Maternity Quality & Safety Programme

Annual Report

July 2013 – June 2014

WAIRARAPA maternity
Wairarapa Maternity Care

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

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Section One: Aims/Objectives of the MQSP in the Wairarapa

Wairarapa DHB held a workshop with maternity staff and LMCs in October 2012 where the five principles were confirmed as a framework to develop the maternity service and meet the requirement of the Maternity Quality & Safety Programme.

PRINCIPLES OF THE MATERNITY CARE FOR WAIRARAPA WOMEN

1. Develop an inclusive maternity service.
2. Evolve into a more women centered 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).

Following this the Strategic Plan for the Maternity Quality & Safety Programme was written Nov 2012 and included the following objectives:

- To implement the new role of Quality & Safety Programme Coordinator to establish the programme and put systems and processes in place to ensure the programme becomes business as usual
- To develop clinical governance forums that are well attended by core midwives, obstetricians, midwife LMCs, the GP LMC and other health professionals or consumers as appropriate
- Develop robust, measureable and meaningful reports for monitoring and improvement plans against Clinical Indicator KPIs
- Define the model of care as a result of the decreasing number of LMCs in the district
- Work with antenatal education providers to ensure women are offered and receive antenatal education tailored to complement the maternity service provided at Wairarapa Hospital
- Work with antenatal education providers, public health, the Maori Health Team, consumers and iwi to ensure breast feeding rates following discharge are improved.
- Implement a tool for handover from LMCs to secondary care, and return to LMC

These objectives have been set and the Maternity Clinical Governance Group formed to ensure the following Maternity Standards of care are achieved:

Standard One: Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.
Standard Two: Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage.
Standard Three: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

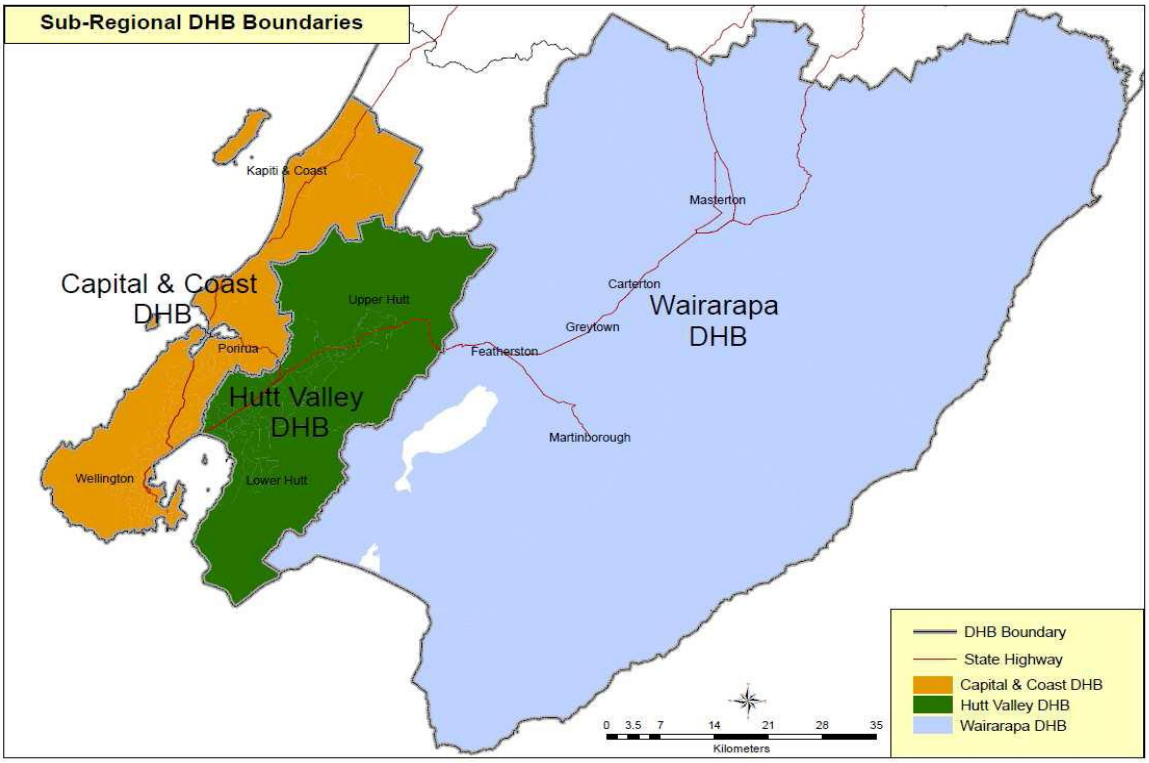
February 2013 a Maternity Quality & Safety Co-ordinator was appointed for a period of 5 months, in October 2013 the current co-ordinator Michelle Thomas was appointed.

Section Two: Wairarapa DHB Maternity Service

Wairarapa DHB is one of the smaller DHB maternity service providers in New Zealand that provides both primary and secondary care facilities. The DHB consistently supports 500 births annually from a population of just over 40,000. The maternity services are based at Wairarapa DHB in Masterton; this is the only birthing facility in the region, the number of homebirths for the district was 11 births for the year 2012.

The Wairarapa region is located in close proximity to three other larger DHBs – Hutt Valley, Capital and Coast, and MidCentral DHBs who all provide additional secondary and tertiary services to Wairarapa residents. With the 3 DHB merger happening the majority of the time transfer to CCDHB and Hutt would be the preference. 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, this is described as rural and remote rural.

Figure1: Sub-Regional DHB Boundaries



Workforce

The beginning of the 2013 year was a very challenging time for the maternity services in the region as the sudden loss of a GP LMC with a high caseload impacted tremendously on the maternity unit. This loss left 4 LMC midwives in the community and an approximation of 150 women without a named LMC.

As an interim measure the DHB became the LMC for women due to birth in the immediate term while a national drive to recruit midwives to the area was launched. This pressure was intensified by the fact that the DHB also was under FTE at this time. Over a period of 6 months the women of the

Wairarapa were cared for by locum LMC's and DHB core midwives, the support nationally was immense and the end result ensured a high standard of care for women. LMC numbers gradually increased in the region and a full compliment of core midwives was achieved. There are now 15 core midwives employed by the DHB who work between 0.8-0.6FTE. Several of the midwives have worked for the DHB for many years and a number have also worked in primary midwifery teams and/or as LMC midwives, giving the team a broad experience in the provision of maternity care.

The Maternity Service also includes the following staff:

- Director of Operations, Surgical, Women's and Children
- 2 Obstetric Consultants including 1 who is Clinical Head of Department, Obstetrics and Gynaecology
- Charge Midwife Manager
- Midwife Educator and Maternity Quality & Safety Programme Co-ordinator
- Newborn Hearing screener and Co-ordinator
- 2 Antenatal and Parenting Education Midwives
- 1 HIV coordinator Midwife
- Midwifery and medical students on placement

Primary maternity care is provided by self employed LMC Midwives who have an access agreement to use the facility. The DHB has 9 LMC midwives with primary access agreements providing care to the majority of women in the region; there are no GP or private obstetricians offering LMC services and longer.

Women who require Secondary Care services, as outlined in the Guidelines for Consultation and Referral (MOH, 2012) are cared for by hospital obstetricians and midwives .

Maternity Ward and Birthing Suite

The maternity ward is made up of 6 single rooms with en-suite facilities; these cater for postnatal stay following birth and antenatal admissions over 20 weeks gestation. The paediatric ward has 'Rooming- in' facilities for mothers whose baby is on SCBU.

Birthing Suite

The birthing suite consists of 2 rooms; each is fully equipped for labour, birth and neonatal resuscitation. In addition there is the LDRP room which is currently used by LMCs as an antenatal assessment room for women who present with conditions such as reduced fetal movements or ?pre labour rupture of membranes. It is also used as an additional birthing room. The LDRP room and 1st labour and birth room have access to an adjoining waterbirth pool/ en suite room.

There are 2 core midwives on each shift who work across the ante/postnatal ward and birthing suite. They provide emergency care and support the LMC midwives as required.

There are 2 obstetric consultants, including one who is Clinical Head of the Department Obstetrics & Gynaecology, there are visiting O&G specialists to provide additional weekend and leave cover. The obstetric consultants are rostered to provide on call cover for the service 24hours a day.

Secondary Care Obstetric Clinic

Women are referred by their LMC for obstetric assessment as per the Guidelines for Referral and Consultation (MOH 2012). Referrals may be made by the LMC from point of registration onwards. The decision to transfer clinical responsibility is dependant on the reason for referral and made in accordance with the MOH guidelines. However, there are LMCs who continue to provide midwifery care for the woman alongside the secondary service.

Acute episodes e.g. pain/bleeding in early pregnancy are managed by the Emergency Department.

Anaesthetic Services

A pre-assessment clinic service is available for LMC's to refer high risk women to. There is a 24 hour epidural service provided with an epidural rate of 5 %; this is a relatively low rate for epidural and was identified in the c/s audit undertaken. The recommendation following this is to access epidurals earlier in labour and is in the action plan to address as a response to Maternity Clinical Indicators.

Paediatric Services

We have 3 consultants providing 24 hour emergency CS attendance, we are in the process of reviewing this to include elective CS. They are on call for maternity ward problems and queries.

Lactation Consultant

The DHB employs one lactation consultant (0.8FTE) who provides specialist assistance with breastfeeding for inpatients and on-going support for postnatal mums in the community. Referrals are made by Core Staff, LMC's and sometimes the women themselves.

An important part of the role is to provide Education to DHB staff to maintain BFHI accreditation and midwifery recertification. They also assist with BFHI audit, and quality improvements e.g. reviewing and updating of policies and documentation.

Vulnerable Women's Group

This group has been set up to offer a more formal approach to the support and planning of care to the vulnerable women that are identified by LMC's. The group commenced work on the terms of reference and agreed them in February 2014, appendices attached.

It has a multi-disciplinary and multi-agency approach ensuring that the best opportunity to communicate and facilitate appropriate care for women and their whanau is achieved.

Social Worker

A dedicated women's health social worker is available Monday- Friday. They are a visible presence on the maternity ward and provide an invaluable service. Referrals are made by LMC and core midwives.

CYF Liaison

A CYF liaison Social worker is available to provide support for the service; she works closely with the social worker to attend to the needs of vulnerable women and babies.

Theatre

We do not have a dedicated obstetric operating facility attached to the birthing suite. These facilities are provided by the main DHB theatres which is two minutes from maternity and a same level transfer.

Ultra Sound

Ultrasound scanning has previously had limitations due to lack of sonographers and the expectation was that women were referred to Pacific Radiology in the Hutt Valley or Broadway Radiology Palmerston North for routine scans.

We do have a portable ultrasound available in Delivery Suite and ANC for any emergent obstetric assessment and a limited formal scanning in the imaging department for emergencies. However there is now a private scanning service in Selina Sutherland which is easy to access and thus eliminating the need for women to travel out of region. Though any initial growth scan will have a charge any serial scanning following this would be free for the woman. Tertiary level scanning is provided by Wellington MFM unit.

SCBU

The DHB has a level Special baby Care Unit which has 2 cots; it provides care for babies who are 34 weeks and above. Infants below 34 weeks are transferred out to Hutt or Wellington SCBU.

Pregnancy and Parenting Education

As a result of feedback from consumers and LMC's in the region regarding a lack of classes for young or single parent mothers and information that was not relevant to the maternity unit. The DHB decided to remove the funding for antenatal education from the contracted Parents Centre and advertise the 0.3 FTE to midwives with an interest in pregnancy & parenting education.

Two midwives have been appointed to share the role and thus offer classes to women and their families/whanau on the hospital premises and also in the local Teen Pregnancy Unit at Makoura College. They have also extended this to Whaiora in the hope to target Maori and Pacific Island whanau. The alternate local Antenatal Education provider has returned to providing their education on a basis of payment to attend. The DHB classes are free, provided on-site and in the evening accommodating the working families. Two sets of classes were held towards the end of 2013 and the following shows the data for these:

Class 1:

- The average gestation for admission to class one was 33 weeks gestation.
- The age range of women attending was from 24 years to 31 years

- 8 New Zealand European, 2 European, 1 South African & 1 New Zealand Maori.
- 11 Were primiparous women and 1 multiparous woman.
- There were 3 women waitlisted for this course who, due to the withdrawals, were all accommodated.

Class 2:

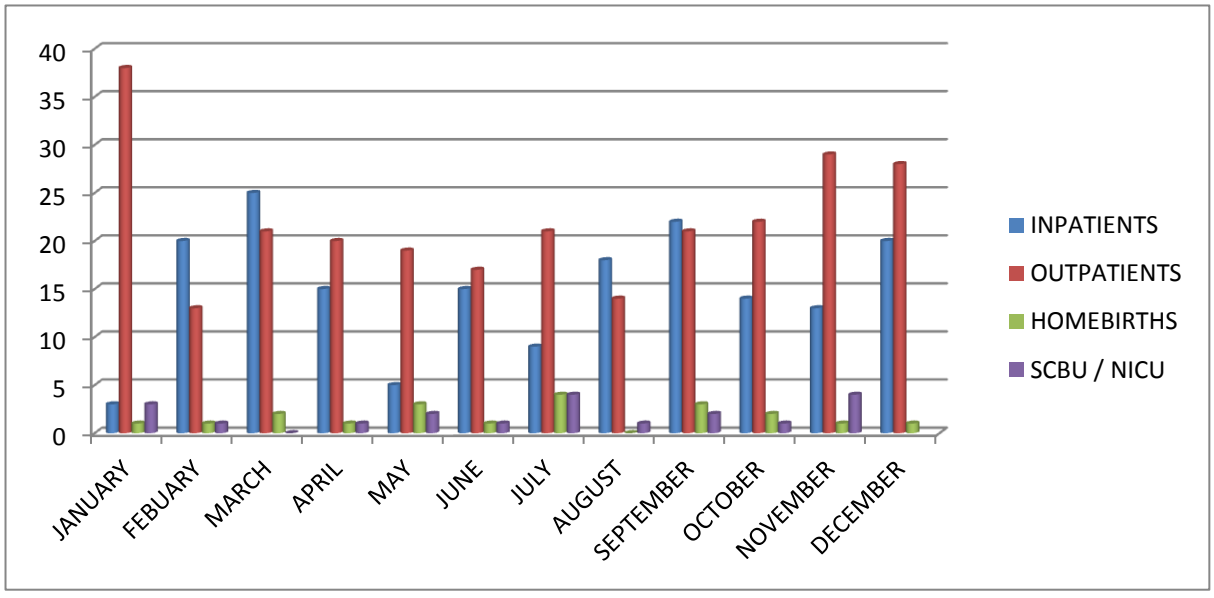
- All 13 women booked on the course were primiparous women.
- The age range of women attending was from 22-36
- 10 were New Zealand European, 1 New Zealand Maori, 1 South East Asian, 1 European.
- The average gestation for admission to class two was 31.3 weeks

Feedback forms are offered to attendees at the end of each course. Participants are encouraged to feed back on the venue, how effective they found the classes, the handouts and the educators. At the end of each course, the feedback forms, along with any verbal feedback received are reviewed by both educators and an action plan is designed to identify and implement areas of for improvement.

Newborn Hearing Screening

Wairarapa Newborn Hearing service is based in the Maternity department at Wairarapa DHB. The coordinator / screener works 0.5 FTE usually Monday to Friday. Because the screener is based in Maternity, babies who are present during her work hours are able to be screened while still in hospital. An outpatient clinic is available to babies that have not been screened as inpatients prior to being discharged home or are homebirths.

Maternity has a close link with Paediatric staff and the Paediatricians, so SCBU babies are screened at appropriate times before they are discharged home.
See below a graph with the breakdown of where the screening is undertaken.



Graph 2.1: Location of Newborn Hearing Screening, 2013.

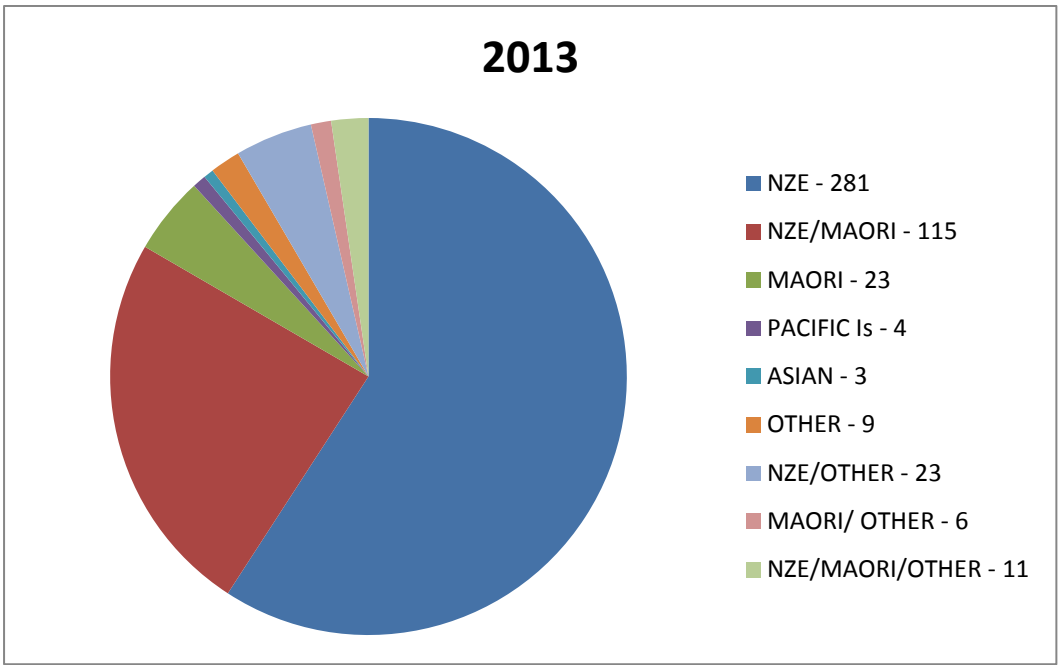
As there is no audiology service available at Wairarapa DHB, all our babies that need referring to audiology services go to Hutt Valley DHB and are seen by them in a timely manner.

An annual survey was under taken and the findings from the survey concluded that the service has been well received and provided in a manner that meets the needs of the population. The success of the programme is evident with the statistics showing 98% of babies screened in 2013.

Data on babies born 2013		
Total number of babies offered screening	**490**	
Total babies screened	**479**	**98%**
Total number of babies declined screening	**4**	**0.8%**
Total number of babies DNA appointments	**7**	**1%**
Total number of babies referred to audiology	**3**	**3**
Total number of babies diagnosis with a hearing loss	**2**	**2**

Table 2.1: Screening outcomes, 2013

The percentage of babies being screened in the Wairarapa is good though we can always do better. The follow up and communication with families/whanau as DNA's is a robust process and one that must be commended on. LMC's support this screening programme and work very well with the Newborn hearing Screener in ensuring the attendance of most of the women and their babies.



Graph 2.2: Ethnicity population screened in the NBHS programme, 2013

Midwifery Education

Professional development and recertification education is provided by the Wairarapa DHB employed Midwife Educator. There has been a regional approach to the Midwifery Council Emergency and Practice Days for midwives which means that the days are held and run locally thus eliminating difficulties of midwives accessing the days, though if they choose to undertake the days out of region this is also supported.

Compulsory breastfeeding, Sudden Unexpected Death in Infancy and Shaken Baby Prevention is a day held for all midwives and paediatric nurses and medical staff, meeting Baby Friendly Hospital Initiative requirements and baby safety.

There are monthly education/audit sessions for midwives and medical staff which are well attended and can focus on issues that may have been identified through a reportable event, or refreshing/updating education regarding reviewed guidelines. These days invite suggestions from midwives as to what they make like updating on and it also offers an opportunity for midwives to give feedback from any workshops/conferences/training they may have attended recently. This also provided evidence for individual portfolios and we are encouraging the participation on the Quality & Leadership Programme.

Section Three: Wairarapa Maternity Data

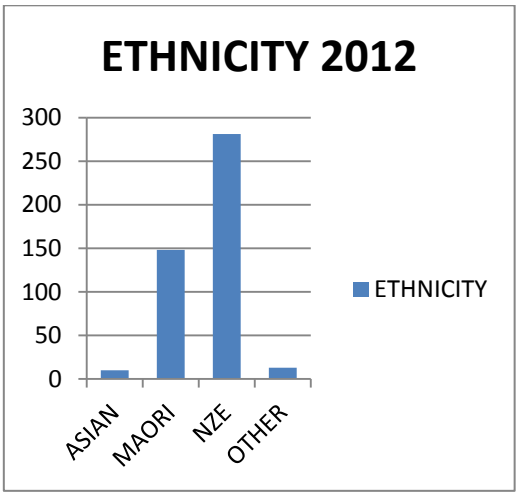
The birthing population of the Wairarapa is made up of a small diversity of ethnic groups. Offering support to the Maori and Pacific Island population Wairarapa DHB has a Maori Health Directorate and Pacific Island support workers and translators'. The maternity service works very closely with Whaiora the region's local Maori Health Provider ensuring to meet inequalities in care identified nationally. As displayed in the graph below births for the year 2012 comprised of :

NZ European 61.5%

Maori 33.1%

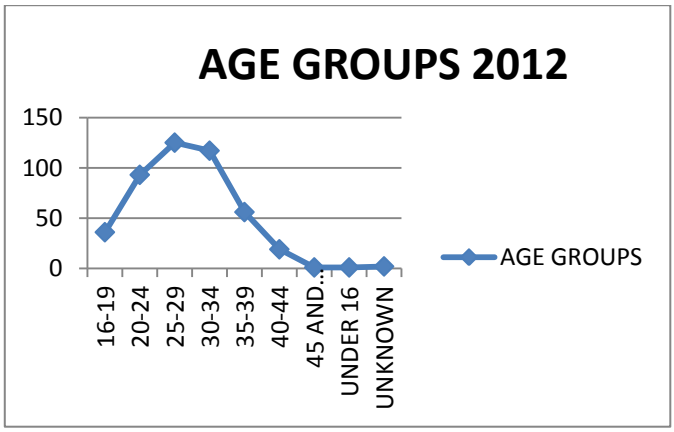
Pacific Island 2.9%

Asian 2.3%



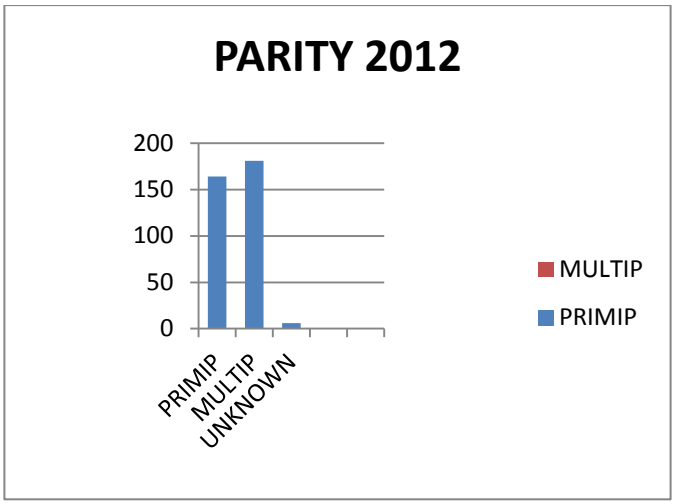
Graph 3.1: Ethnicity population birthing in Wairarapa 2012

As identified in the table below the average birthing age is 25-29, however it does not go unrecognized that there is a significant number of teenagers birthing at 7.9%. To appropriately meet the needs of these young mums, antenatal classes are being held in the Teen Parent Unit at a local college and Whaiora.



Graph 3.2: Birthing population Age 2012

There is no significant difference in parity of birth in the Wairarapa region, as shown in the table below.



Graph 3.3: Parity of birthing population 2012

Trimester of Registration

The data below shows time of registration with an LMC in the Wairarapa region, 2012 has been sourced from MOH.

1st Trimester	2nd Trimester	3rd Trimester	Postnatal	Unknown
314	172	16	2	7

- As a result of the above data which is relatively unchanged from 2011 Pregnancy packs have been developed and have been issued to all GP services in the Wairarapa. The packs included the new Wairarapa Maternity website leaflet, local LMC's leaflets; find your midwife leaflet and information regarding healthy pregnancy and screening. This will ensure all the pregnancy population that initially source GP's regarding pregnancy will all be receiving the same information as early as possible.
- All LMC midwives in the Wairarapa region are on the find you midwife website, we have a link to this on our maternity website.
- Consumers on the Maternity Clinical Governance Group are influential in how we are able to ensure the DHB is improving the barriers that may occur for some when early pregnant.
- The Maternity Clinical Governance Group has decided to see the next activity or phase that we enter will be a project focusing on early registration with an LMC. This will follow on from the Pregnancy Information Packs issued to GP's and the 5:10 campaign.

Birth events

Below in table 3:1 the comparison of data on mode of birth has not differed greatly between the 2011/2012 year. However the expectation that data will have a significant change will be for the 2013 year. Evidence has been provided in the maternity clinical indicators as to how the WDHB maternity service proposes to improve the cesarean section rate.

Table 3.1: Comparison of mode of Birth, years 2011 & 2012.

Mode of Birth	2011		2012	
Normal Birth	299	61%	302	63%
Instrumental Birth	41	9%	37	8%
Elective Cesarean Section	70	14%	59	17%
Emergency Cesarean Section	75	15%	83	12%
Breech Birth	1	<1%	0	0
Stillbirths	1	<1%	2	<1%
Total births	492	100%	483	100%

Below is a comparison on induction rates between the year 2011/2012. Though no significant change has occurred between these years we should see a reduction in the 2013 data.

Table 3.2: Comparison of induction rate, years 2011 & 2012.

Induction Procedure	2011	2012
Medical induction of labour, prostaglandin	34	36
Medical and surgical induction of labour	33	20
Medical induction of labour, oxytocin	13	6
Surgical induction of labour by artificial rupture of membranes	5	4
Other medical induction of labour	1	2

PMMRC

The PMMRC programme is coordinated by the local Midwife Educator/Quality Leader and PMMRC meetings are provided as required when an adverse event occurs. There is excellent support from midwives for these meetings and there has been a very positive response from the LMC's presenting their cases at the review. The meetings are a non-threatening environment and learning and changes to processes are the focus and outcomes of the meetings.

Maternity Clinical Indicators

Due to not having the 2012 maternity clinical indicator data available from the MOH, WDHB is unable to comment on any statistical improvements for that period. However the DHB has identified indicators in the MOH, New Zealand Maternity Clinical Indicators 2011 data that have been a work in progress over the 2012/2013 year.

Indicator 3: Caesarean Section among standard primiparae
A recent (2012-2013) retrospective audit of caesarean section was undertaken to identify indications for both elective and emergency caesarean. The audit was presented in both clinical and administrative forums with recommendations for changing practise in an effort to reduce our relatively high caesarean section rate.

Changes in practise include:

- Increased recourse to epidural anaesthesia
- Augmentation of labour and trial of assisted delivery in operating theatre for prolonged labours
- Improved partogram for assessing progress and need for intervention in labour
- A very positive approach to trial of vaginal birth after previous caesarean section (VBAC)
- A review of VBAC guideline (this was started last year) and IOL to include VBAC induction.
- Careful induction of labour in cases of previous caesarean section Increased recourse to ultrasound assessment in cases of uncertain presentation
- Consideration of external cephalic version in all cases of breech presentation
- Improved fetal resuscitation procedures with abnormal cardiotocographs
- Additional changes in practise are proposed in the future.

Ongoing, prospective audit of emergency caesarean continues to measure the impact of the above changes in practise.

Indicator 4: Induction of labour among standard primiparae
Due to a significant change in the LMC population (now midwifery only LMC's) there is a hope that the induction rate will have reduced over the 2013 /14 year. As identified in the birth data above there has been a decrease in the local data, however this is not against the definition of the standard primiparae. The induction guideline has been reviewed and there is clear definition surrounding the responsibility of care to the woman and the virtual consultation process between LMC and obstetrician. This is a relatively new concept and will be audited in 3 months to be able to evaluate the effectiveness of this new process.

Indicator 12: Premature Birth (at 32-36 weeks gestation)

The premature birth rate in the Wairarapa is 5.1% of the total births, compared to the national average of 6.1%. Moreover, the 2011 data shows that we are significantly below the national average with 2.1% of the births occurring in the Wairarapa facility and the remainder being appropriately transferred to tertiary level care.

However, we do not have any further break down on this data regarding any risk factors identified during pregnancy, nor do we have any relationship with regard to ethnicity, age or parity. This is something that we could be investigating further for our next annual report.

Smoking rates in pregnancy for 2012

Smokers identified	86	17.3%
Advice offered	81	94%
Total discharges	497	

Table 3.3: Smoking rates on the maternity unit, 2012

Smoking rates are just under the national average of 18.4% as discussed in a recent paper published in the NZCOM Journal, (issues 48 & 49, 2013). The numbers in the table above do

allow for antenatal admissions that are discharged home, hence it is not equal to the birth rate.

The smokefree health target for the DHB is that 95% of all smokers are offered advice regarding smoking cessation, maternity falls just under this. For those smokers admitted to maternity they are now offered patches or gum as inpatients and given support for their discharge home. There is a dedicated smokefree champion midwife who in collaboration with the smokefree coordinator is working toward improving outcomes on the uptake of nicotine replacements therapy.

Home Births in Wairarapa

Of 483 births in the Wairarapa region in 2012, 11 of these were homebirths with care provided by LMC midwives. Four of the LMC midwives in region provide the option of home birthing.

Breastfeeding rates at discharge from Wairarapa DHB

Wairarapa DHB is a BFHI accredited facility and views breastfeeding as the norm for all babies born in the unit. With an exclusive breastfeeding rate of 83% on discharge from the unit for 2012 year it is good but there is room for improvement. With this in mind we have focused on improving information shared with the women and educational tools used by the midwives. The DHB has developed a breastfeeding flip chart that is given to women in the antenatal period, the consultation of this included the lactation consultant, LMC's, core midwives, paediatrics and consumers. This flipchart has now been laminated and issued to LMC's to use as an educational tool for the postnatal period and on the unit for core staff. The utilization of this tool for both professionals and consumers has been done to eliminate the confusion or conflicting adivse that women highlight as a concern.

Table 3.3: Breastfeeding status on discharge from maternity, 2012

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Exclusive	86%	94%	81%	82%	76%	87%	91%	79%	89%	89%	82%	85%
Full	2%	0%	7%	5%	0%	6.5%	0%	13%	3%	7%	9%	6%
Partial	7%	4%	5%	5%	12%	0%	7%	0%	8%	2%	0%	6%
Artificial	5%	2%	7%	8%	12%	6.5%	2%	8%	0%	2%	9%	3%

The above statistics are based on 450 births 2012, the remaining 38 births have had no breastfeeding status noted on discharge.

Section Four: MQSP Governance (MCGG)

Maternity Clinical Governance Group

Wairarapa DHB established the Maternity Clinical Governance Group to oversee the Maternity Quality & Safety Programme. The recruitment process for the members of this group commenced in June 2013 with a variety of methods to reach a wide group of stakeholders, the inclusion of the Senior Leadership Team provides links to the clinical board, ensuring they are alerted to relevant matters.

Local recruitment for the position of 2 consumer representatives had a positive response with many applicants. Following interviews the consumers were chosen and attended their first meeting in December 2013. Maori representation is strong on the group with a member from the DHB's Maori Health Directorate and the local Maori Health Provider along with 2 members being Maori. It is our vision that having this representation will enhance the relationships and services available to our Maori birthing population and their whanau.

MATERNITY CLINICAL GOVERNANCE GROUP MEMBERS	
David Cook, Obstetrician	Alison Andrews, Charge Midwife Manager
Sarah Boyes, Director of Operations	Janeen Cross, Maori Health Directorate
Annemarie Gibbs, Core Midwife Rep	Clare Bardsley, LMC Rep
Michelle Thomas, MQSP Coordinator	Kiri Playle, Consumer Rep
Anita Roberts, Consumer Rep	Michelle Halford, Associate Nursing Director
Yvette Grace, Primary Health Rep	Lisa Burch, SIDU
Andrea Teahan, Whaiora	Michelle Sole, Plunket

Three meetings have been held to date and Terms of Reference were developed and agreed, these are attached as appendices 1.

MQSP Presentation to the Board

In March 2013 the MQSP Coordinator and Charge Midwife Manager were given the opportunity to present the Maternity Quality & Safety Programme to the Clinical Board to report on what had been achieved locally. The response to the presentation was immense, the Board was very impressed with the programme and how it has been implemented; the Chair has requested that a presentation is made to the DHB Board.

5 to do's when first pregnant (5:10 Campaign)

This is an advertising campaign which has a 3 DHB approach and will be sourced through media, newspapers, back of buses and local community newsletters.

The aim is to advertise:

- Find a LMC
- Take folic acid and iodine
- Make a decision about screening tests
- Give your baby the best possible start
- Eat well and stay active

Identification of lack of USS Service

In response to the National Maternity Monitoring Group requests in the letter January 2014 regarding ultrasound services the consumers on the MCG Group both shared concerns regarding the need to access USS out of region. The Maori Health Directorate also agreed that there is often barriers for women to travel out of the region and therefore often do not attend.

Fortunately there is now a private USS service at WDHB but again this can be a barrier in the need to pay. The group agrees that there needs to be some changes or recommendations made to ensure the delivery of this service is equitable to all women. Within the Imaging Service there is a new member of staff being trained to undertake scanning and hopefully this will enhance the public service at WDHB and reduce the need for women to travel out of the region.

Consumer Feedback

Due to the maternity specific consumer feedback form being such a recent initiative we have not yet compiled the data and formally feedback to the appropriate forums. However a brief overview of them is of a positive nature and we look forward to analyzing this data further. The feedback forms will be shared with the MCG Group at the next meeting.

Section Five: Quality Improvement

Referral Guidelines 2012

The Referral Guidelines 2012 have been implemented in the Wairarapa by means of several education sessions which have good attendance from LMC's, obstetrician's and core midwives. Through this implementation process it was identified that an improved referral form from LMC to obstetrician would be required. This was developed and included the plan of care from the consult, 3 way conversation and documentation of such.

The transfer of care sticker was also developed with the intention that it gives clear recognition in the body of the woman's notes as to whom is responsible for her clinical care.

MOH Post Partum Haemorrhage Consensus Statement

To meet national recommendations WDHB reviewed the local Post partum haemorrhage guideline and made reference to the MOH Post partum haemorrhage consensus statement. The revised guideline and consensus statement are an integral part of the education provided on the Midwifery Emergency Day meeting recertification requirements for midwives.

Community

December 2013 saw the launch of the maternity website for Wairarapa women. The website consists of information from initial pregnancy to 6 weeks postnatal. There are a multitude of links on the website appropriate for women to access i.e. find a midwife, women matter, etc. Posters about the website were delivered to GP surgeries, day cares, Kohanga's, pharmacies, and libraries throughout the Wairarapa promoting it to the community.

Vulnerable Women's Group

This group has been set up to offer a more formal approach to the support and planning of care to the vulnerable women that are identified by LMC's. The group commenced work on the terms of reference and agreed them in February 2014, appenices 2.

It has a multi-disciplinary and multi-agency approach ensuring that the best opportunity to communicate and facilitate appropriate care for women and their whanau is achieved.

Local Policy and Guideline work

Historically the local maternity policies and guidelines have not had the required attention to keep them up to date, with some guidelines being as many over 6 years old. This has been made a priority since August 2013 to ensure the provision of current evidence based guidelines at a local level for professionals working within the maternity unit.

A spreadsheet was devised of the guidelines to review. Each policy/guideline was allocated to obstetricians and midwives who had an interest in particular areas. During the review we collaborated with HVBHD & CCDHB to ensure 3 DHB alignment where possible; all reviewed policies and guidelines are now available via the DHB intranet and Midwifery Workspace.

Pregnancy Information Packs

February 2014 was the beginning of the Maternity Quality & Safety road trip around the GP surgeries of our region. We recognize that historically and culturally there has been a strong GP presence within the maternity services and therefore many women still continue to see the GP as the initial contact when becoming pregnant. This was the opportunity for the M Q & S Coordinator and Charge Midwife Manager to go to the surgeries and talk about the M Q & S Programme and what we have done so far. We went with the Pregnancy Information Packs that we have developed as a DHB resource, it contains information for women regarding finding an LMC, LMC flyers, maternity website flyer, healthy eating, exercise, being smoke free, folic acid, iodine, initial bloods, screening options early in pregnancy. The aim of the pregnancy information pack was to ensure a consistent approach to the information that women receive when first pregnant and also current information especially with regard to LMC's in our local area.

The intent is that this initial engagement with the GP surgery's will be a stronger and long lasting relationship between maternity services and general practice. The visits have been very welcomed and the practices certainly look forward to seeing us again and providing information and feedback to the coordinator as a point of contact.

Maternity Newsletter

This newsletter has been developed to provide information for consumers and health care professionals about what is happening with the M Q & S Programme, it will be a quarterly newsletter, the first one was published in March 2014.

5:10 Campaign

As a region Capital & Coast, Hutt Valley and Wairarapa DHB decided to run a campaign on the 5 most important things to do in the first 10 weeks of pregnancy. For the Wairarapa region this follows on well from the Pregnancy Information Pack that we have distributed to GP surgeries. The campaign was to be marketed through different means of media advertising. Following consultation with local communications and funding department the 2 DHB's agreed we would advertise through radio, newspapers and printed posters in the community. The posters in the community again gave the opportunity for the co-ordinator to be visible and spreading the word on this campaign. The posters were put up in a huge variety of venues from pharmacies, GP surgeries, Kohanaga Reo's, childcare centres, libraries and Plunket.

Midwifery Workspace

The midwifery workspace is available via the DHB intranet and has evolved into a resource for staff both midwifery and medical that is a central base for communication, sourcing of information and location of local policies and guidelines. This if working very effectively and is excellent preparation for the evolving of a more electronic future.

Section Six: Forward Planning

Priorities, deliverables and planned actions for 2013/14

To hold regular MCGG meetings.

Recruitment of LMCs to area.

Antenatal education:

- Who attends
- How they access this service

Breastfeeding improvements:

- We will work with stakeholders to improve breastfeeding results on discharge from the ward.

Other Objectives:

- Review of local guidelines and protocols.
- Standardise policies between 3DHBs and add to workspace.
- Launch of a Maternity Website.
- The development of a Maternity specific feedback survey.
- Ensure consumer input is established at all levels of Maternity services.
- Improvement in number of women who book with an LMC by 12 weeks.

As shown above were the priorities and planned actions for 2013/14 and throughout this report evidence and explanations have been given as to how these have been achieved. The reflection that so much has been achieved throughout this 2013/14 year is due to the team of motivated and enthusiastic individuals who are working together to improve the service offered to women and their whanau. The 2013/14 year has been an opportunity to embrace the Maternity Quality & Safety Programme.

Following are the priorities and planned actions for the 2014/15 year.

Priorities, deliverables and planned actions for 2014/15				
Objective	**Action**	**Progress notes**	**Expected completion date**	**Completed date**
Consultation with CCDHB to implement using Maternity Early Obstetric warning score documentation (MEOWS)	○ Obtain copy of developed MEOWS ○ Discuss with Consultants and CMM ○ Roll out to staff if appropriate	○ Consensus on the chart layout		
Collection of Data	○ The collection of local data in relation to the Maternity Clinical Indicators has proved to be difficult due to the way DHB data is collected.	○ Discussions are occurring at present with the lead obstetrician, coders, IT department and Hutt Valley IT department to progress the collection of data and put into a dash board system such as Hutt Valley. ○ The urgency to ensure a robust system to collect is of priority in view of reporting on this in the future. ○	October 2014	
Ensure Maternity specific procedures and guidelines are updated and document controlled	○ Undertake stock take of Maternity procedures/guidelines and their currency ○ Establish a timetable for review ○ Consult with 2/3 DHBs to establish priority and shared guidelines	○ Spreadsheet developed ○ 8 Guidelines uploaded onto intranet April 2014	Ongoing	
Audit the completion and feedback of obstetric consultations to the LMC, as per the Referral Guidelines 2012	○ Discussed at interface meeting ○ Referral document to be amended ○ Consultants to contact LMC by phone or letter with plan of care	○ Referral document amended March 2014 ○ Letters are being generated to LMC's or phone calls.	Ongoing	

Consumer Engagement	○ A consumer feedback form specifically for the maternity services has been developed and was launched 2 months ago.	○ To date we have received 19 responses and moving forward it is a priority to plan how the feedback will be analysed and filtered to the appropriate channels. ○ The electronic version will be available on the maternity website by Aug 2014.	August 2014	
Improve early registration with an LMC as 38 % of women are not registering with an LMC until 2nd trimester or later.	○ The MCGG are to discuss how to get the message out to consumers regarding the importance of registering early with an LMC. Discussions in the coming months will provide some direction on our next project	○ To be tabled for the next MCGG meeting	December 2014	
Formalise a local Maternal Mental Health Pathway	○ We are fortunate that Wairarapa DHB has just recruited a new clinical psychologist who has a particular interest and a wealth of experience of working in Maternal Mental Health. This will provide us with an opportunity to focus on improving support structures and processes required to care for these women appropriately.	○ We are currently collating support services that are available in our region and developing a list to be distributed to the LMC's. ○ As part of the midwifery recertification process midwives will be attending a midwifery practice day that has a specific section on maternal mental health. This will therefore be the ideal forum to educate midwives on what the process is and which services are available to women in their region.	February 2015	

Transition to business as usual, Wairarapa DHB maternity unit is very fortunate to have a Quality Leader employed by the Quality Department with a specific focus on maternity care.	○ The Quality Leader is the MQSP Coordinator and can envisage that by July 2015 the business as usual component of the MQSP will be absorbed into the Quality Leader role	○ However the DHB will need to assess where supporting funding will come from in order to support the consumers on the MCGG, the maintenance of the midwifery website and the Pregnancy Information Packs to the GP surgeries.	July 2015	
Providing antenatal education for Maori/Pacifica population.	○ To provide an antenatal programme specifically aimed at the Maori/Pacifica women and whanau. ○ To collaborate with Maori Health Directorate and an individual from local Iwi.	○ Meeting is planned with Maori Health Directorate, Iwi, Charge Midwife Manager, Quality Leader and Antenatal Educators.	October 2014	

APPENDIX 1

Maternity Strategy Group

Terms of Reference

DHB GOAL:

An integrated Maternity Service that enables the best possible care and support for the women of the Wairarapa.

Members of the Maternity Strategy Group (MSG), including organizations and representatives external to the DHB agree to:

- Nominate an organization member to fully participate in the MSG.
- Allow regular service delivery information and reports, to be shared with the MSG to enable the service monitoring role of the Group.
- Maintain confidentiality of all information provided through the MSG other than that which has been agreed by the Group as being available for public use.
- Through minutes, record the views of each member/organization on a matter, but agree to support the decision of the Group majority in recommendations and subsequent implementation .
- Full representation of the Group's recommendations to participating organizations and actively work to implement these where feasible.

The MSG will make the assumption that inter agency and contract management relationship meetings will occur between organizations outside the parameters of the MSG, as needed. Parties will agree to take issues that arise from these meetings to the MSG where they impact on the integrated service and would benefit from the input of all participating organizations or require a systemic response.

BACKGROUND

Wairarapa DHB held a workshop with maternity staff and LMCs in October 2012 where the five principles were confirmed as a framework to develop the maternity service.

PRINCIPLES OF THE MATERNITY CARE FOR WAIRARAPA WOMEN

6. Develop an inclusive maternity service.
7. Evolve into a more women centered service.
8. Clarify/update the role and expectations of the core midwives.
9. Maintain a midwifery leadership voice within the DHB.
10. Identify workforce needs and recruit strategically (grow the workforce).

These principles were initially developed in a workshop led by the DHB in July 2011 that included maternity staff, obstetricians and LMCs.

PURPOSE OF THE GROUP

The Maternity Strategy Group (MSG) is established as a collaborative leadership group responsible for guiding the development and delivery of integrated maternity services.

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 organizations 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.

RESPONSIBILITIES OF THE GROUP

The MSG will:

1. Encourage collaboration and good working relationships between DHB staff including maternity staff, obstetricians and the Maori health team, together with LMCs, Well Child Providers, antenatal education providers and other relevant NGOs to ensure seamless service delivery for women.
2. Encourage active participation in the group by a consumer representative, as appropriate.
3. Facilitate service improvement initiatives and workforce development and ensure these are reflected in practice.
4. Advise on practice quality standards, evidenced based approaches and any other matters that will result in improvements in the delivery of maternity care.
5. Facilitate and enable integrated information system initiatives, in line with the MOH requirements.
6. Discuss and consider the application to the Wairarapa integrated service, any other issues facing maternity services that arise, and recommend changes to current service specifications, guidelines or other aspects of the service framework regionally, nationally or internationally.

COMPOSITION

The MSG will include representatives from:

- DHB Maternity Service including Charge Midwife Manager, RM, Obstetrician.
- Planning and Funding
- Maori Health Team
- A LMC representative
- Compass Health
- Well Child Provider/s
- Consumer representative, as appropriate
- Antenatal education provider, as appropriate.

Term of membership to the MSG is initially for two years. Replacement of members will be staged to ensure the continuity of the group.

DHB representatives are confirmed/mandated by the General Manager, Clinical Services. Representatives from other organizations or providers are confirmed by their respective senior management or governance as appropriate.

All members will actively participate in the MSG. A member who is unable to attend a meeting is able to be substituted by another person from their organization if arranged with the Chair of the group in advance. If a member of the group misses a number of meetings in a row, the group will consider asking them to be replaced by another person from their organization.

The MSG is able to agree to co-opt members in order to ensure the group has the appropriate skills and expertise to progress the initiatives and work plan of the group.

MEETING FREQUENCY

Meetings will be held three monthly.

The group will review the frequency of meetings and agree to reduce them to no less than quarterly.

Ad hoc meetings may be called if required.

MEETING STRUCTURE

Communications

Request for agenda items will be circulated by the group administrator a week prior to the meeting.

Members who wish to raise an issue will place it on the agenda and provide a brief written summary of the issue that can be circulated by the administrator with the agenda and meeting papers three days prior to the meeting.

A progress report on agreed indicators will be circulated no less than three days prior to the meeting.

Minutes of the meeting will be drafted and circulated within five working days of the meeting.

Key messages from each meeting will be agreed and accompany the meeting minutes. These will be distributed to the group by the administrator and will be able to be shared with participating organizations and providers.

Confidentiality

Information and discussions are to be regarded as open unless otherwise stated.

Any confidential material will be clearly marked ‘confidential’ prior to circulation.

Any confidential issues will be recorded as such and must not be shared outside of the group.

Meeting Dates and Times

Meeting dates and times will be agreed with the group. It is anticipated that these meetings will not exceed two hours duration. Other contact is likely to be via email routes.

Quorum

The group will meet with a minimum number of members being agreed upon as (to be confirmed).

Working Together

The MSG is an advisory body. The process should be collaborative and as inclusive as possible, and where advice cannot be acted on the DHB or participating organizations or providers will explain why.

Representatives will ensure members of their organizations are kept informed of the activities of the group and communications shared as required.

GROUP FUNCTIONS

Function	Group/People Responsible
Administrative support and co-ordination (meetings, agendas, minutes, general communications)	Debbie Beech
Chairperson	Michelle Thomas
Data provision	All participating organizations as agreed

MEMBERSHIP

Name	Role
Michele Halford	Nursing Director
David Cook	Obstetrician
Sarah Boyes	Director of Operations – Surgical, Women's & Children Health – HVDHB & WDHB
Alison Andrews	Charge Midwife Manager
Anne Marie Gibbs	Core Midwife
Clare Bardsley	LMC Representative
Michelle Thomas	Maternity Quality and Safety Coordinator
Janeen Cross	Maori Health Representative
Lisa Burch	Portfolio Manager, Planning and Funding
Yvette Grace	Compass Health (PHO)
Michelle Sole	Well Child Representative
Kiri Playle Anita Roberts	Consumer Representatives

SCHEDULE OF MEETINGS

- Meetings will be held three monthly
- The January meeting will differ to allow for holiday season leave arrangements.

- Meeting frequency will be reviewed after the first six months.

APPENDIX 2

Wairarapa DHB Terms of Reference for the Vulnerable Women and Unborn Babies Group

Purpose

To make a difference by identifying pregnant women with vulnerabilities, proactively wrapping services around them their newborn baby and their families, building partnerships with external agencies and ensuring transparent decision making process.

Background

The development of this group has been a gradual transition from that of an informal process to one that is more formal and will involve a multidisciplinary and multiagency approach where appropriate.

The strategic purpose of the Vulnerable Pregnant Women's Group is to enable the best possible outcome for vulnerable pregnant women and their families. To strengthen families / whanau by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.

This forum / group adheres to and works alongside the memorandum of Understanding (MOU) between CYFS, New Zealand Police and Wairarapa District Health Board (DHB) in relation to child protection. The MOU identifies our formal commitment to collaborative practice in child protection between the three agencies, and extends it beyond the safety of children in the hospital. Additionally the DHB Child Protection and Neglect Procedures apply.

Principles / Functions of the Group / Forum

- Welfare and safety of the unborn child is paramount
- All women are entitled to mother (parent) in a supportive safe nurturing environment free from abuse, neglect and harm
- Families / whanau are supported to stay together and in particular the fostering of healthy attachments between baby and mother
- Information will be shared amongst the parties that will keep a woman and her unborn baby safe in a manner that is consistent with the current legislation
- Parties will communicate regularly in an open, honest, respectful and timely way.
- Safety issues that are identified will be shared as appropriate
- Effective multi-agency partnerships are facilitated through shared communication and a commitment to ensure health and safety outcomes for women, their babies and family.
- Provide early identification of pregnant women with vulnerabilities or risk

- Strengthen protocols and practices for the safe delivery and discharge of women and babies including collaboration with health, community and government agencies (CYF and Police), when a risk or concern has been identified for the woman and/ or their baby
- Be a point of reference and a forum for health professionals working with vulnerable women and unborn babies to discuss these complex cases
- Respect of cultural beliefs and values, women and their families are treated with respect and in a sensitive manner
- To support the child protection processes

Scope

Primary and Secondary providers who work with and care for vulnerable women and their families.

Membership

There will be a core membership group including the following

- Maternity Charge Midwife Manager
- Paediatric Charge Nurse Manager
- Woman and Children DHB Social Worker
- Maternity Quality and Safety Co-ordinator
- DHB / CYF Liaison social worker

With all cases referred associated key workers are invited to attend the meeting to discuss and be part of the planning, and may include the following

- Lead Maternity Carers
- Paediatrician
- G.P's
- Maori Health Directorate Member
- Family Start, Whaiora
- Tamariki Ora and Wellchild, Whaiora and Plunket
- DHB Mental Health Team
- Community Mental Health and Addiction Services
- Family Safety Team – Police
- Child, Youth and Family social workers
- Rangitane
- Woman's Refuge
- Open Home Foundation

Group Processes

<u>Facilitator</u>

- Women and Children DHB Social Worker will lead the facilitation role.
- Maternity will chair meetings

- Minutes will be recorded which outlines the case discussed brief issues and will include a clear record of any actions / decisions made. Minutes to be available on the Maternity workspace within 4 working days after the meeting, and a copy of the plan/agreed actions to be circulated to those involved in the care of the woman.
- Invite participants relevant to cases discussed

Referrals

- Referrals can be made at any time to the Women and Children DHB Social Worker by anyone involved in the care of pregnant woman and their families.
- Ideally referrals should be made as soon as possible to ensure time for the supports and interventions if needed, to be put in place
- Completion of a written referral is necessary using the referral template and can either be emailed or forwarded in hard copy
- Key concerns need to be identified
- Existing key workers or agencies involved should be identified with their full name and contact details
- Once the referral is received the Women and Children DHB Social Worker will determine if the referral is appropriate or if further information / assessment is required prior to bringing to the group for discussion.
- LMC's and key workers can expect to be contacted and invited to the meeting specific to the woman they are involved with

Referral Reasons

A referral should be made when it has been identified that a woman would benefit from an intervention plan when one or more of the following risk factors are present. Consideration should first be given to the nature and magnitude of the issue and the impact of this upon the woman and her unborn

- Concerns for the care and or safety of the unborn child
- Vulnerability of the woman
- Maternal comorbidities (medical)
- Social Work assessment
- Self-harm / Neglect of self
- Family Violence – consideration needed of the nature and magnitude
- Mental health concerns
- Drug and alcohol abuse
- Poor social circumstances
- Child, Youth and Family history

Meetings

- Team meets monthly on the 1st Wednesday of the month at 10-11:30 in the Imaging room at the DHB
- Agenda will be sent out the Friday before the meeting
- Woman and Children DHB Social Worker will send out invitations to all key workers involved in the woman's care

- If invitees / members are unable to attend, apologies are to be sent, email update given to the chair on cases involved in.
- Discuss new referrals and develop plan accordingly
- Plan reviewed as required, but at least 3 times including just prior to the EDD and after delivery
- Documentation is clear and accurate and a copy of the plan is placed on the woman's clinical file
- Minutes will be recorded in the maternity workspace and will include an agreed action plan. A copy of the plan/agreed actions to be circulated to those involved in the care of the woman.
- Decision to be made specific to each woman as to how the plan will be shared with them and their family as appropriate and who will be responsible to do this.

Plan

- The intervention plan to be shared with the Woman (and family if appropriate) unless it is deemed that sharing the plan would further place the Woman and unborn child at risk.

Confidentiality

- Minutes are to be available to the core group members and Maternity staff via the Maternity workspace. The action plan will be emailed to those additional key workers involved in the woman's care.
- As with other personal information and statutory requirements, all members and relevant stakeholders must comply with information service security agreements of their organisation.

Discharge Meeting

- A multiagency postnatal discharge meeting including family members (if appropriate) is held for those cases where it has been identified that a care plan is required for the safety of the infant, which needs to be understood and agreed to when Child Youth and Family are involved.

Review process / Audit requirements

The Terms of Reference will be initially reviewed in 3 months on 2 April 2014 by the core group members with feedback sought from attending key agencies, then they will be reviewed annually.

Statistics will be kept, collated and reported on as per Ministry Of Health requirements.

References / Related Documents

CYF, Police, WDHB Memorandum Of Understanding between Child, Youth and Family, NZ Police and Wairarapa District Health Board in relation to care and protection.

WDHB (2012) Child Protection Alert Management Policy

WDHB (201?) Family Violence Policy

WDHB (2012) Child Protection and Neglect Procedures

WDHB (20) Place of Safety Guidelines

WDHB (2011/12) Maternity Quality and Safety Programme

Social Work Assessment tool