

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warragul — 8 December 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witnesses

Ms Kathy Kinrade, director, clinical operations, nursing and midwifery, and

Ms Wilma Wallace, maternity unit manager, West Gippsland Healthcare Group.

The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee’s inquiry into perinatal services in Victoria. This is the 10th public hearing held by the committee for this inquiry, and we had a great day a little bit further east yesterday.

I would like to acknowledge the traditional owners of the land on which we meet today and pay respect to elders past and present.

The committee has held hearings in Melbourne and in regional Victoria and has also been conducting community forums to encourage participation from as many people as possible. We are delighted to be in Warragul here today. These proceedings today are covered by parliamentary privilege, and as such nothing that is said here today can be the subject of any action by any court. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted, and I would ask everyone to place their mobile phones on silent.

I now wish to call our first witnesses, Kathy Kinrade and Wilma Wallace. Welcome here today, and thank you for attending. I understand that Kathy is the director of clinical operations, nursing and midwifery, at West Gippsland Healthcare Group. And we have Wilma. What is your role, Wilma?

Ms WALLACE — I am the maternity unit manager at West Gippsland Hospital.

The CHAIR — All evidence at this hearing taken by the committee is protected by parliamentary privilege, as provided by the Constitution Act 1975, and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is also a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript.

Now that is over with, I just want to say that our mission here today is to find out as much as possible about the perinatal services in the area — strengths and weaknesses — so we can formulate that into recommendations for this inquiry for the state government to act on. Certainly we are fairly relaxed. We want to find out as much information as possible, so please do not feel nervous.

Ms KINRADE — There is nothing very relaxed about a parliamentary hearing.

The CHAIR — We are in your town, and we are the guests. If we can, we will get Kathy or Wilma to start with a 10-minute presentation or a spiel, I guess you would call it, and if we can have a discussion, some questions, after that, that would be fantastic.

Ms KINRADE — I did have a PowerPoint, which is just being loaded.

The CHAIR — While that is being loaded, do you want to tell us a little bit about your role, Kathy, and the organisation?

Ms KINRADE — My role as director of clinical operations is to look after the acute inpatient services of West Gippsland Healthcare Group. The organisation underwent a restructure midway through last year and a bit of a role change. We did have the traditional old roles and titles in our organisation, but we have tried to look at a broader structure to help us with our growth into the future. I look after 110 aged-care beds across two sites — one in Warragul and one at Trafalgar — and 100 acute inpatient beds at our hospital site, which includes an emergency department, acute medical, surgical, paediatric and special care nursery services. We also have community-based services in hospital in the home, district nursing services and subacute programs run from the hospital. The focus of today of course is our maternity and gynaecology services, which include breastfeeding support; antenatal, intrapartum and postpartum services; and home domiciliary visits.

The CHAIR — What do you do with all your spare time, Kathy? It does not sound like there is much of it.

Ms KINRADE — I like to take a deep breath.

The CHAIR — We are ready to start the presentation when you are ready.

Visual presentation

Ms KINRADE — As I said, this is just an overview of our services at West Gippsland Healthcare Group. At the moment our other big priority is a business case for a new hospital on our greenfield site to look at doubling the capacity of our acute beds to 180 in the future. Our biggest issue at the moment is our population growth in the Baw Baw shire is increasing all the time, and we have an ED presentation rising at around 9 per cent per year and an ageing and inadequate infrastructure, which prohibits us from having any temporary care models. We have a huge number of young families moving into our area as well.

The key three issues that we want to discuss at this hearing are the capacity of our facility to meet demand, our capability framework and regional relationships across Gippsland and our workforce issues, which is why I brought Wilma to talk about those in particular, as the unit manager of the maternity services.

Graphically, these are our birth numbers over the last 10 years. We deliver the most numbers of babies in the whole of the Gippsland region, and we have for a long period of time. As you can see, our peak in 2012–2013, when we went over 1000 births, was a pressure point for the organisation not only in the safety of the service that we were delivering but being faced with an ongoing increasing demand and no formal ability to contain that.

In terms of some of the work then that we had to do in view of that — we have got a projected growth in this shire to be close to 100 000 by 2030 — as I said earlier, we have got a business case in the final stages with the department and government, looking at building a new hospital on the greenfield site that we have, being 60 acres of land. Some of the things that we have had to do internally include that we did run a four-bed high-dependency unit in an area of our hospital and an eight-bed postnatal ward. So when we hit over 1000 births, we looked at converting what was currently the high dependency unit into a postnatal area to try and increase our bed numbers and meet demand. That only potentially gave us two extra postnatal beds, and it has meant that we have had a decrease in our ability to look after high-dependency patients.

We also had a really serious issue in our ability to meet secondary referral patterns across Gippsland. We have a very strong relationship with South Gippsland, so Bass Coast, Leongatha and Foster really are supported by our organisation for their complex births, but we also had a huge problem with people coming from Casey shire and also Latrobe shire to West Gippsland, for birthing in particular. There is a very long historical reason around that.

From Casey's point of view, up until a few years ago they were only doing low-level non-complex births. They were not meeting the need of the complex women within the Pakenham shire, so they were tending to refer themselves to Warragul hospital, and then of course that ongoing relationship with our paediatric services. In the mid-1990s, when the government at the time made the decision to close the Moe hospital and the Traralgon hospital and build a regional hospital, which was Latrobe Regional Hospital, the community at Moe turned their backs on the desire to be serviced by Latrobe Regional Hospital, and they have become part of our catchment area, although outside of our service. We had to do a lot of work in decreasing those secondary referrals so that we could meet the demand of our actual own population.

By 2014 we were looking at a projection of hitting 1150 births, so we got some external consultants in to do a total review of our service and look at how we could look at changing our model, meeting the service and needs of our growing community and, more importantly, meeting the needs of the midwives, who were feeling that they were not having a good model of care and the ability to provide midwifery-led care under that current structure. As our community grows, we continue to struggle with that. Our maternity complexity is growing. Our special care nursery is a level 3 special care nursery with four cots. We have just recently done an internally funded expansion to increase that to six cots so that we can continue to keep mothers and babies where they should be, which is within our community.

Our other serious issue is that we have two operating theatres. They run sessions morning and night in both theatres to try and meet our elective surgery demand. The impact of a growing caesar rate — only having two theatres — is another issue for us to meet our targets and demands. Only three weeks ago we had an unfortunate incident where we had an emergency caesar happen in our recovery room area because both theatres were occupied at that time. Fortunately, due to good planning, we have a live mother and baby but also a very anxious workforce looking at the future. We have got plans to expand to a third theatre and a short-stay unit attached to our emergency department, which are very welcome to us, but they do not absolutely help us meet the demand of our community in a safe way. Really the only way to do that is a totally new designed hospital.

Under the framework we are a level 4 maternity service. As I said, though, we still are the major birthing centre for Gippsland, and our referral patterns for complex births from South Gippsland and Bass Coast continue to be an area where we offer support. Our referral patterns for our mothers and babies are towards the metro rather than Latrobe Regional Hospital. There are probably a few historical reasons around that, and the Latrobe Regional Hospital is now a level 5 maternity service but still developing to meet the needs of and service the whole of the Gippsland region, which is quite a large area. But our referral patterns and our relationships have been firmly set with Monash Medical Centre, so our referral patterns tend to be metro based rather than back in Gippsland.

One of the issues around that is the PIPER transfer principles. If we notify them of a transfer, they tend not to transfer away from the metropolitan hospitals. They like to refer back into metro, so even if Latrobe had capacity, they will not take referrals there. They will always send them back to metro. And our growing workforce of younger families that come from here really have relationships with the metro because we are on that peri-urban really. It makes us a very specific culture set, I suppose, which is a little different to some other areas.

We have also, over a long period of time — and you may have heard if you had been to South Gippsland — had an obstetrician that has been attached to our organisation for a very long period of time who has, on his own, developed very good GPO and GPA training support across South Gippsland areas, and he has just recently resigned from our organisation.

The CHAIR — What was his name, Kathy?

Ms KINRADE — David Simon. I am sure you have heard the name.

The CHAIR — We have heard a little bit about him, yes.

Ms BRITNELL — We heard about him yesterday.

Ms KINRADE — So we still want to provide that support to the lower level hospitals that we support. We have to grow our own obstetrician workforce to provide that support, but we still have GPs from those areas that come over and do placements with us to upskill. We also provide support to their meetings and their services.

So moving on to workforce issues, as I said, we have had our longstanding obstetrician just recently make the choice to move to the Northern Territory, but he has left behind a good framework for us to continue to develop, and we have recruited some new obstetricians to start in our area. We are using a senior registrar model to recruit. The other thing that we are also looking at is that across Gippsland in 2019 they are looking at implementing the RANZCOG reverse model of registrar training.

Ms BRITNELL — What was it?

Ms KINRADE — RANZCOG.

Ms WALLACE — The college of obstetricians.

Ms BRITNELL — Sorry, yes.

Ms KINRADE — So that reverse model means the registrars are placed into rural areas for the majority of their training and do a small component in metro rather than them being metro based and coming out.

I will hand over to Wilma to talk a little bit about the midwifery training models and what we have in place as an organisation.

Ms WALLACE — Regarding midwifery training models, at the moment we have got our paid model, or our employed model, where we take on two postgrad midwives each year. Postgrad midwives are supported. They work three days a week with our clinical teacher actually in the unit and then go out to do their university, so they are basically hands-on for that two-year period of working, and they are actually counted in the numbers that they do.

We then also have the double-degree students who come through to us for placement in the hospital. They are also supported with a clinical teacher, and there would be a number of those that come through each year. They are now looking at the model as purely university based and non-employed. So they are postgrads. They are registered nurses that are wanting to do a midwifery program, and we are also having some of those come through this year as well. That is still in process as to how many will actually come through each year, but we have an ageing workforce at the hospital. We have a number of staff that have hit 60 years plus, so we have got a bit of a gap — that I am very aware of — in the middle where we are trying to actually get the others to upskill. We also had a skill matrix in upskilling of midwives out in this local area. Sorry, Kathy, I have jumped forward.

Ms KINRADE — No, you are all right.

Ms WALLACE — Do you want to talk to —

Ms KINRADE — No.

Ms WALLACE — So we ran a skill matrix nearly two years ago. We are about to do a re-run on that to see what effect that has actually had, but a number of midwives have been able to upskill in their clinical area and in what they are able to do. We also have Maternity Connect, in which midwives go down to Melbourne and actually do a two-week program down there — that has been really valuable to actually help and upskill them in particular areas such as special care — or they will go and do two weeks in the antenatal clinics, labour ward or that sort of thing.

The CHAIR — Is there an accreditation, Wilma, that comes with that or is it just experience?

Ms WALLACE — Yes, it gives a combination, so they often become accredited in a particular skill and also gain experience as well. We have had that going on as well.

Ms KINRADE — One of our major issues with our workforce is keeping their upskilling and education, because we are a level 3 special care nursery. Lower level special care nursery education and training is very limited, and most of the staff need to actually travel to metro areas to get that skill base and training. We have a regional midwife educator at the main four hospitals that do midwifery services that we all support as an EFT across the region to try and help standardise practice and education and promote some of the competencies that we undertake, such as the PROMPT training — the practical obstetric multiprofessional training — the fetal surveillance education program and the new one that has been mandated from last year, the maternity and newborn education, which we ran a session on earlier this year very successfully.

As an organisation we have supported and paid for our midwifery staff since 2004 to undertake their fetal surveillance education program, which has now been mandated through the Duckett reports. We are now seeing the results of that, being one of the highest performers. Wilma has just recently got the results back from this year, and we are really pleased to say that —

Ms WALLACE — Done really well. They are level 3. We have got 50 staff at the moment that are sitting at level 3, which is really good. It has increased. You can see it going up each year with the support that we have had. It has been excellent.

Ms KINRADE — One of the other major issues that we have is recruiting against the regional hospitals, the metros and the new private facilities. The Latrobe Regional Hospital is undergoing a redevelopment and an expansion. So is Casey Hospital, and St John of God is just about to open a new facility in January. Our ratios as a subregional hospital are different to the other hospitals, so our midwives and nursing staff work at a higher nurse-to-patient or midwife-to-patient ratio than the hospitals that sit 30 minutes away from us. For a recruitment strategy we have got to look at other things to attract our staff to our organisation. We are an old facility and we have the worst ratios in the area, but we have the highest number of increasing births and patients coming to our doors.

They are some of the issues that we face as an organisation, but we are also very proactive. We have just become part of a national collaborative with Women's Healthcare Australasia, improving outcomes for reducing avoidable third and fourth-degree tears in women, so we are one of, I think, 17 hospitals across Australia that have become part of that collaborative. So although we are a small organisation with an ageing

infrastructure and workforce issues, we also like to think of ourselves as very contemporary and doing the best we can to meet the needs of the women who come to our service.

The CHAIR — Kathy, do you mind if we ask some questions?

Ms KINRADE — Yes, sure. That was the end.

The CHAIR — Firstly, you mentioned increasing caesar rates. Anecdotally, what is the reason behind that, do you think?

Ms KINRADE — Traditionally we had one of the highest success rates of VBAC, vaginal birth after caesar, and that was very dependent on the obstetrician, who has currently left. His skill level in that area was very advanced. We now have a workforce that is not so skilled, so caesarean section is sometimes now undertaken because it is safer.

The CHAIR — I wanted to know what your accreditation or standardisation is. We have heard throughout the inquiry about a number of levels of standardisation, ISO internationally and we heard of another one yesterday that we had not previously heard about. What standard does West Gippsland adhere to?

Ms KINRADE — That threw me. I cannot think of it. We do EQUIP 11 to 15 and the national standards 1 to 10.

The CHAIR — We would love to get the answer. I was not trying to trip you up or anything like that.

Ms KINRADE — That is okay.

The CHAIR — It is just interesting, to me at least — and I think Cindy as well — that we have so many standards that we are operating under at the moment, it seems. The other question I had was just in regard to resourcing staff, which you were talking about. What are the incentives you use to actually get staff down here? You have said that the hospital has very high stats but at the same time has ageing infrastructure and whatnot. How do you get staff here?

Ms KINRADE — We try to look at above-award study leave for particularly midwives. We think our employment model is very generous in the support that we give them, the clinical education support and the opportunities. I think we have got a good culture in our organisation of supporting staff and helping grow them to stay as part of our workforce.

The CHAIR — Do you ever have questionnaires for the staff that might leave?

Ms KINRADE — Exit, yes. We do.

The CHAIR — And what do they come up with generally?

Ms KINRADE — A lot of the time moving out of the area is the main reason. We have a lot of the workforce that have been there for 25-plus years. Then you have your younger ones who want to always go to metro hospitals for more experience; they think that working in the big hospitals is where you get experience. But they tend to come back to settle with their families.

The CHAIR — They get through the *Grey's Anatomy* period of their life and want to move on.

Ms KINRADE — Yes.

Ms McLEISH — Thank you very much, ladies, for coming in today, and thank you also Kathy in particular for the guided tour that Roma and I were able to take at West Gippsland Healthcare Group earlier today, and Wilma for your role in that as well. It was good to see a hospital that is at capacity and how you manage to deliver what you do in a very old facility. I think you said it is some 80 years old or something like that?

Ms KINRADE — Yes, the majority of the building is 1940.

Ms McLEISH — And it is certainly a tight squeeze. I guess it was probably quite concerning when you were talking about the growing caesar rate and that because you have had only those two theatres you have had

to do things not as ideally, but you have had successful outcomes because of the quality of care. So congratulations on doing your best. You mentioned the greenfield site — 60 acres, I think. Has that been purchased already?

Ms KINRADE — The land has been owned by the board since the early 2000s period of time.

Ms McLEISH — So that is ready to go.

Ms KINRADE — Yes.

Ms McLEISH — So you have got that block of land identified and the hospital, if there was a rebuild, could be there?

Ms KINRADE — Yes.

Ms McLEISH — Let us hope that happens sooner rather than later. Can you tell me: which is the closest teaching hospital? Does Latrobe do that or Casey?

Ms KINRADE — We are a teaching hospital as well.

Ms McLEISH — So you are as well?

Ms KINRADE — Yes.

Ms McLEISH — I just wanted that for my records. One of the things that we have heard a lot about since we have been conducting this inquiry has been about the emotional health of women pre and postnatally. I am wondering if you identify those people as they come in and what you do, what screening you may do or what services you refer them to as they leave. How does that work?

Ms WALLACE — The midwives who are in the antenatal clinics when the women come in to book in have a screening tool that they go through with those women. We have a dedicated social worker, but not for outpatients as such. There is a dedicated social worker working within the maternity and paediatric centre. She is a wealth of knowledge for the midwives to be able to refer to. She knows all the people and all the different areas. Because our clientele do come from such a vast area, we are still getting people from Pakenham, so they are outside our catchment area and outside our normal services. She has the ability to tell them who to be able to refer those on to and help them support them from there. A lot of the GPs still care for their women outside of the pregnancy as well, so there will often be liaising and communication through that as well. So in general there is pretty good support.

Ms KINRADE — They are all trained to screen for family violence as well, in the antenatal, and we are doing some work in relation to one of our other services in the area, Quantum — so looking at how we can provide a Quantum on-site support for those women who are identified as having aggression or family violence in a protected way when they are coming up to the antenatal clinics. Again, because of the infrastructure and oldness of our building, to try and do that in a way that protects their privacy and does not put them at risk is very difficult, and we are still working through some of those things.

Ms McLEISH — At what point does that happen — that, say, the midwives do that screening for family violence?

Ms WALLACE — The ideal time is around about 12 to 14 weeks into the pregnancy. Ideally we are seeing women around about the eight-week mark or eight weeks and before for their very first appointment. From there, their second appointment is with a midwife, and that is their booking-in appointment at that stage.

Ms McLEISH — How often do they see the midwives?

Ms WALLACE — It depends on which stream they go into. We have three or four different streams. There is a midwife stream, where they are low-risk women; they only need to see a doctor three times, I think it is, in their pregnancy. Otherwise they are cared for by the midwives right through. They have all their antenatal visits with a midwife. We try and keep continuity by having regular midwives in the clinic at that time so they see the same one each visit that they have. Then we have the consultant stream. They also see the midwives quite often.

The midwives work with the consultant down in the antenatal clinic, so they are touching base with the women most visits and are able to flag any things that are coming up. Because it is still a community-based hospital, we build quite strong ties with our women, so they get to see them. Then there are the GPs as well. Some of the GPs are still seeing their women in the community, but some of them come up and do an antenatal visit. In supporting our medical workforce, the GPs are working quite closely with the consultants that are in the hospital.

Ms KINRADE — That is our shared care role.

Ms McLEISH — Would they do a screening for anxiety and depression as well?

Ms WALLACE — Yes.

Ms McLEISH — Do you think that you capture most of them or do you have a reasonable rate of people who pop in unannounced at 39 weeks, about to give birth?

Ms KINRADE — Unbooked presentations, we do have a small percentage, yes.

Ms WALLACE — We do have a small percentage of that. I have had more things recently come to me for women who do not attend appointments. If we have actually had them booked in and then do not attend, the follow-up for that is quite tricky, can I say. There is not a lot of funding there, and it is quite difficult to be able to support them to come in. It could be transportation. They might live in Drouin and they have got to get to Warragul. When you ring and ask why they have not been able to attend appointments, it is because they are unable to get transport. Then we try and assist them with that and try and sort it out.

Ms COUZENS — Thanks for coming along today. We appreciate that. You showed the graph earlier that in 2012–13 it peaked at over 1000 and now that is dropping. Do you know why that has happened?

Ms KINRADE — It has been the work of reducing the out-of-area referrals. We are trying to just manage our catchment area and then look at the secondary referrals that can come in over the top of that rather than it being an open door for all. Particularly the Pakenham area, we have worked really closely with the services down there in Monash and Casey to take some of their women back in that referral pattern, and with Latrobe Regional Hospital.

Ms COUZENS — And obviously that is working and the numbers have reduced.

Ms WALLACE — It is working, and the fact that they are taking a higher acuity. Some of the women we touched on before were coming this way because of acuity. For them living in Pakenham, if they did not meet the low-risk area that Casey was providing, it meant they had to travel all the way through to Clayton. So if you lived in Pakenham it was much easier to do a 30-minute drive to Warragul rather than turn around and go all the way back through to Clayton, because that was their next stop.

Ms KINRADE — In saying that, though, there are the early predictions. We did 940 births last year. We are looking at being closer to 980, even with those.

Ms COUZENS — So it is growing.

Ms KINRADE — And that is our local population.

Ms COUZENS — Do you have many Aboriginal women using your service?

Ms KINRADE — Yes, we have a small cohort of Aboriginal women locally, and we have an Aboriginal clinic in Drouin that helps support that. One of Wilma's midwives also supports that clinic.

Ms WALLACE — I have an ANUM who actually works at Ramahyuck and works for us on the ward, and she gives the Aboriginal community really good support because she is touching base with them there. She has the ability to help bring them to clinics for their appointments if they need to come in, and then she also organises and follows up with VPC afterwards. It is an unofficial support, but a very good one.

Ms COUZENS — Is she Aboriginal herself?

Ms WALLACE — No, she is not.

Ms COUZENS — Do you have any Aboriginal staff?

Ms KINRADE — We have an Aboriginal liaison officer.

Ms WALLACE — And I have one midwife that I have been trying to get on board for a long time but she keeps scooting down to Melbourne on me.

Ms COUZENS — So she is not actually working in your service?

Ms WALLACE — She is casual. She works casual. Tracy works casual for us, but she has actually been doing a great job supporting Aboriginal students. She was working at Dandenong. She is still in that area but supporting and helping nursing students.

Ms COUZENS — Do you have a number of students in the area within your service?

Ms WALLACE — Within our service, yes. At any one given time we have four midwifery students doing their postgrad course. We actually have a lot of students, because we also have med students as well.

Ms COUZENS — Would there be any that are Aboriginal people?

Ms WALLACE — Sometimes, absolutely.

Ms COUZENS — Have you got a rough estimate?

Ms WALLACE — No, I have not. I could not. You cannot tie me down to that one, sorry.

Ms COUZENS — That is alright.

Ms WALLACE — It is a small percentage, which is really quite probably sad in some ways, because it is good to have everybody.

Ms COUZENS — Within the overall service, do you have the cultural training?

Ms WALLACE — We do. Troy is our liaison officer. He does training right throughout the organisation in regard to Aboriginal services.

Ms KINRADE — And to our board members as well.

Ms WALLACE — Yes.

The CHAIR — Just before I pass around, I just had a question in regard to PIPER. My understanding of PIPER is that they will organise a bed. Do they organise transport as well?

Ms WALLACE — Yes. They organise transport.

Ms KINRADE — Yes.

The CHAIR — They organise transport as well. Okay.

Ms COUZENS — They organise a bed, do they?

Ms KINRADE — Yes, but it is metro based more than —

Ms BRITNELL — So it is everyone coming into metro.

Ms WALLACE — Part of the reason I think they tend to go to metro as well is that LRH take babies from 32 weeks on. We take them from 34 weeks on, so it is not a large gap there. If they backtrack through LRH and that baby becomes more unstable and they cannot look after it, they tend to have to turn around and go back past us. I think that is part of the reason as to why they tend to go metro.

The CHAIR — Yes, understood.

Ms BRITNELL — A lot of my questions have been asked, but I just wanted you to explain for the record a bit more deeply around the risks of increasing above the 1000 births that you have now capped and what that risk looks like with only having two theatres and the challenge of managing that. I just wanted you to elaborate a bit more on what that actual risk results in.

Ms KINRADE — Particularly when we were doing over that number of births back in 2012–13, we could not meet our elective surgery targets due to the interruptions of the theatres during the day. Also the workforce was becoming exhausted because a lot of those inductions and caesars were happening after-hours. We were having theatre staff called in overnight and then having to cancel elective lists. I think the level of complexity of the women we were delivering back then became a concern prior to me, being part of the executive, but historically it became a concern to the executive at the time. We then got a director of medical services by the name of Liz Mullins, who came on board and who just was risk averse to the practice that we were having happening in our hospital. The BMI level was too high, and we did not have a set BMI level across the Gippsland region for all the organisations, which was clear. That work has been done regionally now through the Gippsland maternity regional steering committee. We have now got a regional BMI document.

Ms BRITNELL — Where you will not take certain women above —

Ms KINRADE — We take a booking BMI of 48. Our regional hospital takes a booking BMI of 50, and I think they are about to increase to 55, but that has not happened yet.

Ms BRITNELL — We were able, as Cindy said, to come up and have a tour of the hospital and facility, and it was very, very good to see what a tremendous job you are doing not only in maternity services but also in your A and E, which is clearly very cramped in the theatres when you have got such a burgeoning population in the region. Can you tell me a bit more about ratios and explain for the record what the current ratio is for your hospital versus where I think you said it was different somewhere else? You also mentioned the special care nursery ratios while we were up there. Can you explain the challenge you have with meeting the challenges and what might be your role?

Ms KINRADE — Across the acute sector the medical surgical ratios in the regional hospital — and I have got the ANMF sitting the behind me, so I had better get them right — are 1 to 4, 1 to 5 and 1 to 8. Our ratios are 1 to 5, 1 to 6 and 1 to 10. The maternity ones, I believe, are standardised at 1 to 6 postnatal. The labour ward is 2 to 3 while not in active labour, and then it goes to 1 to 1. Just the equation of two midwives to three birth suites is a nonsense as far as we are concerned in how to manage that.

Ms BRITNELL — Two midwives across three women in labour?

Ms WALLACE — No.

Ms KINRADE — To three labour rooms. When they are in established labour it has to go to 1 to 1.

Ms BRITNELL — But if you have got three women all in early labour, you have got two midwives across the three.

Ms KINRADE — Yes.

Ms WALLACE — You can have two midwives.

Ms KINRADE — Special care nursery is 1 to 4 cots.

Ms BRITNELL — Right. Is that a very stressful environment for the person managing three babies in special nursery?

Ms KINRADE — It certainly can be, and now that we have increased to six, we have also got to increase the workforce there.

Ms BRITNELL — Six cots?

Ms KINRADE — Six cots. We will move to two staff in there to manage six cots, which has the advantage of training up and supporting new staff in that area.

Ms BRITNELL — At a cost to the hospital, though.

Ms KINRADE — At a cost to the hospital.

Ms WALLACE — Another issue of course is our 10 postnatal beds. If we have got over 1000 births a year, our women are needing to turn over and go home fairly quickly.

Ms BRITNELL — And what is the stay time?

Ms WALLACE — Our normal stay is around about 24 to 48 hours.

Ms KINRADE — Interestingly you lose funding. If a woman does not stay for two midnights, the hospital is penalised and your funding drops, so we have been innovative in looking at hospital in the home support for the second night to get women out earlier for our capacity issue but also to give them the support in the home.

Ms BRITNELL — Thank you for sharing that.

Ms KINRADE — That is okay.

The CHAIR — Thanks, Kathy. Thanks, Wilma. We appreciate your time today. We know you are awfully busy people, and we want to make sure we are not holding you up from delivering babies at the hospital. It has been very informative. Know that the information you have given us today gives us the tools we need to write our report. Thank you so much.

Ms KINRADE — Thanks for inviting us.

Witnesses withdrew.