: Patient and provider survey, patient interviews and additional consultation.

This phase commenced after ethics approval was obtained and occurred between May to July 2025. This phase involved distributing a patient survey and provider survey, conducting semi-structured interviews with patients, and running additional consultations with EPAS providers in alternative health settings.

Patient and provider survey

Deloitte administered two online surveys through the Qualtrics survey platform: (1) a survey of EPAS patients, and (2) a survey of EPAS providers. Both surveys were open for a period of five weeks between 12 May 2025 to 16 June 2025.

The patient survey was distributed using an anonymous link embedded in an email and a QR code presented on a virtual and physical poster. The email and posters were sent by Deloitte to previously contacted NGOs, state and territory government departments and to EPAS providers for them to distribute. The patient survey was also advertised on online forums and through social media (e.g., Facebook and LinkedIn).

The provider survey was distributed as a link embedded in an email sent by Deloitte to contacts identified in the previous phase of data collection, including NGOs, state and territory government departments and EPAS providers to distribute and complete. State and territory government departments were encouraged to share the survey with EPAS clinics in their jurisdictions, and EPAS providers were encouraged to complete the survey. A link to the provider survey was also shared via organisation-specific email lists by professional bodies and advertised online through social media (e.g. LinkedIn).

In total, 211 patient survey responses and 166 provider survey responses were included in the analysis. Significantly incomplete responses and responses that did not provide consent were excluded from analysis. Responses were collected from patients and providers from across all jurisdictions.

Table 2.2: Total number of provider and patient survey responses

State	Patient survey responses		Provider survey responses	
	Number of survey respondents	% of total number of patient survey responses	Number of survey respondents	% of total number of provider survey responses
New South Wales	54	26%	35	22%
Victoria	54	26%	28	18%
Queensland	33	16%	29	22%
Western Australia	13	6%	17	10%
South Australia	11	5%	15	9%
Tasmania	10	5%	11	7%
Australian Capital Territory	5	2%	20	9%
Northern Territory	5	2%	5	2%
Unknown*	52	25%	6	4%

Total*	211	100%	166	100%
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Source: Deloitte Access Economics, 2025.

*Unknown represents patient survey respondents who opted not to respond to the survey question on their primary place of residence.

Regarding the provider survey, most responses (80%, n=133) were from EPAS providers who operate in alternative health settings, with the remaining 20% (n=33) from EPAS clinics. EPAS clinic responses were collected from all jurisdictions except for Tasmania, and most commonly from NSW (33%, n=11) (see Table 2.3). Responses from EPAS providers in alternative health settings covered all jurisdictions. A higher-than-expected proportion of responses came from providers in ACT (14%, n=18), primarily due to the high representation of GPs. Providers listed as 'unknown' did not provide an identifiable Australian postcode in their survey response.

Table 2.3: Provider survey response by jurisdiction and type of provider

State	Provider survey responses			
	EPAS clinic		EPAS providers in alternative health settings	
	Number of survey respondents	% of total number of EPAS clinic survey responses	Number of survey respondents	% of total number of EPAS in alternative health settings responses
New South Wales	11	33%	24	18%
Victoria	5	15%	23	17%
Queensland	5	15%	24	18%
Western Australia	3	9%	14	11%
South Australia	4	12%	11	8%
Tasmania	0	0%	11	8%
Australian Capital Territory	2	6%	18	14%
Northern Territory	2	6%	3	2%
Unknown	1	3%	5	4%
Total	33		133	

Source: Deloitte Access Economics, 2025.

As seen in Table 2.4, more than half of EPAS clinics and EPAS providers in alternative health settings who responded to the survey are based in metropolitan areas. Regionality was classified based on the Modified Monash Model.⁹ Providers listed as 'unknown' did not provide an identifiable Australian postcode in their survey response. The most common types of EPAS in alternative health settings reported in the provider survey included GPs (34%, n=57), maternity, obstetrics, or antenatal hospital unit (31%, n=52), and ED (7%, n=12).

Table 2.4: Provider survey response by regionality

Regionality	Provider survey responses			
	EPAS Clinic		EPAS providers in alternative health settings	
	Number of survey respondents	% of total number of EPAS clinic survey responses	Number of survey respondents	% of total number of EPAS in alternative health settings survey responses
Metropolitan	20	60%	72	54%
Regional, rural or remote	12	36%	56	42%
Unknown	1	3%	5	4%
Total	33	100%	133	100%

Source: Deloitte Access Economics, 2025.

The provider survey provided an opportunity for respondents to opt in for a follow-up consultation. Approximately 50 EPAS in alternative health settings recorded their interest in attending a follow-up consultation. Deloitte conducted five additional semi-structured interviews with a total of five EPAS providers. Deloitte also conducted a focus group with 12 EPAS clinic providers representing NSW local health districts in Phase 2 as contact details for these stakeholders were provided by the NSW Health during this period (see Table 2.5).

Case studies (patient journey maps)

Deloitte completed 8 case studies (in the form of patient journey maps) as part of the national audit. Selection criteria for participation in the case study were agreed upon in consultation with the Department, and included:

- patient location (regional, rural, remote, metropolitan) and by jurisdiction,
- type of EPAS provider (clinic, alternative setting, emergency department),
- clinical inclusion criteria,
- pregnancy outcome (carried to term, miscarriage, stillbirth, ectopic), and
- referral pathways after accessing EPAS services.

Patient survey respondents who agreed to participate in case studies were approached via email with an invitation to participate in a semi-structured interview. In this invitation, they were provided with a participant information and consent form (PICF), which detailed the purpose of the interview, key questions, and ethics approval information. To avoid causing any distress, each patient was approached once for participation and not followed up. While the patients approached for consultation covered a broad range of demographic characteristics, pregnancy outcomes, and EPAS experiences, the eight patients who responded and consented to participate were mostly from metropolitan locations with more negative sentiments about their care journey. As such, while these case studies highlight some important areas for improvement in the provision of EPAS, they are not necessarily reflective of the broader sentiment as reflected in the patient

survey, where 59% (n=118 of 197 responses to that question) rated the quality of care received as either 'good' or 'very good'.

Once consent was provided to participate via return email and a completed PICF was received, patients were scheduled for a 60-minute semi-structured virtual interview held on Microsoft Teams. Two Deloitte team members were present to facilitate the conversation and take notes. The Deloitte team member leading the interview was a registered nurse and midwife with extensive experience conducting healthcare consultations and clinical expertise in the early pregnancy space. Ahead of the case study interview, patients were provided with a list of nine interview questions. Patients were able to elect not to answer any questions of their choosing. These discussion items to guide the conversation were as follows:

1. Could you please provide a description of the services you received as part of your visit to an EPAS provider?
2. Did you access EPAS through an EPAS clinic or were these services provided in another setting?
3. How were you made aware of the EPAS?
4. What was the referral process link and how long was the wait time for you to access an EPAs provider?
5. Did you experience any barrier to accessing your EPAS provider?
6. Were you satisfied with the service and quality of care you received at the EPAS clinic/health setting?
7. Were you provided with follow up care and support after your initial appointment?
8. How do you feel EPAS could have been better delivered to meet your needs?
9. Is there anything else you'd like to tell us about your experience?

To ensure patient privacy and confidentiality, these interviews were not recorded or transcribed, and instead written notes were taken during the conversation. These notes were then translated into the patient's story within their journey map. Throughout each case study, terminology has been utilised as described by the patient. As each case study is a unique and personal account of each patient's experience, participants were sent their case study for review and feedback prior to inclusion in this report.

Stakeholder consultation

In total, across the two phases, 76 stakeholders were consulted (see Table 2.5). See Appendix C for a full list of consulted stakeholders and organisations.

Table 2.5: Stakeholder consultation

Stakeholder group	Consultation
EPAS providers	30
Non-government organisations (including maternity consumer groups)	15
Professional Bodies	10
State and territory health departments	8
Patient case studies	8
EPAS providers in alternative health settings	5

Total	76
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Source: Deloitte Access Economics.

2.3 Research questions

Research questions were developed and agreed upon with the Department in line with the scope of this national audit presented in Section 1.5. The research questions were grouped under five domains as presented in the table below.

Table 2.6: Research questions and domains

#	Domain	Sub-question
A	EPAS Characteristics	A.1 How many EPAS clinics are in Australia?
		A.2 Where are the EPAS clinics located?
		A.3 What are the operation hours of each clinic?
		A.4 What is the estimated proportion of EPAS clinics who have registered their service on the National Health Services Directory and Provider Connect Australia?
B	Service scope	B.1 What are the types of services provided by EPAS providers?
		B.2 What are the clinical and non-clinical inclusion and exclusion criteria for accessing each EPAS clinic?
		B.3 How do EPAS providers operate in relation to and in collaboration with other health services?
		B.4 What are the patients' referral pathways from EPAS providers if other services are required?
C	Governance and staffing	C.1 What are the governance and staffing structures implemented by EPAS clinics?
		C.2 What are the capability and training requirements for EPAS staff members?
D	Patient characteristics and experience	D.1 How many patients are seen by EPAS clinics in a calendar year?
		D.2 What are the demographic characteristics of patients who access EPAS?
		D.3 How were patients made aware of the services provided by EPAS providers?
		D.4 How accessible are EPAS providers, particularly for people with disability?
		D.5 To what extent do EPAS providers provide culturally safe and suitable services for patients from priority population cohorts, including clients from First Nations, migrant and refugee backgrounds and clients who identify as LGBTQIA+?
		D.6 To what extent are patients satisfied with the services they received from EPAS providers? (e.g., quality of psychosocial supports received, appropriate referrals to other services)?
		D.7 What are the success factors which enable the effective delivery of EPAS?
E	Future areas of improvement	E.1 What are the potential areas for improvement to enable EPAS providers to better achieve intended outcomes?
		E.2 What are the possible implementation changes to increase national consistency in service access and quality?

Source: Deloitte Access Economics.

2.4 Analysis approach

Consultation transcripts were thematically analysed. An initial set of themes was developed based on the sub-questions outlined above (Table 2.6) and an inductive review of the consultation notes, informed by the frequency and salience of issues raised by stakeholders. The notes were then systematically coded against these themes using a deductive framework and analysed by stakeholder groups. Key findings were derived from this analysis, focusing on themes that demonstrated prominence across stakeholders.

Survey analysis was aggregated and analysed quantitatively using descriptive statistics (e.g., proportions, means) and was analysed by different characteristics (e.g. type of EPAS provider, regionality of provider and service, etc.). Open text responses were analysed thematically, drawing out common themes.

2.5 Caveats and limitations

When reviewing this report, the following caveats and limitations should be taken into consideration:

- The stakeholder consultation process was opt-in, meaning there was no way to compel all providers who deliver EPAS to participate in the project. While Deloitte took steps to identify and connect with EPAS providers in alternative settings, such as engaging with Primary Health Networks (or equivalent in other jurisdictions, such as Local Health Districts) and state and territory health government departments, Deloitte primarily engaged with EPAS clinics during the consultation process. This limitation has been mitigated through the provider survey, which had a total of 172 responses (80% of EPAS provider survey respondents were EPAS providers who operate in alternative health settings).
- Due to ethics requirements, survey questions that identified patients' First Nations heritage were unable to be included in the survey. Consequently, there was no way to distinguish between the experiences of First Nations and non-First Nations patients.
- Both the patient and provider surveys were opt-in and voluntary. While Deloitte adopted multiple methods to maximise the reach and uptake of both surveys, the collected survey data may not be representative of all patients who accessed EPAS and providers who deliver EPAS. For example:
 - For the patient survey, 58% (n=108) of patient survey responses were based in NSW and Victoria, and 74% (n=139) of respondents were between 30 and 39 years old.
 - For the provider survey, 80% (n=133) of EPAS providers who responded to the survey were providers who operate in alternative health settings. 34% (n=57) of provider survey respondents indicated they were a GP and 31% (n=52) of provider survey respondents indicated they were a maternity, obstetrics or antenatal hospital unit.
- Many patients found it difficult to distinguish their experience of EPAS from the maternity system, and therefore some patient themes may not be distinct to EPAS experience but rather reflect challenges faced by the healthcare system in general. To mitigate this, in case studies, each step of the journey experienced by a patient is mapped out to distinguish between EPAS-specific challenges as opposed to health system challenges.
- There is currently no nationally consistent definition of what constitutes early pregnancy. In some healthcare settings, early pregnancy may also include services provided to people in their second trimester. In this report, most identified EPAS clinics have defined their service scope to be people in the first trimester of their pregnancy. On this basis, it is assumed that

EPAS are typically delivered to people experiencing pregnancy complications in the first trimester of their pregnancy.

3. EPAS Characteristics.

Key Findings

- While definitions and service models vary, there are estimated to be at least 84 EPAS clinics in Australia.
- EPAS clinics are primarily located in metropolitan areas. In regional, rural and remote areas, EPAS is more commonly delivered through alternative health settings
- EPAS clinics are generally only open on weekdays and within work hours. Outside of opening hours, most EPAS clinics provide limited or no support.
- Most EPAS clinics are not aware of and therefore have not registered their service on the National Health Services Directory or Provider Connect Australia.

This section focuses on the characteristics of EPAS clinics. It summarises findings from stakeholder consultations, EPAS patient and provider survey analysis and semi-structured EPAS patient interviews, which respond to the following research questions:

- A.1 How many EPAS clinics are in Australia?
- A.2 Where are the EPAS clinics located?
- A.3 What are the operating hours of each clinic?
- A.4 What is the estimated proportion of EPAS clinics who have registered their service on the National Health Services Directory and Provider Connect Australia?

3.1 Quantity of EPAS clinics

While definitions and service models vary, there are estimated to be at least 84 EPAS clinics in Australia, and significantly more EPAS providers operating in alternative health settings such as EDs, GP clinics and maternity wards.

As discussed in Section 1.3, an EPAS clinic refers to a designated outpatient clinic that specialises in providing assessment, diagnostics, care and referrals for patients experiencing complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation. This national audit has identified 84 EPAS clinics in Australia. 75 EPAS clinics were identified online, while an additional 9 EPAS clinics were identified from the provider survey based on reported postcodes of EPAS clinics.² The full list of EPAS clinics is provided in Appendix D. There are likely significantly more providers who deliver EPAS in alternative health settings such as EDs, maternity wards and GP clinics.

3.2 Location of EPAS clinics

EPAS clinics are primarily located in metropolitan areas. In regional, rural and remote areas, EPAS is more commonly delivered through alternative settings, including maternity and gynaecology services within regional hospitals.

² One additional EPAS clinic from the survey provided a postcode that could not be matched to an existing service.

60% (n=51) of identified EPAS clinics are based in metropolitan areas. Available data indicates that EPAS clinics are often attached to tertiary metropolitan hospitals. This trend is consistent with patient survey feedback. 78% (n=103) of patient survey respondents who reside in metropolitan areas accessed EPAS in a clinic setting. In contrast, a lower proportion of patient survey respondents who reside in regional and rural areas (47%, n=25) access early pregnancy complication care within an EPAS clinic. Operating hours of EPAS clinics

EPAS clinics are generally only open on weekdays and within work hours. Outside of opening hours, most EPAS clinics provide limited or no support. As a result, people experiencing pregnancy complications outside of operating hours are often required to visit the ED, a GP or delay care.

EPAS clinics are predominantly open across multiple weekdays. When assessing the operating hours of the 84 identified EPAS clinics:

- 69% (n=20) of EPAS clinics indicated they are open five days per week,
- 38% (n=11) of EPAS clinics indicated that they are open five days per week for at least seven hours per day (up to eight and a half hours per day), and
- only two EPAS clinics reported being open on weekends.

Tailored after-hours support services are limited. In the provider survey, all EPAS clinic respondents (n=28) identified the ED as an after-hours support, and 25% (n=7) of provider survey respondents also suggested a GP. Fewer clinics offered direct phone support, with only 11% (n=3) of EPAS provider survey respondents reporting an after-hours monitored phone number, linking patients to the reception or a midwife. After-hours support, such as a 24/7 helpline or clear referral pathways for urgent care, is essential to guide patients experiencing early pregnancy complications outside clinic hours.

There appears to be a misaligned expectation among patients and EPAS clinics on the service scope of EPAS clinics. Patients often expect EPAS clinics to deliver urgent care to individuals experiencing pregnancy complications. In contrast, providers argue that EPAS clinics are not designed to be an emergency service (as is evidenced by their exclusion criteria), and that they lack the resources to expand opening hours to achieve this (See Section 4.1 for more information regarding the service scope EPAS clinics).

"Having an on-call line of some sort where people can call at any point if they're experiencing early pregnancy bleeding or something like that, needs to be available." – Professional body

"How does an EPAS clinic operate in a way that either allows for a 24/7 service or allows for things like digital resources or referrals where they are not able to operate? So, when you call the EPAS clinic they go 'this is where you find the resources, this is where you decide if you need to go to ED, this is what may happen if you have a miscarriage at home and we're not open'." – NGO

There is widespread consensus internationally among official guidelines, including the UK National Institute for Health Care Excellence (NICE) guidelines, that, at a minimum, EPAS services should be available daily from Monday to Friday during office hours.^{10,11,12} While EPAS clinics noted potential gaps in service delivery for patients who require care during weekends, they reported that the expansion of operating hours is limited by staffing resources. These resource constraints relate to both budgetary constraints and an inability to recruit staff. This was reflected in the provider survey, where only 32% of EPAS clinics (n=9 out of 28 EPAS clinics) agreed that their service was

appropriately staffed to meet demand and deliver high quality care (see Section 5 *Governance, training and staffing*).

The two EPAS clinics that reported being open on weekends were both metropolitan services that reported seeing 40 or more patients per week, which is above the average EPAS clinic weekly patient volume (~29 patients per week, see Section 6.1). Expanded clinic operating hours, especially on weekends, may allow EPAS providers to support more patients and meet patient demand for weekend care, while removing demand pressure experienced by clinical staff throughout the weekdays, especially on Monday.¹³ Furthermore, when services are closed on the weekend, people with suspected miscarriage may experience distress and anxiety due to delayed care.¹⁴

"I've worked in an [EPAS service] in the UK and it was a seven day service, there'd be midwives, you would see the women, and then you would also potentially see them next time if they've had another miscarriage, this relationship builds up." – EPAS clinic provider

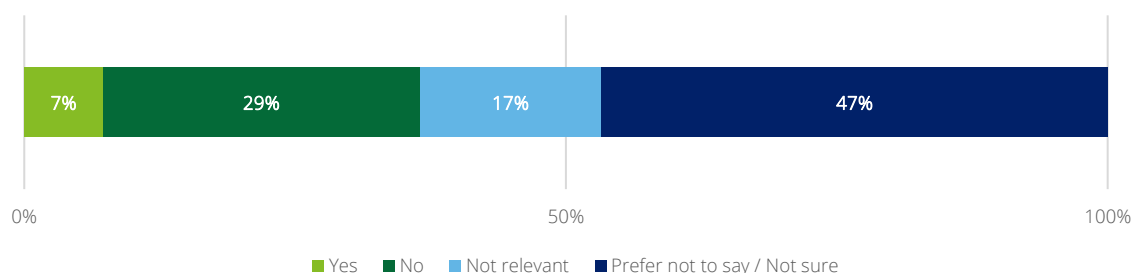
"EPAS should really be open on weekends. Waiting three days for care is not reasonable." – NGO

3.3 Registration to National Health Services Directory and Provider Connect Australia

Most EPAS clinics are not aware of and therefore have not registered their service on the National Health Services Directory (NHSD) or Provider Connect Australia.

In the provider survey, only 7% (n=2) of EPAS clinics confirmed their service was registered for the NHSD and/or Provider Connect Australia. EPAS clinics are less likely to be registered on the NHSD compared to EPAS providers in alternative settings. Of the EPAS providers that are registered to the NHSD and/or Provider Connect Australia, the majority (60%, n=6) were maternity, obstetrics or antenatal units. As part of this audit, Deloitte provided further information to encourage providers to register on both platforms, however, the actual level of additional registrations are unknown. Registration to the National Health Services Directory and Provider Connect Australia can be promoted to increase provider awareness, for instance through state/territory health departments contacting individual EPAS providers.

Chart 3.1: Responses to provider survey question A4 – If your healthcare facility has a specific service for early pregnancy complications, is it registered on the National Health Services Director (NHSD) and/or Provider Connect Australia? (n=137)



Note: Single response permitted.

Source: Deloitte Access Economics survey analysis (2025).

4. Service scope.

Key Findings

- The service scope of EPAS providers is inconsistent across Australia. At a minimum, EPAS providers deliver and/or facilitate pregnancy assessment and management.
- The most common exclusion criteria of EPAS clinics similarly include urgent cases and includes a maximum gestation period of between 14-20 weeks.
- The extent of collaboration between EPAS providers and other health services varies due to differences in awareness levels on the availability of EPAS as a service for women experiencing early pregnancy complications. Referrals from EPAS providers to other parts of the health system are also inconsistent.

This section covers findings which relate to both EPAS clinics and EPAS in alternative health settings. It summarises findings from stakeholder consultation, EPAS patient and provider survey analysis and semi-structured EPAS patient interviews, which respond to the following research questions:

- B.1 What are the types of services provided by EPAS providers?
- B.2 What are the clinical and non-clinical inclusion and exclusion criteria for accessing each EPAS clinic?
- B.3 How do EPAS providers operate in relation to and collaborate with other health services?
- B.4 What are the patients' referral pathways from EPAS providers if other services are required?

In total, the provider survey collected 33 responses from EPAS clinic providers and 133 responses from EPAS providers in alternative health settings.

4.1 Service scope

The service scope of EPAS providers is inconsistent across Australia. At a minimum, EPAS providers typically deliver and/or facilitate pregnancy assessment and management. The inclusion criteria varies by individual clinic but generally excludes urgent cases and includes a maximum gestation period of between 14 – 20 weeks.

EPAS clinics

The service scope of EPAS varies significantly. According to the provider survey, the most common services (i.e., provided by over 90% (n=26) of surveyed EPAS clinics) include (see Chart E.34):

- Consultation, including assessment of pregnancy viability (96%, n=27)
- Surgical procedures (e.g., dilation and curettage, removal of ectopic pregnancy) (96%, n=27)
- Management of miscarriage (medical or surgical) (93%, n=26)
- Ultrasound, including transvaginal ultrasound (89%, n=25)
- Blood test (89%, n=25)
- Sharing of written information (e.g., leaflets explaining the condition or how to access other healthcare services) (86%, n=24)

Assessment of current service scope against best-practice guidelines

When assessing the current service scope against best-practice guidelines in other domestic and international jurisdictions, EPAS clinics appear to deliver some of their supports in a manner consistent with recommended guidelines. Current guidelines which relate to early pregnancy complications include UK's NICE guidelines, Queensland Health's Early Pregnancy Loss Guideline, NSW Health's Maternity – Management of Early Pregnancy Complications, and RANZCOG's Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy (C-Gyn 38) Clinics guidelines.¹⁵ Table 4.1 assesses the degree to which current service scope and delivery models align with recommended guidelines. Evidence in the table indicates that while the service scope of EPAS clinics is broadly aligned with recommended guidelines, there are opportunities for improvement (e.g. referrals to psychosocial supports, and access to appropriate waiting areas).

Table 4.1: Assessment of current EPAS clinic services against recommended guidelines

Recommended guideline for EPAS clinics	Assessment of current EPAS delivery
EPAS clinics offer ultrasound, including transvaginal ultrasound, and assessment of hCG levels, both of which are key diagnostic tools for early pregnancy problems. ^{16,17}	There is evidence that EPAS clinics strongly adhere to this guideline, with 90% (n=26) of EPAS clinics providing ultrasound, including transvaginal ultrasound and blood tests. However, in consultation, some EPAS clinic providers noted challenges in accessing the ultrasound during periods of high demand, as the ultrasound machine is a shared resource between other hospital services. For the 10% (n=7) of EPAS clinics that do not offer in-house ultrasounds, patients have to seek private sonographers to complete the ultrasound which impose additional time and costs to the patient.
Guidelines recommend that providers assess for psychological risk and refer patients to mental health supports where needed. ¹⁸	A significant number of EPAS clinics do not adopt specific processes to assess psychosocial risks of patients. Just over one-third (36%, n=10) of EPAS clinics reported providing psychosocial risk assessments. As discussed in section 4.3, less than two-thirds of EPAS clinics reported that they provide referrals to additional healthcare services, including for mental health supports. This indicates scope to improve the quality and accessibility of psychosocial supports within selected EPAS clinics. These supports could include facilitating access to supports provided by NGOs or formal mental health services.
EPAS clinics should have a discrete waiting area, private rooms separate from general waiting areas, and an appropriate consultation room. ^{19,20,21}	While all EPAS clinics reported having private consultation rooms (n=28), only half (14 of 28) reported having discrete waiting rooms separate from maternity and antenatal waiting rooms. As discussed in section 6.5, patients reported that sitting in proximity to visually pregnant women can be distressing and traumatising. As such, providing a separate waiting room for EPAS patients away from the maternity ward can be beneficial for the psychological wellbeing of EPAS patients.
EPAS should have an appointment system. ^{22,23,24}	Adoption of an appointment system is high, with all EPAS clinics using an appointment system. Of which 64% (n=18) accepted appointment only, and 29% (n=8) of clinics allowed walk-ins in addition to booked appointments. The remaining 7% (n=2) of

EPAS clinics indicated that they accommodate walk-ins but prefer booked appointments.

Inclusion and exclusion criteria

There was broad agreement among EPAS providers that EPAS clinics are services for people experiencing non-urgent early pregnancy complications, such as light bleeding or pregnancy of uncertain viability. Inclusion and exclusion criteria reported in the provider survey were consistent with this sentiment. The most common exclusion criteria included:

- Patient is clinically unstable (93%, n=26)
- Patient experiencing severe pain (79%, n=22)
- Patient experiencing heavy bleeding (68%, n=19)
- Foetal anomaly detected on ultrasound (61%, n=17)

Inclusion criteria were quite consistent between clinics, with the most common inclusion criteria including the following:

- Patient has retained products of conception (100%, n=28)
- Patient is experiencing light pain and/or light bleeding (96%, n=27)
- Patient has a non-viable pregnancy on ultrasound scan (96%, n=27)
- Patient is experiencing a pregnancy of uncertain viability (96%, n=27)
- Patient requires β hCG tracking (96%, n=27)
- Patient with gestational trophoblastic disease (molar pregnancy) (93%, n=26)
- Patient is experiencing ectopic pregnancy or pregnancy of an unknown location (93%, n=26)
- Patient requires methotrexate treatment of ectopic pregnancy (89%, n=25)

"We found that some EPAS will see people up to 12 weeks, some up to 16 weeks, some up to 20 weeks...It would make it much easier if it was standardised." – NGO

While there is no consistent definition of the period of gestation that constitutes early pregnancy, a desktop review of EPAS clinics identified that the gestation cutoff period for EPAS clinics typically ranged from 14 to 20 weeks. This was consistent with the provider survey, which found that 43% (n=12) of EPAS clinics reported a gestation cutoff of 14 weeks, 39% (n=29) reported a cutoff of 20 weeks, 11% (n=3) reported a cutoff of 16 weeks and 7% (n=2) reported no specific cut-off gestation period.

In terms of data collection and reporting, a minority of EPAS clinics have implemented structured data collection and reporting mechanisms to collect feedback on patient experiences. Many EPAS clinics providers shared that they do not typically collect feedback on patient satisfaction or outcomes, and instead rely on anecdotal evidence to understand whether their service is meeting the needs of patients. Several EPAS clinic providers noted that they were in the process of collecting data or had conducted patient satisfaction reviews in an ad hoc manner. However, some EPAS clinic providers noted that data collection and reporting places an administrative burden on staff who are already operating at capacity and is likely not possible without additional resourcing. To improve the quality of care delivered, a more structured and regular approach to collecting patient feedback should be considered.

EPAS providers in alternative health settings

In general, EPAS providers in alternative health settings were observed to exhibit greater variation in service scope relative to EPAS clinics. This reflects the diverse types of services that deliver EPAS

and the fact that EPAS providers in alternative health settings often lack a specific focus on EPAS. The most common services delivered by EPAS providers in alternative settings included:

- Consultation, including assessment of pregnancy viability (83%, n=98)
- Blood test (81%, n=95)
- Management of miscarriage (medical or surgical) (66% n=78)
- Medical termination of pregnancy (69%, n=81)

Comparison of service scope between EPAS providers in alternative health settings and EPAS clinics

When assessing the survey responses of EPAS clinic providers and EPAS providers in alternative settings, the following trends were observed:

- **EPAS providers in alternative health settings are more likely to provide psychosocial risk assessments (64%, n=75) compared to EPAS clinics (36%, n=11).** This is likely because a higher proportion of EPAS in alternative health settings (25%, n=33) report to be staffed with a social worker or mental health support staff compared to EPAS clinics (0%).
- **Most EPAS providers in clinics and alternative health settings share written information to support patients to access follow up care.** 80% (n=133) of EPAS clinics and EPAS in alternative health settings share written information to support access to follow up care (e.g. leaflets explaining the condition or how to access other healthcare services).
- **EPAS providers in alternative health settings were less likely to provide follow-up care.** The provider survey found that EPAS clinics (89%, n=25) were more likely to report that they mostly or always follow up after they visit a service compared to providers who operate in alternative health settings (71%, n=79).
- **EPAS providers in alternative health settings were less likely to deliver surgical procedures.** Less than half of EPAS providers in alternative settings delivered surgical procedures (e.g., dilation and curettage, removal of ectopic pregnancy) (45%, n=53) and surgical termination of pregnancy (39%, n=46). Additionally, half (52%, n=62) of EPAS providers in alternative health settings deliver ultrasound services. This proportion is lower than 89% (n=25) of EPAS clinics.

4.2 Collaboration between EPAS and other health services

The extent of collaboration between EPAS and other health services varies due to differences in awareness levels on the availability of EPAS clinics as a service for women experiencing early pregnancy complications.

This section focuses on the collaboration between EPAS clinics with other health services. This national audit received limited feedback on collaboration between EPAS providers in alternative health settings and other health services.

Patients are typically made aware of EPAS clinics through friends, family, GPs, or ED staff. It was observed that GPs often refer patients who experience pregnancy complications to EDs, where they may be treated or referred to an EPAS clinic. EPAS clinics located in hospitals noted that a large proportion of referrals were from the ED. According to the patient survey, patients were most likely to be referred to the EPAS through the ED (38%, n=55), GP (n=50, 35%), and self-referral (n=17, 12%).

Despite being one of the main sources of referrals into the EPAS clinics, awareness of EPAS clinics among other health services such as GPs and EDs is broadly perceived by NGOs, Peak Bodies and

EPAS providers to be low. This is an issue of concern as GPs are often a key referral point for patients who experience early pregnancy complications. When GPs are unaware of EPAS clinics, they may refer patients to EDs, despite the availability of EPAS in their local areas. Awareness among GPs and other key referrals is especially important because most EPAS clinics require referrals. Based on the provider survey, 64% (n=18) of EPAS clinics reported requiring a referral for patients to access their service.

"GPs would often just send you to ED without realising that there's another route." – NGO

Notwithstanding this overarching observation, there are discrete examples of individual EPAS clinic providers proactively taking steps to raise awareness of their service among local residents, GPs and health providers. This is especially true in smaller rural and remote towns that have a small network of healthcare providers. This indicates opportunities for other EPAS providers to take similar steps to increase community awareness of EPAS as an important service for pregnant people.

4.3 Referral from EPAS to other services

The absence of consistent referral protocols has also contributed to variations in referral practices among all types of EPAS providers.

This section focuses on the referral processes from EPAS clinics to other health services. This national audit received limited feedback on the appropriateness and strength of referral processes adopted within EPAS providers in alternative health settings.

Referral from EPAS clinics to other services currently occurs through three mechanisms:

1. referrals to on-site supports (e.g., a hospital-employed social worker, nurse and/or Aboriginal liaison officer for First Nations patients).
2. referrals to supports delivered by primary health services (e.g., GPs).
3. referrals to NGOs (e.g. Pink Elephant).

There are observed variations in access to on-site supports:

- Many EPAS clinic providers noted that they do not have on-site supports, such as a social worker, available. For example, one stakeholder highlighted that, while the hospital's EPAS clinic does not have any in-house psychosocial supports, the hospital's abortion clinic and maternity service have access to an onsite social worker.
- When referral to on-site supports is available, access to the support services is often limited and untimely due to insufficient resourcing and high demand.
- Another contributing factor is variations in EPAS clinic provider protocols. EPAS clinic providers acknowledged that there is currently no clear, universally followed process for making referrals, leading to variation in how different healthcare professionals handle similar EPAS-related cases. Examples of inconsistencies include unclear referral criteria which leaves room for subjective judgement and variable documentation which makes it difficult to track patient journeys. This is supported by feedback from peak bodies who noted that referrals to psychosocial supports (e.g. mental health supports) often depends on the visibility of patient distress, the decisions and experiences of individual health professionals and the protocols in place.

A high proportion of EPAS clinics inform primary healthcare providers of outcomes and provide referrals to additional services. It is less common for EPAS clinics to provide transfer of care letters.

According to the provider survey, over four-fifths (82%, n=22) of EPAS clinic providers reported that they inform primary healthcare providers of outcomes after a patient is discharged. 82% (n=23) of EPAS clinic provider survey respondents agreed that there are clear referral pathways in and out of their EPAS clinic. However, a slightly lower proportion (63%, n=17) of EPAS clinics reported that they write referrals to additional healthcare services, including for mental health supports. After a patient is discharged, only half (52%, n=14) of EPAS clinics reported providing transfer of care letters.

"Apart from some pastoral care that we can give them in their in the acute moment, we tend to refer back to their general practitioners to deal with that in the community." – EPAS clinic provider

"We provide clinical care, but we don't provide any wrap around care. There's no wrap around service unless you...continue to be pregnant and need a social worker for other reasons." – EPAS clinic provider

Beyond on-site supports, some EPAS clinic providers refer patients to their GP for a follow-up appointment or NGOs (e.g. Pink Elephant, Bears of Hope, etc.) for support services (e.g. phone counselling, peer support groups, online chat room counselling etc.) and resources, although the frequency of referrals to NGOs are unknown. Regardless of the setting and practitioner, best practice guidelines recommend that psychosocial supports (e.g. mental health supports) should ideally occur with a healthcare professional of the patient's choice.²⁵

"In terms of bereavement support and follow-up, yeah, there is nothing." – EPAS clinic provider

"Protocols for follow-up supports do not exist. The only psychosocial care women have access to after receiving EPAS care is being told to call a helpline such as PANDA or Red Nose, but this puts a lot of the onus on care on the woman instead of being nurtured." – Researcher

While most EPAS providers follow up with patients after they visit the service, half of follow-ups do not consider both physical and mental health conditions of EPAS patients. Within the provider survey, 89% (n=25) of EPAS clinic providers and 71% (n=79) of EPAS providers in alternative health settings reported to mostly or always follow up with patients after they visit the service. The most common methods of follow-up reported by patients included phone follow-up (81%, n=63), in-person (40%, n=31) and via text message (5%, n=4). However, half of follow-ups do not consider both the physical and mental health conditions of EPAS patients. 56% (n=15) of EPAS clinic providers who responded to the survey noted that they enquire about the patient's mental health during the provision of follow-up care. This was consistent with the patient survey, where only 25% (n=35) of patients received a follow up focused on both their physical and mental health.

"After they attend the EPAS clinic, there is no real follow-up." – NGO stakeholder

It is critical for more standardised and consistent access and approaches to psychosocial supports to be implemented in all health settings, including both EPAS clinics and EPAS providers in alternative health settings. Pregnancy loss can have significant negative psychological impacts on patients and can result in grief, anxiety and depression.^{26,27} International and domestic best practice guidelines recommend that EPAS clinics assess patients for psychological risk, refer patients to mental health supports where needed, and provide a timely follow-up appointment.^{28,29,30} Despite this, referrals to mental health support, even in the case of pregnancy loss, are inconsistent across EPAS clinics.

5. Governance, training and staffing.

Key Findings

- The models of care adopted by EPAS providers are contingent upon the type of provider, available resources, and jurisdiction- / hospital-specific protocols.
- EPAS clinics are typically staffed by non-specialist doctors, obstetricians and midwives.
- There appears to be no structure and consistent education and training mechanisms for health professionals who deliver early pregnancy complication care. Some EPAS clinic providers have proactively developed training and induction resources to support greater consistency in service delivery within their respective clinics.

This section summarises findings which relate to both EPAS clinics and EPAS in alternative health settings. The findings are drawn from stakeholder consultation, EPAS patient and provider survey analysis and semi-structured EPAS patient interviews, which respond to the following research questions:

- C.1 What are the governance and staffing structures implemented by EPAS clinics?
- C.2 What are the capability and training requirements for EPAS staff members?

5.1 Governance and staffing structures

The models of care adopted by EPAS clinic providers vary and are contingent upon the type of provider, available resources and jurisdiction-specific or hospital-specific protocols. EPAS clinics are typically staffed by non-specialist doctors, obstetricians and midwives.

EPAS clinics

There is some variation in staffing composition and models of care across EPAS providers. These variations are driven by differences in resources allocated to EPAS across different hospitals and the adoption of different jurisdiction-specific or hospital-specific protocols. Two common delivery models emerged from consultation:

1. **EPAS clinics staffed by junior doctors, with a supervising obstetrician / registrar.** Junior doctor(s) are tasked to deliver EPAS. A senior medical professional (a registrar or supervising obstetrician) oversees the delivery of services. Depending on the size and type of hospital, patients may also have access to other specialist health professionals, such as sonographers and gynaecologists. Most EPAS clinics were observed to adopt this model, with 70% (n=23) noting that doctors are involved in the delivery of early pregnancy assessment services.
2. **EPAS clinics led by midwives and/or nurses, with a supervising obstetrician / registrar.** This model was observed by some stakeholders to deliver positive patient experiences due to the increased likelihood of patients receiving continuity of care from midwives or nurses and improved access to psychosocial supports such as referrals to mental health supports. In EPAS

clinics, 61% (n=20) involve midwives and 39% (n=13) involve nurses in their care delivery models.

Consultation with EPAS providers revealed that the establishment of an EPAS clinic is often driven by a motivated health practitioner. These health practitioners develop the operating model of their EPAS clinic based on best practice examples in other countries (e.g., the United Kingdom) and based on the availability of funding, staffing and infrastructure resources, such as in-house ultrasound machines and blood tests. For example, several EPAS clinic providers described challenges in reliably delivering on-site imaging due to limited availability of ultrasound machines. In many cases, the ultrasound equipment was shared with other hospital departments, which were often prioritised due to perceived greater clinical need. Similarly, the operating hours of many EPAS clinics are based on staffing availability as opposed to the level of demand.

Please see Appendix E, *Section E.2.2 Provider Survey Section B – About Your Workplace* (Chart E.22) for further information on EPAS clinic and EPAS providers in alternative settings staffing profiles.

EPAS in alternative health settings

Many patients present with early pregnancy complications to GPs and EDs. In these alternative settings, patients would be supported by healthcare professionals who may not have prior experience and expertise in delivering EPAS.

In regional, rural and remote areas, it is generally not possible to have dedicated EPAS clinics within local hospitals due to the small birthing population. Instead, EPAS are delivered by EPAS providers in alternative settings (e.g., ED, GPs), and can often rely on locum obstetricians or GPOs with a special interest in early pregnancy to deliver this care to the community. However, this can lead to healthcare professionals without specialisation in early pregnancy complications or knowledge of psychosocial risk assessments (as articulated in guidelines³ – see Section 4.1). One rural patient reported in their case study interview that her EPAS appointment was led by a locum OBGYN who struggled to communicate effectively or empathetically regarding the loss of her baby and could not provide health advice specific to early pregnancy (see *patient journey map 4 for further details*).

While most providers deliver EPAS in person, some provide components of care (e.g., initial assessment and triage processes before in-person appointment, follow-up) through telehealth. A virtual model of care is broadly perceived to be beneficial as it increases the accessibility of EPAS services, especially for those who are required to travel long distances to attend an in-person appointment (e.g., people in rural and remote areas). Virtual models of care were supported in stakeholder consultations, with one EPAS provider noting that these could be integrated with online educational resources so patients can understand more about threatened miscarriage symptoms and when it is appropriate to attend a clinic, ED, or GP for further care.

Staffing structures – EPAS clinics

EPAS providers are staffed by a range of medical professionals, including GPs, ED professionals, nurses, midwives, junior doctors, sonographers, obstetrician gynaecologists and consultants. EPAS clinics typically consist of non-specialist doctors (70%, n=23), obstetricians (64%, n=21) and midwives (61%, n=20). EPAS clinics were less likely to be staffed by a gynaecologist (42%, n=14),

³ Current guidelines which relate to early pregnancy complications include UK's NICE guidelines, Queensland Health's Early Pregnancy Loss Guideline, NSW Health's Maternity – Management of Early Pregnancy Complications, and RANZCOG's Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy (C-Gyn 38) Clinics guidelines

nurse practitioner or registered nurse (39%, n=13), or sonographer (27%, n=9). Reflecting the paucity of psychosocial supports among EPAS clinics, no clinics reported having a mental health nurse or midwife, or mental health professional, and only three EPAS clinics reported having a social worker. However, EPAS clinics more commonly reported that the psychosocial needs of patients are met at their service (57% n=16, 'Agree' or 'Strongly Agree') compared to EPAS providers in alternative settings (50% n=60, 'Agree' or 'Strongly Agree') potentially reflecting lower levels of experience and expertise delivering early pregnancy complication care among EPAS providers in alternative health settings.

Staffing structures – EPAS in alternative health settings

EPAS providers who operate in alternative healthcare settings are most commonly led by GPs (54%, n=72). These providers also reported the presence of social workers (15%, n=23), mental health professionals (5%, n=6) and mental health nurses or midwives (3%, n=4).

Assessment on recommended staffing structure for EPAS providers

Best practice guidelines do not recommend particular staffing arrangements; however, there is some literature suggesting that senior/specialist nurses and midwives supported by sonographers (specialised in obstetrics) and consultants represent the optimal EPAS configuration.^{31,32,33,34} This suggests the staffing model of some EPAS providers is over-reliant on non-specialist doctors and is not consistent with the optimal configuration. EPAS providers noted that non-specialist junior doctors often complete temporary (e.g., six-month) rotations into an EPAS clinic early in their career, due to the perception that early pregnancy complications are not complex or high risk. When combined with a lack of training, these junior doctors are often underprepared to manage complex medical early pregnancy complications and demonstrate limited empathy when engaging with parents experiencing pregnancy complications or loss. For example, several NGOs highlighted instances where health professionals have historically used medical jargon and other insensitive language when describing pregnancy loss (e.g., referring to the pregnancy loss as a "foetus" when the parent had used the word "baby"). As a result, this compounds experiences of grief, confusion, and trauma for parents.

"Sometimes junior doctors in their first rotation are put into EPAS because it's considered to be a mild medical emergency/ side-effect of pregnancy." – NGO

"An ultrasound machine might be removed and just taken somewhere where the doctors perceived that it was going to be more use." – NGO

"Our managers are given a direction that they have to cut resources in certain places. And I feel like EPAS has always been an area that things are cut from. It's not seen as an essential service." – EPAS clinic provider

Insufficient funding and resourcing were a challenge identified by many EPAS clinics. Many providers noted difficulties in obtaining funding for additional staff and specialist mental health support staff, such as a social worker. Reflecting this, half (50%, n=14) of EPAS clinics who responded to the provider survey disagreed that their clinic was appropriately staffed to meet high demand and deliver high-quality EPAS. Inconsistencies in staffing arrangements across EPAS providers and the reliance on junior doctors reflect both provider resource constraints and varying perceptions on the requisite skills and competencies to deliver EPAS. Several providers noted that it was challenging to acquire additional funding to deliver EPAS-specific supports, as care for early pregnancy complications is broadly perceived not to require significant additional financial and staffing resources. As a result, the delivery of EPAS (across both clinics and alternative health

settings) is typically funded through existing funding streams for other related services, such as antenatal and maternity care.

5.2 Capability and training requirements

There appears to be no structured and consistent education and training mechanisms for health professionals who deliver early pregnancy complication care. Some EPAS clinic providers have however proactively developed training and induction resources to support greater consistency in service delivery.

There are overall no significant differences in training approaches within EPAS clinics and EPAS in alternative health settings. Training for healthcare professionals who delivers EPAS in both clinics and alternative health settings mainly occur through 'on-the-job training'. Current evidence indicates inconsistent levels of access to training in early pregnancy care. Based on the provider survey, 44% (n=61) of EPAS providers agreed that their staff have received appropriate training in psychosocial support and empathetic care capabilities.

A commonly cited issues among all types of EPAS providers is the lack of formal education and training on EPAS. Education and training specific to delivering EPAS and managing early pregnancy complications are not currently included in the formal university education of doctors, nurses or midwives who deliver these supports.³⁵ The inclusion of later-stage pregnancy care as a standard component of formal medical education in Australia results in the healthcare system being structured to support childbirth rather than miscarriage. This approach is in contrast with other jurisdictions, such as the United Kingdom, where early pregnancy competencies are included in curricula.

"Pregnancy care was not touched on in my formal training." – EPAS provider

"A lot of the midwives like feel really alone...they're kind of just thrown in. The support just isn't there for that midwife, and neither is you know that that education." – EPAS clinic provider

"Our graduate or early career midwives, when they come to work here in our ward, it's their first experience really with early pregnancy." – EPAS clinic provider

As a result, many junior doctors, nurses and midwives' first exposure to early pregnancy complications is during their initial rotation into an EPAS clinic or EPAS providers in alternative health settings. As there are no official training or education resources developed by a governing body (i.e. Australian government or state and territory health departments) that are consistently leveraged to support the service-wide reliance of 'on-the-job' training, this contributes to the inconsistent quality of empathetic care at the initial stage of pregnancy complications and loss and psychosocial supports received from hospitals and health services that deliver EPAS.

Many EPAS providers noted that 'on-the-job' training typically involves a senior consultant demonstrating common early pregnancy complication interventions and overseeing the development of a junior doctor's ability to provide empathetic care in an EPAS setting. The frequency of guided training is dependent on the availability and capacity of a senior consultant. In some instances, EPAS providers have played a role in upskilling referring health providers. One EPAS provider located in regional Western Australia revealed that their service was working to upskill GPs in their local area to provide EPAS at their practice instead of requiring patients to travel far distances to attend the EPAS clinic.

The reliance on 'on-the-job' learning and voluntary training creates inconsistencies in workforce capabilities. Some EPAS clinic providers reported developing their own training resources, including guidelines for clinical care and best practice, including protocols to deliver psychosocial supports, but these are site-specific and not standardised across EPAS clinics or EPAS providers in alternative settings. Some EPAS healthcare professionals stated that they electively sought training through NGOs such as Red Nose. Several EPAS clinic providers have developed their own protocols. For example, the Mater Hospital, along with the Centre for Research Excellence in Stillbirth, publishes resources for clinicians and parents related to care for early pregnancy complications. There is an opportunity to leverage existing protocols and resources to develop a consistent resource that supports the delivery of high-quality EPAS care nationally.

While most EPAS clinic providers appear to have adopted similar training and induction approaches, the current clinic-driven approach would inevitably lead to variations in content, depth and the currency of training materials. As such, there are benefits to developing more formalised and standardised training resources on EPAS. More consistent and frequent access to training would promote greater consistency, reduce variability in patient experience and fosters a culture of continuous improvement.

"I was being told by doctors within hospitals that EPAS clinics were seen as just somewhere to place a trainee for a day where there was funding for say, like an ultrasound machine." – NGO

"Grief training and systematic processes can make such a difference in the recovery of the families that are experiencing an early pregnancy loss" – Patient

"Because I had a history of miscarriage, the nurse who called (to organise an antenatal care appointment) asked 'are you actually pregnant?' which was not a great start to the process" – Patient

"We characterise miscarriage as not being life threatening and just being a normal side effect of pregnancy... [parents] see this as the loss of their child, but health practitioners just see it as a pregnancy test that is no longer positive." – NGO

6. Patient characteristics and experience.

Key Findings

- EPAS clinics typically experience higher patient volumes (an average of ~29 patients per week) compared to EPAS providers in alternative health settings (an average of ~16 patients per week). These figures are likely an underestimation of actual need for services due to low awareness of EPAS as a service.
- Women who access EPAS in clinics and alternative health settings are often in their 30s and living in metropolitan areas. This pattern may be driven by the physical location of EPAS providers and may not reflect the full spectrum of need for their services.
- Patients were made aware of EPAS clinics through a hospital emergency department or their GP. This reinforces the importance of educating health providers about EPAS.
- The services offered by EPAS providers often meet the medical needs of patients. There is overall a gap in the delivery of empathetic care and psychosocial supports to patients who experience early pregnancy complications.
- The delivery of EPAS is overall less tailored to the needs of priority population cohorts due to resource challenges and a perception that EPAS patients from these cohorts do not require tailored supports.
- The critical factors that influence patient experience and enable the effective delivery of EPAS include (1) rapid access to early pregnancy complication care, (2) empathetic communication skills, (3) consistent access to appropriate psychosocial supports and (4) continuity of care during a particular episode of care.

This section summarises findings which relate to both EPAS clinics and EPAS in alternative health settings. The developed findings are based from stakeholder consultation, EPAS patient and provider survey analysis and semi-structured EPAS patient interviews, which respond to the following research questions:

- *D.1 How many patients are seen by EPAS clinics in a calendar year?*
- *D.2 What are the demographic characteristics of patients who access EPAS?*
- *D.3 How were patients made aware of the services provided by EPAS providers?*
- *D.4 How accessible are EPAS providers, particularly for people with disability?*
- *D.5 To what extent do EPAS providers provide culturally safe and suitable services for patients from priority population cohorts, including clients from First Nations, migrant and refugee backgrounds and clients who identify as LGBTQIA+?*

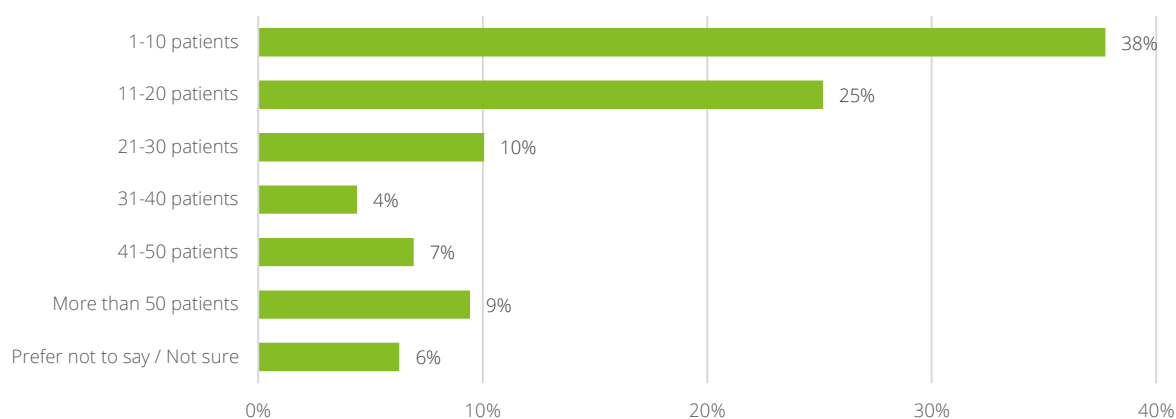
- D.6 To what extent are patients satisfied with the services they received from EPAS providers? (e.g., quality of psychosocial supports received, appropriate referrals to other services)?
- D.7 What are the success factors which enable the effective delivery of EPAS?

6.1 Patient volumes

While most EPAS providers see between one and 20 patients per week, patient volumes vary by provider type and location. EPAS clinics typically experience higher patient volumes (~29 per week) compared to EPAS providers in alternative health settings (~16 patients per week). This is likely an underestimation of actual need due to low awareness of EPAS more broadly.

Based on provider survey results, EPAS providers see on average between 1 and 20 patients per week (63%, n=100). More than one-third (38%, n=60) of EPAS providers reported seeing on average 1 to 10 patients in a week (see Chart 6.1).

Chart 6.1: Responses to Provider Survey Question B5 – How many patients, on average, receive early pregnancy assessment services at your healthcare setting or EPAS clinic in a week? (n=159)



Source: Deloitte Access Economics' survey analysis (2025).

EPAS clinics on average see more patients per week compared to EPAS providers in alternative health settings. EPAS clinics who completed the provider survey on average reported seeing 29 patients per week, compared to EPAS providers in alternative health settings who reported seeing on average 16 patients per week. Most GPs (65%, n=37) reported seeing 10 or fewer patients per week, while maternity, obstetrics or antenatal hospital units showed greater variation – with 41% (n=20) reporting 20 or fewer patients, and 31% (n=15) reporting seeing more than 40 patients weekly.

Patient volumes appear to vary based on the geographic locations of EPAS providers. Metropolitan EPAS providers reported higher patient volumes compared to regional, rural and remote providers. Over one quarter (27%, n=24) of metropolitan EPAS providers see more than 30 patients per week compared to only 11% (n=7) of regional, rural and remote EPAS providers. The majority (55%, n=36) of regional, rural and remote EPAS providers reported seeing on average 1-10 patients a week, compared to one-quarter (26%, n=23) of metropolitan EPAS providers. Higher volume (30+ patients per week) regional, rural and remote EPAS providers were mostly (n=5) located in regional centres (i.e., Modified Monash Model level 2) rather than rural and remote areas, and were either EPAS clinics, or maternity, obstetrics or antenatal hospital units.

Given stakeholder observations of low patient and GP awareness of EPAS (see Sections 4.2 and 6.3), these figures may understate actual demand for EPAS. More systematic data collection on EPAS patient volumes is recommended to support appropriate service planning and resource allocation across services.

6.2 Patient demographic characteristics

Women who access EPAS in clinics and alternative health settings are often in their 30s and living in metropolitan areas. This pattern may be driven by the physical location of EPAS providers and may not reflect the full spectrum of need for their services.

Table 6.1 provides a demographic summary of respondents from the patient survey. There is currently no systematic or consolidated data collected by EPAS clinics or EPAS providers in alternative settings. As a result, it is challenging to develop an accurate systemwide view on patient characteristics and/or priority population service use of EPAS (see Section 6.6). Based on the patient survey, individuals who recently accessed EPAS are:

- **Mostly aged between 25 and 39 years old** (88%, n=167), with 30 to 34 years as the most common age bracket (44%, n=84). This broadly aligns with AIHW data suggesting 84% of Australian women who gave birth in 2022 were aged between 25 and 39 years old.³⁶
- **More likely to be born in Australia.** Only 13% (n=26) of survey respondents were born overseas, compared with an estimated one-third of Australian births to migrant women.³⁷ Migrant/CALD populations are likely to be underrepresented in EPAS due to barriers including language, limited cultural safety, low trust in healthcare and experiences of discrimination.³⁸ Language barriers may also have contributed to underrepresentation in the survey – almost all (96%, n=25) of those born overseas reported speaking English ‘Very well’ (highest proficiency), with one respondent reporting speaking English ‘Well’ (second highest proficiency).
- **Less likely to have disability.** The vast majority of EPAS patients did not report any disability. Of the 10 (5%) of respondents who did report a disability (a limitation, restriction or impairment restricting everyday activity for at least six months), four respondents reported a physical disability, two respondents reported a psychosocial disability, one respondent reported both a physical and a psychosocial disability, one respondent reported autism, and one respondent reported a neurological disability. One respondent reported a disability but did not specify the nature of their condition. Nationally, approximately 9% of women aged between 15 and 44 (considered childbearing age) are living with a disability.³⁹ The lower proportion of patients reporting a disability in the survey may reflect underreporting due to stigma or privacy concerns, lower birthing rates,⁴⁰ or limited accessibility and awareness of EPAS amongst people with disability.
- **Less likely to identify as LGBTQIA+.** According to the patient survey, 3% (n=6) of patients reported identifying as LGBTQIA+. This compares to an estimate of 5% of Australians aged 16 and over who are LGBTQIA+.⁴¹ LGBTQIA+ people are a low birthing population overall and may therefore be less likely to access pregnancy related services compared to the general population. However, pregnant LGBTQIA+ people are at increased risk of pregnancy complications and thus pregnant people in this cohort may have a greater need for EPAS compared to the general population.⁴² It should be noted that stigma or privacy concerns, and/or limited awareness of EPAS may lead to underreporting of LGBTQIA+ patients in the survey.

Table 6.1: Patient survey respondent demographic summary.

Patient demographic	Response option	% of survey respondents	Number of survey respondents
Gender	Woman or female	100%	188
Age	20 to 24	2%	3
	25 to 29	15%	28
	30 to 34	44%	84
	35 to 39	29%	55
	40 to 44	10%	19
Disability	No limitation, restriction or impairment	94%	177
	Limitation, restriction or impairment	5%	10
	Physical	<1%	5
	Psychosocial	<1%	3
	Autism	<1%	1
	Other	<1%	1
	Prefer not to answer	<1%	1
LGBTQIA+	No	97%	182
	Yes	3%	6
Born in Australia	No	14%	26
	Yes	86%	162
	Prefer not to say	0%	0
Self-assessed spoken English proficiency	Well	1%	2
	Very well	99%	186
	Prefer not to say	0%	0

Source: Deloitte Access Economics analysis of patient survey.

6.3 Awareness of EPAS

Patients were primarily made aware of EPAS clinics through a hospital emergency department or through their GP, reinforcing the importance of educating healthcare providers, as well as patients, about EPAS.

Community awareness of EPAS in both clinics and alternative health settings appear to be broadly low. Stakeholders attribute this to several reasons, including limited public information on EPAS operating hours and referral pathways and instances of outdated EPAS provider websites:

- Less than half (42%, n=61) of patient survey respondents who accessed an EPAS clinic agreed that information about EPAS clinics was easy to find.

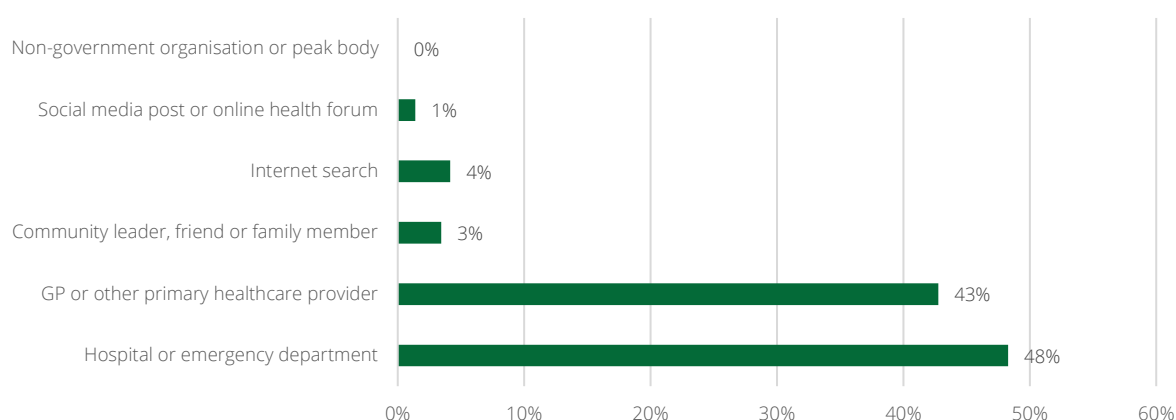
- Similarly, less than half (49%, n=32) of patients who accessed EPAS in alternative health settings agreed that they knew where to go to access early pregnancy supports.
- Less than half (43%, n=12) of EPAS clinic provider survey respondents agreed that the inclusion and exclusion criteria to access their EPAS clinic were clear.

"The awareness of the general public [regarding EPAS clinics] is close to zero." – NGO

"You're going to have to dig through even if you Google [EPAS clinic], there's no information about. I know they've got an early pregnancy assessment service." – EPAS provider

In the patient survey, the vast majority of patients reported initially becoming aware of EPAS clinics primarily through either a hospital/ED (48%, n=70) or their GP/other primary healthcare provider (43%, n=62) (see Chart 6.2). Other awareness channels, discussed in consultations, may include social media advertisement, internet search or previous engagement with EPAS.

Chart 6.2: Responses to patient survey question B2 – How did you first hear about EPAS providers? (n=145)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

6.4 Accessibility of EPAS

EPAS clinics are generally perceived to be accessible during their operating hours. However, regional, rural and remote patients were more likely to face challenges in accessing timely EPAS care compared to metropolitan patients.

Accessibility of EPAS clinics

EPAS clinics are generally accessible within their opening hours, which are typically across weekday business hours (see Section 0). Over one third of patients (35%, n=50) reported accessing EPAS clinic care within 24 hours of receiving their referral, and the majority were seen within one week (89%, n=129). One fifth of patients (20%, n=29) reported travelling for less than 15 minutes to access care, and the vast majority had a travel time under one hour (92%, n=134).

Survey results indicate that regional patients waited longer on average to receive care from an EPAS clinic than metropolitan patients. One quarter (24%, n=6) of regional, rural and remote patients received care within a day of receiving their referral, compared to 34% (n=26) of metropolitan patients. Furthermore, regional, rural and remote patients may experience longer travel times to access an EPAS clinic, with 24% (n=6) of these patients travelling for 1-2 hours to access an EPAS clinic (compared to metropolitan patients who reported much shorter travel times – none travelled for more than an hour to access EPAS). One rural patient reported via patient

case study (see Section 7.3 Patient 4) that they were required to travel 110km each way to attend an EPAS clinic appointment, and due to medical management of their miscarriage, needed to spend three days actively miscarrying in their local ED as they lived over two hours from the nearest hospital capable of managing a miscarriage.

Despite reporting longer wait and travel times to EPAS clinics, regional, rural and remote patients indicated similar levels of satisfaction to metropolitan patients. Over half (56%) of both metropolitan (n=57) and regional, rural and remote (n=14) patient cohorts felt satisfied with the length of time taken to be seen by an EPAS clinic, and less than a third (31% (n=32) of metropolitan patients and 32% (n=8) of regional, rural and remote patients felt dissatisfied. Similarly, four in five (80%, n=20) regional, rural and remote patients agreed that the EPAS clinic was located a reasonable distance from their home, compared to 77% (n=77) of metropolitan patients. This may reflect differences in expectations around receiving care based on regionality, where regional, rural and remote patients anticipate delays due to factoring in travel and wait times.

There was limited feedback on the experiences of patients with disabilities in accessing EPAS. The patient survey captured a small proportion of patients (5%, n=10) who reported a disability, and comments from these survey respondents were more focused on EPAS experience (see section 6.5) than perceived accessibility.

Accessibility of EPAS providers in alternative health settings

As there are fewer standalone EPAS clinics in regional, rural and remote Australia, patients experiencing early pregnancy complications are more likely to seek care in alternative settings, such as in EDs, through GPs, or in maternity and gynaecology services within regional hospitals. More than half of regional, rural and remote patient survey respondents (53%, n=28) accessed EPAS care through EPAS providers in alternative health settings only. Regional, rural and remote patients appear to seek care at other hospital units, which are generally more tailored to patients who are experiencing late pregnancy, childbirth or post-partum.

"I haven't heard of any [EPAS clinics] happening in regional and remote ... as far as I understand, those women would be going to either local emergency departments or urgent care clinics, depending on what's available to them and what they need at the time. I assume GPs are managing a lot of that care as well." – Professional body

Patient satisfaction with EPAS providers in alternative health settings was overall lower. This is due to feedback on longer wait and travel times to access care. 42% (n=28) of respondents felt satisfied with the time taken to be seen by a health professional, and 61% (n=40) agreed that the location of the EPAS service was a reasonable distance from their home. These results suggest patients experience longer waiting times in alternative health settings such as EDs, compared to EPAS clinics. This was validated by stakeholders, who shared instances of patients waiting many hours to receive EPAS in ED settings.

Opportunities to improve EPAS accessibility

EPAS accessibility could be increased through alternative models of care (e.g., virtual), community-specific outreach activities, access to culturally safe supports (e.g., Aboriginal Liaison Officer) and translation services (see Section 6.6). Virtual care models could see non-acute EPAS provided via telehealth, allowing for earlier patient triage, and, where possible, safe management of pregnancy loss at home rather than in an ED. The ED was noted to be an inappropriate space for delivery of

pregnancy loss care due to a lack of discrete waiting areas, lack of psychosocial supports and a generally disruptive environment (see Section 4.1).

"The telehealth component is an interesting option because coming in physically to see someone these days can be challenging, especially as we talked about the regional areas...having those options of speaking to someone online or that vitally helps. ...we are launching a virtual women's health clinic in a couple of months." – Government stakeholder

6.5 Patient experience and satisfaction

The services offered by EPAS providers often meet the medical needs of patients, depending on the availability of staff and equipment. There is overall a gap in the delivery of empathetic care as well as psychosocial supports to patients experiencing early pregnancy complications.

Medical care

The quality of medical care delivered by EPAS providers broadly meets the needs of patients, with 64% of patient survey respondents reported feeling either mostly or always feeling confident in the safety of their treatment and care. Most patients reported receiving key early pregnancy services, including consultation/assessment (81%, n=170) and ultrasound (76%, n=159). However, some patient survey respondents specific instances of not receiving the services they needed, or experiencing delayed care due to the limited operating hours of EPAS clinics (see Section 0) and unavailability of ultrasound equipment (see Section 4.1). Additionally, pain relief during medical or surgical termination of pregnancy did not always meet patients' needs, with one in three (33%, n=9) reporting it was never, rarely, or only sometimes adequate.

Empathetic care

Empathetic care is related to but distinct from psychosocial supports. It is defined as the delivery of respectful, compassionate, holistic and culturally sensitive care from health professional to patient during acute care.

Empathetic care is central to quality service delivery and differs from psychosocial supports in that it relates to the manner and approach of care delivery, rather than to provision of specific community-based support services.

Most of the feedback in this national audit, however, focused on gaps in empathetic care. A lack of empathetic care from staff is a key factor contributing to a poorer care experience for EPAS patients, particularly amongst those who experience miscarriage. Patients who experienced miscarriage were less likely to rate their overall EPAS experience as 'good' or 'very good' (57%, n=94), compared to those who had a termination of pregnancy (82%, n=22) and those who carried to term (83%, n=15). Additionally, from the EPAS patient survey:

- Nearly half (45%, n=73) of miscarriage patients 'never', 'rarely' or 'sometimes' **felt their individual needs were met**, compared to 22% (n=6) of those who had a pregnancy termination, and 17% (n=3) who carried to term.
- Nearly half (43%, n=71) of miscarriage patients 'never' rarely' or 'sometimes' **felt cared for**, compared to 22% (n=6) of those who had a pregnancy termination, and 22% (n=4) who carried to term.
- One third (34%, n=55) of miscarriage patients 'never', rarely' or 'sometimes' **felt sufficiently informed about their treatment and care**, compared to 19% (n=5) of those who had a pregnancy termination and 11% (n=2) who carried to term.

- The most common reason patients reported experiencing unfair treatment was due to a lack of sensitivity from staff toward pregnancy loss (reported via open text response).

It should be noted that a majority of patient survey respondents (86%, n=164) reported experiencing miscarriage, and so the sample size is small for other outcomes including termination of pregnancy (14%, n=27) and carrying to term (10%, n=18). Some respondents also had more than one outcome across successive pregnancies.

Many patients feel that their upset or distress at potential pregnancy loss is overlooked, that staff do not take them seriously, or that they were pressured into decision-making despite experiencing extreme distress or seeking further information. For instance, one patient interviewee (see Section 7.3 patient 6) recalled having her preferred choice of surgical miscarriage management denied and instead being pressured to accept medical management. These anecdotal examples indicate how approaches to service delivery could potentially exacerbate the distress and trauma experienced by patients.

Psychosocial supports

While there is currently no consistent definition for psychosocial supports in an early pregnancy context, the term generally refers to non-clinical and recovery-oriented services delivered in the community and tailored to individual needs. It is recognised that these supports can encompass a range of services, designed to meet specific needs.

Early pregnancy loss, such as miscarriage, can cause significant psychological morbidity,⁴³ and timely and appropriate support at the time of loss can greatly improve patient psychological outcomes.⁴⁴ Structured psychosocial supports, including information on or referral to mental health supports (including supports such as phone counselling and peer support groups offered by NGOs) and follow-up inquiring about patient mental health, are not consistently provided to patients. Fewer than half of patients (38%, n=79) reported receiving information on accessing additional supports, such as leaflets, and only 11% (n=22) of patients reported being referred on to additional supports, including for mental health. Furthermore, a lower share (24%, n=48) of patients reported receiving a follow-up focusing on their mental health in addition to physical health (see Section 4.3).

The provision of more empathetic and sensitive care during pregnancy complications, with appropriate and structured post-care mental health psychosocial supports, is thus key to improving EPAS patient experience. This may be supported through staff training (see Section 5.2), and the implementation of national EPAS guidelines (see Section 8.1).

"We provide clinical care, but we don't provide any wrap around care. There's no wrap around service unless you...continue to be pregnant and need a social worker for other reasons." – EPAS provider

"For a lot of women and families that have come through feeling as though their clinical care was good, but sometimes the other aspects of that care [such as] their emotional wellbeing and referral to other services are lacking." – NGO

"Women are wanting more care, bereavement care, counselling... But if we could do, say, follow-up appointments with bereavement and potentially counselling, that would be really appreciated by women." – EPAS clinic provider

Patient awareness of pregnancy complications

Patient experience may also be impacted by low awareness of the prevalence of early pregnancy complications. This is a particular challenge given the often sudden and unexpected nature of

these complications. Patients' knowledge gap around early pregnancy complications can result from:

- health practitioners not adequately informing patients about the risks of early pregnancy complications and loss, for instance during family planning consultations with GPs,
- pregnant people having limited contact with health services in the early stages of their pregnancy, and
- in some cases, significant stigma in discussing issues related to miscarriage and other early pregnancy complications due to shame and other religious/cultural-related reasons.

As a result, when bleeding or pain occurs, many pregnant individuals are shocked and may, in some instances, experience significant distress. Improving awareness around pregnancy loss and associated complications may empower patients to seek timely care, make informed decisions, and ultimately have a more supported care experience.

"So we say to people congratulations, you're pregnant. But we don't say, [during the] first appointment when the pregnancy is confirmed, do you know there is a chance that you may have a miscarriage?" – EPAS clinic provider

"Women get often very anxious, and they don't really feel like they have much support. Especially, you know, if they don't know what's going on in their own body and they don't actually know what to do." – Government

6.6 Quality of tailored supports for priority populations

The delivery of EPAS is overall less tailored to the needs of priority population cohorts due to resource challenges and a perception that EPAS patients from these cohorts do not require tailored supports.

Overall, there is a lack of systematic, tailored EPAS supports delivered to priority populations including First Nations peoples, LGBTQIA+ people, CALD and recent migrants, and people with a disability. This is observed across both EPAS clinics and EPAS providers in alternative health settings. Some health providers acknowledged the gap in delivering tailored supports but noted resource constraints to enable the delivery of tailored supports to priority population cohorts. As a result, the key actions taken by these providers to deliver tailored care may not cover the full spectrum of need— for example, a few EPAS clinic providers state that they facilitate access to interpretation services for EPAS patients who are culturally and linguistically diverse.

All EPAS providers who were consulted shared that they strive to meet the unique needs of all their patients, including those from priority groups; as such, they do not see the need for specific protocols for patients from diverse backgrounds and/or with additional needs.

"Like all the marginalised populations, we haven't even come anywhere near addressing any of their needs" – NGO

Tailored supports for First Nations people are most commonly provided by consulted EPAS clinic providers. This may reflect existing investment in health system services. For example, a EPAS clinic provider shared that patients are required to fill out a form, which asks if they identify as an Aboriginal and/or Torres Strait Islander person. If they do identify as such, they are asked whether they would like the support of an Aboriginal Liaison Officer. However, services tailored for First Nations people are more likely to be available in areas with large First Nations populations.

The delivery of tailored supports to priority populations should be centred on culturally safe care, which aims to make these cohorts feel included, empowered and informed when receiving care for early pregnancy complications. It should include:

- outreach and/or promotional activities to improve awareness and health literacy around early pregnancy,
- training for healthcare professionals on providing culturally sensitive care for early pregnancy complications,
- translation services for CALD populations, First Nations people and recent migrants and refugees,
- understanding of and respect for diverse cultural and religious perspectives on pregnancy loss, including differing beliefs, practices, and the potential for stigma or shame,
- plain English and culturally sensitive resources for patients – for example, pamphlets that include inclusive language and information specific to LGBTQIA+ patients, and
- research into the specific needs of different priority groups in relation to early pregnancy complications.

In the provider survey, EPAS providers who operate in areas with a high proportion of priority population cohorts generally felt they could deliver appropriate and high-quality support to these groups. Of the six provider survey respondents who reported that First Nations people made up at least 30% of their EPAS patients, five services felt 'Highly confident' in providing appropriate care for early pregnancy complications to First Nations patients, while one felt 'Not confident'. From providers who reported at least 30% of patients with a CALD background, 64% (n=7) felt 'Highly confident' in providing appropriate care to CALD patients, compared to the remaining 36% (n=4) who felt 'Somewhat confident'.

The providers' perceived confidence in delivering appropriate tailored care contrasts with patient survey results. In the patient survey, some patients from priority cohorts indicated receiving unfair treatment when accessing EPAS:

- One in five people (20%, n=1) who reported a physical disability reported experiencing unfair treatment due to a physical condition.
- One in three people (33%, n=1) who reported a psychosocial disability reported experiencing unfair treatment due to a mental health condition.
- One in six people (17%, n=1) who reported identifying as LGBTQIA+ reported experiencing unfair treatment due to their sexual orientation, as well as due to their gender identity.
- One in two people (50%, n=1) who reported speaking English 'well' (rather than 'very well' as the highest proficiency option) also reported experiencing unfair treatment due to their English language proficiency.

It should be noted that the patient survey sample sizes of patients from priority populations are small and thus may not be representative of the priority population EPAS patient cohort. However, this feedback aligns with the perspectives of many NGOs who reported discrete examples of priority populations receiving unfair treatment and having negative patient experiences when accessing EPAS.

The support needs of priority groups around early pregnancy complications are varied and complex. A lack of tailored supports may mean that patients are less likely to receive culturally appropriate care in some health settings that do not have jurisdiction, and/or hospital-specific

protocols in this area. Table 6.2 summarises the unique needs and supports provided to priority groups.

Table 6.2: Priority group needs and services available

Priority group	What supports are needed?	What supports are available?
First Nations	• In-person outreach activities, such as hosting yarning circles. First Nations peoples typically access trusted healthcare services through word-of-mouth within their community. • Access to pregnancy care in community (where possible) to reduce geographical and financial burdens related to accessing care. • Availability of collection kits to enable patients who miscarry to bury their foetus on Country. • First Nations-led EPAS, under a midwifery-led model of care. • Sensitivity to stigma around early pregnancy loss and/or hesitation to use an Aboriginal Liaison Officer. The patient may not want their community to know they've had a miscarriage.	• The following supports are offered by some EPAS providers: ○ Aboriginal Liaison Officers ○ Translation services ○ Resources (e.g., flyers, pamphlets, guides) tailored to First Nations communities (e.g., PANDA, COPE, Red Nose) ○ Rural and remote outreach services (e.g., travelling obstetrician) ○ Telehealth services ○ First Nations-led community health organisations (e.g., South Coast Women's Health and Wellbeing Aboriginal Corporation Waminda)
LGBTQIA+	• Resources to increase pregnancy literacy for individuals who identify as LGBTQIA+ • Inclusive language and pronouns (e.g., 'pregnant person' instead of 'pregnant woman') from healthcare professionals to ensure diverse identities and relationships are recognised and respected. • The needs of non-birthing parents in lesbian couples should be considered, especially if they have experienced a previous miscarriage.	• Limited specific tailored supports for people identifying as LGBTQIA+ • The use of inclusive language is ad hoc and depends on the knowledge and understanding of individual healthcare professionals. • There is overall limited collaboration between EPAS providers and LGBTQIA+ NGOs.
CALD and recent migrants (including refugees)	• Interpreter services as well as translated resources for patients with low English proficiency. Relying on a family member for interpretation and translation may result in inaccurate translation and/or coercion. • Sensitivity to stigma and differing cultural practices around early pregnancy loss. • Financial assistance to improve EPAS affordability for migrants who cannot	• The availability and quality of interpretation services (e.g., phone or in-person) vary by provider. High-quality interpretation services are more likely for common languages and among EPAS within a tertiary hospital. ○ 61% (n=72) of EPAS providers in alternative health settings reported easy and convenient access to

Priority group	What supports are needed?	What supports are available?
	access Medicare, and, where available, identification of EPAS that do not require Medicare. - Resources to increase literacy on early pregnancy complications and the Australian healthcare system. - More research is needed to understand the specific needs of different cultural groups related to early pregnancy complications.	translation and interpretation services. While translated EPAS materials have been released by NGOs (e.g., PANDA, COPE, Red Nose), there is little evidence that these are widely circulated to EPAS providers and, subsequently, to patients.
People with disability	- Patients with physical disabilities may require pain or other management related to their condition during early pregnancy procedures. One patient survey respondent with a chronic pain disability expressed not being taken seriously by staff when they requested pain relief that met their needs. - Patients with a psychosocial disability may experience heightened symptoms when accessing EPAS, and thus require sensitivity and understanding. One patient survey respondent with severe anxiety expressed being made to feel they were overreacting when experiencing pregnancy loss because of their mental health condition.	Some EPAS providers will adhere to general hospital-specific protocols and guidance about supporting people with disability (e.g., providing access to a social worker or Disability Liaison Officer).

First Nations

"In some cases, you may find that Aboriginal and Torres Strait Islander women may have earlier access because of the investment in First Nations services and the focus on that." – Government

"We have Aboriginal health workers who work within the hospital, so we might use those staff members to sit in on, consult, and see if our patients wish to. We have translators for the various dialects within our regions."
– EPAS clinic provider

"For Indigenous mums and Indigenous families, we don't have any particular pathways for them that are any different to anyone else." – EPAS clinic provider

"Also, there are issues around, like you know, we return our pregnancy tissue to the country to be buried, and often they're not offered that opportunity where they've had a loss or a D&C." – NGO

LGBTQIA+

"Falling pregnant is a long journey for queer people, it is also often an isolating journey. They might not have a great connection to their biological family, they may be the first of their friend group to have a baby." – NGO

"And pronouns are really problematic in maternity spaces. It's quite a battle even to just refer to people as pregnant people rather than as women. And so it's a very difficult conversation to have with maternity care providers." – Professional body

"... they're not necessarily set up for anyone other than a cisgendered, heterosexual woman walking into those spaces. They don't look like welcoming spaces to people who are non-binary and for trans men." – NGO

CALD/Recent migrants and refugees

"We absolutely do need to do a lot more basic research on this, because there's also evidence of different physical ways of coping and different sort of practices around reproduction. We really don't know." – NGO

"Mothers from non-English speaking countries generally will attend antenatal care later on... than Australian-born women. Has a lot to do with the cost of pregnancy care and also lack of access to information and education." – NGO

People with disability

"Similar to kind of all pregnancy care, I don't think that we receive adequate training in looking after people with disabilities. I think in general, it's if they're physically able... they fall into one box and if they're physically incapable... then they fall into a different box." – Professional body

6.7 Success factors

The critical factors that influence patient experience and enable the effective delivery of EPAS include (1) rapid access to early pregnancy complication care, (2) empathetic communication skills, (3) consistent access to appropriate psychosocial supports and (4) continuity of care during a particular episode of care.

Four key success factors have been identified as contributing to the effective delivery of EPAS:

Rapid access to EPAS.

The timeliness and accessibility of care is important for patients who experience early pregnancy complications. The ability to receive timely point-of-care ultrasound services by a qualified health professional (e.g., sonographer) is particularly valued by patients as it enables them to receive an assessment on the viability of their pregnancy. A number of patients reported in consultations that they were encouraged to attend private ultrasound and imaging appointments outside an EPAS clinic's hospital network. This extended wait times for care and added additional emotional and financial burden, as not all private facilities offer bulk billing. The patients' preferred delivery model would be for EPAS clinics to adopt a "one-stop-shop" for all aspects of early pregnancy assessment services such as ultrasound and pathology services.

There was broad stakeholder consensus that EPAS clinics would provide a better patient experience to non-acute patients experiencing early pregnancy complications compared to other health settings that do not have an explicit focus on EPAS. NGOs and professional bodies noted that since many early pregnancy complications (e.g., miscarriages) are typically non-complex and non-acute, patients are often deprioritised in other health settings, such as the ED. This was validated in patient interviews, with many who attended ED to receive EPAS reporting extended wait times, and a lack of tailored early pregnancy supports. Approaches to miscarriage care appear to differ between EDs, with some patients triaged in the general waiting area, and others fast-tracked to a private room with specialised midwifery and social support workers.

"Patients like to be able to get information straight away at a one-stop shop. We get positive feedback." – EPAS provider

"Point-of-care ultrasound should be available across the country." – EPAS clinic provider

Empathetic communication skills and access to psychosocial supports.

Empathy and the feeling of “being heard” are among the most critical aspects of care for patients accessing EPAS. Patients noted that it is important for healthcare professionals to acknowledge and validate the physical and emotional impact of early pregnancy loss or complications. A healthcare professional’s empathy can help patients feel understood and supported, which leads to a more positive overall experience. During patient interviews, the delivery of care for early pregnancy complications without empathy and compassion was a recurring theme that substantially affected patient satisfaction, regardless of the perceived quality of medical care received. Stakeholders and patients also raised the importance of language, including an acknowledgement of loss and mirroring of the language of the patient (e.g., if the patient says ‘baby’ rather than ‘foetus’, so should the healthcare practitioner).

It is equally important for EPAS healthcare professionals to support patients’ access to appropriate psychosocial supports following pregnancy complications which are tailored to individual needs and circumstance. Clear communication, trust-based interactions, and patient involvement in decision-making are critical. Many patients felt overwhelmed when receiving information related to early pregnancy complications. According to best-practice guidelines on psychosocial supports, including those produced by Queensland Health, EPAS clinics should ensure clear communication by:

- offering and/or facilitating the presence of a support person,
- ensuring all parents are present at discussions, and
- providing written and verbal information (e.g., leaflets, web addresses and helpline numbers).^{45,46}

Consistent feedback was received in patient interviews regarding the need for healthcare professionals who deliver EPAS to adopt a more consistent approach in facilitating referrals to mental health services and emotional and bereavement support services, such as Pink Elephant and Red Nose. Those who received these referrals noted they found it easier to recover emotionally from their loss.

“It’s not the responsibility of the medical team to support someone’s grief. It is, however, the responsibility of the medical team to ensure that their grief is supported in some way” – Patient

“I interviewed like, hundreds of people about their experiences ... and what kept coming up was, you know, examples of people who’d call an EPAS and the EPAS clinic was just not equipped to handle their cases with any empathy or kindness that is necessary under the circumstances.” – NGO

“There are some occasional stories that do come up where women are feeling heard, they’re feeling understood, they’re feeling that empathy, the clinicians are ticking all the right boxes.” – NGO

Continuity of care.

Having an assigned health professional (e.g., midwife) to provide high quality continuity of care throughout an episode of early pregnancy complication is the patients’ perceived optimal staffing model for the delivery of EPAS. This reduces instances of other health professionals, such as ED physicians, delivering EPAS to people who experience early pregnancy complications. Stakeholders noted that ED staff often do not have the required capabilities to deliver sensitive care and sufficient psychological supports, and that the ED is not an appropriate space to deliver care for early pregnancy complications due to the lack of privacy and disruptive environment. Additionally, patient follow-up care is essential for continuity of care during an early pregnancy complication episode and contributes to effective EPAS delivery. Provider survey respondents

noted that follow-up is most commonly performed via phone or text, but only a minority include a mental health check as standard during this process (see Section 4.3 *Referral from EPAS to other services* for statistics on patient follow-up). During case study interviews, some patients shared they either didn't receive any follow-up care (25%, n=2) or that this care didn't include any mental or emotional health support (37%, n=3). A lack of follow-up care has been found to leave people feeling emotionally isolated and unsupported.⁴⁷ The follow-up should focus on the emotional state of the patient, as well as their physical health.⁴⁸ While referral to additional services and supports is crucial to support a patient's wellbeing (see Section 4.3 *Referral from EPAS to other services*), some patients reported in their interviews that they were automatically enrolled in their hospital's maternity service after experiencing a miscarriage and receiving care from an EPAS clinic. There is a need for clear communication between EPAS clinics and hospital maternity services when a patient attends and has experienced a miscarriage to avoid further distress and trauma.

Access to appropriate physical infrastructure and ultrasound facilities.

Discrete waiting rooms and a clear physical separation between EPAS and maternity services are especially important for patient experience. Patients who attended EPAS clinics adjacent to hospital maternity services recalled feeling distressed while in a shared waiting room amongst visibly pregnant people.

Further, patients reported that some EPAS clinics did not have a dedicated ultrasound machine or sonographer available to perform scans, resulting in the need to attend private ultrasound appointments. This detracted from patient experience by extending wait times for treatment and adding a financial burden.

"One of the most common issues is patients who are waiting with a threatened miscarriage in a waiting room for an ultrasound with people who are heavily pregnant. Again, incredibly traumatic." – NGO

"We still hear this one as a major trigger for trauma is sitting in a waiting room next to a pregnant woman." – NGO

7. Patient journey maps.

This section details nine different EPAS experiences from eight patients across Australia.

7.1 Purpose of patient journey maps

These journey maps have been developed following eight semi-structured interviews with patients who had accessed EPAS since the beginning of January 2023. The purpose of these journey maps is to delineate the common steps a patient will follow when seeking care for complications experienced during early pregnancy, understand the unique perspectives of those accessing care from different EPAS providers, and highlight what factors might influence a positive or negative EPAS experience. The case study methodology and selection criteria are provided in Section 2.2 *Data Sources - Patient Journey Maps*.

7.2 Structure of the case studies

Each case study adopts a consistent structure and are written from the perspective of the patient being interviewed. The case study is structured to include information on the patients' demographic background, the primary EPAS type where care was received (i.e., EPAS clinic or EPAS in alternative health setting), a thematic overview of the patient journey, and a detailed account of their personal story which is broken into three key care phases and a final summary of their experience.

The thematic overview summarises the most common pathway for a patient to access EPAS. Key stakeholders are identified at each step in this pathway. These stakeholders are either those who the patient engaged with directly (i.e. for assessment, diagnosis and treatment), or those who should be responsible for the provision of this care in instances where it may not have been received (i.e. for counselling, support and referrals). An emotive visual has also been included in this section to communicate the patients overall experience during each step. The meaning of these 'experience' visual aids are as follows:

- Green – the patient had a positive experience and/or was happy with the quality of care provided
- Yellow – the patient had an average or neutral experience, there may have been elements of the care provided which they were happy with, and others which they weren't happy with
- Red – the patient had a negative experience and/or was unhappy with the quality of care provided



Negative experience



Neutral experience



Positive experience

The detailed account of each patient's story has been broken into three key phases of care, covering the entire EPAS journey.

Initial engagement:

- Determination of need – why did the patient require EPAS (may be self-determined)?

- Referral – who referred the patient to an EPAS provider (may be self-referred)?
- Preparation – was the patient required to gather any information (i.e. scans, blood tests) or take particular action prior to their EPAS appointment?

EPAS experience:

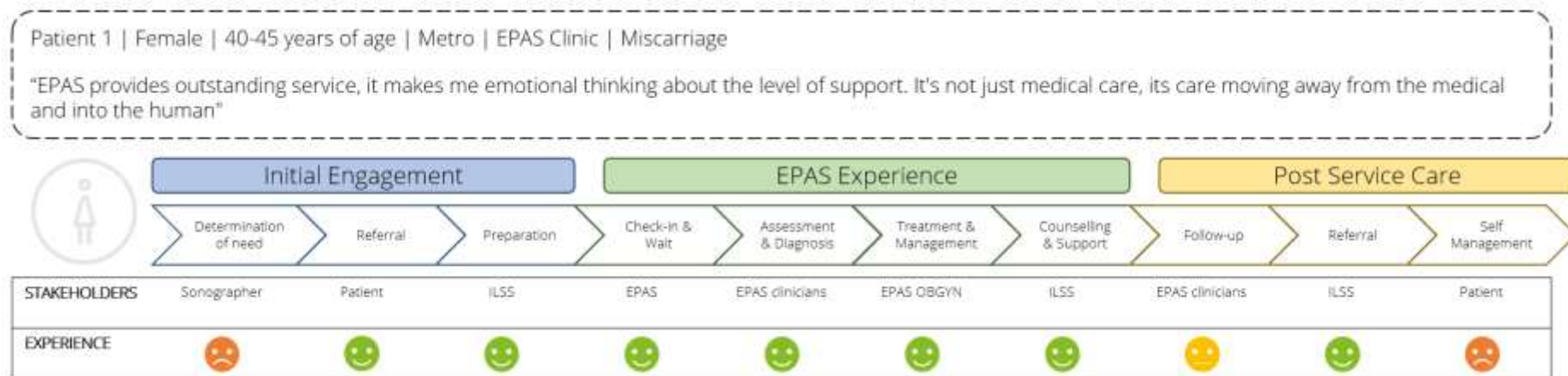
- Check-in & wait – was there a discreet waiting area for the patient if attending an EPAS clinic, or was there an extended wait time to get an appointment (i.e. more than 48 hours)?
- Assessment & diagnosis – what healthcare provider assessed and diagnosed their condition, and which healthcare setting did this occur in?
- Treatment & management – what management option did the patient elect to manage their early pregnancy outcome? Did they return for additional treatment or attend a different healthcare provider to receive this?
- Counselling and support – was the patient offered any mental health support during their EPAS experience and/or receive care in a way which was sensitive to their psychosocial needs?

Post service care:

- Follow-up – did the patient receive any follow-up care (could be in-person or via telehealth), and did this focus physical and/or mental wellbeing?
- Referral – was the patient referred on to additional psychosocial support services and resources such as Pink Elephants or Red Nose?
- Self-management – how did the patient manage their mental health and wellbeing?

Final thoughts are provided at the end of each case study, which reflects what the patient detailed as an opportunity for improvement in how EPAS could better meet their needs.

7.3 Patient case studies



Initial engagement: The patient presented to her sonographer for a 12-week gestational scan following a successful IVF implantation. The baby's heartbeat was not progressing as expected, and unfortunately, this news was not delivered in an empathetic or professional way. From attending EPAS for previous miscarried pregnancies, the patient self-referred to the service. This EPAS provider has an integrated Infant Loss Support Service (ILSS) with a dedicated bereavement midwife who the patient had previously engaged with, so emotional support was provided during preparation and re-entry to the EPAS clinic, which created a more positive experience for the patient.

EPAS experience: Having received care for previous miscarriages via this EPAS clinic, the patient was triaged and assessed almost immediately. The patient noted that her short time in the waiting room was distressing as she was seated alongside visibly pregnant women. However, it was acknowledged that not all services have the capacity to designate a separate waiting area for those who are actively miscarrying. Once seen by the EPAS clinicians, an additional scan was performed to confirm the active miscarriage. This news was delivered to the patient in an empathetic and supportive manner, with options for next steps clearly laid out. The patient chose to proceed with a D&C, which was performed by the OBGYN alongside further testing for the baby to help determine possible causes of this miscarriage. Subsequent support and counselling were provided via the ILSS, with the midwife providing a consistent point of support to guide the patient through her infant loss. The patient noted that she was very satisfied with the quality of medical care and emotional support she received during her visit to the EPAS clinic.

Post service care: Following her D&C procedure the patient continued to have her blood and hormone levels monitored, receiving a call on day three from the EPAS clinic to check on her wellbeing and health presentations, and to transition her back into the care of her GP. However, the patient felt that this follow-up did not provide an adequate level of mental and emotional support required during this difficult time. As the patient was previously referred to and enrolled within the ILSS program, she received a home visit from the ILSS midwife, which was noted to be a positive experience and highly impactful for her physical, mental, and emotional recovery.

Final thoughts: Overall, the patient was satisfied with the timeliness and quality of clinical care received, as well as the mental health and emotional supports available during her miscarriage. However, there is no long-term support system in place for bereaved parents, and this was identified as a significant gap in the overall EPAS experience during the patient's self-management phase. Additionally, sonographer training for the empathetic delivery of news regarding a miscarriage would have resulted in better patient satisfaction.

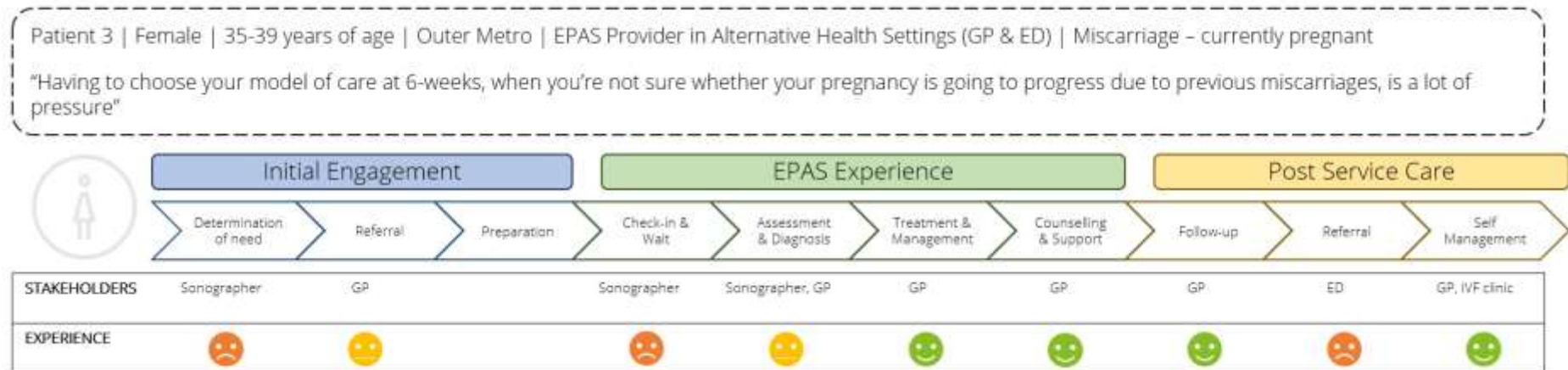


Initial engagement: The patient experienced cramping and bleeding at 8 weeks' gestation, and after calling the hospital, she was pleased to receive advice about seeing their GP for referral to the EPAS clinic. The patient was aware of EPAS from attendance during previous pregnancies, which she noted were positive experiences, and from social media advertising. Unfortunately, the patient's regular GP was booked for over two weeks, so she decided to attend an out-of-hours GP. While waiting for this appointment, the GP staff encouraged the patient to attend the ED instead, which the patient's partner declined, as this would have been a very traumatic experience while actively miscarrying. After seeing the GP and receiving a referral, the EPAS clinic called the next day, advising that no sonographers were available, and a private imaging appointment was required, with results to be returned to the EPAS clinic. This was very distressing for the patient, and fortunately, her partner was able to call around and arrange an ultrasound appointment for the following morning.

EPAS experience: When attending the private imaging clinic, the patient was seen to by a foetal medical specialist, who confirmed the miscarriage in an empathetic manner while providing information pamphlets on next steps, discussing expectant management options, and referring the patient to Pink Elephants which was greatly appreciated. The patient felt supported and heard through this phase of treatment. Results from the ultrasound were sent to the EPAS clinic, who then arranged hCG blood testing. The EPAS clinic called to relay her hCG results after each test, and the patient noted that more than once this information was left via voicemail which she found alarming and impersonal. Once her hCG levels reached zero, the patient was discharged having received no in-person consultation or care.

Post service care: Unfortunately, the patient's engagement with EPAS resulted in an automatic enrolment to the hospital maternity service, and she received a call from the hospital offering a place in the continuity midwifery service. The patient had to explain she had miscarried which was retraumatising, however the midwife provided exceptional support and reassurance by liaising with the maternity service doctor about the heavy bleeding she was experiencing. The patient received no follow-up on physical or mental wellbeing by the EPAS clinic. Subsequent care was provided by the patient's regular GP who referred her on for another ultrasound to ensure the miscarriage was complete. During this appointment, the patient was asked when she had given birth as the technician had not read the report prior to consultation, causing more distress for the patient as she had to explain she had experienced a miscarriage. The patient reported a significant decline in her mental health following their miscarriage, but fortunately had access to a psychologist for additional long-term support.

Final thoughts: Overall, the patient was not satisfied with the quality of care she received throughout her EPAS journey, and stated this experience deeply affected her. She noted this could be improved with the provision of empathetic care, information on what to expect during a miscarriage, and being linked to support services throughout her clinical journey.



Initial engagement: The patient had experienced a recent chemical pregnancy, and after being referred for testing and public fertility support, she fell pregnant again and attended a private sonographer for a dating scan. During this scan, the pregnancy was a few weeks smaller in growth than anticipated, and the patient told the sonographer she was ovulating at the time. The sonographer, unfortunately, dismissed this, telling her everything was fine and instead provided an updated due date for the baby. This did not make the patient feel heard or supported, particularly considering her previous history of miscarriage. She returned to her GP for hCG monitoring and was referred for an additional scan, which would be a two-week wait.

EPAS experience: At the 8-day mark, the patient decided to attend a public clinic to receive an ultrasound as her hCG levels were lowering, rather than waiting the fortnight for a private scan. She detailed this as being a horrible experience, having an extended wait for confirmation of a miscarriage she knew was actively occurring after being dismissed during the initial appointment. This scan confirmed she had lost the baby, but no advice was provided to the patient about where to go or what to do, which only exacerbated her distress. The patient decided to phone her regular GP clinic, and noted the receptionist provided amazing support, understood the severity of the situation, and was able to fit her in for a telehealth consultation after the last appointment of the day. This occurred on a Friday afternoon, and unfortunately, the imaging clinic did not transfer the sonographer's report to the GP before closing for the weekend. When the patient requested Misoprostol to support medical management of her miscarriage during the telehealth consultation, a script was provided, but she was advised that this should not be filled until the next week, once the sonographer's report had been reviewed. The patient expressed immense gratitude that her GP was understanding and supportive throughout this process, providing referrals to support services such as Pink Elephants, and was disappointed to find the same level of empathy and information was not granted during her engagements at the private and public imaging clinics.

Post service care: The patient's GP provided consistent follow-up care, which addressed both physical and mental health needs. She fell pregnant again and was 28 weeks' gestation at the time of the interview. At 16-weeks' gestation, she recalled a bleed which resulted in her attendance at the ED. While the quality of clinical care received during this episode of care was good, the patient noted that during a follow-up phone call, she was asked, "Are you actually pregnant?" due to her history of miscarriage, which was very upsetting. The patient feels confident that, between the care of her GP and fertility specialists, she can effectively manage her physical and mental health during her current pregnancy.

Final thoughts: Overall, the patient was satisfied with the quality of care received by her GP but called for more information to be readily available for women experiencing miscarriage, as well as further training provided to clinicians delivering EPAS so this can be facilitated in an empathetic, compassionate, and supportive manner.



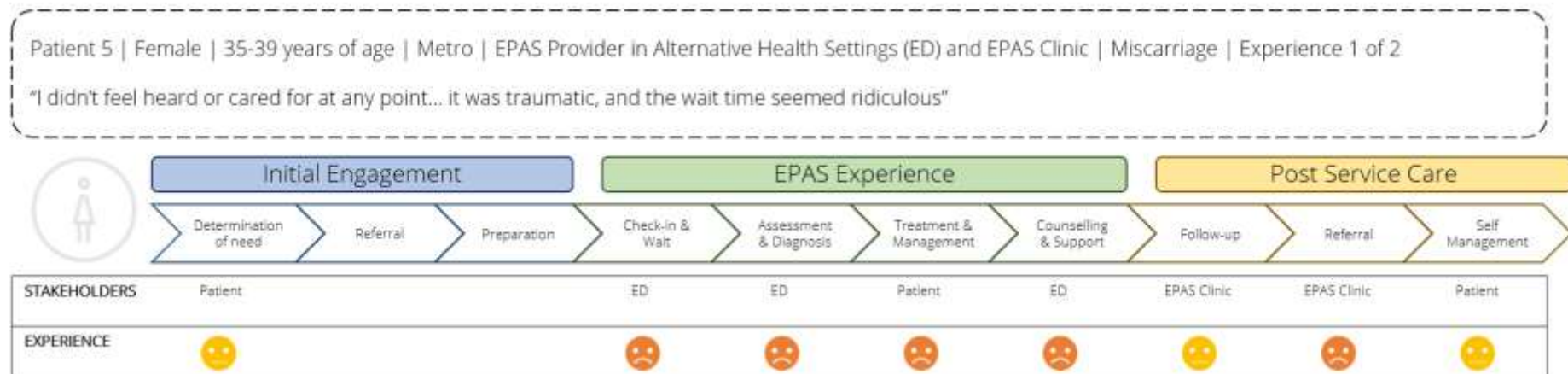
Initial engagement: The patient attended her GP at six weeks' gestation after feeling something was wrong. She was listened to and referred to the local sonographer for an emergency ultrasound, which showed her baby was smaller than expected and had bradycardia. The patient's GP referred her to the nearest EPAS clinic immediately; however, it took two weeks and several follow-ups before receiving an appointment notification via text, in which she was not given any say in the day or time that this was scheduled for. During this wait, the patient attended another scan, which could not find a heartbeat for her baby, and when contacting the EPAS clinic to check what to expect and what she needed to prepare, the clinic staff were not forthcoming with this information.

EPAS experience: Living rurally, the patient had to travel 110km to attend the EPAS clinic appointment. Thankfully, her husband was able to drive and support her during this process, however, the patient highlighted how distressing it was sitting in a waiting room full of visibly pregnant women while not knowing whether her baby was alive. A locum obstetric registrar led the appointment, and the patient noted she struggled to communicate effectively or empathetically regarding the loss of her baby, didn't understand how far she had travelled to attend the appointment, and only provided general health advice such as "don't drink or smoke" to increase her chances of successful future pregnancies. Additionally, the clinician was reluctant to offer an ultrasound while the patient was at the clinic, saying the machine would "take some time to warm up". Due to the considerable distance travelled to make their appointment, the patient and her husband decided to proceed with the ultrasound, but noted that the scan was conducted without changing the environment (i.e. dimming the lights). Unfortunately, the imaging was not clear enough to receive a decisive diagnosis, which only added to the patient's disappointment, stress, and anxiety. She booked a private ultrasound appointment at a clinic back home a few days after their EPAS visit that confirmed her miscarriage. The patient then saw her GP, who presented all options for miscarriage management, and the patient opted to proceed with medical management so she could miscarry at home and bury her baby. While the patient's GP was very understanding and

acknowledged how emotional and challenging the experience was, there were no mental or emotional health referrals provided to the patient throughout her EPAS experience, which only exacerbated her distress and trauma.

Post service care: The patient was surprised to receive a follow-up call from the EPAS clinic, as she had discharged herself from their service following her poor experience. Unfortunately, her attendance at this EPAS clinic resulted in an automatic referral to their maternity service, and she received a text message notifying her of this enrolment a few weeks after the appointment. When referred for medical management, the patient's GP unfortunately failed to mention the requirements for outpatient ambulatory care due to her distance from the nearest hospital. As such, the patient was forced to attend the ED over several days, with wait times ranging from three to five and a half hours while bleeding heavily and in pain. The patient recalled the trauma this experience caused her, and that the staff made her feel like she was "overreacting" and "a burden on the health system". Unfortunately, the patient was left to seek out her own mental health and emotional support services throughout this process, and as such did not feel that comprehensive care was provided.

Final thoughts: Overall, the patient was very dissatisfied with the service and quality of EPAS she received throughout her journey. She highlighted the need for easily accessible and digestible information regarding what to expect and how to prepare for an EPAS clinic appointment, and the provision of empathetic and emotionally sensitive support. She noted that simple things, such as clinicians acknowledging the loss of a baby, understanding how stressful and challenging the experience is, and providing clear options for management and follow up care, with a particular focus on referrals to emotional support services, would greatly improve the patient experience.



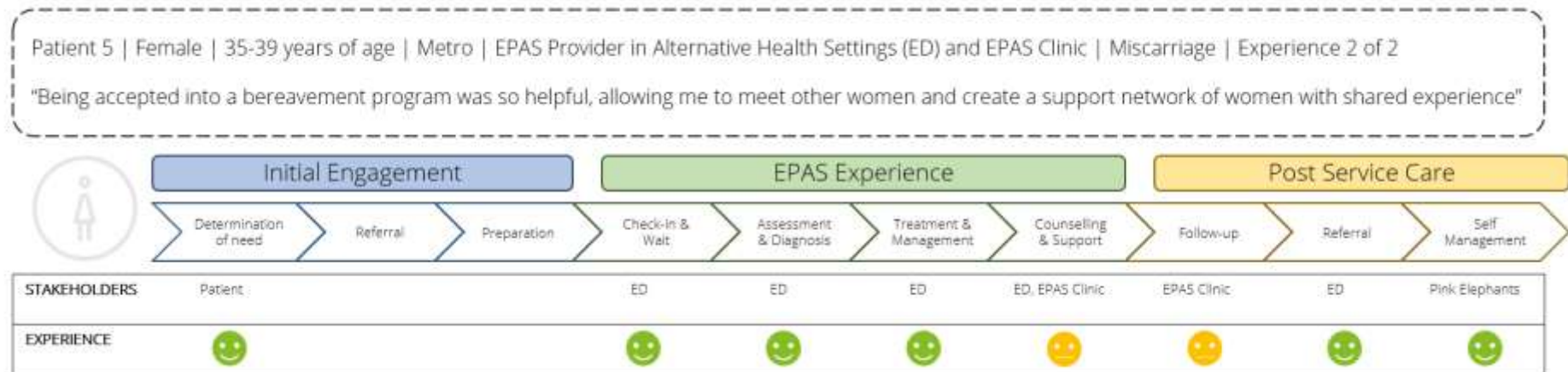
Initial engagement: The patient experienced bleeding during the early phase of her pregnancy and believed the best thing to do was to attend the hospital for support. She self-referred and presented to the ED immediately after the bleeding commenced.

EPAS experience: Upon presentation to the ED, the patient spoke to the triage nurse. She notified the nurse that she was at risk of ectopic pregnancy, but felt that her condition was not taken seriously as an emergency, and her risk factors were not taken into consideration. She noted that while arriving at the ED at 5 pm, she was not seen by a clinician until 2 am and was made to sit in the general ED waiting area while continuing to bleed. The patient was eventually taken in for a speculum examination and described being left in a recliner chair for the rest of the night. She was seen by a sonographer around 8 am for an ultrasound, then waited until 2 pm to receive the scan results and 4 pm for an OBGYN to assess her. The patient's slow course of treatment over her 24 hours in the ED was very distressing and made her wish she had stayed at home. The ED referred the patient to the hospital's EPAS clinic for follow-up, but provided the patient with no information on what to expect or how to manage her miscarriage at home. She was left to research for herself what appropriate home care was for expectant management. At no point was the patient provided with any mental or emotional health care or referred to any support services or resources. The patient described that she didn't feel heard or cared for throughout her time at the emergency department.

Post service care: The patient was contacted by EPAS a few days after presenting to the ED to organise an appointment for the following week. She attended the appointment and received an ultrasound to confirm that her pregnancy had passed. She noted that the doctor who saw her at the EPAS

clinic was kind and compassionate, but also stated that it felt rushed and as though the process was performed to “tick a box”. Again, the patient was not provided with any mental or emotional health care nor referred to resources for long-term support.

Final thoughts: The patient found this initial engagement with EPAS to be an incredibly negative experience. She found the lack of urgency and empathy, particularly during her time in the ED, to be traumatic, and was reluctant to return to the service for her subsequent miscarriage. She felt dismissed by clinicians throughout her EPAS journey and stressed that more information needed to be provided to women experiencing miscarriage, so she knew what to expect and where to go for help.



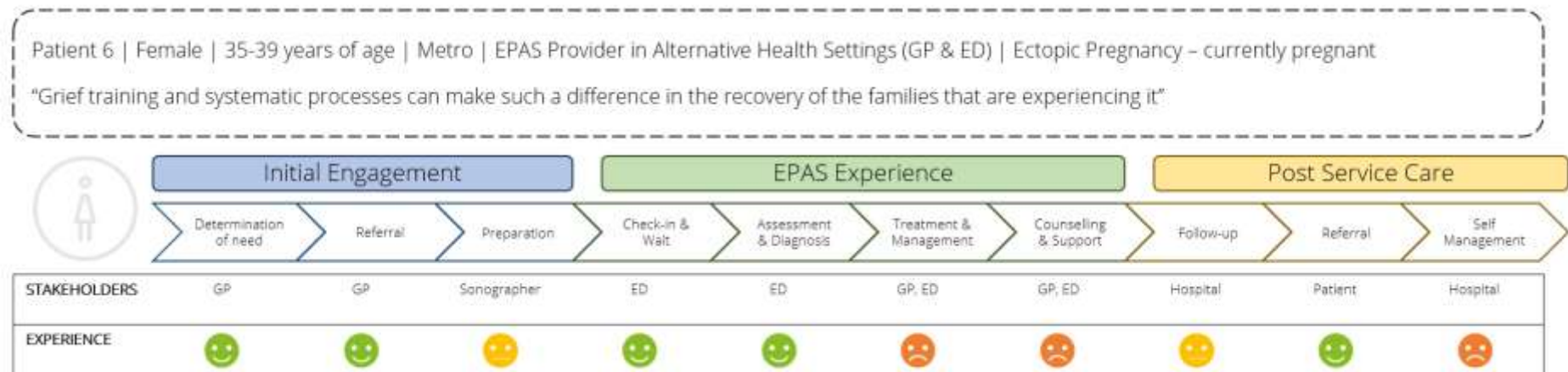
Initial engagement: About 18 months later, the patient experienced early bleeding during a subsequent pregnancy. Due to the traumatic experience she had previously had, the patient was reluctant to present to the ED; however, she decided to return as there was no clear alternative for immediate care or information.

EPAS experience: When attending the ED, this time after sharing her symptoms and history with the triage nurse, the patient was taken through to a private room within five minutes, and told by ED staff that they did not like women experiencing threatened miscarriage to be kept in the general ED waiting room. The patient was surprised by this revelation, considering her previous experience, and queried whether the ED had changed its model of care or received additional training for staff on miscarriage management. She noted that the nurses were very attentive and consistently checking in for status updates on her bleeding and pain levels. The patient expressed that she was grateful for this level of engagement and stated she felt well cared for by the nurse practitioner. A speculum examination was performed, bloods were taken, and a sonographer attended to provide the patient with an ultrasound. After the miscarriage was confirmed, the patient was seen by a support worker who provided her with a charity care package from Sweet Peanuts, as well as referrals to support services including Pink Elephants, Lifeline, and Beyond Blue. While she was grateful to receive stronger emotional support during this experience with EPAS, the patient was concerned that information on home care and expectant management was still not provided. She also noted that this ED visit took less than half the time her previous presentation did.

Post service care: The patient was again referred from the ED to the hospital's EPAS clinic after discharge. Having more awareness of the processes for expectant management of a miscarriage, the patient decided that a telehealth consultation would be appropriate. She noted that the staff were once again pleasant, but she didn't feel that particularly useful information was provided during this consult. Additionally, the focus remained on her physical health, rather than exploring possible psychological distress. After learning about Pink Elephants from her ED support worker, the patient was

fortunately accepted into their bereavement support program. She noted this was incredibly helpful for her recovery, as it allowed her to meet other women who had this shared experience and build a strong support network for long-term physical, mental and emotional recovery.

Final thoughts: Overall, the patient was satisfied with the quality of care she received during this second engagement with EPAS. However, she highlighted a need for patients to be provided with more information about what to expect both physically and emotionally during a miscarriage. Additionally, she suggested further follow-ups which focussed on mental wellbeing and psychological distress would be advantageous to support women during what is a vulnerable, distressing, and often traumatic period of their lives.



Initial engagement: The patient attended her GP to confirm her pregnancy after experiencing chemical pregnancies in the past. The GP raised the risk of ectopic pregnancy considering slow-rising hCG and said to attend the ED if any pain was experienced. This care was supported with regular blood tests to track hCG levels and several early scans. While attending the radiographer for a routine scan, the results came back inconclusive, and shortly after, the patient experienced some discomfort and presented to the ED.

EPAS experience: When presenting to the ED, the patient felt well supported by staff, describing the midwife as caring and sympathetic, and was attended to by the OBGYN on call relatively quickly once an ectopic pregnancy was confirmed. An ultrasound was performed, and the ectopic pregnancy was diagnosed. The patient noted that the options to proceed, and details of each process, were clearly explained to her by the doctor. The patient was left to make an informed decision between medical management via methotrexate or surgical management via D&C. She decided to proceed with a D&C, which, later on, both her private OB and Fertility Specialist agreed would be the better option; however, when being assessed the next day, the OBGYN on call had changed. The new doctor strongly advised against the option for a D&C, instead insisting that methotrexate was the most effective management option. The patient felt that her bodily autonomy had been taken away. The patient believes this decision may have occurred due to bed shortages at the hospital, and that it was not made in her best medical interest. Unfortunately, the previous midwife who had been supporting the patient while in ED had also ended her shift, so the patient did not have any medical staff to support and advocate on her behalf. Reluctantly, the patient received a methotrexate shot. However, while she was made aware she was not to try to conceive within 3 months, she was not warned of the potential side-effects, including mood changes and impacts on fertility. The patient experienced further chemical pregnancies and miscarriages in the nine months following administration of this drug and believes it may have influenced these outcomes.

Post service care: The patient returned to the hospital for her first week follow-up, then had weekly telehealth calls for six weeks to monitor her progress and manage the ectopic pregnancy, with regular bloods taken for assessment. The patient noted that while the midwife who conducted these follow-ups provided comprehensive care, explaining the physical health outcomes as well as checking in on her emotional health during the calls, no information was provided regarding further resources which could be accessed for ongoing mental health and bereavement support, including Pink Elephants, Red Tree Foundation or Red Nose. The patient was already aware of these resources, having experienced a loss at a significantly later gestation in the past, but noted that she genuinely asked for help and received no referral to these supports. Due to the patient being forced to undergo medical management for her ectopic pregnancy, she felt that this prolonged her grief and made it significantly more challenging to recover physically, mentally and emotionally.

Final thoughts: Considering how distressing her EPAS experience was, the patient decided to engage a private OBGYN for her current pregnancy. While she had some positive elements early into her EPAS journey, the removal of bodily and medical autonomy created an incredibly negative and traumatic experience. However, something the patient continued to reiterate was the need for emotional support. She suggested the introduction of mandatory grief training for EPAS providers, alongside systematic processes that ensure clinicians refer patients to long-term support services. The provision of EPAS with not only empathy, but comprehensive information on what to expect and what options are available, was noted to be crucial at any stage of pregnancy loss. Ultimately, while it was acknowledged that it's not the responsibility of a clinical team to directly support someone's grief, there is a responsibility to ensure that a patient's grief is supported in some way.



Initial engagement: The patient experienced bleeding at seven weeks' gestation, so she decided to attend her local ED. Medical staff performed an ultrasound, which showed that the baby had a strong heartbeat, which was thought to be a symptom of regular early pregnancy bleeding. The ED referred the patient to the hospital's EPAS clinic for further assessment and support. However, the patient presented to the ED on Wednesday before a long weekend, and the first available EPAS appointment wasn't until Monday the following week. The following morning, she was experiencing pain and particularly heavy bleeding, and so she decided to return to the ED. Thankfully, the same clinicians were on shift when she returned, and the patient was fast-tracked for triage and assessment, considering her miscarriage risk. An additional scan was performed, and her miscarriage was confirmed. While this experience was distressing, the patient noted that the ED nurse practitioner provided exceptional care and support, being honest and upfront about what was happening and what her management options might look like.

EPAS experience: While the nurse practitioner explained that the EPAS clinic generally operated over the weekend, the patient described the extended wait until her appointment as extremely stressful. The patient was not provided with an option for the format of her EPAS appointment, and on Monday, she received a call from the clinic reconfirming her miscarriage and offering either surgical or medical management options. The patient decided to proceed with surgical management, and the clinic organised a D&C, which was scheduled for that Friday. During this telehealth appointment, the patient was not provided with any emotional or mental health support or resources; she was simply told to expect a call from her anaesthetist before the procedure and referred on to her GP for follow up care. The patient found this interaction to be impersonal and said she felt the clinic lacked empathy and compassion for her situation. Additionally, the 4-day delay between her EPAS consultation and the booked D&C had the patient feeling like she was left in limbo, with no understanding of what to expect from her body or what else might happen, as there was no information or support provided by the clinic like she received from the ED nurse initially.

Post service care: Following the D&C procedure, the patient returned to her GP for follow-up care via telehealth. The patient was shocked to learn during the appointment that her pregnancy tissue had been sent for testing without her knowledge or consent, and that the results of this testing were inconclusive as to why she may have miscarried the baby. The patient said that her appointment felt very rushed and that no additional mental or emotional health supports were provided, noting that overall, this follow-up was not a pleasant experience. While these supports were not provided by her GP or during her EPAS clinic experience, the patient shared that her nurse practitioner went “above and beyond” during her time in ED, not only supporting her mental, emotional and physical health but also researching mental health supports and referring the patient on to Pink Elephant. She said that this referral provided her with so much support for her early pregnancy loss and has inspired her to advocate for reform in the early pregnancy space, particularly regarding public health management of pregnancy loss.

Final thoughts: Overall, the patient was satisfied with the quality of physical healthcare provided, but very dissatisfied with the broad lack of mental and emotional health supports provided throughout her EPAS experience. She noted there is a need for clinicians to approach early pregnancy loss with empathy, rather than a purely medical lens. She also called for more emotional support services to be connected to EPAS clinics and GPs, with a framework for how these providers can deal with pregnancy loss in a compassionate way.



Initial engagement: At around six weeks' gestation, the patient experienced light bleeding and cramping over the course of a week. When the bleeding became heavy, she contacted *healthdirect*, who advised her to go to hospital. When attending the ED, the patient said she was ushered through to a private room relatively quickly and seen by a doctor within an hour. As there wasn't anything the ED could do to intervene with a threatened miscarriage, the patient was encouraged to return home and referred to the hospital EPAS clinic from which she was told to expect a call the following day. However, it should be noted that the possibility of miscarriage was not raised with the patient during this process.

EPAS experience: The patient remained anxious and worried about her baby and was relieved to receive a call from the EPAS clinic the next morning. She explained that she had a scan through her private clinic the week before which showed baby's heartbeat and noted that her hCG levels had not raised much. She was advised to monitor her symptoms and call back if needed, but the patient said that she didn't receive any information from the midwife during this call about symptoms of early pregnancy loss or what to expect and was just told that everything should be fine without addressing her concerns regarding the bleeding or cramping. The patients bleeding and cramping continued over the coming week, however when the consistency of her bleeding changed, she decided to call the EPAS clinic back for advice. She was alarmed when the staff member taking her call stated she had no record of her previous referral on file, so the patient had to recount her history, symptoms and timeline. She didn't receive any helpful advice or support from the midwife during this interaction. A clinic doctor called her back the next day after reviewing the notes, saying everything looked fine and not to worry. At this stage, the patient was nearing nine weeks gestation with no other pregnancy symptoms. The doctor did not encourage her to attend an in-person appointment at the clinic or with her GP, and unfortunately the patient began actively miscarrying her baby two days later.

The patient decided to proceed with expectant management of her miscarriage, experiencing bleeding for two weeks. She attended her GP during this period, however felt she didn't receive any relevant advice from her appointment so had to conduct her own research on what to expect during an active miscarriage and what supports were available to her. 10 days after the patient believed her miscarriage had completed, she started bleeding heavily again. She was concerned about the possibility of retained tissue, so decided to call the EPAS clinic for advice on how to proceed. She recalled the shocking response she received from the midwife who took her call, who provided no advice, support, or referral on where to go next, and ended to call with "we're not the clinic for you anymore sweetie". She decided to attend the ED, where she was again taken through to a private room but not seen by a doctor so decided to discharge herself and conclude her miscarriage process from home. The patient stated she was provided with some information on miscarriage and what to expect while at the ED, reiterating the same was not received from the EPAS clinic.

Post service care: Even with her multiple engagements with the EPAS clinic and her GP, the patient received no dedicated follow-up care from either provider. She was alarmed to receive a text message from the hospital's midwifery care program inviting her to attend their clinic for a 14-week scan, demonstrating there was no communication between clinics regarding the patient outcome. Adding to the distress the patient experienced when replying to the text letting the midwifery team know she had experienced a miscarriage, the clinic mobile phone had 'read receipts' on, and the patient saw someone had read her message but received no response. At no point throughout her EPAS journey was the patient referred on to any emotional or mental health supports. After being forced to do her own research into miscarriage, and due to her health literacy, the patient decided to refer herself for an hCG blood test at the 3-week mark via InstantScripts as she was concerned to receive no such recommendation from her GP.

Final thoughts: Due to this distressing and traumatic public EPAS journey, the patient has decided to receive care from a private OBGYN for her current pregnancy, which she noted has been a much better experience. Overall, she was not satisfied in the slightest with the quality of physical or mental health care she received. She reiterated the general lack of sympathy, empathy and compassion she was shown throughout her EPAS experience, noting that the provision of basic information or advice on what to expect and symptoms to look out for should at least be a minimum standard of care, which she unfortunately did not receive. Additionally, she noted the range of support services and resources which she was fortunate to find during her own research should be made available to women experiencing early pregnancy loss while she are engaged with EPAS providers, along with the fundamental need for clear communication regarding a risk of miscarriage when presenting with these symptoms.

7.4 Summary of patient feedback by research domain

The table below summarises the key themes that have emerged from the completed patient case studies. These themes have been embedded throughout different parts of the report.

Table 7.1: Patient feedback by research domain

Research Domain	Summary of patient feedback (from case studies)
EPAS Characteristics	- Operating hours are limited for most dedicated EPAS clinics. Patients are generally unable to nominate an appointment time that suits them, and/or face extended wait times to access an appointment. - A lack of available appointments is also seen in GP led EPAS care, however, there were more instances of flexibility with some appointments being granted out-of-hours due to need and the distressing nature of early pregnancy outcomes.
Service Scope	Patients would benefit from clear referral pathways between EPAS providers (including dedicated EPAS clinics, GPs, EDs), adjacent early pregnancy services (such as Sonographers), and onto long-term psychosocial support resources and services such as Pink Elephants, Red Nose, and/or psychologist led care.
Governance and staffing	There were observed inconsistencies among healthcare professionals in the provision of empathetic and compassionate EPAS care, particularly the delivery of news regarding miscarriage and/or early pregnancy complications.
Patient characteristics and experience	- The provision of follow-up care is inconsistent. Some EPAS providers address mental and emotional wellbeing as well as physical, while some only address physical, and others provide no follow-up care at all. - EPAS patients are rarely referred on to long-term support resources and services such as Pink Elephant and Red Nose by healthcare professionals. However, when they do receive support from these resources, self-management and emotional recovery improves.
Future areas of improvement	Some EPAS clinics co-located within a hospital have automated referral processes from their clinic into maternity services. This has resulted in a number of patients who experienced a miscarriage being enrolled into these services and contacted about their pregnancy which causes significant distress and can be retraumatising. Patients have requested this practice be ended, with the suggestion that those who experience miscarriage are flagged and removed from the referral system.

8. Recommendations

This section summarises the key recommendations to improve the quality and accessibility of EPAS, both through EPAS clinics and other EPAS providers in alternative health settings.

No. Recommendations

Relevance of recommendation by EPAS provider type

1	Build on Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and state governments' guidelines to establish guidelines for the provision of EPAS in clinics and alternative health settings.	EPAS clinics and EPAS in alternative health settings
2	Collaborate with community representatives to develop more standardised and context-specific resources, supports and guidelines for healthcare professionals who deliver EPAS to patients from priority populations.	EPAS clinics
3	Expand resourcing to ensure appropriate staffing and infrastructure (e.g., ultrasound machines) to deliver high quality EPAS.	EPAS clinics
4	Develop standardised education, training and induction resources on trauma-informed early pregnancy complication care and provide dedicated funding to support uptake of training.	EPAS clinics
5	Investigate and expand alternative service models that increase accessibility and enable continuity of care within an episode of care. This could include consideration of telehealth (e.g., 24-hour hotlines), virtual and midwifery-led delivery models.	EPAS clinics and EPAS in alternative health settings
6	Develop standardised informational resources for EPAS patients, covering the medical and psychosocial aspects of care and ensure patients consistently provided these resources.	EPAS clinics and EPAS in alternative health settings
7	Improve community and health system awareness of early pregnancy complications and EPAS – this could involve a community awareness campaign, outreach activities to GPs and a review of health system protocols	EPAS clinics and EPAS in alternative health settings
8	Introduce structured data collection and reporting mechanisms (including patient feedback) to strengthen the evidence base on EPAS.	EPAS clinics

8.1 Guidelines

Build on and enhance existing guidelines for the provision of EPAS in clinics and alternative health settings.

This recommendation relates to both EPAS clinics and EPAS in alternative health settings.

The provision of EPAS is inconsistent across the country. For example, both NGOs who represent patients and EPAS patients reported that patient experience was impacted negatively by variations in the:

- availability of EPAS clinics (e.g., opening hours and out-of-hours processes)
- access to ultrasound and laboratory testing,
- emotional sensitivity of EPAS providers,
- delivery of follow up care, and
- referrals to mental health supports.

This variation reflects the absence of a clear, nationally endorsed definition of an EPAS clinic and a lack of nationally adopted guidelines for the delivery of care for early pregnancy complications. As a starting point, all relevant stakeholders (the Department, state / territory governments, professional bodies and medical colleges) can work collaboratively to:

- develop guidelines that are specific to EPAS. These guidelines can draw on existing guidelines, such as RANZCOG's clinical guidelines on *Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy (C-Gyn 38)* which was established in March 2025 and other existing state/territory guidelines (e.g., Queensland's clinical guidelines on *Early pregnancy loss*). These guidelines can provide guidance on the scope of services provided by EPAS clinics.
- publish a consistent definition on the scope of practice within EPAS clinics within established guidelines. This national audit recommends for EPAS clinics to be defined as a designated outpatient clinic which provides assessment, diagnostics, referrals for patients experiencing pregnancy complications (typically pain and/or bleeding) from conception to 14-20 weeks gestation.

In relation to guidelines, findings from this national audit recommend that EPAS clinics should at a minimum:

- provide easy access to an ultrasound machine (including transvaginal ultrasound), specialist sonography services and laboratory facilities,
- are staffed by dedicated specialist staff (e.g., midwives, specialist sonographers, consultants) with expertise in trauma-informed care for early pregnancy complications,
- have, where possible, a discrete waiting room and physical separation from maternity services,
- deliver consistent follow-up of patients after an episode of care (e.g., the same health practitioner calls after the first EPAS appointment), focused on both physical and mental health,
- facilitate the provision of psychosocial care through:
 - informing patients of their diagnosis in a timely, tactful and transparent manner
 - providing standardised written and verbal information, including on accessing mental health supports,
 - conducting an assessment to determine the need for follow on psychosocial supports (e.g. mental health care, family violence supports), and

- considering the need for a referral to other primary health services (e.g., in-house mental health nurse or external grief counsellor),
- establish clearly defined lines of communication, governance and accountability with the EPAS,
- identify written pathways for clinical management,
- have an appointment system and clear clinical inclusion and exclusion criteria,
- develop clear referral and transfer of care pathways, and allow people with recurrent miscarriages or a previous ectopic or molar pregnancy to self-refer or be referred to relevant support organisations.
- operate during business hours from Monday to Friday and, ideally, on weekends
- implement clear out-of-hours processes (e.g., a triage nurse, recorded message, directory of appropriate after-hours facilities or a referral to a national support service).

The guidelines should also establish expectations for EPAS delivered in alternative health settings (e.g., GPs, EDs, maternity units). For example, they should require that providers who deliver EPAS in alternative health settings to:

- provide access to an EPAS specialist (e.g., midwife, nurse, obstetrician),
- refer non-urgent patients, where appropriate, to EPAS clinics and other specialist providers in a timely manner,
- provide privacy and timely support to patients experiencing pregnancy loss (i.e., to avoid patients miscarrying in the emergency room/bathroom), and
- facilitate the provision of psychosocial care (as above).

The development of these guidelines should occur alongside the development of standardised resources and training on EPAS (see section 8.4).

8.2 Tailored supports

Collaborate with community representatives to design context-specific resources, supports and guidelines for healthcare professionals who deliver care to patients from priority populations.

This recommendation relates to both EPAS clinics and EPAS in alternative health settings.

Priority populations (e.g., First Nations peoples, LGBTQIA+ people, CALD communities, refugees and migrants, and people with a disability) face unique barriers in accessing quality care for early pregnancy complications. Despite this, there is a lack of systematic, tailored EPAS supports delivered to priority populations.

All relevant governments can consider collaborating with relevant stakeholders to:

- develop and distribute tailored and translated informational resources to patients who access EPAS in clinics or alternative health settings,
- conduct outreach activities to increase awareness and trust among priority populations,
- ensure interpreter services are consistently available and are offered to patients, particularly those from First Nations, CALD, refugee or migrant backgrounds,
- deliver education, training and induction resources on tailoring care to the needs of priority populations to EPAS providers,
- ensure support officers (e.g., Aboriginal Liaison Officers, Disability Support Officers) are consistently offered to relevant priority populations who require care for early pregnancy complications, and

- conduct further research into the unique needs and experiences of priority populations, particularly for those within the broad CALD umbrella.

EPAS clinic providers should leverage the expertise of existing First Nations-led community health organisations who provide care for early pregnancy complications, such as the South Coast Women's Health and Wellbeing Aboriginal Corporation Waminda.

8.3 Resourcing

Expand resourcing to ensure appropriate staffing and infrastructure (e.g., ultrasound machines) to deliver high quality care.

This recommendation relates to EPAS clinics only.

EPAS clinics often face staffing and infrastructure (e.g., ultrasound machines) constraints. These constraints can impede the delivery of effective EPAS. Some EPAS clinics currently operate within shorter operating hours (e.g. a few hours on weekdays) due to these constraints. Patients may face delays for care (e.g., waiting at the clinic or returning another time), or be required visit a different healthcare service (e.g., a private sonographer), exacerbating patient distress and impeding the quality of their care. This can also have an unintended consequence of creating a greater reliance on EDs, placing additional pressure on this high-cost, high-demand setting and reducing overall system efficiency.

Given patient preference for receiving specialised care in standalone EPAS clinics, all governments can consider expanding the resourcing (e.g., funding, staffing and infrastructure) available to EPAS clinics which are experiencing high levels of unmet demand, as evidenced through wait times to secure appointments and patient volumes. This will ensure patients can access timely and appropriate care. To determine the need for further resourcing, more structured and systematic data needs to be collected to inform assessments of unmet demand and less timely access to care (e.g., wait lists, delays to care) and compare the performance of current EPAS clinics against best-practice guidelines. Additional resources should be prioritised for clinics with strong evidence of unmet demand.

For example, under the guidelines specified in Section 8.1, a EPAS clinic should provide access to a transvaginal ultrasound. As such, relevant Governments can consider providing additional resourcing to EPAS clinics that lack the staff and equipment required to ensure a transvaginal ultrasound service can be provided for all EPAS clinic patients.

Other best-practice guidelines that may necessitate the provision of additional resources to EPAS clinics include that EPAS clinics:

- operate during business hours from Monday to Friday and, ideally, on weekends
- deliver consistent follow-up of all patients
- facilitate the provision of psychosocial care
- develop clear referral processes between and among EPAS providers and other health services, and
- implement clear out-of-hours processes.

Improved resourcing will enable EPAS clinics to meet clinical and psychosocial care standards, improve patient experiences and outcomes, reduce reliance on emergency care, and contribute to a more equitable and efficient health system.

8.4 Education, training and induction resources

Develop standardised education, training and induction resources on trauma-informed early pregnancy complication care and provide dedicated funding to support uptake of training.

This recommendation relates to EPAS clinics only

Content on early pregnancy complication care is not substantively covered within the formal education of healthcare professionals who deliver EPAS (e.g. doctors, nurses and midwives). While some EPAS providers have created their own training and induction resources to support the induction and training of healthcare professionals in this area – however, training generally occurs on an ad hoc and inconsistent manner. Healthcare professionals who deliver EPAS stated that they rely on informal, on-the-job training, which leads to variability in clinical knowledge, communication approaches and confidence levels – especially when managing complex EPAS cases. Further, clinical guidelines and academic literature recommend that EPAS staff members be appropriately trained in delivering empathetic care in an early pregnancy context.^{49,50,51} The provision of appropriate support that is trauma-informed and sensitive during early pregnancy complications can reduce the likelihood of experiencing significant psychological morbidity.⁵²

To improve the consistent and quality of care, it is recommended that relevant medical colleges, professional bodies and health services work collaboratively to implement a structured and standardised EPAS training program for all EPAS clinic healthcare professionals (including nurses, midwives, sonographers and doctors). This could include embedding educational resources on the delivery of EPAS within relevant degrees (e.g. midwifery, nursing and medicine), and the development of training and induction resources for EPAS health professionals

These resources should be developed in collaboration with existing EPAS healthcare professionals and should leverage existing resources. For example, some EPAS clinics have developed induction and training resources for new starters. Examples of core modules that can be included in both educational and training resources include ultrasound interpretation, clinical pathways, referral protocols, compassionate support (including pregnancy loss support). The development of education and training resources should ideally be aligned the development of guidelines (see Section 8.1).

In addition to the development of more standardised resources, it is also essential to ensure that all staff who work in EPAS clinics actively undertake this training. This can be achieved through mechanisms such as mandatory completion of online and in-person training modules during induction, regular refresher sessions and integration of training completion into performance appraisals. Mechanisms to ensure healthcare professionals undertake training should be supported through dedicated funding to ensure both the development of training resources and ongoing participation are sustainable for EPAS clinics.

8.5 Alternative service models

Investigate and expand alternative service models that increase accessibility and enable continuity of care within an episode of care. This could include consideration of telehealth (e.g., 24-hour hotlines), virtual and midwifery-led delivery models.

This recommendation relates to both EPAS clinics and EPAS in alternative health settings.

In an effort to improve the accessibility and quality of care, providers of EPAS clinics or EPAS in alternative health settings have trialled a range of alternative service delivery models such as:

- virtual and telehealth EPAS services (e.g., 24-hour Maternal and Child Health Line),
- midwifery-led EPAS services (e.g., Women's and Children's Hospital Adelaide),
- outreach services, involving travelling obstetricians, midwives, sonographers, and regional/rural/remote generalist GPs, and
- First Nations-led EPAS services (e.g., Koori Maternity Ramahyuck District Aboriginal Community Controlled Health Organisation).

The Department can consider working with other state / territory health departments to explore the feasibility of implementing alternative service delivery models to address identified accessibility challenges for EPAS. According to providers who deliver EPAS, virtual and telehealth EPAS services have the potential to reduce travel costs and wait times for people in regional, rural and remote areas.

Continuity of care within an EPAS episode is particularly important for women because they are often experiencing a time of emotional distress and uncertainty. This national audit has identified scope to ensure women receive more consistent and coordinated care during an episode of care. This could be achieved through:

- **Consistent staffing:** Aim for a dedicated EPAS staff (e.g. junior doctor) to see the same patients throughout their care episode (from initial assessment to follow-up care)
- **Standardised care pathways and protocols:** The adoption of clear clinical guidelines and pathways to ensure consistent decision making and reduces variation in care
- **Proactive communication with referring healthcare professionals:** EPAS healthcare professionals should ideally provide timely feedback to GPs to keep them informed for follow-up and emotional support after an episode of care
- **Comprehensive documentation:** Ensure all patient interactions are well-documented in a centralised system accessible to all relevant healthcare professionals to support seamless and safe care, especially if multiple visits to an EPAS provider is required.

8.6 Informational resources

Develop standardised informational resources for EPAS patients, covering the medical and psychosocial aspects of care and ensure patients consistently provided these resources.

This recommendation relates to both EPAS clinics and EPAS in alternative health settings.

According to best-practice guidelines on the treatment of miscarriage and early pregnancy complications, EPAS clinics should provide written and verbal information to patients experiencing early pregnancy complications (e.g., leaflets, web addresses and helpline numbers).^{53,54} However, the practice of providing informational resources is not adopted across all EPAS clinics.

The Department can work collaboratively with state / territory governments to support the development and dissemination of nationally consistent, evidence-based informational resources for patients accessing EPAS. These resources should be developed in collaboration with EPAS providers and people with lived experience of early pregnancy complications and should leverage high-quality existing materials developed by healthcare professionals, professional bodies and advocacy organisations (e.g. Pink Elephants, Sands, RANZCOG).

The resources should address both medical and psychosocial aspects of early pregnancy complications, including:

- common types of complications,

- expected physical symptoms and recovery,
- treatment options and follow-up care,
- emotional resources to pregnancy loss and where to seek mental health and bereavement support,
- information on reproductive planning, future pregnancies and related healthcare rights.

It is equally important to ensure that all women who seek care for complications in early pregnancy receive or are directed to these developed resources. To maximise reach and utility, a printed copy of the resources should be provided to patients by EPAS providers, including EPAS clinics, GPs and EDs and digital versions should be made available online.

In addition to written information, governments can also consider providing support items to assist with the practical and emotional experience of early pregnancy loss. These could be offered as part of a support package and may include a token of remembrance, such as a seed card, candle, or discreet keepsake, or a collection kit for miscarrying at home.

8.7 Awareness campaign

Improve community and health system awareness of early pregnancy complications and EPAS – this could involve a community awareness campaign, outreach activities to GPs and a review of health system protocols.

This recommendation relates to both EPAS clinics and EPAS in alternative health settings.

There is low awareness among both healthcare professionals and the broader community about the prevalence of early pregnancy complications and the availability of EPAS in both clinic and alternative settings. As a result, patients are often unprepared for the possibility of complications and uncertain about where to seek help when they occur. It is especially crucial for healthcare professionals such as GPs to be aware about EPAS in their local area as they are often the first point of contacts for patients who experience early pregnancy complications. However, this national audit identified observed inconsistencies in awareness across jurisdictions. Many healthcare professionals were observed to not routinely discuss the risk of early pregnancy complications and are unaware of EPAS clinics. This knowledge gap can compound patient distress and delay access to appropriate care. For example, a GP may refer a patient experiencing light bleeding to the emergency department despite the likelihood of long wait times because they are unaware of a nearby EPAS clinic.

This presents an opportunity for both Australian and state/territory governments to improve healthcare professionals' awareness of EPAS as a crucial service. This can be achieved through:

- undertaking targeted outreach activities to GP and other frontline healthcare providers, including through Primary Health Networks, to emphasise the importance of preparing patients for the possibility of early pregnancy complications,
- reviewing health system protocols and infrastructure to ensure they recognise and respond appropriately to the risk of early pregnancy complications and loss. The review of health system protocols and infrastructure can also consider mechanisms to pause or cancel antenatal follow-up communications when a pregnancy loss is recorded and explore opportunities to embed EPAS clinics into local HealthPathways platforms used by GPs.
- conducting national community awareness activities to educate the public about early pregnancy complications and available supports,

While it is acknowledged that many EPAS clinics do not accept self-referrals, increasing community awareness can still generate several benefits. Firstly, when people recognise symptoms of early pregnancy complications, they are more likely to seek help promptly via the correct referral pathway (e.g. through a GP or emergency department). Awareness campaigns can also prevent frustration or wasted time by reducing inappropriate or failed self-presentations. Finally, increased awareness of early pregnancy assessment services may normalise discussions about early pregnancy issues (e.g. miscarriage), which reduces stigma and shame and may encourage others to seek supports sooner. Given this, all governments can consider steps to raise community awareness of EPAS as a service. This could include conducting a national community awareness campaign to educate the public about the prevalence of early pregnancy complications and available supports. This can take a similar form to DHDA's "Every Moment Matters" campaign which highlights the risk of drinking alcohol during pregnancy.

8.8 Data collection

Introduce structured data collection and reporting mechanisms to strengthen the evidence base on EPAS.

This recommendation relates to EPAS clinics only.

There is limited national data collected on the characteristics, needs and outcomes of people who experience early pregnancy complications and/or access EPAS. This gap hinders efforts to assess and improve EPAS. To address this, the Department – together with other relevant government agencies and health providers – can support the establishment of more structured and consistent data collection and reporting mechanisms across all EPAS clinics.

These mechanisms should aim to collect standardised data on:

- patient demographics, including age, gender, geographic location, and identification with priority groups (e.g. First Nations, LGBTQIA+, CALD, or people with disability);
- services provided by EPAS providers, such as the use of infrastructure (e.g. transvaginal ultrasound), provision of referrals, and delivery of follow-up care;
- service delivery mode, such as in-person or telehealth, and operational factors (e.g., opening hours, staffing model);
- clinical outcomes, including diagnosis, management decisions, and pregnancy outcomes where available,
- met and unmet demand, including service utilisation rates, wait times, and referral rates from GPs and EDs; and
- patient experience, including perceptions of accessibility, timeliness, and quality of care received.

This data collection could involve the creation of a national minimum dataset for EPAS and should be implemented in consultation with EPAS clinics, PHN and patient representatives. Where possible, data standards should align with existing national reporting systems to enable integration and reduce provider burden.

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Appendix A Additional information on early pregnancy

This appendix provides more in-depth information regarding early pregnancy complication

A.1. Early pregnancy

Early pregnancy is a critical period for both mother and baby. There are multiple definitions on early pregnancy, but the most common definition relates to care provided to people from conception to 14-20 weeks. Early pregnancy assessment services (EPAS) are required due to the potential complications that may occur in early pregnancy. They include:

1. **Bleeding in early pregnancy:** Approximately one in four people will bleed in early pregnancy. People experiencing this problem should contact a health professional to undertake the appropriate investigations and treatment. While miscarriage and ectopic pregnancy (discussed below) may cause bleeding, these are not the only causes and many people who experience bleeding will go on to have a healthy baby. Bleeding in early pregnancy is usually investigated through ultrasound. Ultrasound may be used to help identify an ectopic pregnancy or to show if a pregnancy has stopped growing.⁴
2. **Miscarriage.** Early miscarriage is defined as miscarriage occurring in the first 12 weeks of pregnancy. Miscarriages occur in at least 15% of confirmed pregnancies, though the actual miscarriage rate is estimated to be around 1 in 4 pregnancies.⁵ This equates to approximately 285 miscarriages every day, with more than 100,000 couples affected by miscarriage every year.⁶ Approximately 85% of miscarriages occur during the first trimester of pregnancy.⁷ The cause of miscarriage is often unknown with approximately 40-50% occurring due to chromosomal anomalies resulting in pregnancy loss in the first trimester. Other risk factors include alcohol and drug use, tobacco inhalation, maternal age, obesity and a history of previous miscarriage.⁸ Risk of miscarriage increases with age, particularly above the age of 35. Rates of miscarriage rise from approximately 20% among 35-year-old women up to 80% for

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women at age 45.⁹ Miscarriages do not typically have a treatable cause and a miscarriage cannot be prevented from occurring if a pregnancy is developing abnormally.¹⁰ Miscarriage can have a lasting impact on the physical and mental health, particularly for the 1-2 per cent of women who experience three or more miscarriages in a row.^{11,12} Miscarriage can lead to grief, anxiety, depression and post-traumatic stress disorder.¹³ It is understood that after a miscarriage 30-50% of women experience anxiety and 10-15% of women experience depression – with the impacts of these conditions typically lasting months.¹⁴

3. **Ectopic pregnancy.** An ectopic pregnancy is one that is growing in the wrong place, usually in the fallopian tube. This occurs where the fertilised egg stays inside the fallopian tube rather than travelling into the uterus. An ectopic pregnancy cannot continue to develop as the fallopian tube is unable to expand and grow with the pregnancy. If untreated the fallopian tube may tear or burst – leading to internal bleeding which may require urgent surgery. Approximately one in every 100 pregnancies are ectopic. Risk factors for ectopic pregnancies include:

- after fertility treatment such as in-vitro fertilisation (IVF)
- if there is a history of pelvic infection
- in people with damaged fallopian tubes
- in people who have had previous surgery (such as caesarean section, ovarian cysts or appendix removed)
- in people who become pregnant while using an IUD or a progestogen only pill.¹⁵

4. **Hydatidiform mole.** A hydatidiform mole or molar pregnancy is a rare complication affecting approximately one in 1,200 pregnancies. A molar pregnancy occurs where there is unusual and rapid growth of part or all of the placenta.¹⁶ The placenta becomes larger than normal which may stop the foetus from developing (complete molar pregnancy) or result in an abnormal growth which is not viable (partial molar pregnancy). Molar pregnancies are typically discovered within the first three months of pregnancy, often due to miscarriage.

A basic overview of the decision-making process for people presenting with early pregnancy complications is provided in A.1 below. The flowchart is used to determine if the patient is hemodynamically stable as well as the location and viability of the person's pregnancy.

⁹ Mayo Clinic. Pregnancy loss (miscarriage): Symptoms and causes. Available from: <https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298#:~:text=If%20you're%20older%20than,from%2057%25%20to%2080%25>

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¹¹ Kolte, A.M., Olsen, L.R., Mikkelsen, E.M., Christiansen, O.B. and Nielsen, H.S., 2015. Depression and emotional stress is highly prevalent among women with recurrent pregnancy loss. *Human reproduction*, 30(4), pp.777-782.

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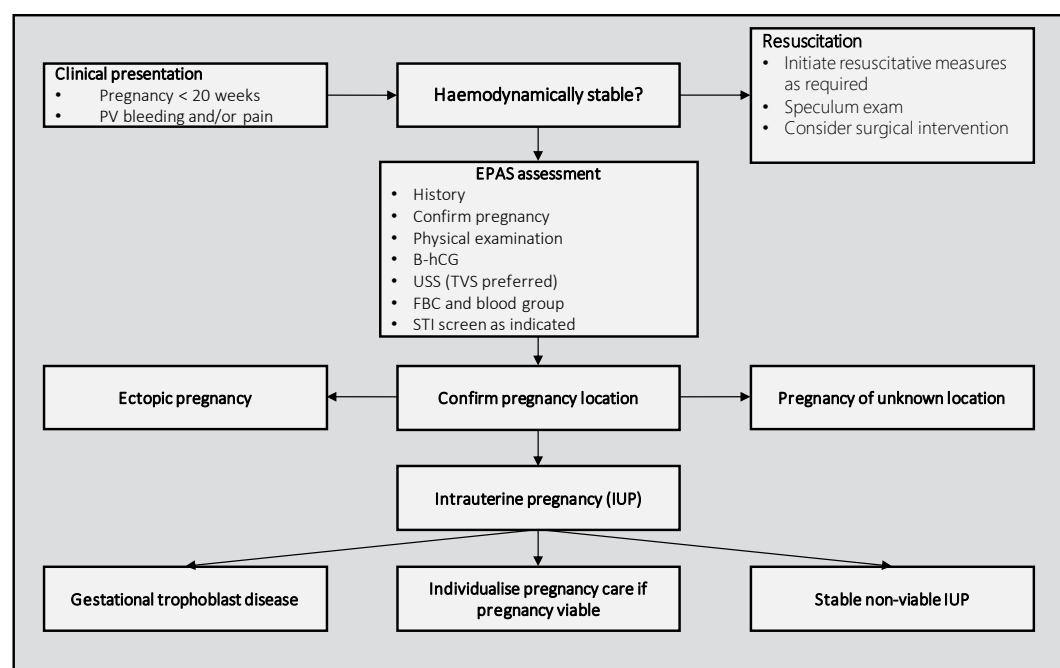
¹³ Ibid.

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¹⁶ Ibid.

Figure A.1: Overview of assessment of early pregnancy loss

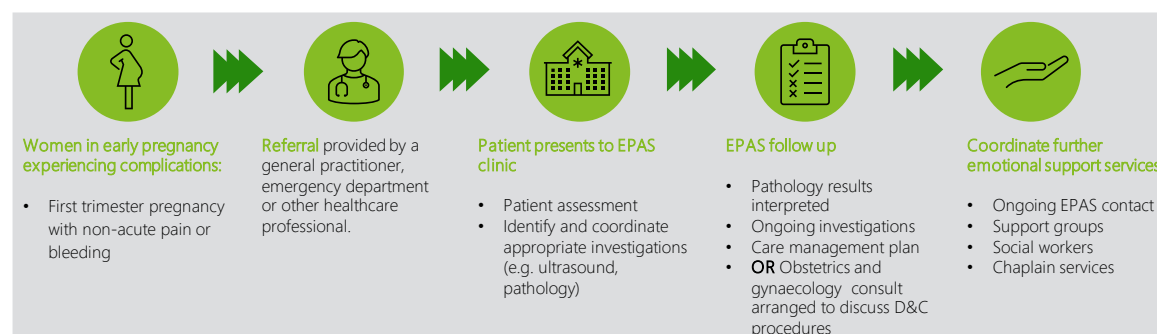


Source: Adapted from Queensland Clinical Guidelines: Early Pregnancy loss.¹⁷

A.2. EPAS clinics

EPAS clinics are outpatient clinics that provide care for people experiencing complications in early pregnancy. Figure A.2 below provides an overview of a typical EPAS clinic pathway.

Figure A.2: Overview of EPAS clinic pathway



Source: Adapted from Queensland Clinical Guidelines: Early Pregnancy loss.¹⁸

There are several benefits which EPAS clinics provide. These include:

1. **Faster diagnosis** – EPAS clinics can help identify the location of a pregnancy and confirm its viability – this includes identifying ectopic pregnancies which can be life-threatening. Early diagnosis also allows for greater decision making regarding non-surgical options for managing early pregnancy complications.

¹⁷ Queensland Clinical Guidelines. Early pregnancy loss. Guideline No. MN22.29-V7-R27 Queensland Health. 2022. Available from: <http://www.health.qld.gov.au/qc>

¹⁸ Queensland Clinical Guidelines. Early pregnancy loss. Guideline No. MN22.29-V7-R27 Queensland Health. 2022. Available from: <http://www.health.qld.gov.au/qc>

2. Improved patient care – EPAS clinics provide services including clinical assessment, ultrasounds, laboratory investigations, management planning, counselling and support.
3. Education – EPAS clinics provide information and education regarding medications, foods and procedures which should be avoided during pregnancy.
4. Social and emotional well-being – EPAS clinics provide additional support to reduce the mental health impacts associated with early pregnancy complications.

Appendix B Consultation guides

The tables below outline the discussion questions asked of each stakeholder group as part of consultation.

B.1. Government stakeholder

Table B.1: Government stakeholder consultation questions

Discussion questions	
1.	Could you please describe your background, role and how this interacts with the delivery of EPAS
2.	Tell us a bit more about how EPAS is delivered within your state/territory. You may wish to answer this with respect to: • The number of EPAS clinics and/or other providers of EPAS services in alternative health settings • Their location (metropolitan/regional distribution) • The general opening hours of EPAS clinics, and how patients access EPAS outside these hours. • The types of service provided by EPAS providers. • The typical patient referral pathways
3	Do you have any reflections on the following aspects of EPAS • The time taken for patients to access EPAS (e.g., time to travel to EPAS service, waiting time to access service) • The level of guidance, supports and professional development provided to health professionals who deliver EPAS. • How EPAS is currently tailored to meet the needs of priority population cohorts (people with disability, patients identifying as Aboriginal and/or Torres Strait Islander, culturally and linguistically diverse patients, patients who identify as LGBTQIA+, patients who are refugees). • The types of supports provided to patients after their initial visit to access EPAS. Where possible you may also wish to comment on any observed differences in the service delivery between EPAS clinics and other providers of EPAS.
4	What are your perspectives on overall patient satisfaction with EPAS in your state/territory? • What is currently working well? • Where are the gaps?
5	What do you think are the key factors which drive the effective delivery of EPAS?
6	What do you think are the enablers and challenges of early pregnancy service delivery

7 Do you have any suggestions on how the delivery of EPAS in your state/territory could be improved?

- What would be needed to implement these improvements?
-

B.2. EPAS provider

Table B.2: EPAS provider consultation questions

Discussion questions	
1.	Could you please describe your background, role and how this interacts with the delivery of EPAS
2.	Tell us a bit more about how EPAS is delivered at your clinic/health setting, including the operation hours and governance/staffing arrangements.
3.	Are you able to provide more detail on the scope of services at your clinic/health setting in relation to EPAS? This includes: - the demographic backgrounds of patients who access EPAS, - how many patients required translation and interpreting services, - how patients are typically referred to your service, - the types of services you generally provide, - the clinical and non-clinical inclusion criteria to accessing EPAS, - the patient referral pathways from EPAS if other services are required, and - the types of health services you typically collaborate with.
4.	Do you have any reflections on the following aspects of EPAS: - The time taken for patients to access EPAS (e.g., time to travel to EPAS service, waiting time to access service) - The level of guidance, supports and professional development provided to health professionals who deliver EPAS - How EPAS is currently tailored to meet the needs of priority population cohorts (people with disability, patients identifying as Aboriginal and/or Torres Strait Islander, culturally and linguistically diverse patients, patients who identify as LGBTQIA+, patients who are refugees) - The types of supports provided to patients after their initial visit to access EPAS
5.	What are your perspectives on overall patient satisfaction with EPAS in your clinic/health setting - What is currently working well? - Where are the gaps?
6.	What do you think are the key factors which drive the effective delivery of EPAS?
7.	Do you have any suggestions on how the delivery of EPAS in your clinic/health setting could be improved? What would be needed to implement these improvements?
8.	What do you think are the enablers and challenges of early pregnancy service delivery?
9.	Are you aware if your service is currently registered on the National Health Services Directory and Provider Connect Australia?

[If not registered], would you like more information on how to register your service on these directories? The NHSD supports health professionals and patients by providing easy access to a central source of service information. If you would like I can share a link that contains more information on how to register: <https://about.healthdirect.gov.au/nhsd/about/register-with-the-nhsd>.

B.3. NGOs

Table B.3: NGO consultation questions

Discussion questions

1. Could you please describe your background, role and how this interacts with the delivery of EPAS?
2. What are your perspectives on how EPAS is currently delivered in Australia? You may wish to consider the following aspects: Characteristics of EPAS clinics – including their location, the types of services provided, and number of patients seen by EPAS clinics

The number of EPAS clinics and/or other providers of EPAS in alternative health settings
 - Their location (metropolitan/regional distribution)
 - The governance and staffing arrangements of EPAS providers
 - The general operating hours of EPAS clinics, and how patients access EPAS outside these hours
3. Are you able to provide more detail on how patients access EPAS?
 - How are patients generally made aware of EPAS?
 - What are the most common types of services provided to EPAS patients?
 - What are the general referral pathways from EPAS providers if other services are required?
4. In relation to patient experience, do you have any reflections on the following aspects of EPAS:
 - The time taken for patients to access EPAS (e.g., time to travel to EPAS service, waiting time to access service)
 - The quality of supports provided to patients during and after accessing EPAS?
 - The types of supports provided to patients after their initial visit to access EPAS?

Where possible you may also wish to comment on any observed differences in the service delivery between EPAS clinics and other providers of EPAS.
5. To what extent do EPAS providers tailor their services to meet the needs of patients from priority population cohorts (people with disability, patients identifying as Aboriginal and/or Torres Strait Islander, culturally and linguistically diverse patients, patients who identify as LGBTQIA+, patients who are refugees)
 - Are there any notable barriers which may limit accessibility for these cohorts?
6. What are your perspectives on overall patient satisfaction with EPAS in Australia?
 - What is currently working well?
 - Where are the gaps?
7. What do you think are the key factors which drive the effective delivery of EPAS?
8. Do you have any suggestions on how the delivery of EPAS could be improved?

-
- What would be needed to implement these improvements?

9 What do you think are the enablers and challengers of early pregnancy service delivery?

B.4. Professional Bodies

Table B.4: Professional bodies consultation questions

Discussion questions	
1.	Could you please describe your background, role and how this interacts with the delivery of EPAS?
2.	What are your perspectives on how EPAS is currently delivered in Australia? You may wish to consider the following aspects: Characteristics of EPAS clinics – including their location, the types of services provided, and number of patients seen by EPAS clinics • The number of EPAS clinics and/or other providers of EPAS services in alternative health settings • The number of EPAS clinics and/or other providers of EPAS services in alternative health settings • Their location (metropolitan/regional distribution) • The governance and staffing arrangements of EPAS providers • The general operating hours of EPAS clinics, and how patients access EPAS outside these hours • The types of services provided by EPAS providers
3	In relation to patient experience, do you have any reflections on the following aspects of EPAS: • The time taken for patients to access EPAS (e.g., time to travel to EPAS service, waiting time to access service) • The level of guidance, supports and professional development provided to health professionals who deliver EPAS • How EPAS is currently tailored to meet the needs of priority population cohorts (people with disability, patients identifying as Aboriginal and/or Torres Strait Islander, culturally and linguistically diverse patients, patients who identify as LGBTQIA+, patients who are refugees) • The types of supports provided to patients after their initial visit to access EPAS Where possible you may also wish to comment on any observed differences in the service delivery between EPAS clinics and other providers of EPAS.
4	What are your perspectives on overall patient satisfaction with EPAS in Australia? • What is currently working well?
5	What do you think are the key factors which drive the effective delivery of EPAS?
6	Do you have any suggestions on how the delivery of EPAS could be improved? • What would be needed to implement these improvements?
7	What do you think are the enablers and challengers of early pregnancy service delivery?

Appendix C

Consulted organisations

The tables below provide a list of NGOs, professional bodies, government stakeholders and EPAS providers who were engaged as part of this report.

C.1. NGOs

Table C.1: List of non-government organisations consulted

No.	Organisation
1.	Centre of Perinatal Excellence (COPE)
2.	Early Pregnancy Loss Coalition (EPLC)
3.	Early Pregnancy Network Victoria (EPNV)
4.	LGBTQIA+ Health
5.	Maternity Consumer Network
6.	Miscarriage Australia
7.	Miscarriage Information Support Service (MISS)
8.	Multicultural Centre for Women's Health
9.	Perinatal Anxiety & Depression Australia (PANDA)
10.	Pink Elephant Support Network
11.	Rainbow Families
12.	Red Nose Australia
13.	Rainbow Families
14.	Red Nose Australia
15.	Safe Motherhood for All
16.	Social Policy Group
17.	The Still Nest

C.2. Professional Bodies

Table C.2: List of professional bodies consulted

No.	Organisation
1.	Australian College of Midwives (ACM)
2.	Australian Nursing and Midwifery Federation (ANMF)
3.	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
4.	National Aboriginal Community Controlled Health Organisation (NACCHO)

C.3. Government stakeholders

Table C.3: List of government stakeholders consulted

No.	Jurisdiction	Department/ Agency
1.	Commonwealth	Australian Government Department of Health, Disability and Aging, Chief Psychiatrist
2.	Commonwealth	Australian Government Department of Health, Disability and Aging, Rural Health Commissioner
3.	Commonwealth	Australian Government Department of Health, Disability and Aging, Australian Commission on Safety and Quality in Health Care
4.	Queensland	Queensland Department of Health
5.	Tasmania	Tasmanian Department of Health
6.	Victoria	Victorian Department of Health

C.4. Health providers

Table C.4: List of EPAS providers consulted

No.	Jurisdiction	Health Service
1.	Victoria	Royal Women's Hospital
2.	Victoria	Northern Health Service
3.	Victoria	Mercy Hospital for Women
4.	Victoria	Geelong Hospital
5.	Victoria	Koori Maternity Ramahyuck District Aboriginal Community Controlled Organisation
6.	Northern Territory	Gove District Hospital
7.	Western Australia	Womens and Newborns Health Service (WNHS) North Metropolitan Health Service
8.	New South Wales	Nepean Hospital
9.	New South Wales	Royal Prince Alfred Hospital
10.	New South Wales	Wollongong Hospital
11.	New South Wales	Bankstown Hospital
12.	New South Wales	Liverpool Hospital
13.	New South Wales	Dubbo Hospital
14.	Western Australia	Fiona Stanley Hospital
15.	Western Australia	Bentley Hospital
16.	Western Australia	Armadale Hospital
17.	South Australia	Northern Adelaide Local Health Network
18.	South Australia	Southern Adelaide Local Health Network
19.	South Australia	Women and Children's Health Network
20.	South Australia	Lyell McEwin Health Service
21.	South Australia	Barossa Hills Fleurieu Local Health Network

Appendix D EPAS Clinics in Australia

This appendix provides the list of 84 EPAS Clinics in Australia.

D.1. EPAS Clinics

Table D.1: EPAS Clinics in Australia

No.	Clinic name	State	Health district	Identified via
1	Centenary Hospital for Women and Children	ACT	ACT Health	Desktop review
2	Coastal Women's Health Gosford	NSW	Central Coast Local Health District	Desktop review
3	Gosford Hospital	NSW	Central Coast Local Health District	Desktop review
4	Broken Hill Health Service	NSW	Far West Local Health District	Survey
5	Maitland Hospital	NSW	Hunter New England Local Health District	Survey
6	Manning Base Hospital	NSW	Hunter New England Local Health District	Desktop review
7	Wollongong Hospital	NSW	Illawarra Shoalhaven Local Health District	Desktop review
8	Coffs Harbour Health Campus	NSW	Mid North Coast Local Health District	Desktop review
9	Port Macquarie Health Campus	NSW	Mid North Coast Local Health District	Desktop review
10	Nepean Hospital	NSW	Nepean Blue Mountains Local Health District	Desktop review
11	Lismore Base Hospital	NSW	Northern NSW Local Health District	Desktop review
12	Tweed Valley Hospital (replacing Tweed District Hospital)	NSW	Northern NSW Local Health District	Desktop review

13	Royal North Shore Hospital	NSW	Northern Sydney Local Health District	Desktop review
14	Marren Campbell & Mackie	NSW	Not classified as a hospital	Desktop review
15	Royal Hospital for Women	NSW	South Eastern Sydney Local Health District	Desktop review
16	St George Hospital	NSW	South Eastern Sydney Local Health District	Desktop review
17	Bankstown Hospital	NSW	South Western Sydney Local Health District	Desktop review
18	Campbelltown Hospital	NSW	South Western Sydney Local Health District	Desktop review
19	Liverpool Hospital	NSW	South Western Sydney Local Health District	Desktop review
20	Queanbeyan District Hospital	NSW	Southern NSW Local Health District	Survey
21	Royal Prince Alfred Hospital	NSW	Sydney Local Health District	Desktop review
22	Bathurst Hospital	NSW	Western NSW Local Health District	Survey
23	Dubbo Health Service	NSW	Western NSW Local Health District	Desktop review
24	Blacktown Hospital	NSW	Western Sydney Local Health District	Consultation
25	Westmead Hospital	NSW	Western Sydney Local Health District	Desktop review
26	John Hunter Hospital	NSW	Hunter New England Local Health District	Desktop review
27	Northern Beaches Hospital	NSW	Northern Sydney Local Health District	Survey
28	Alice Springs Hospital	NT	Central Australia Health Service	Desktop review
29	Gove District Hospital	NT	Top End Health Service	Desktop review

30	Katherine District Hospital	NT	Top End Health Service	Desktop review
31	Palmerston Hospital	NT	Top End Health Service	Desktop review
32	Royal Darwin Hospital	NT	Top End Health Service	Desktop review
33	Cairns Hospital	QLD	Cairns and Hinterland Hospital and Health Service	Desktop review
34	Rockhampton Hospital	QLD	Central Queensland Hospital and Health service	Desktop review
35	Toowoomba Hospital	QLD	Darling Downs Health	Desktop review
36	Gold Coast University Hospital Emergency Department	QLD	Gold Coast Health	Desktop review
37	Haven Ultrasound - Gold Coast	QLD	Gold Coast Health	Desktop review
38	Caboolture Hospital	QLD	Metro North Health	Desktop review
39	Haven Ultrasound - Wesley	QLD	Metro North Health	Desktop review
40	Redcliff Hospital	QLD	Metro North Health	Desktop review
41	Royal Brisbane and Women's Hospital	QLD	Metro North Health	Desktop review
42	Beauresert Hospital	QLD	Metro South Health	Desktop review
43	Haven Ultrasound - Green Slopes	QLD	Metro South Health	Desktop review
44	Logan Hospital	QLD	Metro South Health	Desktop review
45	Mater Mother's Private Brisbane	QLD	Metro South Health	Desktop review

46	Redland Hospital	QLD	Metro South Health	Desktop review
47	Sunshine Coast University Hospital	QLD	Sunshine Coast Hospital and Health Service	Desktop review
48	Townsville University Hospital	QLD	Townsville Health Service	Desktop review
49	Ipswich Hospital	QLD	West Moreton Health	Desktop review
50	Bundaberg Hospital	QLD	Wide Bay Hospital and Health Service	Desktop review
51	Hervey Bay Hospital	QLD	Wide Bay Hospital and Health Service	Desktop review
52	Mount Barker Hospital	SA	Barossa Hills Fleurieu Local Health Network	Consultation
53	Lyell McEwin Hospital	SA	Northern Adelaide Local Health Network	Desktop review
54	Flinders Medical Centre	SA	Southern Adelaide Local Health Network	Desktop review
55	Women's and Children's Hospital	SA	Women's and Children's Health Network	Desktop review
56	Mersey Community Hospital	TAS	North West Tasmania	Desktop review
57	North West Regional Hospital	TAS	North West Tasmania	Desktop review
58	Launceston General Hospital	TAS	Northern Tasmania	Desktop review
59	Royal Hobart Hospital	TAS	Southern Tasmania	Desktop review
60	University Hospital Geelong	VIC	Barwon Health	Desktop review
61	Bendigo Hospital	VIC	Bendigo Health	Desktop review

62	Box Hill Hospital	VIC	Eastern Health	Desktop review
63	Rosewood Women's Health Clinic	VIC	Goulburn Valley Health	Survey
64	The Royal Women's Hospital	VIC	Melbourne Health	Desktop review
65	Werribee Mercy Hospital for Women	VIC	Mercy Health	Desktop review
66	Casey Hospital	VIC	Monash Health	Desktop review
67	Clayton Hospital, Monash Medical Centre	VIC	Monash Health	Desktop review
68	Hospital Epping	VIC	Northern Health	Desktop review
69	Alfred Road Medical Centre	VIC	Not classified as a hospital	Desktop review
70	Frankston Hospital	VIC	Peninsula Health	Desktop review
71	Warrnambool Base Hospital	VIC	South West Healthcare	Desktop review
72	Sunshine Hospital	VIC	Western Health	Desktop review
73	Armadale Hospital	WA	East Metropolitan Health Service	Desktop review
74	Bentley Hospital	WA	East Metropolitan Health Service	Consultation
75	Midland Hospital	WA	East Metropolitan Health Service	Desktop review
76	Fiona Stanley Hospital	WA	North Metropolitan Health Service	Desktop review
77	Joondalup Health Campus	WA	North Metropolitan Health Service	Desktop review
78	King Edward Memorial Hospital	WA	North Metropolitan Health Service	Desktop review

79	Simply Women	WA	North Metropolitan Health Service	Desktop review
80	Perth Pregnancy Clinic	WA	Not classified as a hospital	Survey
81	Rockingham General Hospital	WA	South Metropolitan Health Service	Desktop review
82	Broome Health Campus	WA	WA Country Health Service	Consultation
83	Bunbury Hospital	WA	WA Country Health Service	Survey
84	Hedland Health	WA	WA Country Health Service	Survey

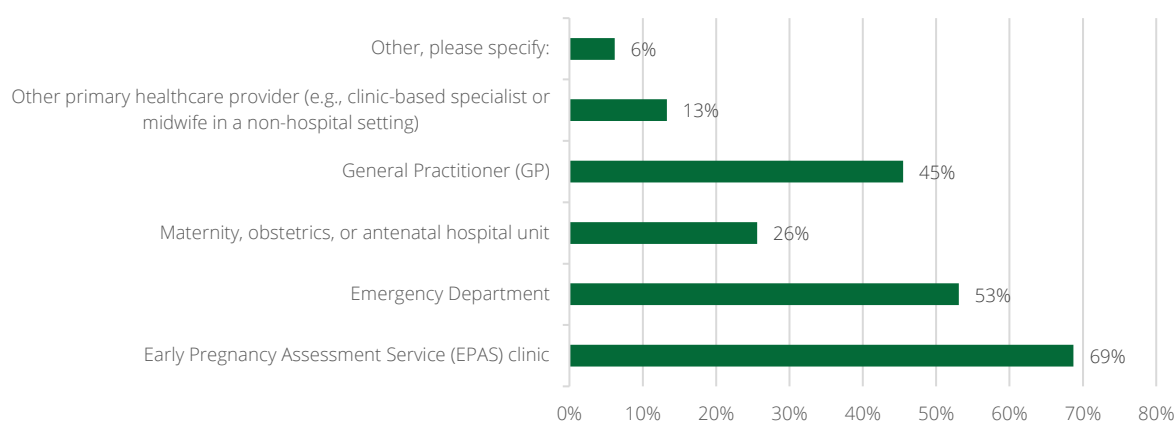
Appendix E Survey analysis.

This appendix provides further information on responses received from the patient and provider surveys. The patient survey received a total of 211 responses, and the provider survey a total of 166 responses.

E.1. Patient survey

E.1.1. Patient Survey Section A – Type of Care

Chart E.1: Responses to patient survey question A3 – Where did you receive medical care for early pregnancy complications? (n=211)

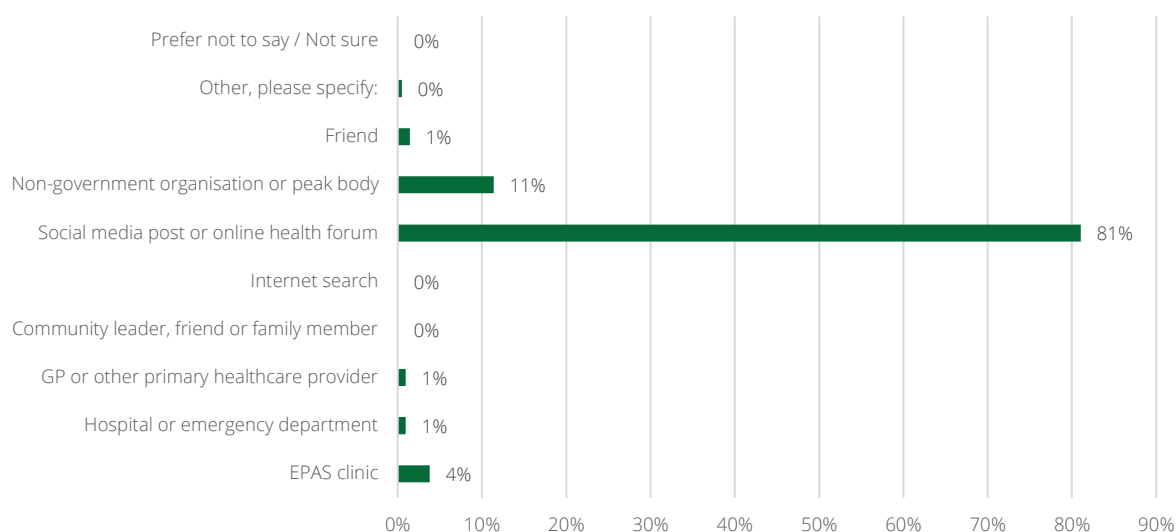


Note: Multiple responses permitted.

Source: Deloitte Access Economics survey analysis (2025).

E.1.2. Patient Survey Section B – Accessibility

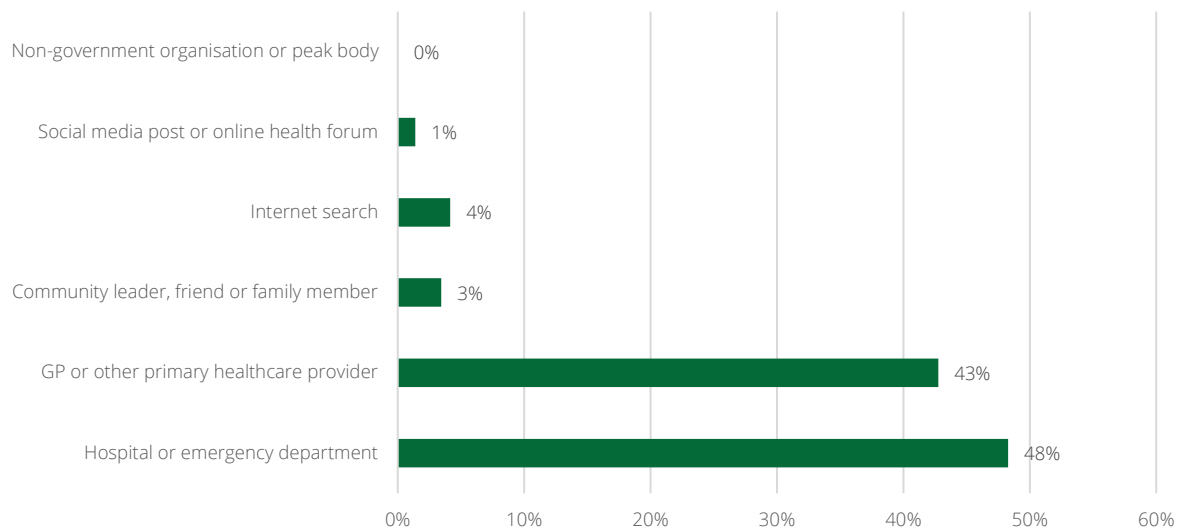
Chart E.2: Responses to patient survey question B1 – Where did you get the link to this survey from? (n=211)



Note: Single response permitted.

Source: Deloitte Access Economics survey analysis (2025).

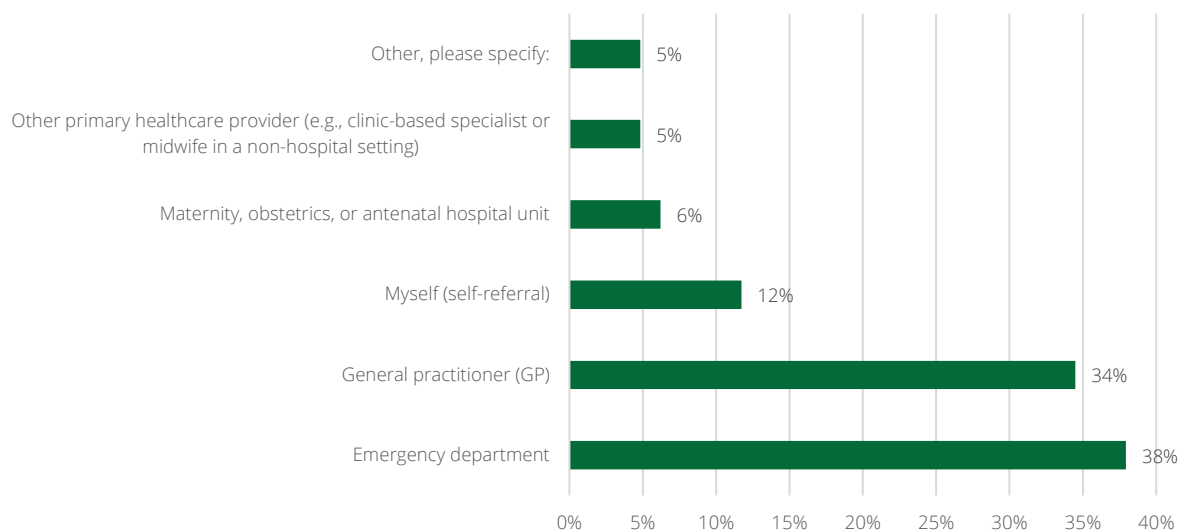
Chart E.3: Responses to patient survey question B2 – How did you first hear about EPAS providers? (n=145)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

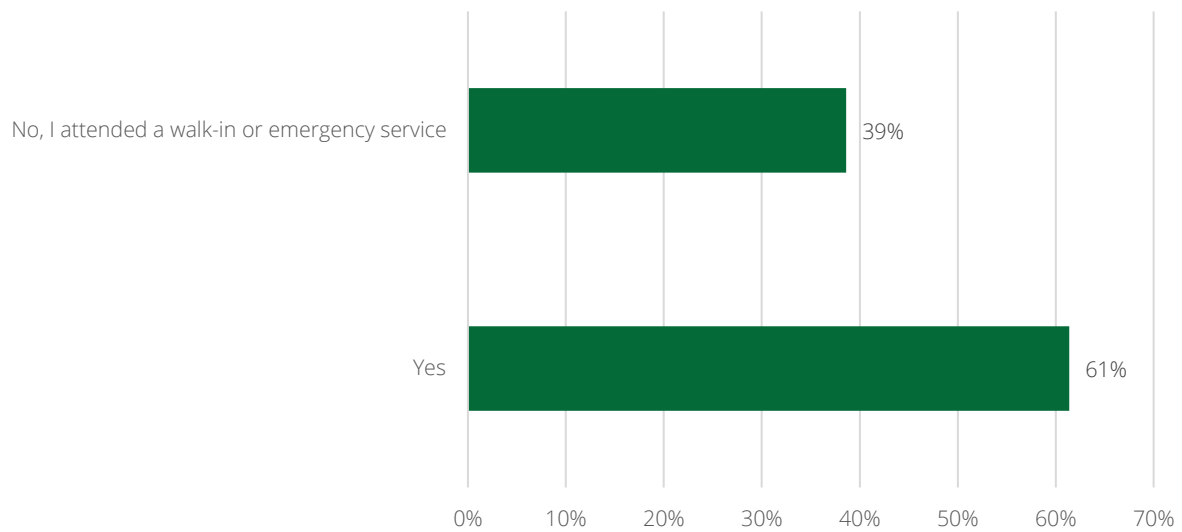
Chart E.4: Responses to patient survey question B3 – Who referred you to an EPAS provider? (n=145)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

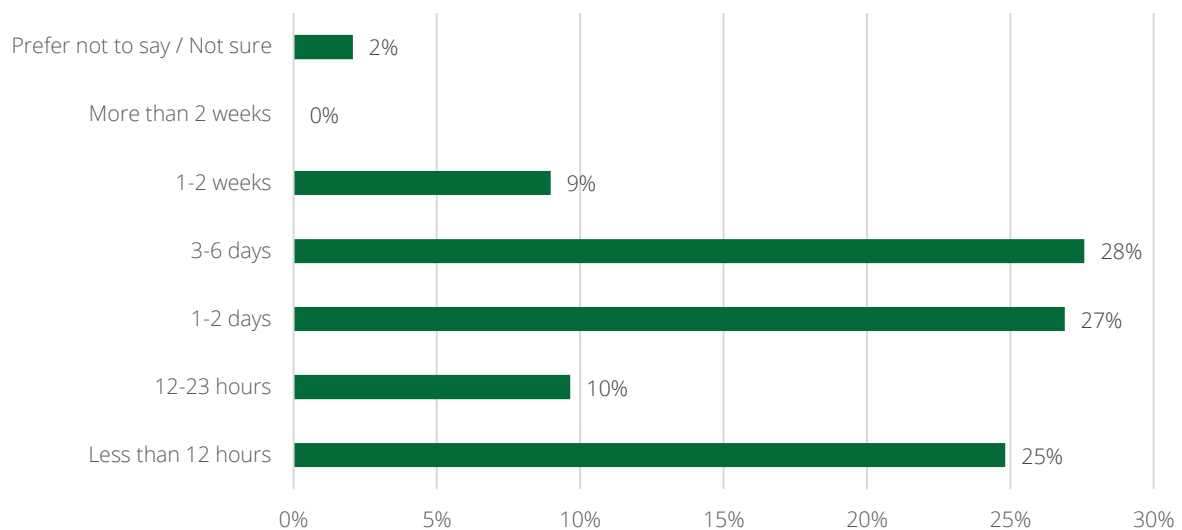
Chart E.5: Responses to patient survey question B4 – Did you book an appointment to attend an EPAS provider (n=145)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

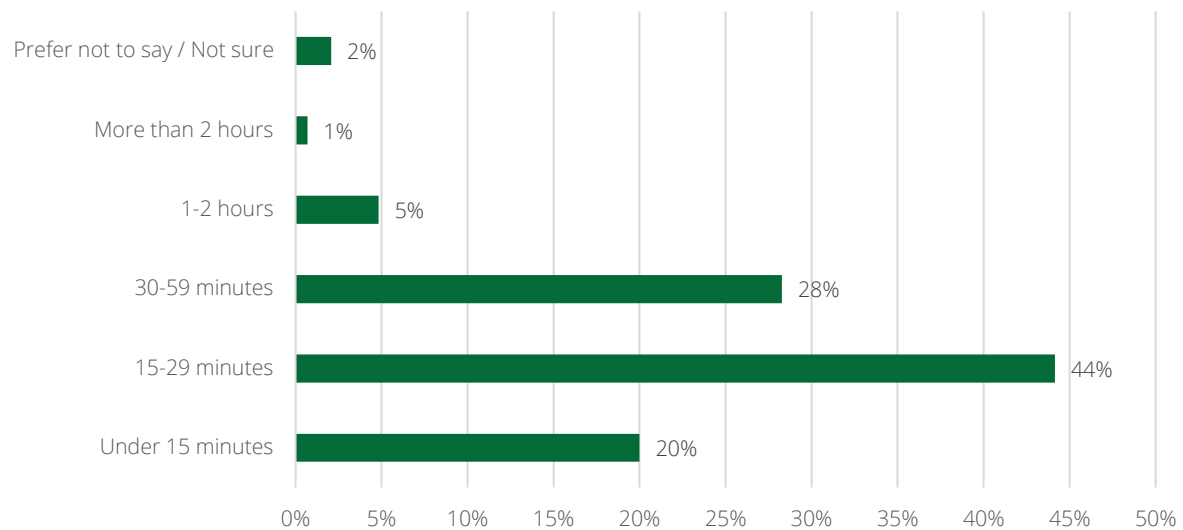
Chart E.6: Responses to patient survey question B5 – After receiving your referral, how long did you have to wait before you received care at an EPAS provider? (n=145)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

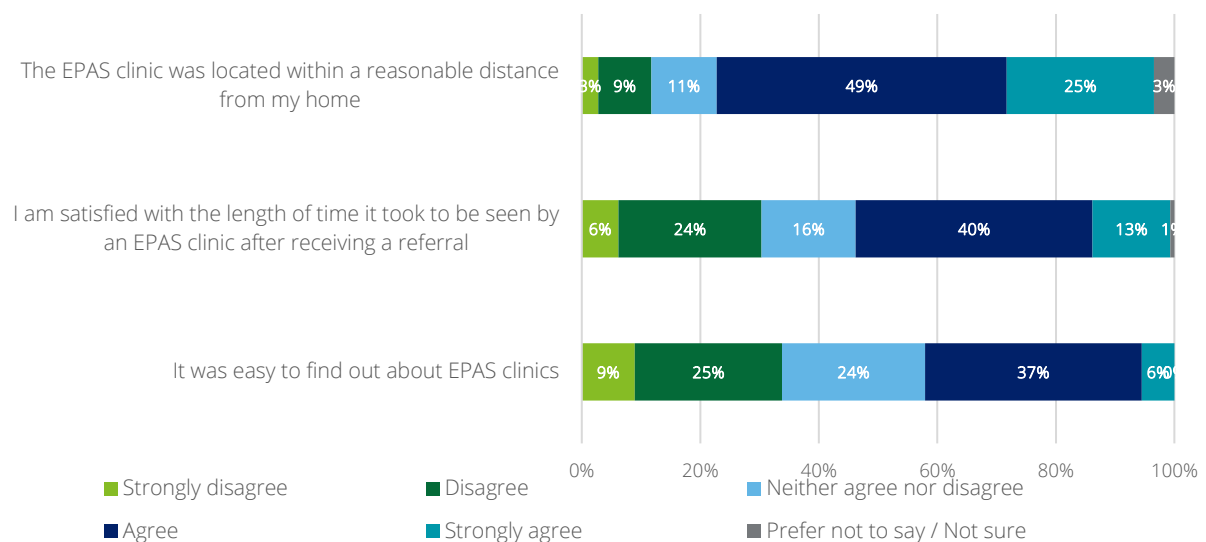
Chart E.7: Responses to patient survey question B6 – How long did it take you to travel from your home to access an EPAS clinic? (n=145)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

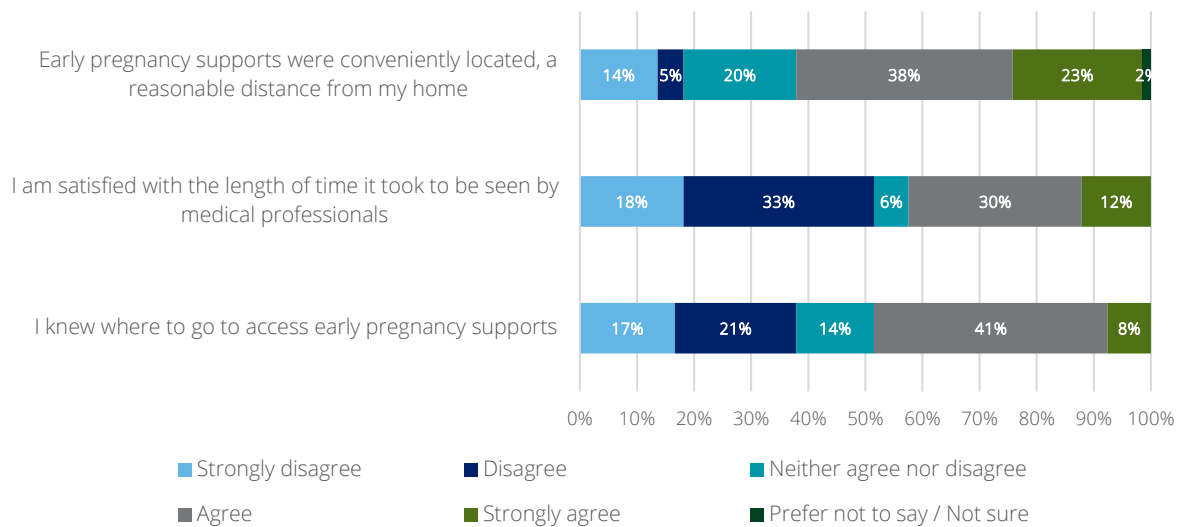
Chart E.8: Responses to patient survey question B7 – To what extent do you disagree or agree with the following statements: (n=145)



Note: Single response per statement permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

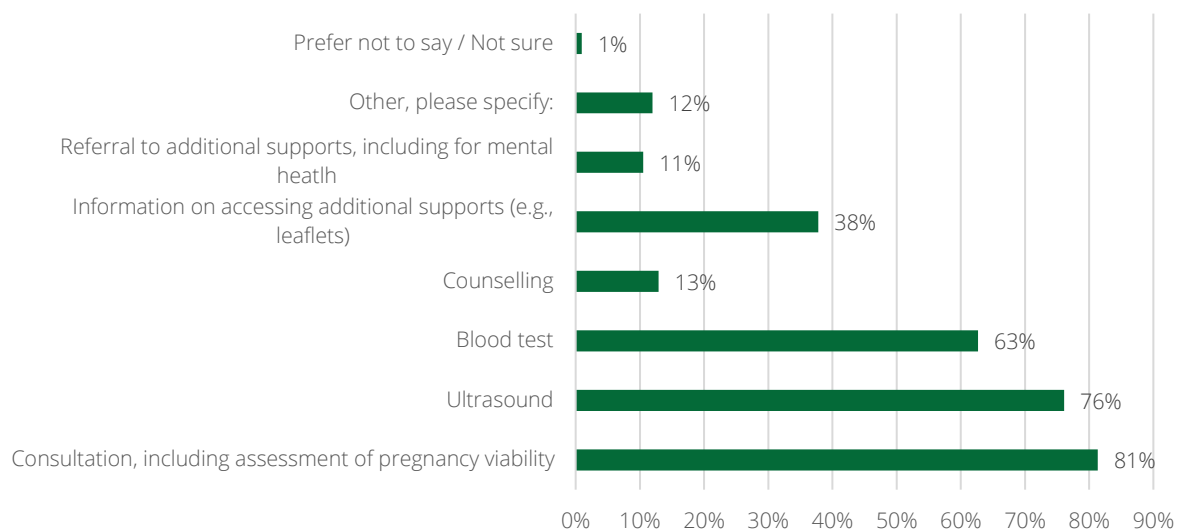
Chart E.9: Responses to patient survey question B8 – To what extent do you disagree or agree with the following statements: (n=66)



Note: Single response per statement permitted. Shown only to patients who accessed EPAS at an alternative health setting. Question A3 =/= Early Pregnancy Assessment Service (EPAS) Clinic.
Source: Deloitte Access Economics survey analysis (2025).

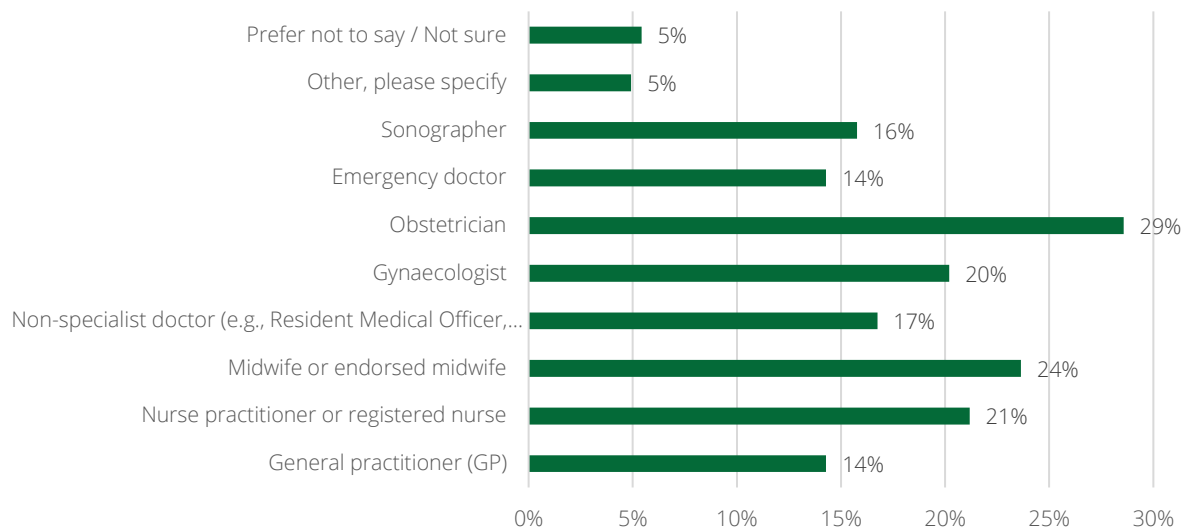
E.1.3. Patient Survey Section C – Service Use

Chart E.10: Responses to patient survey question C1 – Which of the following early pregnancy services did you receive? (n=209)



Note: Multiple responses permitted.
Source: Deloitte Access Economics survey analysis (2025).

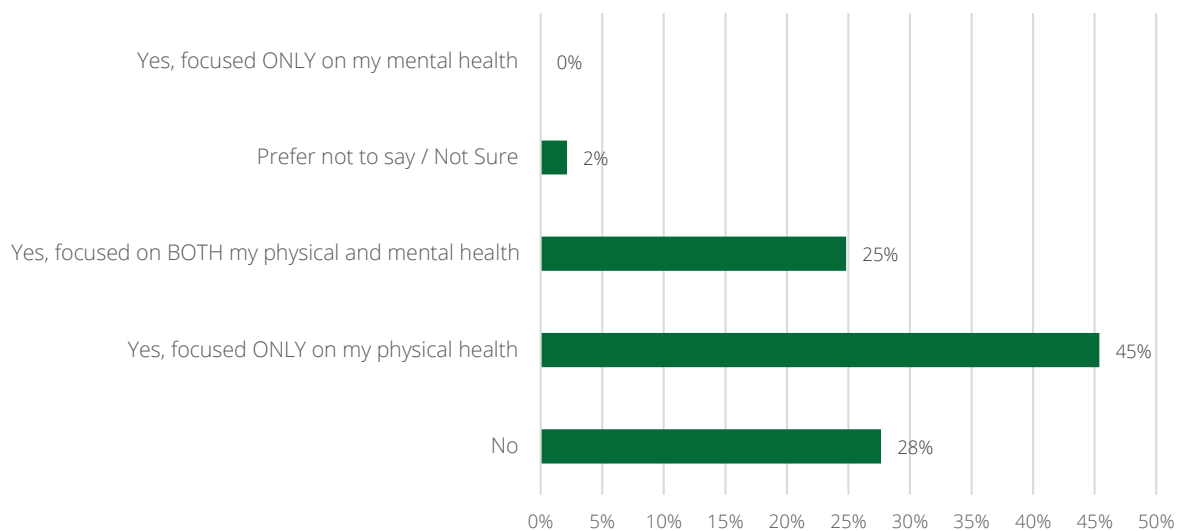
Chart E.11: Responses to patient survey question C2 – Please select the medical professional who delivered most of the care you received in the EPAS clinic/alternative setting. (n=203)



Note: Multiple responses permitted.

Source: Deloitte Access Economics survey analysis (2025).

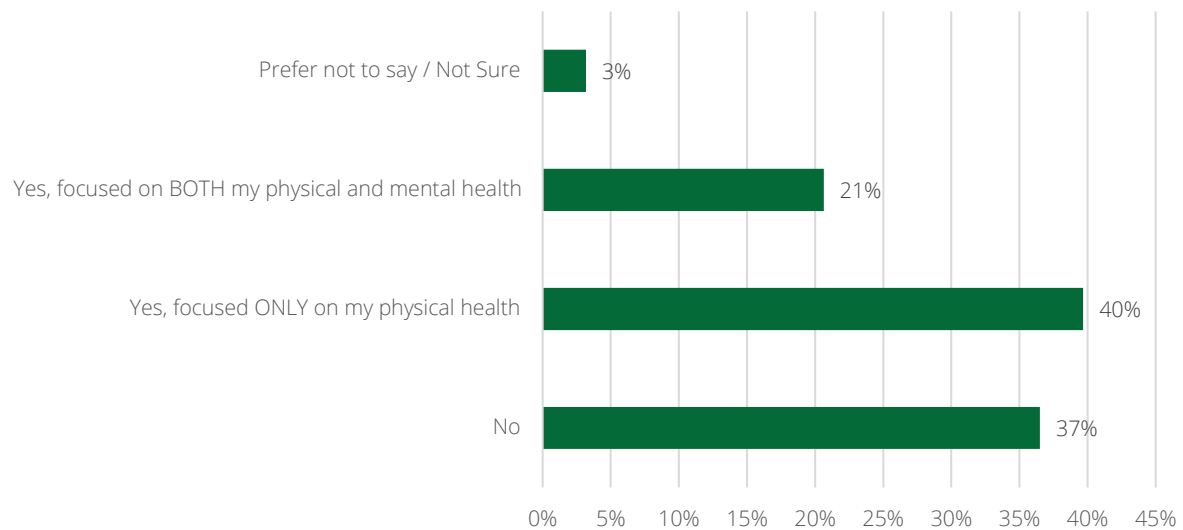
Chart E.12: Responses to patient survey question C3 – Did you receive a follow-up directly from the EPAS clinic you visited? (n=141)



Note: Single response permitted. Shown only to EPAS clinic patients i.e. Question A3 = Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

Chart E.13: Responses to patient survey question C4 – After receiving early pregnancy assessment services, did you receive a follow up? (n=63)

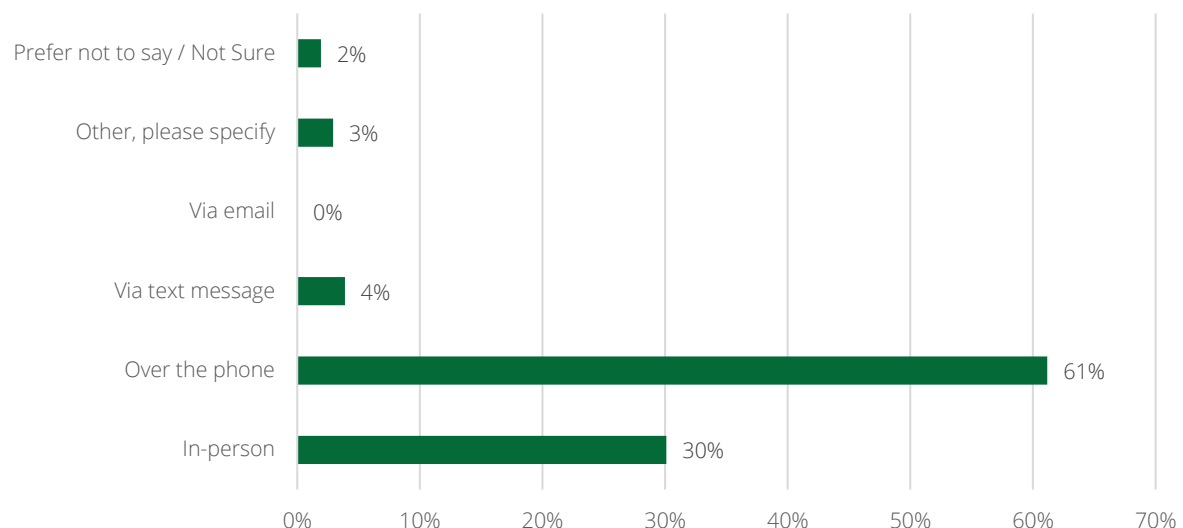


Note: Single response permitted. Shown only to patients who accessed EPAS at an alternative health setting i.e.

Question A3 $\neq$ Early Pregnancy Assessment Service (EPAS) Clinic.

Source: Deloitte Access Economics survey analysis (2025).

Chart E.14: Responses to patient survey question C5 – How did this follow-up occur? (n=103)

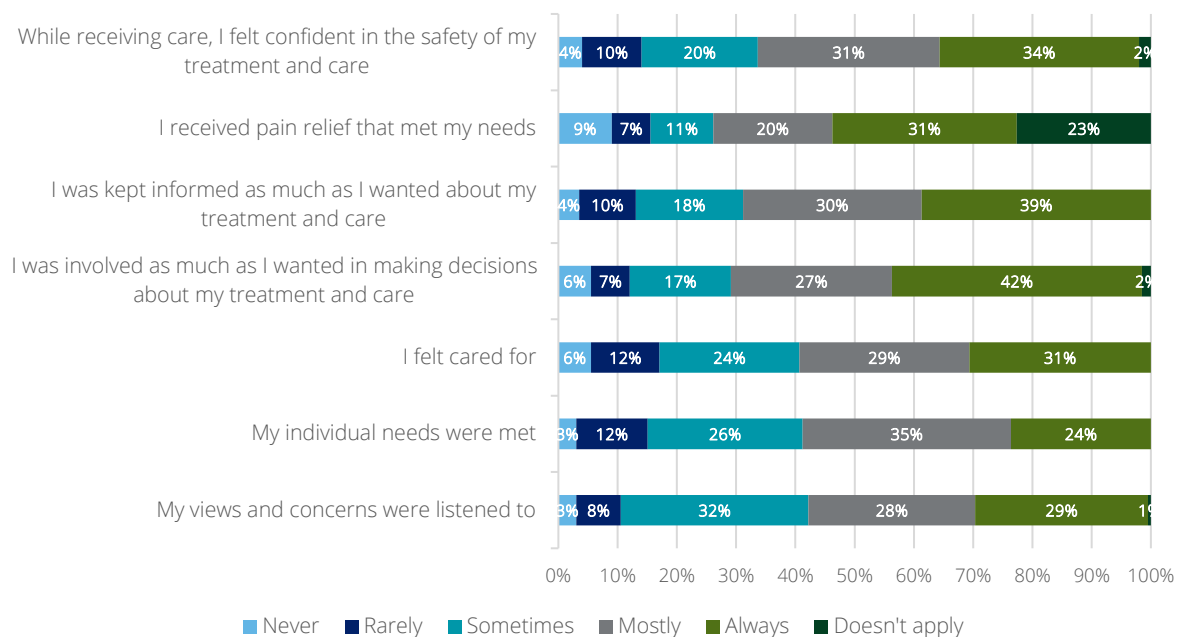


Note: Multiple responses permitted. Shown only to patients who answered "Yes, focussed ONLY on my physical health" or "Yes, focussed on BOTH my physical and mental health" in Questions C3 or C4.

Source: Deloitte Access Economics survey analysis (2025).

E.1.4. Patient Survey Section D – Experience

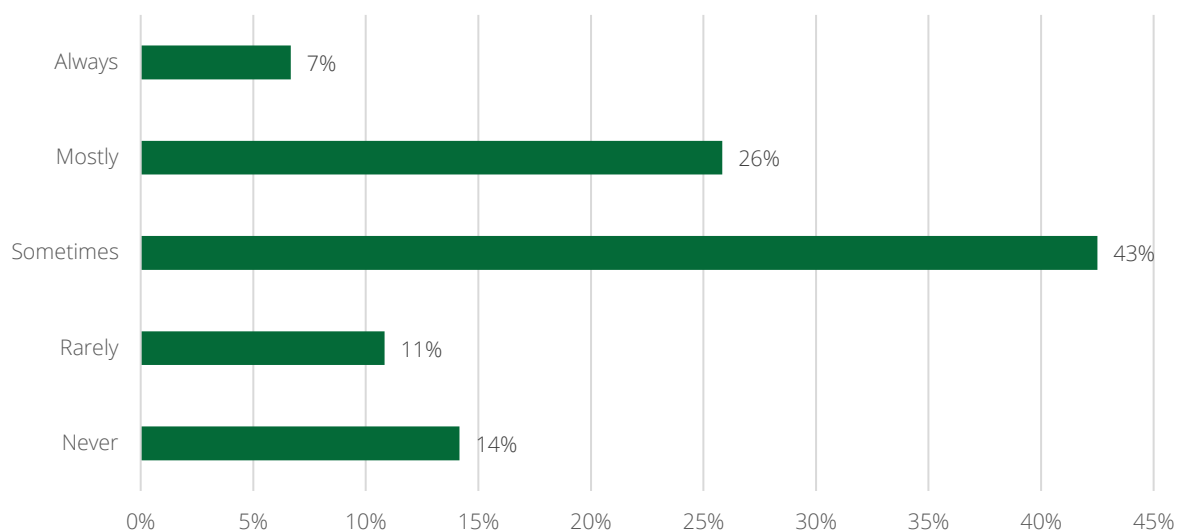
Chart E.15: Responses to patient survey question D1 – Based on your experience receiving early pregnancy assessment services, respond to the following statements: (n=199)



Note: Single response per statement permitted.

Source: Deloitte Access Economics survey analysis (2025).

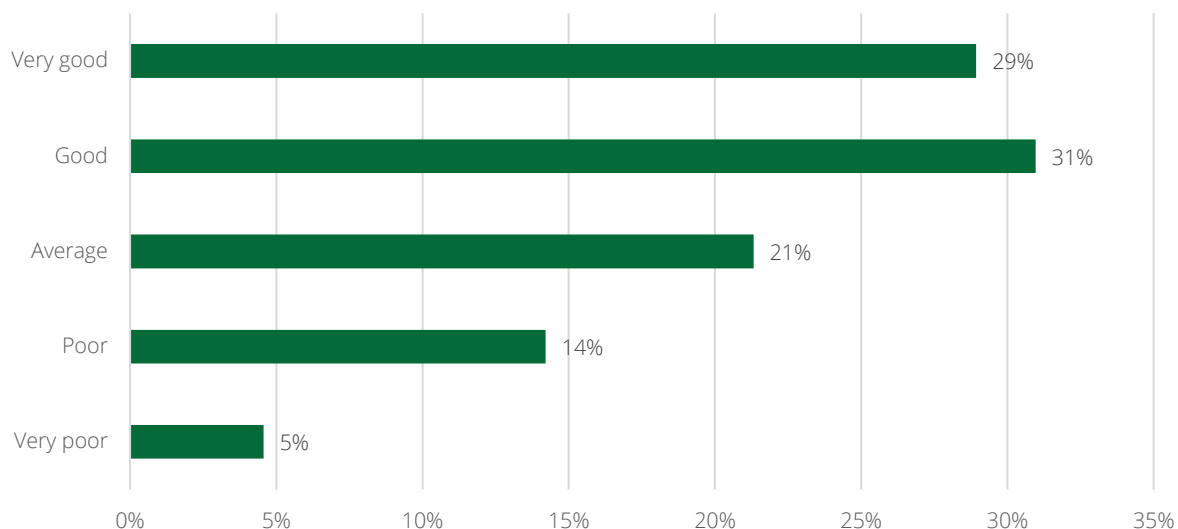
Chart E.16: Responses to patient survey question D2 – When an individual need could not be met, did staff explain why? (n=120)



Note: Single response permitted. Shown only to patients who answered "Never", "Rarely" or "Sometimes" to Question D1.

Source: Deloitte Access Economics survey analysis (2025).

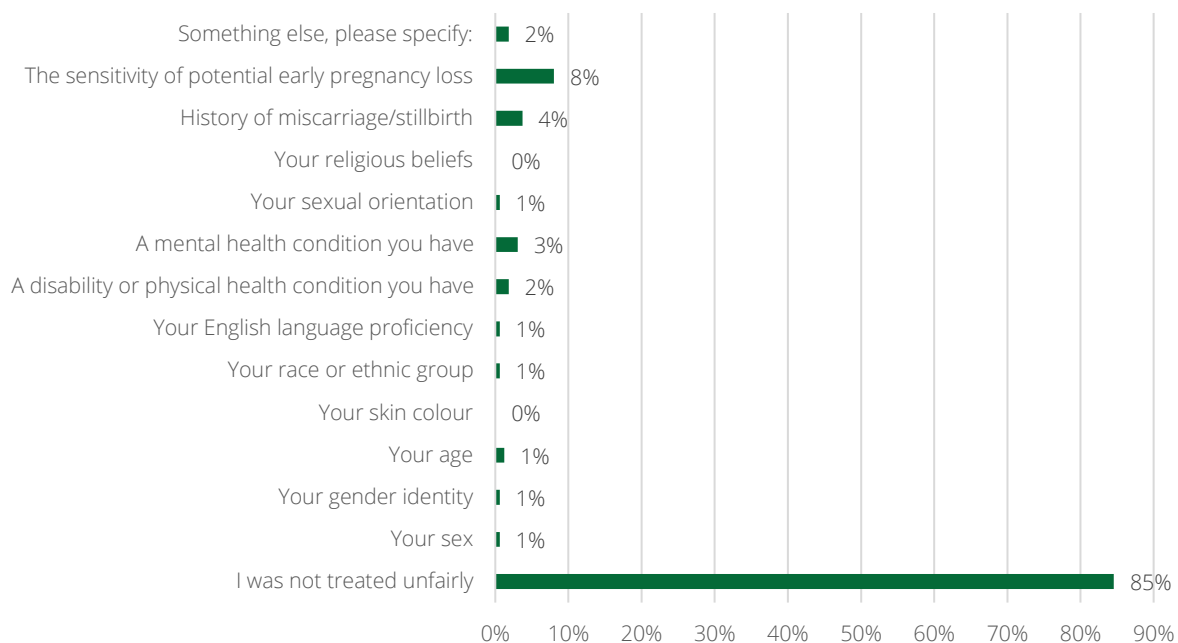
Chart E.17: Responses to patient survey question D3 – Overall, the quality of the treatment and care I received was: (n=197)



Note: Single response permitted.

Source: Deloitte Access Economics survey analysis (2025).

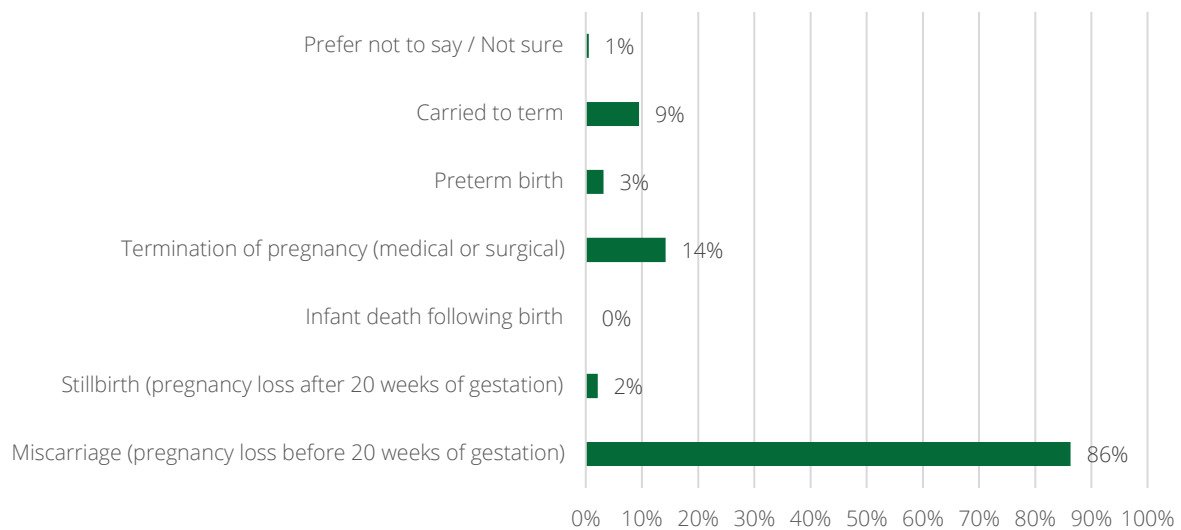
Chart E.18: Responses to patient survey question D4 – When you were receiving early pregnancy assessment services, did you feel you were treated unfairly for any of the reasons below? (n=162)



Note: Multiple responses permitted.

Source: Deloitte Access Economics survey analysis (2025).

Chart E.19: Responses to patient survey question D6 – What was the outcome of your pregnancy? (n=190)



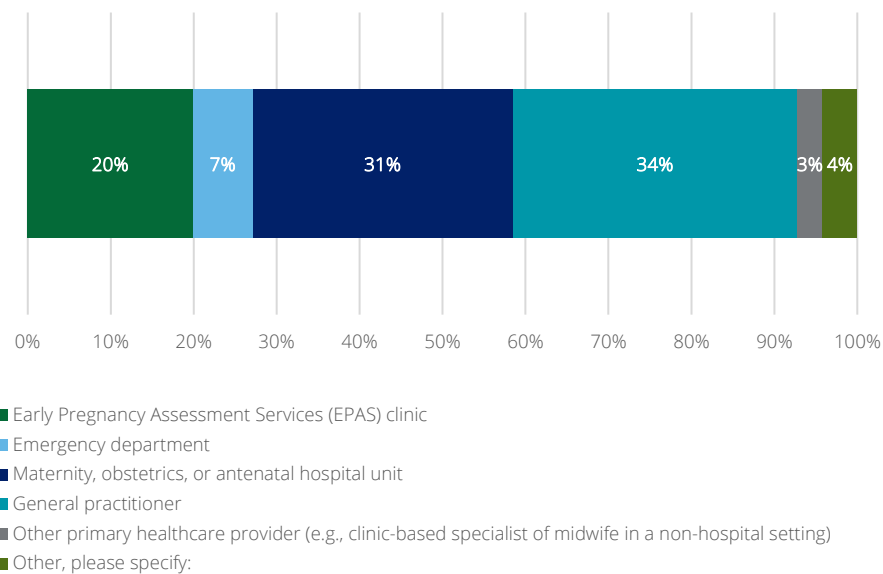
Note: Multiple responses permitted.

Source: Deloitte Access Economics survey analysis (2025).

E.2. Provider survey

E.2.1. Provider Survey Section A – Type of Facility

Chart E.20: Responses to Provider Survey Question A3 – What type of healthcare facility are you employed by? (n=299)

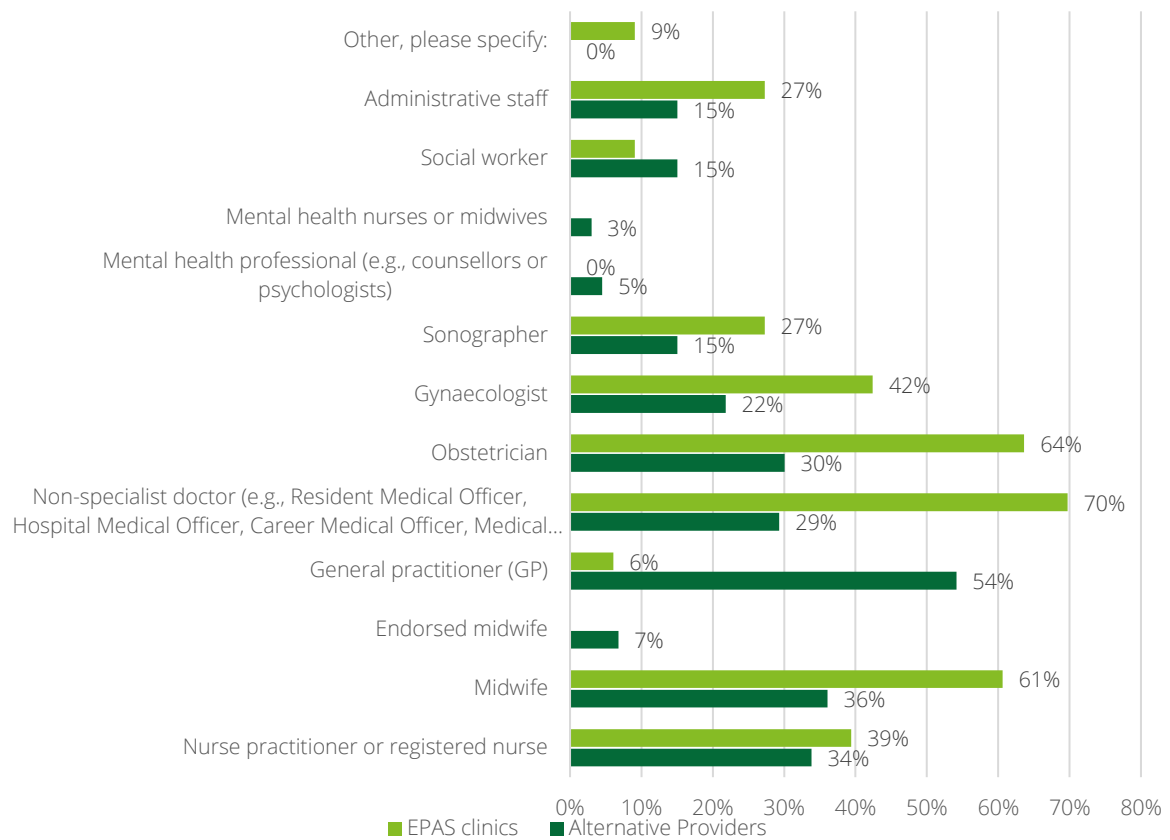


Note: Single response permitted.

Source: Deloitte Access Economics' survey analysis (2025).

E.2.2. Provider Survey Section B – About Your Workplace

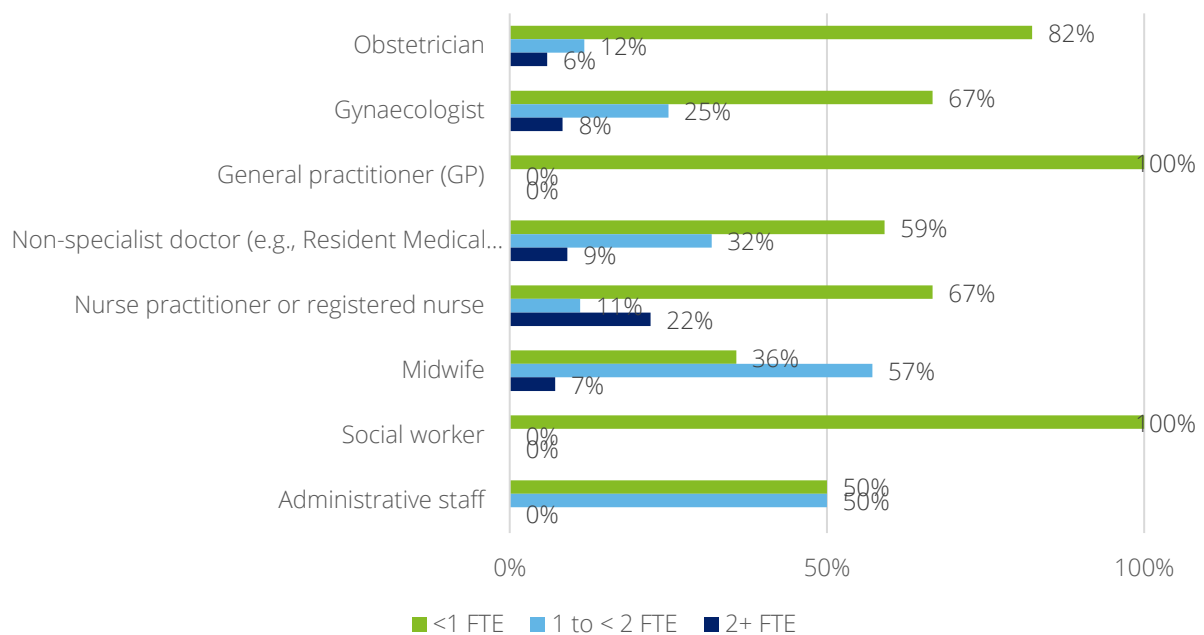
Chart E.21: Responses to Provider Survey Question B2 & B3– Which of the following medical/health practitioners deliver early pregnancy assessment services at your healthcare service/EPAS Clinic? (n=198)



Note: Multi-response permitted. Sample size: EPAS Clinic n=61, EPAS in alternative health setting n=139.

Source: Deloitte Access Economics' survey analysis (2025).

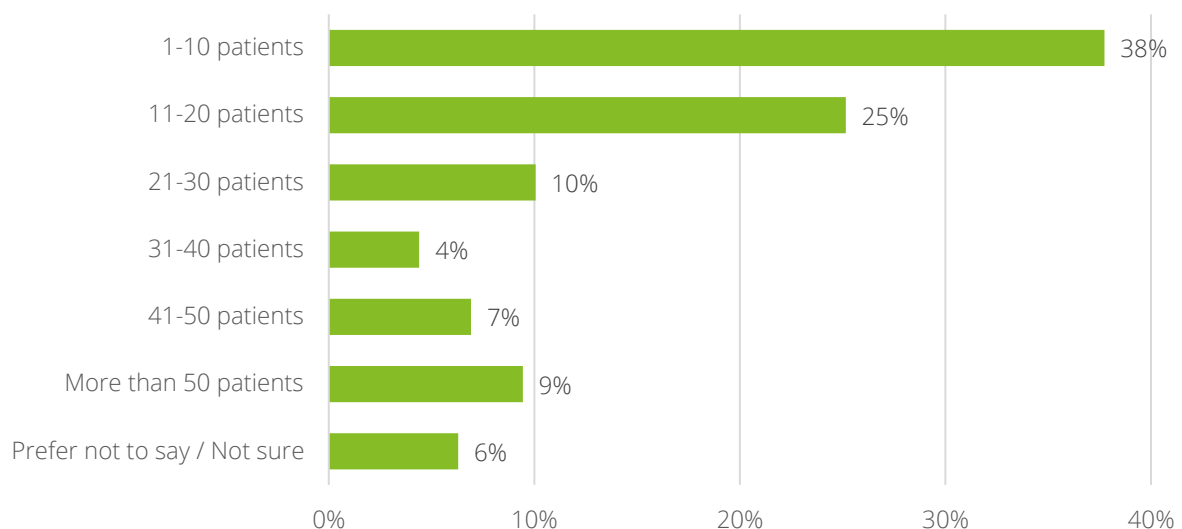
Chart E.22: Responses to Provider Survey Question B4 – For each type of medical professional, how many full-time-equivalent (FTE) employees work at your EPAS clinic? (n=159)



Note: Multi-response permitted. Sample size: Obstetrician n=17, Gynaecologist n=12, General Practitioner n=20, Non-specialist doctor n=22, Nurse practitioner or registered nurse n=9, midwife n=14, Social worker n=0, Administrative staff n=9.

Source: Deloitte Access Economics' survey analysis (2025).

Chart E.23: Responses to Provider Survey Question B5 – How many patients, on average, receive early pregnancy assessment services at your healthcare setting or EPAS clinic in a week? (n=159)

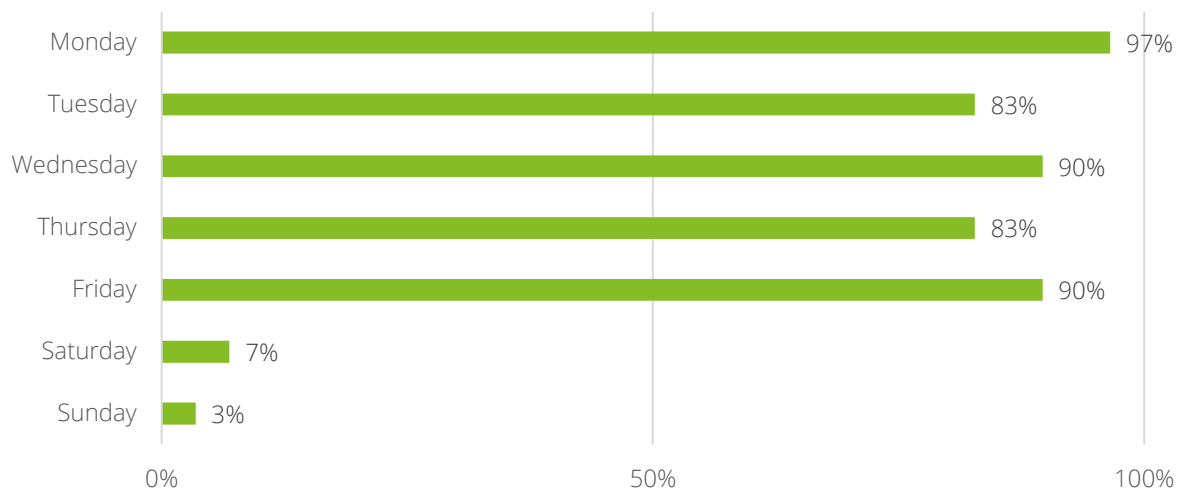


Note: Single response permitted.

Source: Deloitte Access Economics' survey analysis (2025).

E.2.2.2. Provider Survey Section C – Accessibility

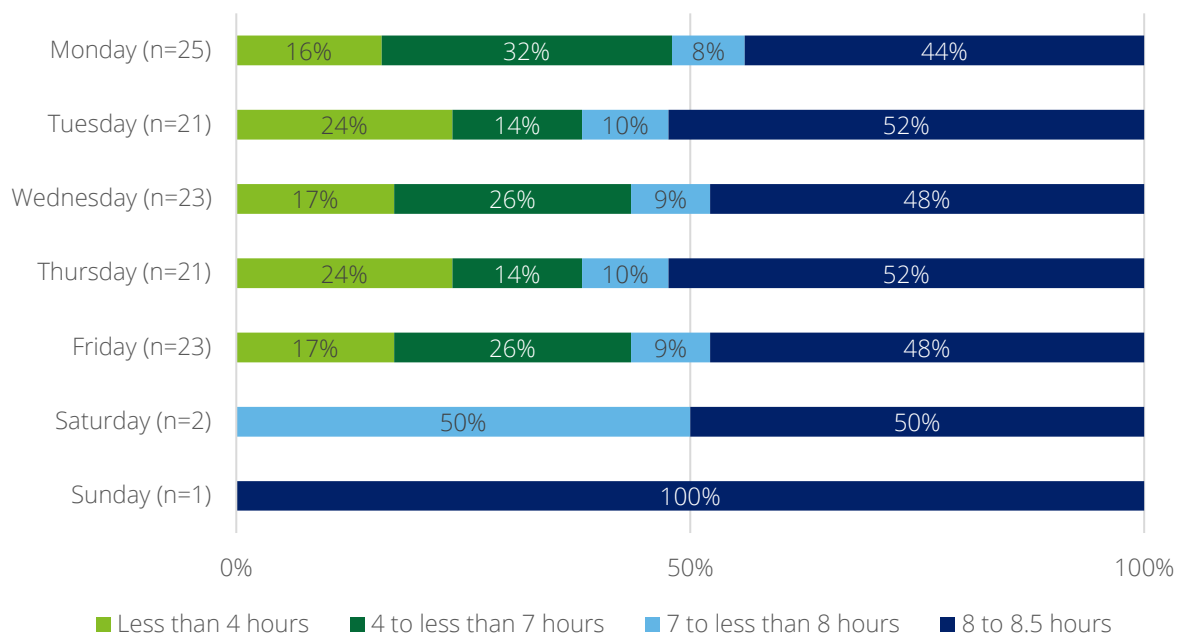
Chart E.24: Responses to Provider Survey Question C1 – Which days of the week is your EPAS clinic open? (n=29)



Note: Multiple responses permitted. Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

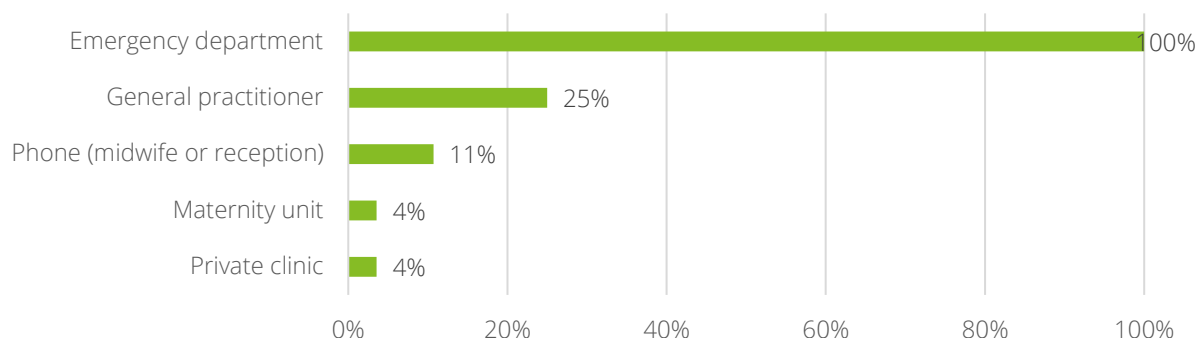
Chart E.25: Responses to Provider Survey Question C2 – How many hours is your EPAS clinic open across the following days of the week? (n=26)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS). Numeric responses were grouped into categories shown above.

Source: Deloitte Access Economics' survey analysis (2025).

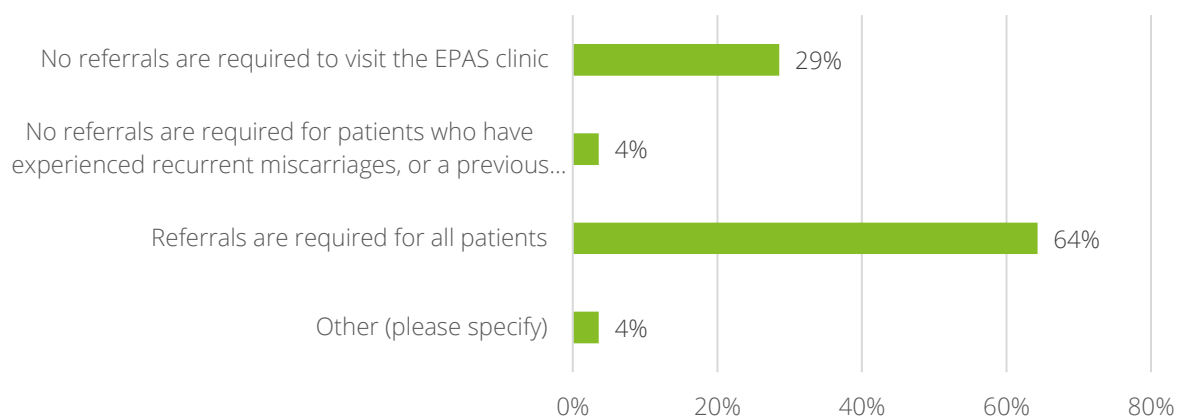
Chart E.26: Responses to Provider Survey Question C3 – When your EPAS clinic is closed, where can people who need early pregnancy assessment services access support? (n=28)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS). Short text responses were sorted into categories shown above.

Source: Deloitte Access Economics' survey analysis (2025).

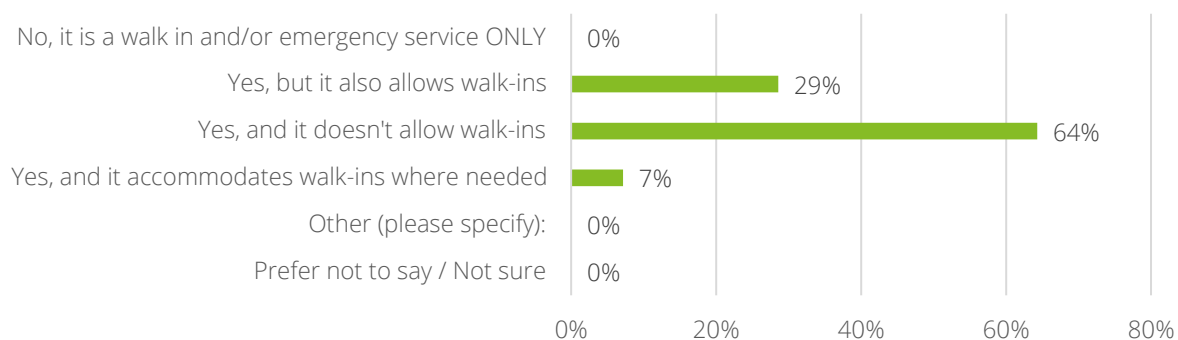
Chart E.27: Responses to Provider Survey Question C4 – What are the referral requirements at your EPAS clinic? (Excluding self-referral) (n=28)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

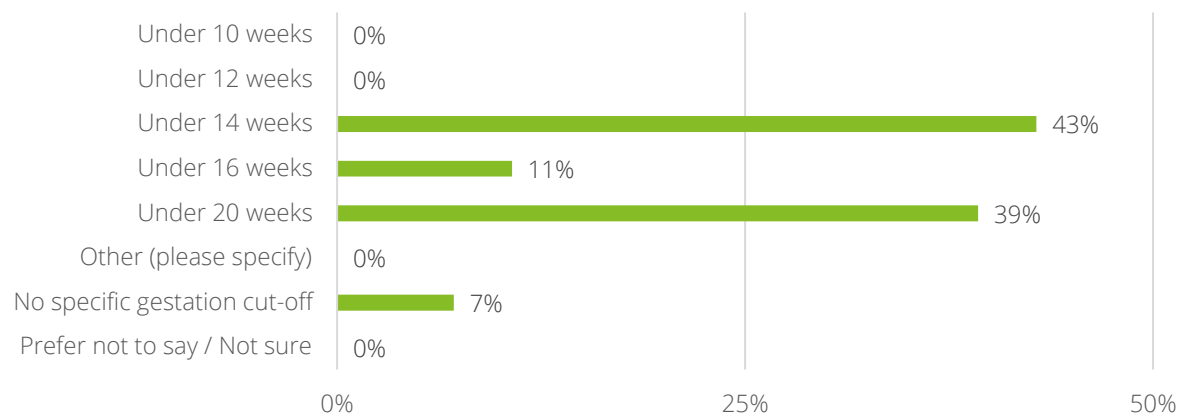
Chart E.28: Responses to Provider Survey Question C5 – Does your EPAS clinic have an appointment booking system? (n=28)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS). 'Yes, and it accommodates walk-ins where needed' was added as an additional category based on open text responses.

Source: Deloitte Access Economics' survey analysis (2025).

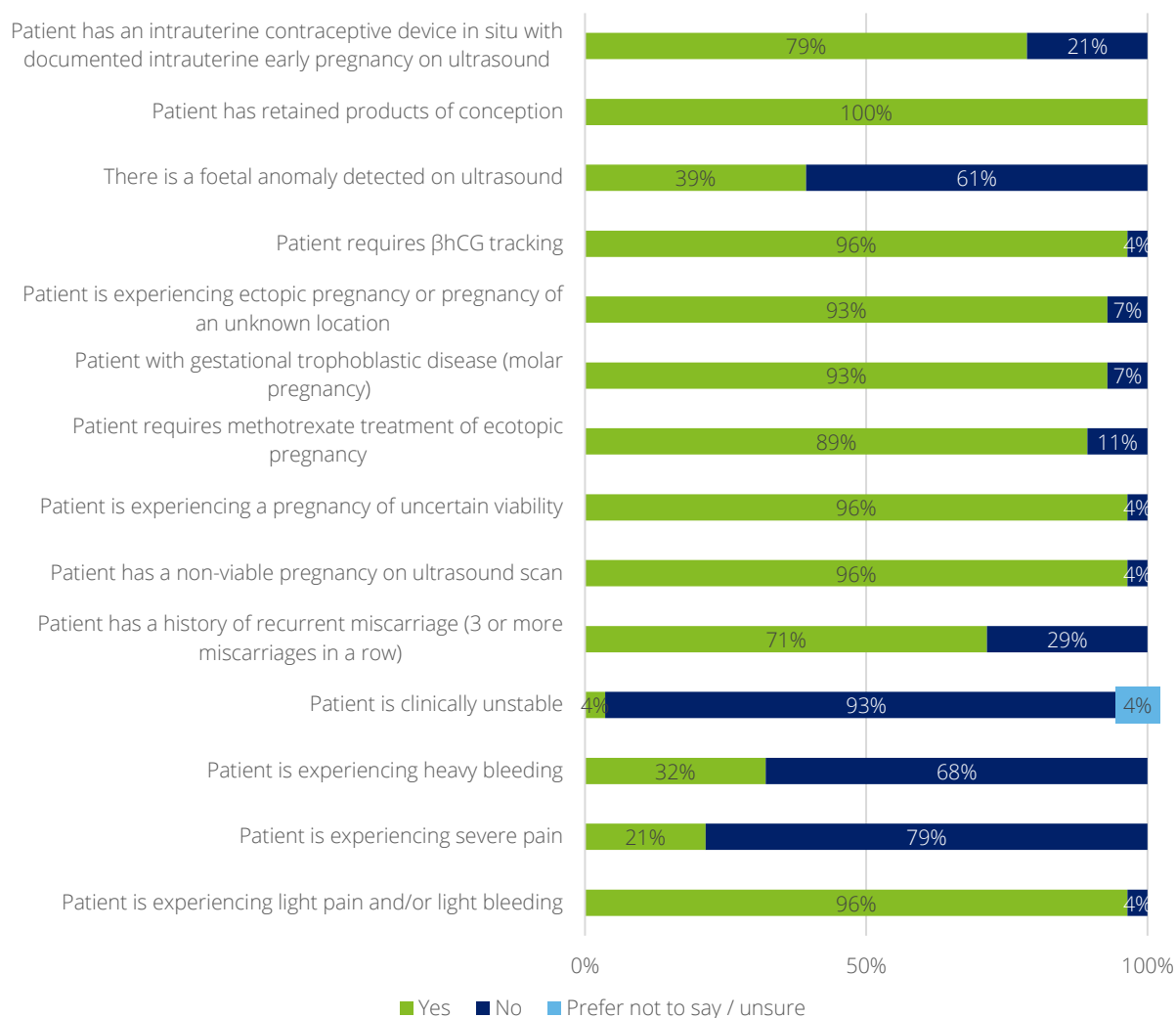
Chart E.29: Responses to Provider Survey Question C6 – What is the gestation cut-off for your EPAS clinic? (n=28)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

Chart E.30: Responses to Provider Survey Question C7 – Would the following patients be eligible to visit your EPAS clinic based on its inclusion and exclusion criteria? (n=28)



Note: Single response per statement. Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

Responses to Provider Survey Question C8 – Does your EPAS clinic have any inclusion and/or exclusion criteria not mentioned in the previous two questions? (n=13)

Additional inclusion criteria mentioned:

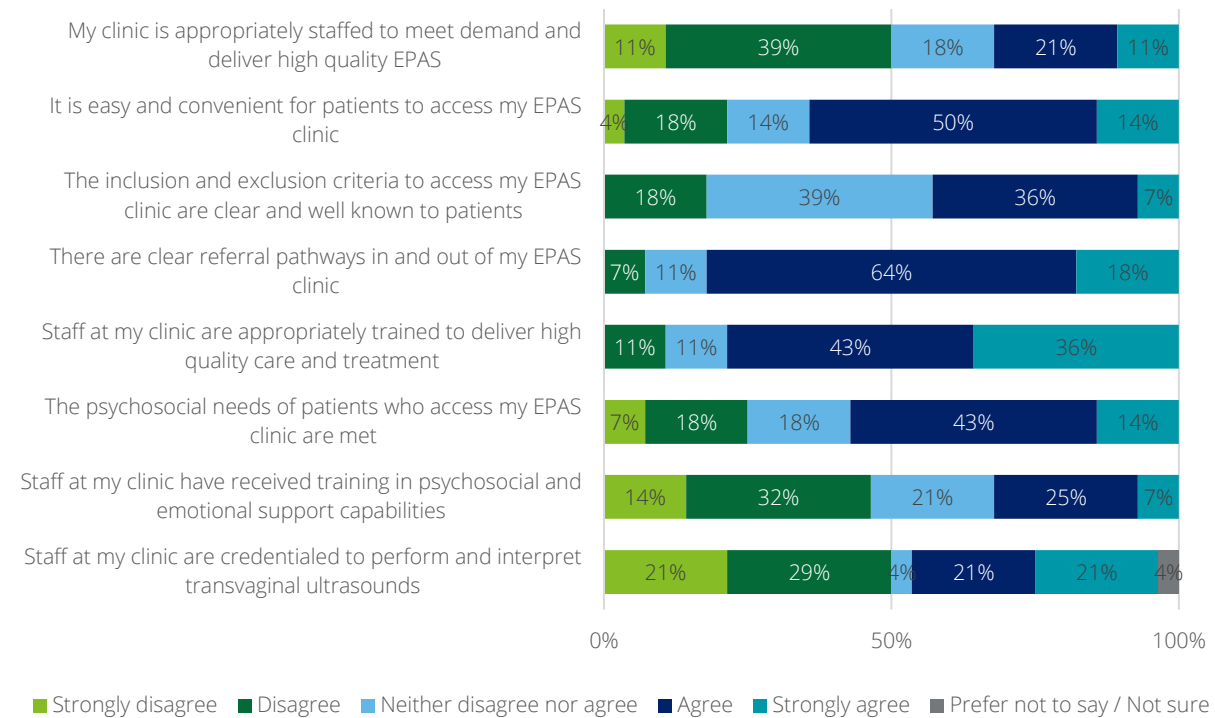
- Hyperemesis gravidarum (n=2)
- Abortion care over 14 weeks gestation (n=1)

Additional exclusion criteria mentioned:

- Termination of pregnancy under some conditions (n=7) or experiencing complications from termination of pregnancy performed elsewhere (n=2)
- Hyperemesis gravidarum (n=1)
- Ectopic pregnancies if clinically unstable (n=1)
- Outside of clinic catchment area or without access to Medicare (n=1)

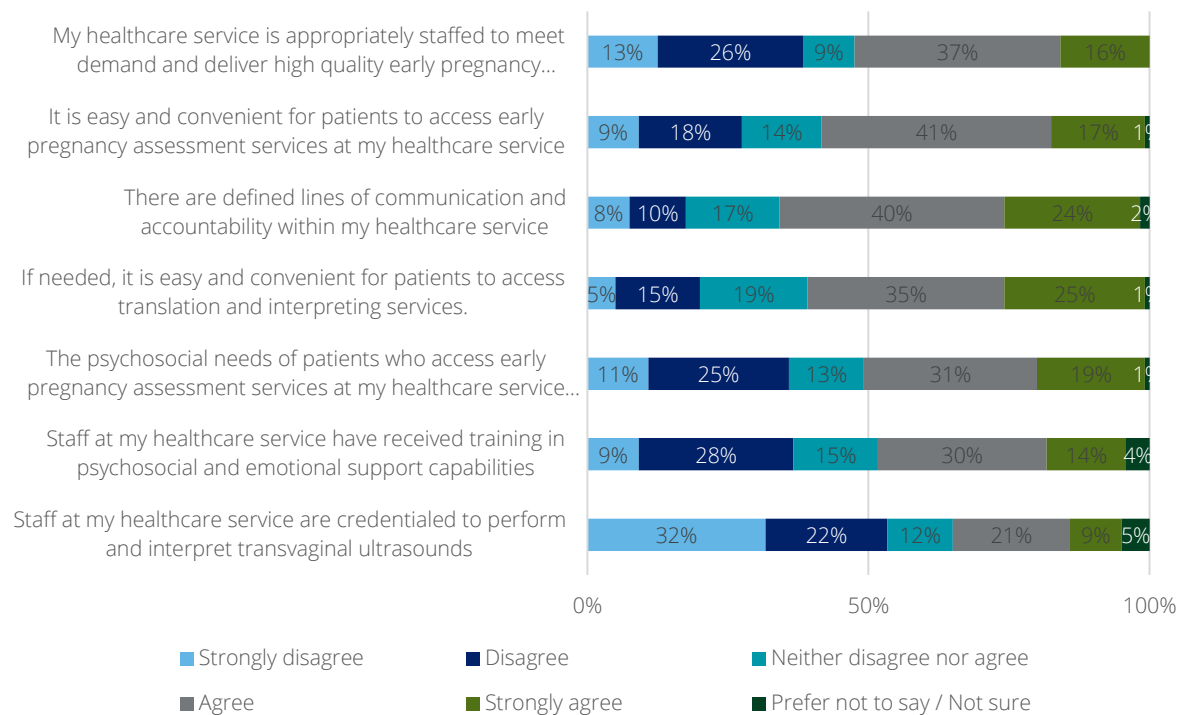
- Non-pregnancy related issues in early pregnancy (n=1)

Chart E.31: Responses to Provider Survey Question C9 – To what extent do you disagree or agree with the following statements? (n=28)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).
 Source: Deloitte Access Economics' survey analysis (2025).

Chart E.32: Responses to Provider Survey Question C10 – To what extent do you disagree or agree with the following statements? (n=120)

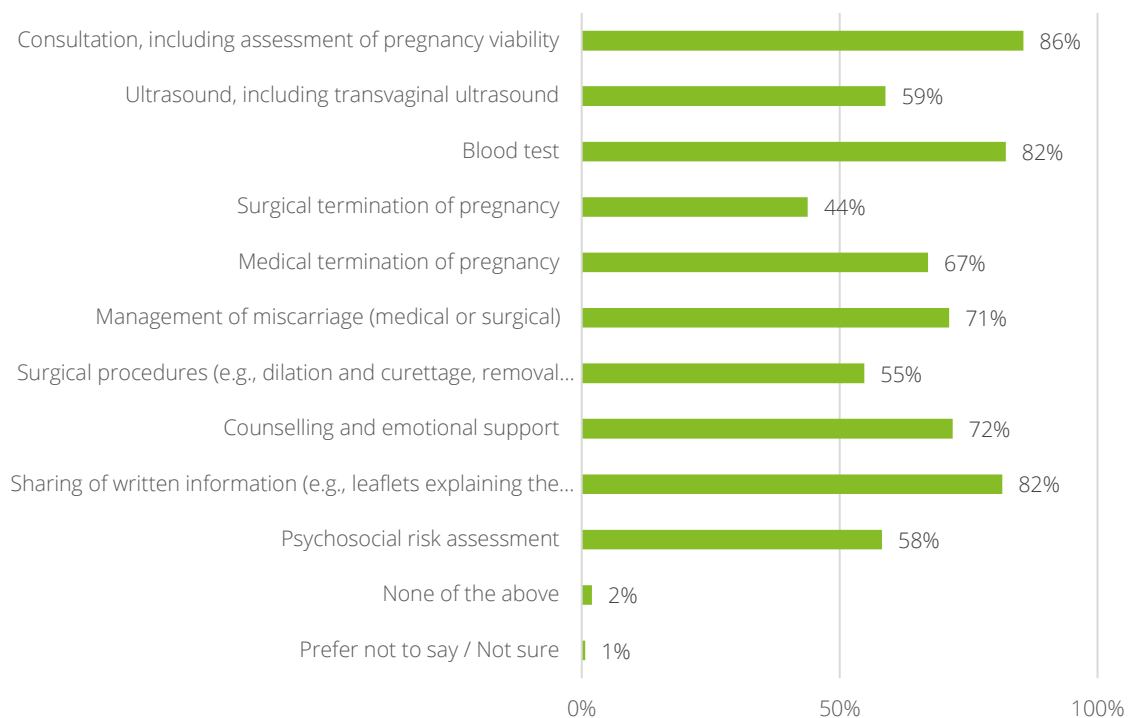


Note: Shown only to respondents who operate EPAS in alternative health settings i.e., if Question A3 = EPAS in alternative health settings.

Source: Deloitte Access Economics' survey analysis (2025).

E.2.3. Provider Survey Section D – Services

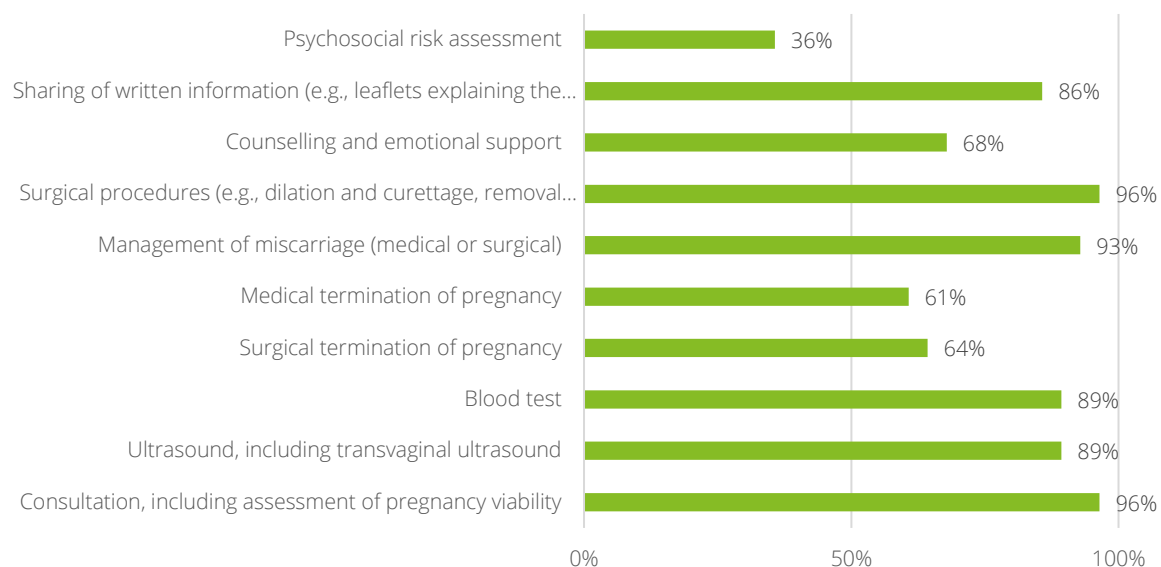
Chart E.33: Responses to Provider Survey Question D1 – Which of the following early pregnancy services are provided by your healthcare service? Please select as many as apply. (n=146)



Note: Multiple responses permitted. Includes responses from all respondents.

Source: Deloitte Access Economics' survey analysis (2025).

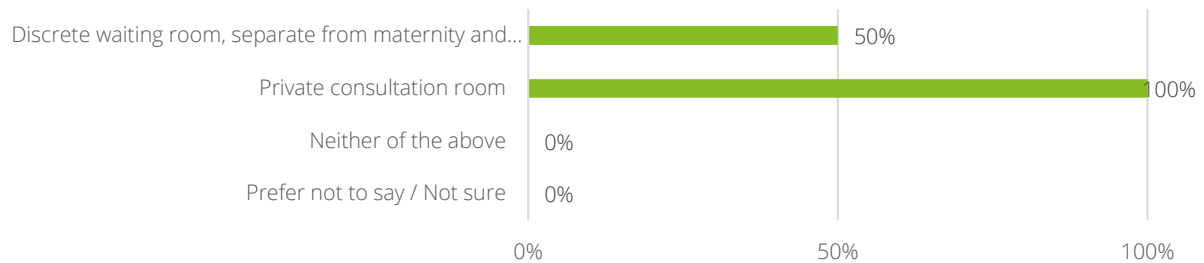
Chart E.34: Responses to Provider Survey Question D1 – Which of the following early pregnancy services are provided by your healthcare service? Please select as many as apply. (n=28)



Note: Multiple responses permitted. Includes responses only from EPAS clinic respondents i.e., if A3 = Early Pregnancy Assessment Service (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

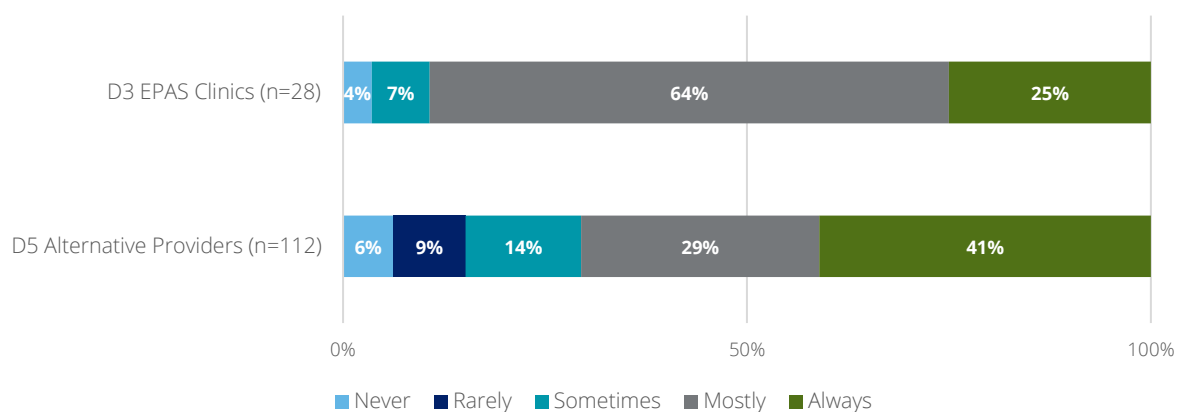
Chart E.35: Responses to Provider Survey Question D2 – Does your EPAS clinic have the following facilities? Please select as many as apply. (n=28)



Note: Multiple responses permitted. Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

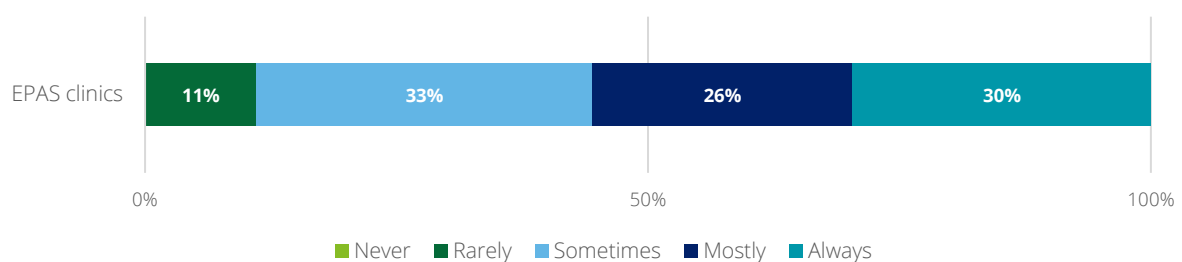
Chart E.36: Responses to Provider Survey Question D3 and D5 – Does your EPAS clinic/healthcare service follow-up with patients after they receive early pregnancy assessment services?



Note: Question D3 shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS). Question D5 shown only to EPAS in alternative health settings respondents i.e., if Question A3 ≠ Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

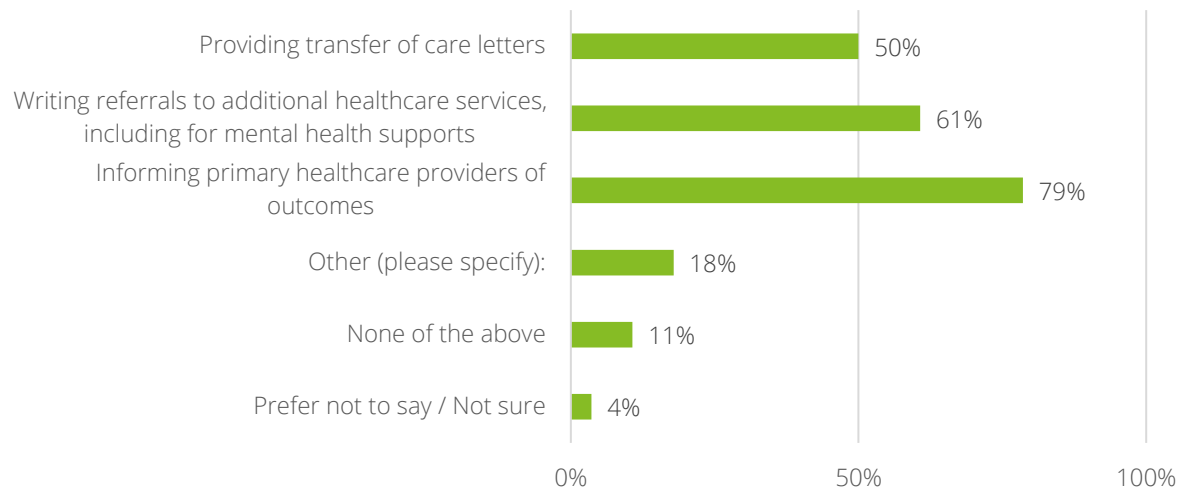
Chart E.37: Responses to Provider Survey Question D4 – Do the follow-ups inquire about the patient's mental health? (n=27)



Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

Chart E.38: Responses to Provider Survey Question D6 – Does your EPAS clinic do any of the following after a patient is discharged? Select ALL that apply. (n=28)

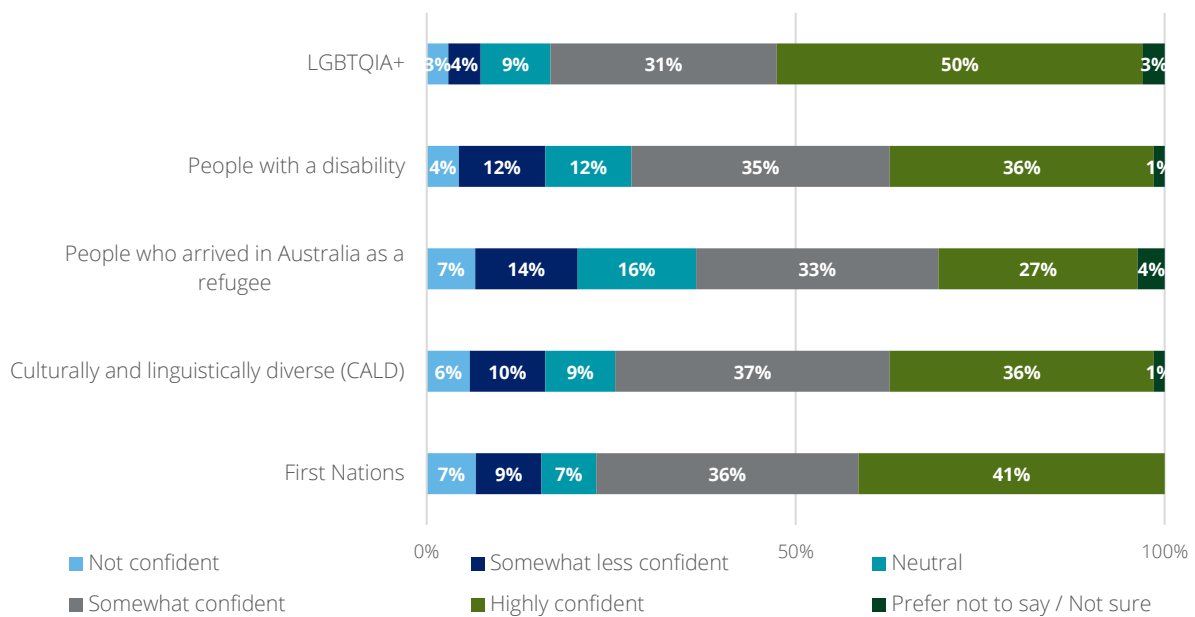


Note: Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

E.2.4. Provider Survey Section E – Tailored Supports

Chart E.39: Responses to Provider Survey Question E2 – How confident are you that your service could deliver appropriate and high-quality early pregnancy supports to patients who identify as the following priority groups? (n=137)



Note: Single response per priority group. Shown only to EPAS clinic respondents i.e., if Question A3 = Early Pregnancy Assessment Services (EPAS).

Source: Deloitte Access Economics' survey analysis (2025).

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