Wairarapa DHB

Maternity
Quality and Safety Programme
Annual Report

July 2012 - June 2013

The Maternity Quality and Safety Programme

The purpose of this programme is to meet the direction given by the Minister of Health in his statement on 4 May 2012 - for a stronger focus on clinical leadership, a programme which aims to ensure women and babies have the same high standard of care throughout New Zealand by bringing community and hospital maternity professionals together to discuss how they can lead and implement the programme to improve the quality and safety of maternity services in their region.

The Maternity Quality & Safety Programme brings together professional and consumer stakeholders to collaboratively monitor and improve maternity care at the DHB level. The programme is supported by quantitative and qualitative data and information that will assist to identify areas for improvement and/or further investigation. It is based in the Wairarapa Hospital Maternity Service at the local level, where the majority of our population's maternity services are provided. In some cases the programme may cross DHB boundaries, particularly with our subregional partners of Hutt DHB and Capital Coast DHB.

One of the keys to improving the quality of services is to have ongoing, systematic review by a local multidisciplinary team, which works together to identify ways that services and care can be improved, and works to implement those improvements. The programme will build on existing clinically led governance systems, while at the same time driving a shift in maternity services to provide safer and better quality maternity care to women and their babies.

The elements required for implementing the Maternity Quality and Safety programme at DHB level are:

- Governance and clinical leadership
- Systems for sharing information
- Data monitoring
- Management and administration
- Clinical networking
- Consumer engagement

Purpose and Objectives in the First Year

The purpose of implementing the Maternity Quality and Safety Programme is to find effective ways to strengthen the clinical leadership activities that already exist and to articulate the future focus of the quality and safety of maternity services. This will be undertaken with a collaborative approach at local level across the multidisciplinary team providing clinical care to the women and their babies, with a particular emphasis on integration of hospital and community based practitioners.

Summary of the aims/objectives

- Implementation of Quality and Safety Coordinator, Key role in place February 2013, to establish the programme and put systems and processes in place to ensure the programme becomes business as usual by June 2014.

- There has been a significant drop in the LMC workforce. This has had an indicative impact on the model of care, recruitment strategies are in place in collaboration with MoH, NZCOM the provider arm and Planning and funding.
- Maternity specific satisfaction surveys - we will be reviewing Information obtained from Consumer surveys and the woman's experience at WDHB, these will include length of stay and services offered during admission.

- Robust, measurable and meaningful reports are being developed for monitoring and improving plans against Clinical Indicator KPIs.

- Consumer engagement – We will endeavour to explore a web based information site, for better dissemination of services available to women in the Wairarapa –this will include the availability of LMCs and their contact details, antenatal education and what to expect at these classes, the importance of consumer education at the primary care level. Reaching hard to reach groups, ward information, including what to pack and equipment you will require for baby ect. BFHI information to improve breastfeeding support, BFCI information leading to support in the community. How and when to contact the ward midwives.

- The maternity Referral Guidelines provide guidance about referrals from Lead Maternity Carers to specialist medical care when a woman or her baby has certain specific conditions during pregnancy, childbirth or the postnatal period.

Wairarapa DHB Overview

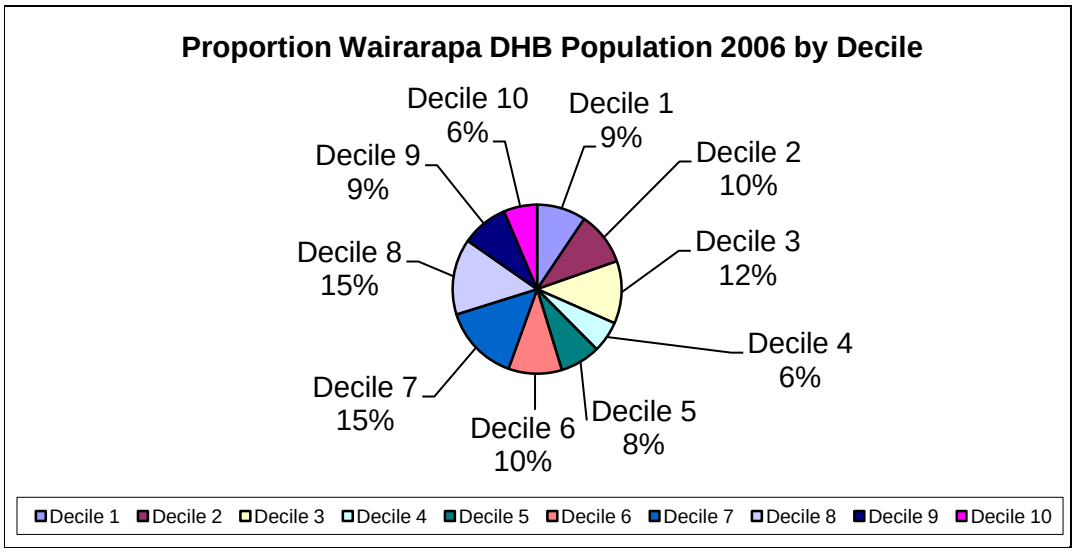
The Wairarapa DHB is home to 1.1% of the national population and is the second smallest of the twenty DHBs, with a population of nearly 40,000.

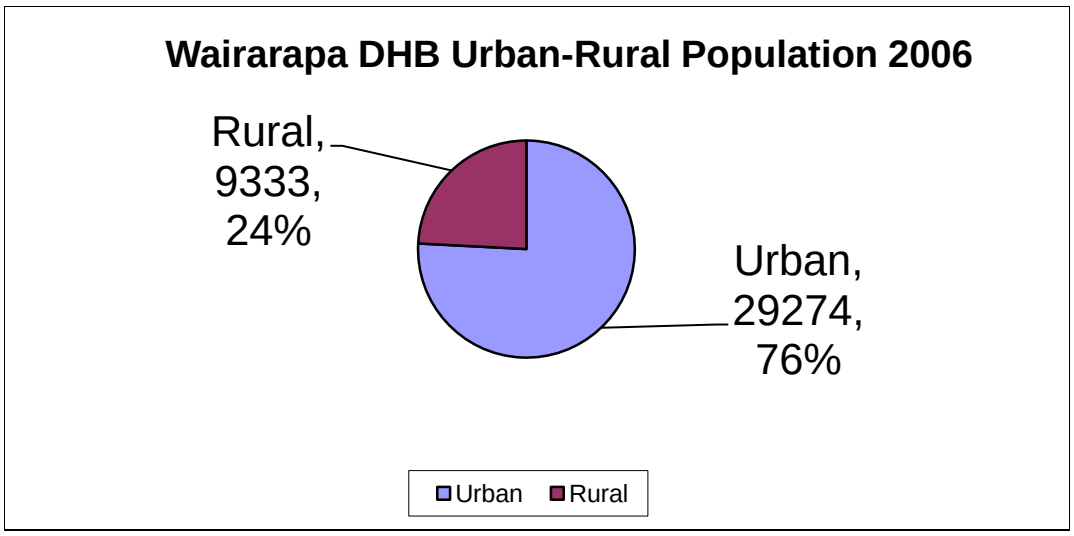
Our small population is spread over a large geographic area extending from the Rimutaka Hill and Ocean Beach in the south to Mount Bruce in the north. It extends from the Rimutaka Hill in the west to Ocean Beach in the south and Mount Bruce in the north, a total of 5,936 square kilometres.

The urban areas of Wairarapa have a greater proportion of people classified as more deprived than the national average and it is well documented that Māori and people of low socio-economic status have consistently poorer health outcomes in comparison with the rest of the population.

While we have a predominantly aging population, the number of births at the hospital has held consistently at around 500 births for the past few years.

Population Data as of 2006





Wairarapa Hospital's Maternity Service

Wairarapa Hospital's maternity service is underpinned by Five Principles developed by the local maternity sector including core midwives, obstetricians, and LMCs

Five Principles of the Wairarapa Maternity Service

1. Develop an inclusive maternity service
2. Evolve into a more women centred service
3. Clarify/update the role and expectations of the core midwives
4. Maintain a midwifery leadership voice within the DHB
5. Identify workforce needs and recruit strategically (grow the workforce)

The unit itself is a six bedded ward with three delivery suites and a clinic room available for the use of core midwives, obstetricians and LMCs.

Wairarapa's maternity unit is a secondary care service, with women who require tertiary level care attending Capital Coast DHB. Around 500 babies are born each year at the hospital. There are approximately 35 homebirths per annum. There has been a change as a number of LMCs in the district have ceased independent practice. As a result, there are up to 18 women per month will have their care provided for by the DHB as the provider of last resort.

The primary maternity services provided at Wairarapa DHB are currently undergoing a period of transition due to the decreasing number of LMCs. The subsequent impact on the model of care delivered by the DHB is under discussion with core staff and the local LMCs .

The maternity service already has a strong collaborative and integrated approach within the local maternity sector, with frequent meetings and engagement across maternity managers, core midwives, obstetricians and LMCs

Data Analysis

Maternity services provided in the Wairarapa include

- LMC midwives
- Ante-natal Education
- Hearing screening
- Lactation consultant
- Well child provider
- Physiotherapy
- Social Worker

Outcome Data

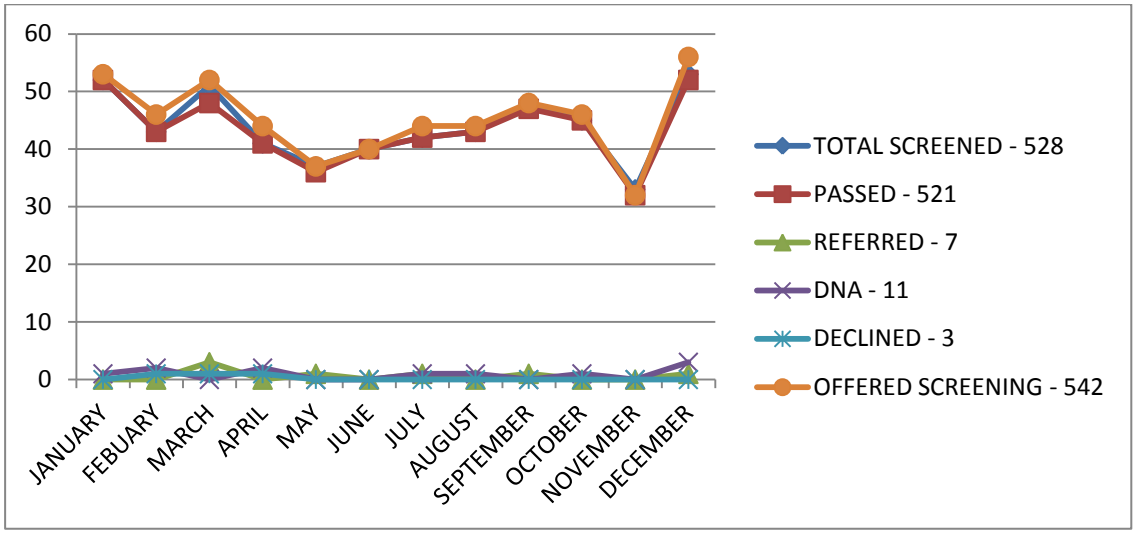
Outcome data that is routinely reported through national reporting mechanisms include Perinatal and maternal mortality, caesarean section rates and breastfeeding rates. This plan provides the most recent data published. This data is being used as the baseline against which improvements will be measured within the Quality and Safety Programme. Data used for this document are compared against the New Zealand Clinical Indicators (2009). Data for the Wairarapa DHB are compared to the standard definition of primiparae.

Infant Feeding

Infant feeding data sourced from Discharge Reporting 2011

BIRTHS	
Number of births in the facility 2011	496
Infants exclusively breastfeeding at discharge	431
Infants fully breastfeeding at discharge	16
Infants partially breastfeeding at discharge	31
Infants artificially feeding at discharge	18

Hearing Screening: Infants screened, declined, DNA, referred 2011



Proportion of women who register with an LMC

Data sourced for Registration with LMC 2011

Data shows all women with a known birth in 2011, including women registered with an LMC (Funded under section 88)

1st Trimester	2nd Trimester	3rd Trimester	Postnatal	Unknown
319	170	23	1	19

Wairarapa DHB Goal – to increase the number of women registering with LMC by 12 weeks.

Perinatal and Maternal Mortality Review Committee (PMMRC)

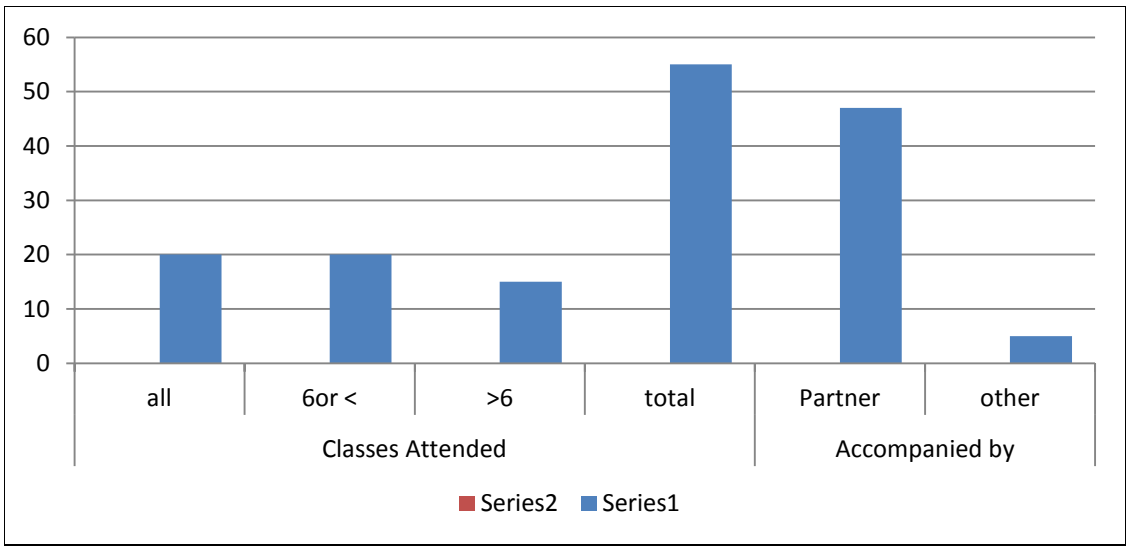
Data collected from the Perinatal and Maternal Mortality Review Committee (PMMRC) 2011

Perinatal related deaths rates (per 1000)					
Maternal Domicile	**Total Births**	**Termination of pregnancy**	**Stillbirths**	**Neonatal Deaths**	**Total Perinatal Deaths**
Wairarapa	496	0	3	0	3

The process for Perinatal and maternal mortality reporting meets the standard requirements of PMMRC. This includes rapid reporting, case review and classifications for individual cases which are reported directly to the PMMRC.

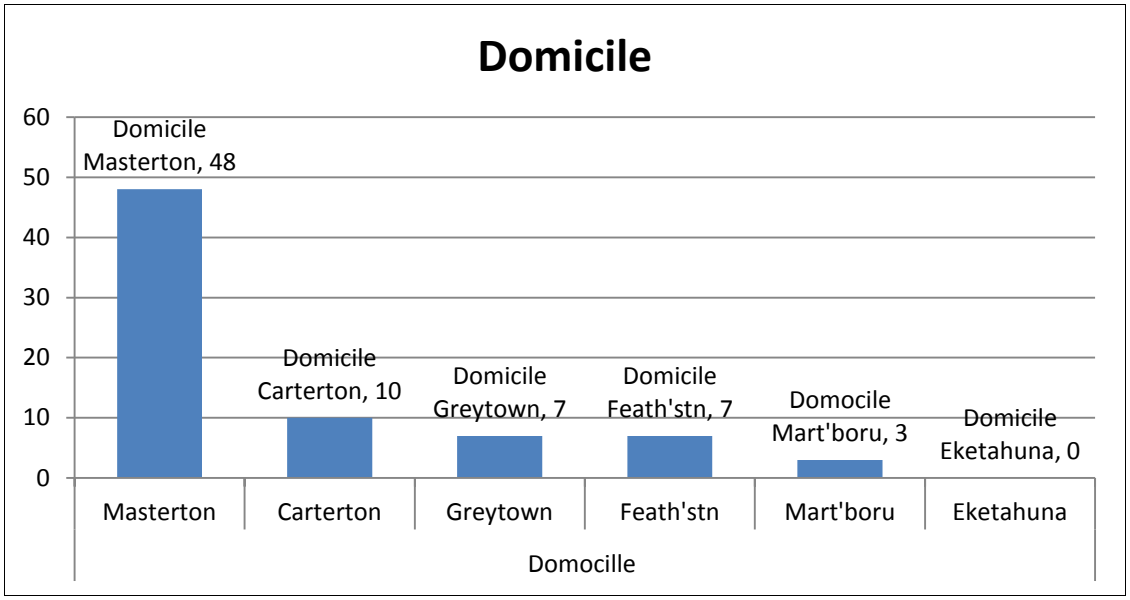
Parent Centre Antenatal Attendance 2011

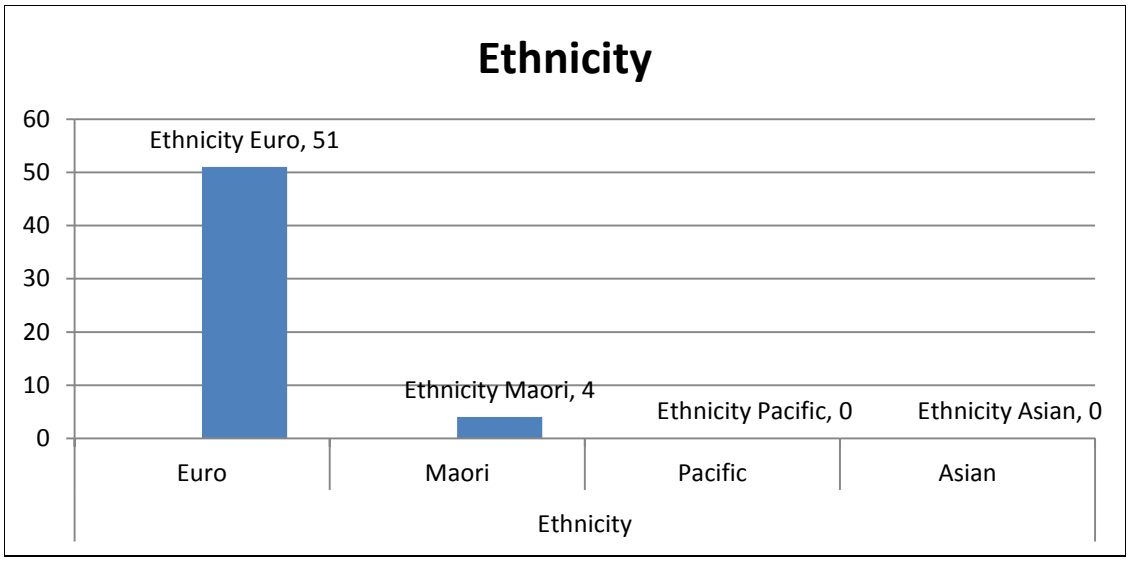
The Wairarapa DHB id committed to improving attendance at pregnancy and parenting classes especially for rural and Maori pregnant women.



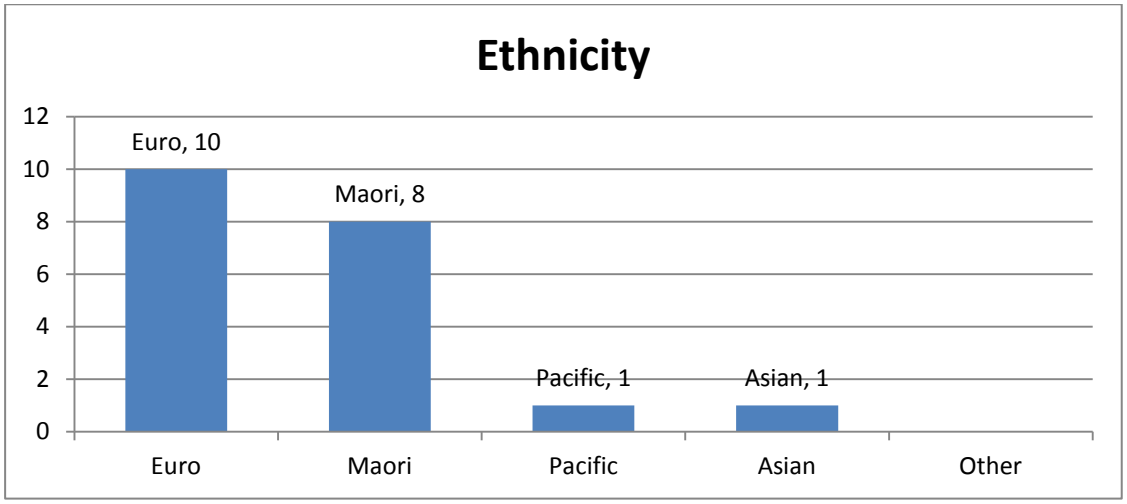
Antenatal Education is outsourced to Parents Centre Wairarapa

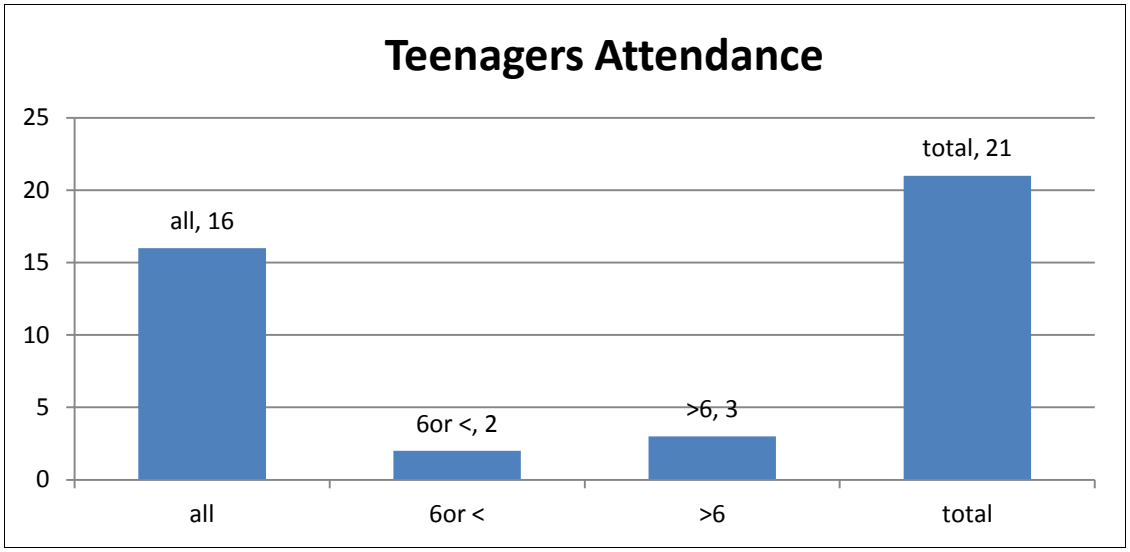
Antenatal Class attendance -





Teen Parent antenatal classes attendance 2011





MQSP Governance and Operations

Governance of the Quality and Safety Programme

The governance of the programme will be lead in partnership between the Quality and Safety Coordinator, Charge Midwife Manager, lead obstetrician and the Nursing Director.
The quorum will include LMCs and consumers. The governance is overseen by the CMO, DONM and GM Clinical Services. There will be an annual report provided to the Clinical Board.
A clinical leadership role has been undertaken by David Cook, Obstetrician, to progress the actions and improvements for the Clinical Indicators.

The Clinical Indicator KPIs monitoring and improvement planning is being led by one of the, Obstetricians. Support to sustain the programme will be provided by the Nursing Director, the General Manager Clinical Services, the CMO and by the Director of Nursing and Midwifery. The General Manager of Quality and Risk is also kept informed to ensure that the KPIs and improvements are incorporated into the Quality Accounts, Balanced Scorecard and regular reporting and monitoring activities.

There will be minutes, with actions within agreed timeframes, taken for all key meetings. The GM, CMO and EDONM will receive regular updates via David Cook and Charge Midwife Manager.

It is important to acknowledge that some clinical governance forums have existed prior to the launch of the programme, with consistent participation from hospital staff and LMCs. What is new, and will take some time to build trust and embed, is that the discussions and monitoring generated from some of those forums will become more easily accessible within the DHB. This means that the introduction of new ways of working as a result of the programme needs to be made in a way that enables the safe environment and pragmatic discussions to continue.

Workforce

Following a long period of midwife vacancies, the hospital is now at full FTE. However, during the same period of achieving full employment, there has been a significant shift in the independent LMC workforce. 2 GP LMCs and 5 LMCs have withdrawn from independent work. This represents about 50% of the LMC workforce that Wairarapa women had access to 18 months ago. This has been the key driver for reviewing the model of care at the hospital, which has been a collaborative process including management from both the provider arm, planning and funding, core midwives and LMCs.

The DHB has employed locum LMC midwives to bridge the gap whilst LMCs are integrated into the area. There are still approximately 10 women a month who cannot book with an LMC so the DHB is providing primary care as last resort.

Inequalities in Outcomes

Inequalities in outcomes have recently been focussed on the caesarean delivery and induction of labour with audits undertaken for both measures. The data is in the analysis stage, with actions to be identified once the analysis is complete. In particular, for caesarean section a monthly audit meeting has been implemented with the first meeting held in May 2012. This includes peer review, and will include case review on a case by case basis with input from the CMO.

MQSP Governance and operations

The MSG will monitor agreed quality performance indicators to ensure effective service delivery and the best possible outcomes for women and their babies.

The Group has an advisory role to Wairarapa DHB, through the Clinical Services management team.

It will provide advice to all relevant stakeholders on:

- The implementation of evidence based best practice in the delivery of maternity care.
- The performance of the participating members and associated organisations both individually and as a collective system of integrated services.
- Issues and opportunities in the maternity service and the wider health sector that provide opportunities to improve outcomes for service users and their family whanau.

Further to this, maternity specific patient surveys are under construction. This programme will further build on consumer engagement and quality initiatives gleaned from the feedback.

Wairarapa MQSP Governance Structure

The Wairarapa DHB maternity quality and safety programme is governed by a multidisciplinary team. The governance group includes professional, consumer, administration and management representation along with representatives for the population to ensure that the cultural needs are met and are safe and appropriate.

Name	Role
Michelle Halford	Nursing Director
David Cook	Obstetrician
Donna Thompson	Charge Midwife Manager
Jo Clarke	Maternity Quality and safety Coordinator
TBC	Hospital Manager
Anne Marie Gibbs	Core Midwife
Clare Bardsley	LMC Representative
Julia Black	LMC representative
Lisa Burch	Portfolio Manager SIDU
Yvette Grace	Compass Health (PHO)
Joan Gibbs	Well Child Representative
Kiri Playle	Consumer Representative
Anita Roberts	Consumer Representative
Janeen Cross	Maori Health representative

MQSP Governance Group Responsibilities

- Oversee the implementation of maternity quality and safety activities.
- Ensure consistency across quality activities.
- Support the implementation of recommendations from national bodies such as the Perinatal and Maternal Mortality Review Committee (PMMRC) and the National Maternity Group.
- Take decisions about quality improvement activities.
- Oversee the production of an annual report on maternity services and outcomes.

The governance Group meets quarterly for up to two hours each meeting to oversee and guide the implementation of the programme.

Clinical Leadership

A clinical leadership role has been undertaken by David Cook, Obstetrician, to progress the actions and improvements for the Clinical Indicators.

A new operational management structure was launched in October 2011 with the advent of a Charge Midwife Manager to provide rigour to the day to day clinical leadership in the Maternity unit.

A business case, in partnership with Capital Coast and Hutt DHBs, has been submitted to the three Chief Executives to establish a Director of Midwifery (DOM) across the subregion. This position is seen as a key driver for the clinical leadership and governance of the quality and safety programme. The DOM would be a strategic clinical leadership role working with the maternity team as well as the senior leadership team and the Inpatient Services Manager.

Quality Improvement

NZ Maternity Clinical Indicators

The work to improve the clinical indicator outcomes is being lead by one of the obstetricians. A clinical indicator will be discussed in depth on a rolling month programme at the MDT education. The format that is followed is that an indicator is discussed and a relevant case review presented as a reflective tool for learning. Issues arising from the case review are identified, and multidisciplinary discussion enables further learning and investigation.

A caesarean section audit for 2011 data is underway as a comparison for the 2010 audit. The caesarean section rate at Wairarapa DHB has been a focus for some time, as the clinical indicators have shown; Wairarapa has a consistently high rate in comparison nationally. The lead obstetrician is undertaking a caesarean section audit and on analysis will be able to identify key themes which will be addressed.

Data against Clinical Indicators 2011

No. of Births

Age 20 - 34 inclusive single births only (excludes twins, still borns)

PRocedureOrder	1

ProcedureCode	ProcedureDescription	Count of NHI
1652002	Elective lower segment caesarean section	46
1652003	Emergency lower segment caesarean section	57
9046700	Spontaneous vertex delivery	225
9046800	Low forceps delivery	1
9046801	Mid-cavity forceps delivery	1
9046900	Vacuum extraction with delivery	25
9046901	Failed vacuum extraction	3
9047000	Spontaneous breech delivery	1
9047001	Assisted breech delivery	1
9048100	Suture of first or second degree tear of perineu	1
9048200	Manual removal of placenta	1
Grand Total		**362**

C-Section Rate - Emergency & elective
103
362
28%

Episiotomy

Age 20 - 34 inclusive single births only (excludes twins, still borns)

15 of them I could identify have had sutures - see sheet 'Episiotomy'

PRocedureOrder (All)

ProcedureCode	ProcedureDescription	Count of NHI
9047200	Episiotomy	49
Grand Total		**49**

Any coding with General Anaesthesia

Age 20 - 34 inclusive single births only (excludes twins, still borns)

Only 2 NHI's were coded with a GA and neither had C Sections

PRocedureOrder (All)

NHI	ProcedureCode	Procedure
ALA6245	9251410	General anaesthesia, ASA 10
GEE1088	9251420	General anaesthesia, ASA 20
Grand Total		

PRocedureOrder (All)

NHI	ProcedureCode	Procedure
ALA6245	1370602	Transfusion of packed cells
	9046501	Medical induction of labour, prostaglandin
	9046700	Spontaneous vertex delivery
	9048100	Suture of first or second degree tear of perineum
	9048200	Manual removal of placenta
	9251410	General anaesthesia, ASA 10
GEE1088	9046500	Medical induction of labour, oxytocin
	9046501	Medical induction of labour, prostaglandin
	9046700	Spontaneous vertex delivery
	9048200	Manual removal of placenta
	9251420	General anaesthesia, ASA 20
Grand Total		

Any coding with blood transfusion

Age 20 - 34 inclusive single births only (excludes twins, still borns)

Only 5 NHI's were coded with a transfusion of packed cells

PRocedureOrder	(All)

ProcedureCode	ProcedureDescription	Count of NHI
1370602	Transfusion of packed cells	5
Grand Total		**5**

Quality and Safety Processes in Place

A number of quality and safety processes that are used for quality improvement purposes are in place, many meet with national reporting measures. These include –

- PMMRC – Perinatal mortality morbidity review committee
  The local PMMRC coordinator holds 3 monthly meetings, attended by a multidisciplinary team; case studies are reviewed as required.
- AMOSS – Australasian Maternity Outcomes Surveillance System
  AMOSS is reported on monthly.
- Reportable Events process
  Robust reportable events are processed by the Quality Leader for maternity and the CMM is involved as appropriate.
- Clinical Case Review
- BFHI – Baby Friendly Hospital Initiative
  Wairarapa DHB is accredited BFHI.
- BFCI – Baby Friendly Community Initiative
- Health Round Table
- Maternity monthly meeting – case review, local audits, relevant education, PMMRC cases, MDT meeting
- Hand hygiene
- Surgical site surveillance (caesarean sections)
  Surgical site surveillance is reported to the HAC by Quality Leader for Maternity.
- Medication management

Smoke free Pregnancy

Significant amount of resources has been put into providing easily accessible smokefree services to pregnant women who smoke in the Wairarapa. The Wairarapa DHB has staff working in smokefree

Health Promotion, enforcement of the Smokefree Environments Act and assisting people to quit smoking.

All women are offered smoke free advice at booking and any admissions to the Maternity Unit. Regular audits are in place to check if women are being offered full support for smoking cessation.

The Wairarapa DHB is progressing towards 90% of women who identify as smokers at the time of registration with LMC are offered advice and support to quit.

Decision Making and Relationship Management Locally and Regionally

Close working relationships already exist between the CMMs and Associate DOM post holders at Wairarapa, Hutt and Capital Coast. The Central Region Midwife Leaders group is well established. The opportunity with the quality and safety programme is to more widely promote the discussions and recommendations of the Central Region Midwife Leader Group within the Wairarapa maternity providers – core midwives, LMCs, obstetricians and DHB management.

Work commenced by the Central Region Midwife Leaders group to standardise processes and competencies across the region will be built on through the programme. For example, the regional midwifery passport which is an initiative to standardise education and practice for epidural certification, foetal surveillance and technical skills workshops.

The Quality and Safety Coordinator will link with our subregion partners to further enhance the relationships.

Quality and Safety Processes as a result of the Programme

The existing processes described above will be supported by the Quality and Safety Coordinator who will develop and implement processes and systems, including routine reporting.

This has been further supported by the formalising of monthly audit meetings relating to clinical practice, the findings/outcomes along with current research on best practice are then presented to Maternity Providers. The minutes are available via the Maternity Workspace on the DHB Intranet. Access to the intranet workspace will be limited to specific logins for the multidisciplinary team to ensure the privacy and safety of the information.

Other reviews and Training/teaching includes NLS (New born life support).

The DHB has become provider of last resort until the LMC shortfall is sorted. Safe staffing is the basis of success for the quality and safety initiative.

The Clinical governance forums (maternity strategic group) are meeting every 3 months these meetings involve LMC and consumers. There are quarterly information updates through midwifery workspace for the dissemination of local audit data and information sharing to health professionals.

The Referral Guidelines are based on best practice and were compiled by the Ministry of Health with input from stakeholders, to provide guidance about referrals from LMC to specialist medical care when a woman or her baby has certain specific condition during pregnancy, childbirth or the postnatal period. The aim is to improve the quality and safety of maternity care to ensure women are referred by their LMC at the appropriate time to the appropriate person.

A tool has been devised and implemented for handover, this has improved the process for transferring the care of a woman under the care of a LMC to an Obstetrician and reversal of process, this underpins

the importance of the "3 way" conversation needed between the woman, LMC and Obstetrician (*Guidelines for Consultation with Obstetric and Related Medical Services 2012*) this ensures the patient journey becomes a safe and positive experience. This is also the process for emergency referral. An out patient referral form has been developed; this is a document to ensure the woman, LMC and Obstetrician have a 3way conversation, and understand the consequences of said conversation. This document is signed by the 3 people involved and stays with the woman's hospital notes.

All women who are referred by their GP for secondary care is triaged by the Charge Midwifery Manager and appropriately booked for secondary care or are given their options of LMC care.

Establishment of the Programme

The establishment and implementation of the programme has been coordinated by the Quality and Safety Coordinator (up to 0.4 FTE). Reporting to the General Manager and on a day-to-day basis will work closely with the Charge Midwife Manager.

The Quality and Safety Coordinator is tasked with developing routine reports and associated analysis. This will include working with the obstetricians, midwives and our business analyst team to develop meaningful, measureable and robust reports.

Community participation in multidisciplinary forums is strong. We do not wish to undermine that or misrepresent their participation by all of a sudden introducing a stipend to attend. Instead we are finding other ways to entice regular participation in the meetings. This will include, but is not limited to production of reports, presentations and providing refreshments for meeting during lunch time.

The programme coordinator, Charge Midwife Manager and General Manager are the drivers behind the development of this robust and achievable annual plan. There has been input from across the multidisciplinary team, Maori Health, Public Health, representatives from provider arm and planning and funding managers, with sign off from the senior leadership team.

Developing a Supportive Environment to enable Open Disclosure

Wairarapa DHB already has an established culture of open disclosure as part of the reportable event process.

There is a conscious and deliberate effort in the multidisciplinary meetings to make it a safe, non-punitive and blame free environment. The woman and her baby is the focus of the discussions and all multidisciplinary members are cognisant of the limitations of the service, that is, in the rural secondary care context. LMC attendance is strong and participation is active, including LMCs presenting cases.

The work of the Quality & Safety Coordinator will further augment this way of working.

Engagement with Community Practitioners and Participation in Governance and Quality Improvement

Wairarapa Hospital has a named LMC Liaison who attends the multidisciplinary meetings. The intent of this role is so that she provides a link between the community and hospital and can provide feedback to the LMCs who are not able to attend, thereby ensuring all our community practitioners are involved and informed. This does not preclude other LMCs attending the meetings.

There are two LMC representatives on the Guideline Review Committee which has recently been instigated.

One of the issues identified was the gap in communication between GP's and hospital based maternity care providers. They have since been informed about the referral guidelines and maternity standards issued by MoH.

To avoid this in future, regular and effective communication between the CMM and GP's has been a priority and a lot of work involving this is underway.

As part of the Maternity Quality and Safety Programme, it was agreed by all to develop a inpatient Maternity specific consumer satisfaction survey which provides a basis for reviewing and upgrading systems and practice. The survey will begin 1st July and results discussed at each Maternity Governance Group meetings.

Priorities, deliverables and planned actions for 2013/14

- Regular MCG meetings.
- Recruitment of LMCs to area.
- Antenatal education.

We will work with antenatal education providers to ensure women are offered and receive antenatal education. Service specification has been in place since 2002. This outlines what each DHB funded course must cover.

There is on going discussion around providers of antenatal education in this area within the DHB.

We will focus on:

- Who attends
- How they access this service
- Breastfeeding improvements. We will work with stakeholders to improve breastfeeding results on discharge from the ward.
- Access and delivery of guidelines and protocols.
- Standardise policies between 3DHBs and add to workspace.
- Website -this is a work in progress.
- Maternity specific surveys
- Ensure consumer input is established at all levels of Maternity services.
- Improvement in number of women who book with an LMC by 12 weeks.

We will link with college of midwives to establish the scope of this project and develop a plan for implementation. To manage the information from one electronic data source, but linked to a range of it systems.

Currently the hospital intranet hosts a Midwifery workspace which LMCs can access when they are at the hospital. The site includes information such as an Event calendar with details about local and regional education. LMCs can apply to attend these events along with hospital staff.

Meeting the strategy to share data and information between the DHB and community practitioners such as LMC registration rates and trimester of registration is considered a significant challenge. It is the DHB understands that there is a national approach being explored through the National lT Health Board. For Wairarapa DHB, the solution would need to fit with the Central Region Information System Plan (CRISP).

The future Strategic Plan will also include involvement from community practitioners and consumers as part of the engagement process under the programme.

Endorsement

This Annual Plan has been collaborated on with the following –

Charge Midwife Manager
Quality Leader, Maternity
Quality and safety Coordinator
Obstetricians
Public Health Manager
Maori Health Manager
Planning and Funding, Maternity Portfolio Manager
Director of Quality, Safety & Risk

The Annual Plan is endorsed by –