



Taranaki District Health Board

MATERNITY

ANNUAL REPORT

1 July 2013 - 30 June 2014

TARANAKI TOGETHER, A HEALTHY COMMUNITY
TARANAKI WHANUI HE ROHE ORANGA

Taranaki District Health Board
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New Plymouth 4310
Taranaki, NEW ZEALAND



ACKNOWLEDGEMENTS

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Message from Dr Jeremy Smith, Head of Department – Obstetric and Gynaecology; Belinda Chapman – Associate Director of Midwifery; and Leigh Cleland – Clinical Services Manager, Maternity & Child Health

The past year has been one of incremental change, no sudden issues, and steady progress.

We have had a steady year in terms of client throughput; we have also had some new midwifery and Consultant additions to the maternity team. Dr Hansen retired after working as a Consultant in the department; we were fortunate that Dr Raj Singh was able to cover until we recently appointed and relocated Dr Anene Chukwujama from the United Kingdom (UK). He commenced work on 3 June 2014.

Significantly for running our ever expanding range of services, we are in the process of recruiting a second registrar to replace a more junior position. This will allow better cover during periods of leave and will improve the work conditions for the other pre existing registrar post. This post has been recently approved. Dianne Herbert, Clinical Midwife Manager (CMM) retired in May 2013 after 26 years of managing both Hawera and Base maternity units. Amanda Antoine was appointed as the new CMM; she has taken on the challenge and commitment of the role with passion and professionalism, and is making her mark on the unit as a valued member of the team. We have also appointed a post natal co-ordinator and welcomed Sharon Howe as the midwife educator. Sharon is excelling by networking with the regional educators to share educational templates and protocols to keep our practices evidence based and up-to-date. She has completed the NZRC newborn life trainers' course in the last year and this will relieve the shortage of local trainers which is most welcome. Unfortunately we have continued to have local midwife shortages and challenges in recruiting midwives to the rural and urban areas.

The incremental changes mentioned earlier have included increasing efforts towards compliance in all areas and the introduction of a registrar-based Fetal Day Assessment Unit for urgent but not emergency antenatal problems. We are also increasing our abilities in providing bedside ultrasound investigations and hope to introduce other point of care tests such as Rapid Fetal Fibronectin testing for identifying premature labour risk to inform our treatment and decision making for transfer to a tertiary centre.

Our department has also continued improving our already good relationships with associated services, particularly Paediatrics and Anaesthesia, Quality and Risk, Perinatal Health, Maori Health and practitioners and stakeholders of maternity care. We will continue to introduce improvement, though not all of our issues have easy or obvious solutions. We have the benefit of a leadership team that are innovative in spirit and along with good team morale, this means we will continue to focus on improving the service we provide to women and their families, and of course provide this as efficiently and effectively as possible.

Message from the Chair, Midland Maternity Action Group

The Midland Maternity Action Group (MMAG) was established in 2011; the group includes stakeholders from across the five Midland District Health Boards (DHB). The current membership is:

- **Bay of Plenty DHB** : Marg Norris (Midwifery Leader); Karen Palmer (Lactation Consultant and Chair, Breastfeeding/BFHI Sub Group); Sachit Gagneja (Maternity Quality & Safety Programme [MQSP] Project Manager); (SMO representative – vacant)
- **Lakes DHB** : Simon Ewen (O&G Head of Department); Sue Finch (Clinical Midwife Manager/MQSP)
- **Tairāwhiti DHB** : Mary-Clare Reilly (Midwifery Leader/MQSP); Liz Lee-Taylor (Maternity Educator ex Officio); (SMO representative – vacant)
- **Taranaki DHB** : Belinda Chapman (Associate Director of Midwifery/MQSP); (SMO representative – vacant)
- **Waikato DHB** : Penelope Makepeace (Clinical Director - Obstetrics); Corli Roodt (Clinical Midwife Director and MMAG Chair); Pip Wright (Maternity Educator and Chair, Maternity Educators & Midwifery Leaders Sub Group); Ruth Galvin (MQSP Project Manager and Chair, Midland MQSP Sub-Group)
- **Chief Operating Officer Representative** : Dale Oliff (Lakes DHB)
- **Director, Nursing/Midwifery Representative** : Sue Hayward (Waikato DHB)
- **Maori Health Representative** : Jade Chase (Waikato DHB)
- **Planning & Funding Representative** : Jenny James (Taranaki DHB)
- **Communications Representative** : Mary-Anne Gill (Waikato DHB)
- **HealthShare Ltd** : Suzanne Andrew (Project Manager)

The primary purpose of the group is to lead regional maternity activity including the implementation of maternity actions on behalf of the Midland DHBs, with a focus on sustainable service delivery through quality improvement and workforce development activities. The outcome of this regional approach is to facilitate improved coordination and responsiveness of services for women and their families requiring maternity services, with a vision to improve equity of access and health outcomes for Midland communities.

The MMAG have focused on educational and quality activities to improve access to education for the region's maternity workforce and supporting a standardised approach to the delivery of maternity services through improving communication, sharing of resources, reducing duplication and developing initiatives that when done collaboratively, will improve efficiency and effectiveness across the five Midland DHBs.

The group looks forward to continuing its work and collectively facing the challenges associated with identifying opportunities to continue to provide sustainable quality maternity services to the Midland region.

Corli Roodt, Clinical Midwife Director, Waikato DHB
Chair, Midland Maternity Action Group

OUR VISION

Taranaki Together, committed to caring in pregnancy, birth and beyond, for a Healthy Community -

HE URUNGA WHENUA

HE URUNGA TANGATA

HE URUNGA OHI

HE URUNGA TARANAKITANGA

KI TE TAIAO

MAU TONU



PURPOSE

This Annual Report covers the outcomes of Taranaki DHB's Maternity Quality & Safety Programme (MQSP) in 2013/14, as required under section 2.2c of the MQSP Crown Funding Agreement (CFA) Variation (Schedule B42).

This Annual Report:

- demonstrates Taranaki DHB's delivery of the expected outputs as set out in Section 2 of the MQSP CFA Variation
- outlines progress towards Taranaki DHB's MQSP Strategic Plan deliverables in 2013/14
- describes Taranaki DHB's activities undertaken in 2012/13 and those intended to be undertaken to improve the quality and safety of its maternity services in 2014/15



BACKGROUND AND SUMMARY OF THE TARANAKI MATERNITY QUALITY AND SAFETY PROGRAMME

Alignment with New Zealand Maternity Standards

This Annual Report has been developed to meet the expectations of the New Zealand Maternity Standards (as set out below).

Expectations of the New Zealand Maternity Standards	
Standard One: Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies	
8.2	Report on implementation of findings and recommendations from multidisciplinary meetings
8.4	Produce an annual maternity report
8.5	Demonstrate that consumer representatives are involved in the audit of maternity services at Taranaki DHB
9.1	Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Taranaki region
9.2	Identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs
Standard Two: Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage	
17.2	Demonstrate in the annual maternity report how Taranaki DHB have responded to consumer feedback on whether services are culturally safe and appropriate
19.2	Report on the proportion of women accessing continuity of care from a Lead Maternity Carer (LMC) for primary maternity care
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	
24.1	Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility (reported in 2012/13)

Aims and Objectives of the Taranaki Maternity Service and MQSP

The following main objectives for 2012/13 were listed in the 2012/13 Maternity Annual Report and have been achieved:

1. Establish the Taranaki Maternity Quality Governance (MQG) Group
2. Implement the new referral guidelines and maternity specifications
3. Establish a framework for multidisciplinary quality audit and reporting framework for maternity (see Appendix 1)
4. Set up communication for the wider community to inform them about access and obtain feedback on maternity services
5. Communicate with maternity providers to identify any concerns and collaborate to assist improvements in services and outcomes (Maternity Quality Newsletter, Appendix 9)
6. Engage consumers in the programme
7. Review data for the first Annual Report
8. Networking, sharing and achieving results by working with the MMAG

A summary of new meeting initiatives, changes in clinical practice and quality improvements that have been driven by MQSP in 2013/2014 can be seen in Appendix 2.

Progress on the planned service deliverables are tabled on Page 14. The proposed work plan for 2014/15 is tabled on Page 38.

Summary of Aims, Objectives and Achievements of Taranaki MQSP in 2013/14

The Taranaki Maternity Services and MQSP aim to provide, monitor and action improvements in services to optimise safety for women, babies, families/whanau, service users and service providers of Taranaki. The past year has seen improved relationships and understanding of the stakeholders and services that are linked to the maternity services within Taranaki. There has also been more sharing of information, communication and collaboration for linked projects such as oral health, newborn hearing screening, Maori health related projects, Well Child provider services, smoking cessation services, perinatal mental health (PNMH) services, community breastfeeding initiatives and community projects such as Taranaki Mama Pepe Hauora (this is a project focused on improving women's health during pregnancy, the postnatal period and child health through promotion of healthy eating, physical activity and promotion of breastfeeding; this project has gained funding for two years through a Ministry of Health [MoH] request for proposal).

A closer relationship has been formed with the local Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP); it now reports to the Taranaki DHB Maternity Quality Committee (MQC) as its governance group on a twice yearly basis. A copy of the first report is in Appendix 3.

Taranaki DHB also participates and collaborates with the four other Midland Regional DHBs through the MMAG, Midland Midwifery Leaders Group and the Midland Regional Educators Sub-Group, the Midland MQSP Sub-Group and the Midland Breastfeeding Sub-Group. They are working together to share education sessions and templates, protocols and other strategies to reduce duplication, workloads and increase efficiency and networking. This has been a most valuable initiative and has seen progress locally and regionally on the shared initiatives as mentioned later in this report.

Summary of Maternity Services Provided in Taranaki (see Appendix 2 for more detail)

Taranaki Base Primary Care plus Secondary Care	Hawera Primary Care	Elizabeth R Primary Care
<ul style="list-style-type: none"> • Normal delivery • Inpatient postnatal care • Outpatient specialist consultation and secondary antenatal clinics • Orthopaedic hip checks • Ultrasound • Caesarean section • Complex delivery • Lactation consultant services • Fetal day assessment unit (FAU) • Inpatient antenatal care • Management of miscarriage • Support for obstetrician LMC • Newborn hearing screening • Level 2A neonatal services 	<ul style="list-style-type: none"> • Normal delivery • Inpatient postnatal care • Outpatient specialist consultation and secondary clinic • Orthopaedic hip checks • Lactation consultant services • Newborn hearing screening • Orthopaedic hip checks 	<ul style="list-style-type: none"> • Normal delivery • Inpatient postnatal care • Newborn hearing screening

Home birth services by Midwife LMCs are available in all three geographic areas

MQSP Governance and Operations

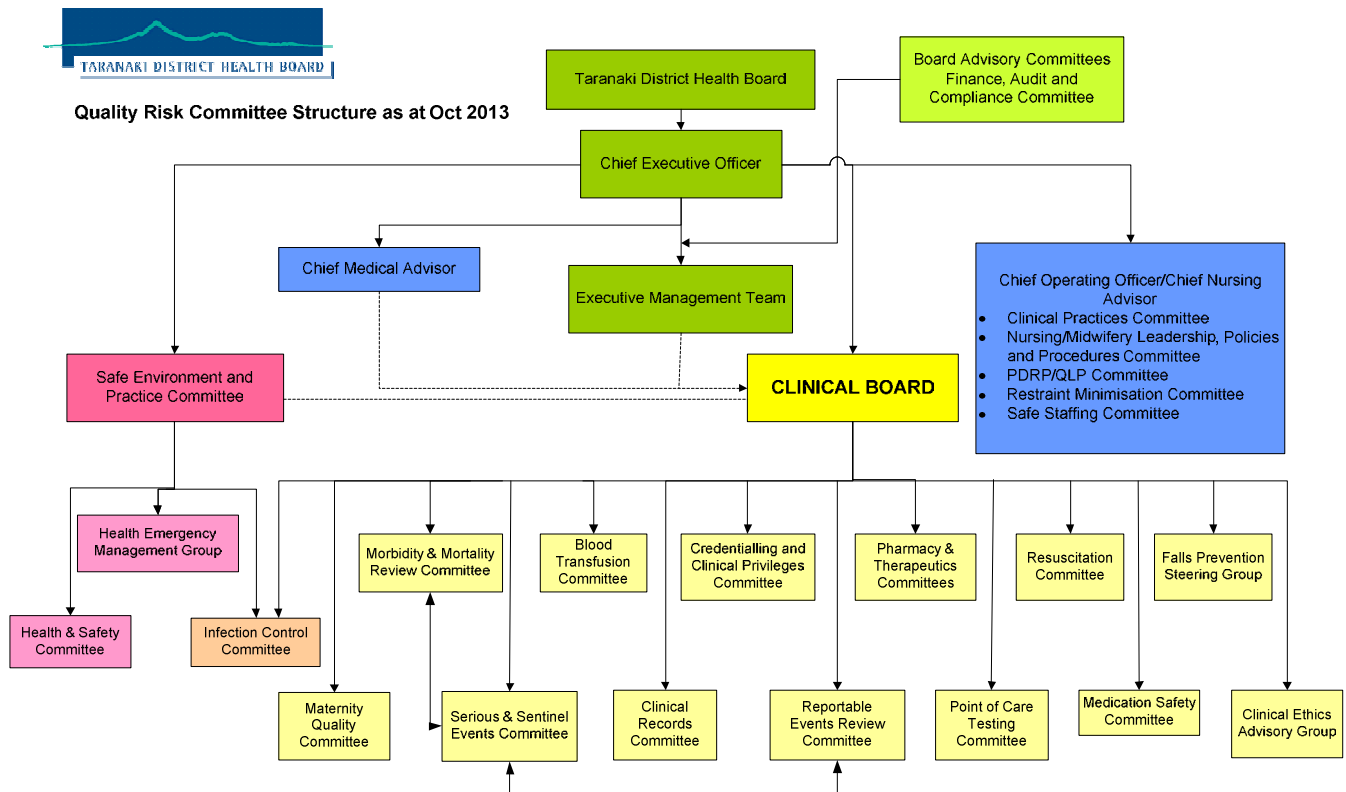
Taranaki DHB MQSP Governance Structure and Purpose

The MQSP Governance Group is known as the MQC and is chaired by the ADOM / MQSP Project Coordinator. It meets monthly to support the Taranaki maternity services, the Taranaki DHB Clinical Board and maternity related multidisciplinary clinical teams to monitor and manage standards of clinical care to ensure they are of a high quality.

Its main functions are to:

- Monitor and oversee regional and local activities associated with:
 - The national MQSP
 - The National Maternity Standards
 - Maternity Service Specifications
- To provide a forum in which decision making and responsibilities for the quality of maternity care are shared between clinicians and managers in consultation with consumers and stakeholders
- To report these activities to the Taranaki DHB Clinical Board
- To manage obstetric clinical risk
- Membership consists of:
 - Clinical Directors : O&G and Paediatrics
 - ADOM
 - CMM
 - Four stakeholders:
 - Clinical Nurse Manager, Neonatal Unit
 - Maternal and Child Health Social Worker
 - Maternal Mental Health Intake Coordinator
 - Clinical Nurse Specialist - Infection Control
 - Clinical service manager for Maternal and Child Health (CSM,M&CH)
 - Quality Improvement and Effectiveness Coordinator
 - CME/Quality Risk delegate
 - Two LMC Representatives:
 - Rural
 - Urban
 - Maori Health representative
 - Consumer representative
 - Core midwife /NZCOM representative

Taranaki DHB MQSP Governance Accountability within the wider Taranaki DHB Governance



The MQC oversees quality improvement, quality assurance and risk management activities within the primary and secondary maternity services.

Priorities for the MQC are to review, monitor and recommend improvements for:

- Actions and themes arising from adverse events submitted to the Serious & Sentinel Events and Reportable Events Committees, and the Perinatal Mortality and Morbidity reviews
- Clinical Indicator Reviews
- Actions and themes arising from complaints submitted to Customer Services and the Reportable Events Committee
- The National MQSP
- The National Maternity Standards
- Maternity Service Specifications

The MQC evaluates service improvements as a result of the Committees' recommendations:

- To set audit priorities, schedules and review audit outcomes and to endorse and monitor implementation of audit recommendations
- To monitor retrospective clinical record reviews with feedback to individual practitioners by nominated lead reviewers

Recommendations and actions from the MQC are forwarded to the Maternal and Child Health Services Manager and CMM or other relevant units:

- The activities/minutes are submitted monthly to the COO/CNA and Quality and Risk Manager

Information and direction is communicated to multidisciplinary clinical teams, including LMCs and stakeholders through relevant members of the MQC.

Consumer Representation on Taranaki DHB MQC

Taranaki DHB MQC has a consumer group representative who is a mother of two young children who were born in Taranaki Base Hospital. She has a letter of appointment and has signed an agreement of confidentiality and the Taranaki DHB Code of Conduct. She is remunerated for her attendance at meetings.

The representative is an active advocate for empowered birthing and informed consent, and brings an open minded and honest view/approach to maternity services in Taranaki. She is an active member of community maternity consumer groups Active Birth Taranaki and La Leche League.

Community Practitioner Representation on Taranaki MQC MQSP

Please see membership above for stakeholder and LMC representation.

There are no GP representatives despite approaching the GP liaison group for nominations for membership however the GP liaison representatives are notified of any pertinent information relevant to them and maternity quality and safety within Taranaki DHB so the information can be shared within their group meetings. The MQC will again campaign to engage a GP on this committee.

Perspectives of Maori, Pacific and Other Groups (as appropriate) Represented on Taranaki MQC

The population of Taranaki is predominately Maori and New Zealand European. The Maori Health Services have a Maori health worker who is a representative and consultant to this committee.

Progress of MQSP Strategic Plan Deliverables for Taranaki DHB and the Midland Region

Progress of List of Priorities, Deliverables and Planned Actions for 2012/13/14

Note : Some quality improvement initiatives may be developed at the regional level for local delivery

Governance				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Ensure cultural responsiveness of all MMAG related activities - delivery on the RSP Māori accountability framework	Ethnicity data in each initiative/ programme of work will be captured All regional planning documents are reviewed against the HEAT tool	Improved responsiveness to vulnerable population	MMAG has a Maori representative responsible to communicate and input into MMAG related activities	MMAG/Maori health project manager/Pepi Pod & SUDI/oral health project Baby summary form now captures ethnicity of mother and baby to ensure Maori Health support if required
Inclusion of consumers in maternity decision making groups – ensure consumer input is established at all levels of maternity services	An agreed regional framework exists relating to consumer involvement, (inclusive of payment, job descriptions, contracts) Implement the Consumer Framework in all DHBs in the Midland Region, at the local governance level	Decisions made inclusive of consumer view	Consumers involved in each DHB's MQ&SP activities and MMAG is developing a regional consumer and LMC framework for the Midland Region	Consumer rep and ADOM for Taranaki DHB MQC has developed a closed Facebook page and a media/communications policy has been published; regional consumer framework is complete and published on MQSP national group site
Administration and community consumer liaison support	Implement set administration and community consumer liaison position in Taranaki DHB	Administration support in place and improved responsiveness to consumers	Evidence of consumer liaison meetings and admin support	Consumer has taken on role to provide admin support
Quality & Safety				
Improve LMC registration - increase number of women registering with an LMC in their first trimester	DHB data regarding number of women who register by end of first trimester with an LMC is available and monitored regionally Enhance GP proficiency in first trimester screening and expedite booking with an LMC	Improved access to care. Early uptake of first trimester screening Increased number of women booking with an LMC by end of the first trimester	MMAG developing regional strategies to encourage consumers to register with an LMC early in the first trimester; increase number of women in Taranaki registering before the end of the first trimester to 77% by 2014; 83% by 2015 and 90% by 2016	Email and newsletters sent to GP Liaison to encourage GPs to use the www.findyourmidwife.co.nz site and the Taranaki DHB information link; refer to ADOM if unable to access maternity care MQC stakeholder newsletter circulated three times per year Social Media campaign

Quality & Safety <i>cont.</i>				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Improve patient care quality and safety through establishing a robust transfer system - implement consistent system for maternity transfers across Midland and beyond	<p>Regional maternity patient flow policy with sign off by COOs</p> <p>Capability of each hospital is agreed so safe repatriations can occur, maternity transfer guidelines in place</p> <p>Quality indicators for maternity transfers developed, standards for midwifery coordination developed and implemented to underpin transfers</p>	<p>Expedient transfers to place of definitive care</p> <p>Reduced number of women experiencing compromised care</p> <p>Improved communication between midwifery coordinators</p>	<p>Evidence of MMAG revised inter facility referral, transfer and repatriation processes, guidelines and standards</p> <p>All cases transferred are reviewed against the guidelines and outcomes.</p> <p>Number of transfers that were appropriate re criteria as a proportion of all transfers; aim = 100%</p>	<p>December 2013-June 2014</p> <p>MMAG are working on this guideline and it has been sent out for consultation and is nearing completion</p> <p>100% transfers have been reviewed at case review sessions, all deemed appropriate</p>
Implement Perinatal Mental Health (PMH) Pathways to improve processes for identification referral and treatment of perinatal mental health illness	<p>Consultation with all practitioners involved with maternity cases up to one year post delivery</p> <p>Launch of the pathway, referral process and education on diagnostic tools and processes</p>	<p>All practitioners are educated and provided with the information to confidently screen and refer cases early if concern for PMH</p>	<p>Number of cases of PMH screened and referred correctly over the total number of cases</p>	<p>August-June 2014</p> <p>PNMH are currently auditing the pathway to ensure 100% of cases are screened correctly using EPNS and timely consultations are offered</p> <p>In-service education has been offered to all maternity and neonatal practitioners on the referral pathway and EPNS screening tool</p> <p>Monthly MMH/MDT meetings have been implemented (see Terms of Reference in Appendix 7)</p>
Strengthen consistency of practices through shared educational activities - maximise collaboration between Midland Regional midwifery educators	<p>E-learning modules are developed in collaboration with GMs HR and e-learning facilitator</p> <p>Regional education plan is developed and activities are prioritised annually</p>	<p>Consistent and supported maternity education delivered across region</p> <p>Midland maternity educators group are sharing resources, training calendars, and assisting with training regionally</p> <p>Regional support for identified items of maternity education and training equipment</p>	<p>Number of staff completing Midland shared education modules over the number of practitioners in Taranaki DHB; aim is 30% by June 2014</p>	<p>MMAG/Taranaki DHB CME and ADOM responsibility</p> <p>Shared template has been developed and approved by MCNZ for compulsory annual emergency day; shared template for the 3 yearly compulsory practice day has been submitted to MCNZ.</p> <p>Taranaki DHB education calendar (Appendix 6) and Midland education calendar have been published</p> <p>Midland/HealthShare decision to progress e-learning modules regionally and be accessed through the Moodle site for all five Midland DHBs</p> <p>Training equipment received so all Midland DHBs have equity in access: PROMPT trainer, suturing trainer, hip check doll, MAMA Natalie, breastfeeding talk cards, revised PROMPT manuals</p>

Quality & Safety <i>cont.</i>				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Reduce the smoking and SUDI rates - support the reduction of SUDI rates and numbers of women who smoke in pregnancy across Midland	<p>All maternity providers have access to education around smokefree pregnancy</p> <p>Progress towards 90% of all pregnant women entering into LMC/obstetric care are assessed using the MoH ABC programme</p> <p>All providers of maternity services are trained in promoting safe sleeping messages</p>	<p>Increased focus on smoking cessation and SUDI prevention with decreased morbidity of infants</p> <p>Increased numbers of pregnant women accessing quit smoking programmes</p>	<p>Aim 100% smoke screening questions and referral process completed on admission to Taranaki DHB</p> <p>All maternity providers have access to education around smokefree pregnancies</p> <p>All Midland DHBs have a safe sleep policy in place; a regional safe sleep policy is developed and in place</p> <p>Midland Regional support through the purchase of Pepi Pod safe sleep devices</p> <p>Number of Pepi Pods distributed over the number of births</p>	<p>Achieving 95% smoking screening and referral on admission</p> <ul style="list-style-type: none"> • Midland Health Network: <ul style="list-style-type: none"> - ABC approach - Dedicated cessation support • Taranaki DHB secondary care (Hawera and Base Hospitals) <ul style="list-style-type: none"> - ABC approach • Mana Wahine Hapu (Tui Ora Ltd and Smokechange) <ul style="list-style-type: none"> - ABC model - Group and 1:1 interventions • Aukati Kaipaipa Service (Tui Ora Ltd) <ul style="list-style-type: none"> - Intervention - Group Session • Aukati Kaipaipa Service (Ruanui Health Centre) <ul style="list-style-type: none"> - Intervention - Group Session • Quitline <ul style="list-style-type: none"> - Quit Coach - Txt2Quit - Quit Blog • Wero (Auckland UniServices) <ul style="list-style-type: none"> - National - Group Stop Smoking Competition • National Heart Foundation <ul style="list-style-type: none"> - Smoking Cessation Training - Specialist Training <p>Tui Ora smokefree pregnancy contract, Taranaki DHB and LMCs continue working together to improve screening, education and intervention programmes</p> <p>Combined smoking cessation, safe sleep and breastfeeding education has been implemented locally and through MMAG November 2013</p>

Quality & Safety cont.				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
				<p>Pepi Pod data in Safe Sleep section; 182 Pepi Pods have been received through MMAG and safe sleep messages/distribution programme implemented in July 2013</p> <p>Regional safe sleep policy implemented, currently planning to audit its implementation and compliance</p> <p>Pepi Pods now purchased and distributed, safe sleep training day in November 2013</p>
Information and Communication Systems				
Strengthen communication linkages across the DHB	Further investigate and implement audio visual tools to support rural practitioners attendance at meetings and forums	Increase in attendance of rural practitioners at meetings, forums, case reviews and education sessions	Number of meetings where Video Conference (VC)/ teleconference is available over number of meetings.	VC facility now in Maternity Meeting room in ward 15. Meetings, debriefings and education to include invites via VC for rural practitioners. No VC facility in Stratford, need to further investigate other IT packages to offer eg Skype
Antenatal clinic data collection	Collection of data to ascertain reasons for consultation and transfer of clinical responsibility align with the referral guidelines	Antenatal clinic midwifery FTE hours reflect antenatal clinic appointment preparation and care schedules	Number of antenatal clinic appointments over hours of midwifery hours available	<p>This information has been unable to be obtained; expanding antenatal clinics and implementation of FAU have increased ward clerk (temp) FTE by 0.4 and core midwifery assistance by 0.2FTE</p> <p>Carry forward to 2014/15</p>
Service Delivery				
Improve attendance at pregnancy and parenting (P+P) classes especially for rural and Māori pregnant women - increase number of pregnant women who enrol in pregnancy and parenting (P+P) /antenatal classes, especially in rural areas	<p>Identify existing classes available, costs, attendance and location</p> <p>Information from the Hapu Wananga Evaluation is utilised as basis for action plan to increase attendance rates for Māori women</p> <p>Implement recommendations from consumer group surveys in rural areas of identified low attendance to determine barriers to attendance and develop plan to improve this</p>	Information to direct recommendations about how many/what sort and where P+P classes need to be held	Evidence of initiatives being undertaken to meet identified needs in pregnancy and parenting/antenatal classes of vulnerable pregnant women	<p>Awaiting final P+P service specs</p> <p>To develop Wahakura weaving sessions and incorporate antenatal education into weaving sessions</p> <p>Investigate Mama, Pepi, Tamariki contract Maori health services/planning and funding/ MMAG/Consumer rep</p> <p>Carry forward to 2014/15</p>

Service Delivery cont.				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Support framework for young vulnerable women who are pregnant - develop a regional programme to address identified issues and provide relevant support	Work collaboratively with primary providers, including Maori health providers, and PHOs to identify the issues and support systems Commence the development with relevant stakeholders and primary providers to develop a regional programme that will wrap support around young vulnerable women who are pregnant, including smoking cessation and substance abuse	Young vulnerable women who are pregnant have improved access to information, support and quit smoking programmes	Collaborative work with primary providers and PHOs towards developing a regional programme for young vulnerable women who are pregnant	MMAG/Maori Health project manager/CMM/ADOM/Paed Referral toolkit and pre and post pregnancy referral directory completed and distributed to maternity stakeholder and practitioners to help guide referral pathways to support agencies for Mama and Pepi at risk Paediatric liaison meeting includes CMM investigating further to become a maternal and child health MDT meeting, accepting antenatal referrals (MMH, drug, alcohol and CYFs concerns) for 2014/15; awaiting national tool kit Need to improve access to Taranaki DHB Family Violence Intervention Training (FVIP) training for LMCs; current charge of \$250 is a barrier in 2014/15. NZCOM now providing a free education session free for SEMs on 3 rd June 2014. Need to improve family violence screening and intervention programme for maternity in 2014/15
Improve access to local Nuchal Translucency (NT) services when the private obstetrician is on leave	Investigate possibility of locum services to cover Taranaki DHB to offer this service when the private obstetrician is on leave	NT services are available locally to all women that choose this screening	Number of days NT scanning was not available in Taranaki	51 days where NT services have not been available in Taranaki; this does not include any scans that have been cancelled at short notice Access training for two consultants employed by Taranaki DHB to become accredited to perform NT scanning by 2016 Take forward to 2014/15 plan
<u>Caesarean Section</u> Improve timing from phone call of decision to birth of baby for Level 1 caesarean section Decrease General Anaesthesia (GA) in emergency caesarean sections Improve elective caesarean section rate in primiparae	Investigate an area that maternity and neonatal unit can be accommodated near to the new hospital building and operating theatres Investigate elective caesarean section rate in primiparae to ensure reasons are in line with RANZCOG guidelines	Area is secured for maternity and neonatal services nearer to the hospital operating theatres; plans in place for commissioning and moving to new location Decrease in GA for level 1 caesarean section Improved timing for decision to birth of Level 1 caesarean section Improved rates for elective caesarean section in primiparae in line with national rate of 15%	GA caesarean section rates performed under GA over all Level 1 caesarean sections Number of Level 1 cases not reaching the recommended time from phone call (decision) to birth of baby over all Level 1 caesarean sections Number of elective caesarean sections performed in line with RANZCOG guidelines over the number that did not align with the guidelines	Please see data section for GA caesarean section and timings of Level 1; this will be an ongoing project to try to improve timings and relocate the maternity unit to an area closer to the main operating theatres Carry forward 2014/15 and 2015/16 The purchase of a portable CTG monitor in August 2013 has aimed at reducing the GA caesarean section rates and is already showing signs of a reduction; the portable monitor reassuring the clinicians there is time to insert spinal anaesthesia in some cases Continued monitoring of all elective caesarean sections to ensure they are not performed prior to 39+0 weeks gestation unless medically indicated and the mother is administered antenatal steroids

Research and Evaluation				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Regional and local data availability - comprehensive data collection systems to enable regional benchmarking and reporting	<p>Regional dashboard for maternity clinical indicators is developed and updated</p> <p>Accurate regional information is available which identifies issues, trends and enables focus for regional initiatives</p> <p>Local data examined on antenatal clinic consultations and transfers to secondary antenatal care</p>	<p>Current regional data is available to shape direction of care and action</p> <p>Sufficient FTE and support services to support Taranaki outpatient antenatal services.</p> <p>Appropriate management of consultation and transfer of care to and from primary LMC services</p>	<p>The availability of comprehensive regional data</p> <p>Audit results to ensure appropriate consultation and transfer of care antenatally and postnatally</p>	<p>MMAG provide regional data to allow benchmarking and reporting; local information obtained from coders and local analysts</p> <p>All antenatal clinical referrals are screened by the antenatal clinic coordinator and if considered not appropriate are discussed with referring practitioners</p>
Improving breastfeeding rates through use of agreed regional tools - regional agreement to the networking and sharing of resources throughout Midland regarding breastfeeding	<p>Identify breastfeeding rates in Midland using regional BFHI data</p> <p>Explore the development of the use of IT applications to improve access to information for Māori and disadvantaged mothers</p>	<p>Improved access to consistent breastfeeding information</p> <p>Enhanced availability of breastfeeding resources in the Midland Region and the sharing of initiatives and resources through the regional breast feeding/BFHI support group</p> <p>Evidence of regional support for the purchase of Mama Aroha breastfeeding resources for each Midland DHB</p>	<p>Aim minimum 75% exclusive breastfeeding rates on discharge from Taranaki DHB facilities</p>	<p>All Taranaki DHB facilities are monitored monthly on exclusive B/F discharge rates and are overall achieving minimum 75% (see data section)</p> <p>MMAG Breastfeeding sub group initiated</p> <p>Mama, Pepe Haurora project.</p> <p>Tamariki Ora and Tui Ora contracts & Ngati Ruanui</p> <p>Regional purchase of Mama Aroha cards for all Midland DHB's</p> <p>4 Lactation Consultant(LC) scholarships have been awarded to assist in implementing community LC clinics</p>
<u>Progressing new Initiatives</u> Congenital Cardiac Heart Disease (CCHD) screening	Purchase of equipment and implementation of staff training and Taranaki DHB protocols are in place	Improved detection and treatment of CCHD	Number of cases detected prior to discharge from hospital over the total of cases detected in the first year of life	Decision for this not to proceed with CCHD screening due to the low levels of these now with improved ultrasound diagnostics in pregnancy
Care of the jaundiced baby in the postnatal ward, and working towards care in the community. Education of staff. Purchase of additional equipment.		Improved services for care of the jaundice neonate including keeping the mother and baby as one unit in the postnatal ward and/or home if appropriate	Number of babies managed at mother's bed side over the number of babies treated	<p>Please see data section of NNU admissions.</p> <p>Education of staff on care of the jaundice baby, phototherapy equipment and new protocol has been completed</p>
Maternity Bariatric Guidelines	Maternity Bariatric Guidelines developed	Clear guidelines in place to inform clients and practitioners on bariatric cases	E learning package completed by staff; aim for 80% pass within one year of guidelines being implemented	Taranaki DHB Bariatric Guidelines implemented with maternity section; e-learning package has been devised and has recently been implemented. MMAG looking at adopting this for regional use
Opportunistic immunisation for flu vaccine and Boostrix	Marketing and advertising the immunisation services	Increased uptake of flu and Boostrix immunisations for staff and clients, decrease in sick leave and hospital admission in relation to whooping cough and flu	Number of opportunistic & drop in pregnant women vaccinated	Taranaki DHB antenatal clinic and ward are offering free vaccinations in the flu season and Boostrix vaccination; awaiting data

Enablers/Support				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Workforce intelligence - plan for a sustainable maternity workforce (especially in rural areas)	<p>Head count to service current population vs workforce needed for future birthing trends is identified</p> <p>Areas of shortage are identified</p> <p>Identify rural midwives' issues and work towards regional solutions</p> <p>Trends in LMC and secondary/tertiary midwifery workforce numbers, distribution and forecasting are analysed by regional workforce group</p>	Understanding of current state and future state needs to achieve sustainability	Total FTE vacancies over total FTE	<p>Maori Health team are working with HR to develop new workforce initiatives to reduce inequalities</p> <p>HWNZ funding for upskilling those that work with Maori; WRR is the Taranaki Maori workforce project being implemented (incubator and cadetships)</p> <p>Currently Taranaki DHB maternity Maori workforce is around 15% which reflects the population</p> <p>No current shortage of self employed midwives but 1.8 FTE core midwives shortage; advertising with incentives and training locally via AUT satellite training</p>
Workforce utilisation - identify future maternity workforce requirements and develop plans to ensure appropriate maternity care provision continues	<p>Utility of existing workforce model critiqued against workforce forecasting</p> <p>Options for innovative models explored to support sustainable midwifery care in rural units and geographical areas.; also Vaginal Birth After Caesarean (VBAC) clinics and allied health support and collaborative models of care</p> <p>Options for midwifery labour and birth and postnatal services investigated for private obstetricians</p> <p>Staff appraisals completed on an annual basis</p>	<p>Accurate baseline data and engagement of service providers in developing innovation solutions</p> <p>Core midwifery predictable efficient workloads</p>	Total staff appraisals completed over total number of staff	<p>A reduction in private obstetrician cases and the withdrawal of private obstetrician postnatal community midwifery services has freed up 1.5FTE midwifery to cover other areas in times of shortages</p> <p>Staff appraisals are progressing, with around 50% completed. A new Taranaki DHB system is being currently introduced</p>
Workforce planning and forecasting for medical staff - work with RANZCOG to plan for O&G placements in identified areas	<p>Quantification of percentage of consultant time spent in obstetrics to ascertain level of obstetric workforce need</p> <p>Quantification benchmarked across other three regions by RDOTs</p> <p>Strategic plan for sustainable obstetric physician service provision inclusive of obstetric anaesthetists, SMOs, RMO training, and placements is developed</p>	Robust understanding of workforce issues and identification of workforce needs for the future	Total number of obstetric registrars over positions available	<p>Visit from RANZCOG approved two registrar positions for Taranaki DHB.</p> <p>The last year has had one position each for June-December and December-June; the first position resulted in a registrar commencing at short notice but was not replaced from August 2013.</p> <p>We currently have a registrar in the December-June position.</p> <p>Further planning needs to be taken forward for sustainable obstetric services with registrar support</p>

Enablers/Support cont.				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Use ICT to improve information sharing - improve access to information between LMCs and with consumers	<p>Web portal for LMCs and consumers in place</p> <p>Application development for LMC and consumer smartphone use explored</p>	Increased access to information for consumers and LMCs	Shared electronic space open to LMCs and consumers to access information.	<p>Consumers can access Taranaki DHB internet site including information on how to access a midwife; also information can be accessed through the Taranaki DHB MQSP Facebook page</p> <p>MMAG still investigating smartphone applications</p>
Progress connected health concepts to improve access to clinical maternity information - implement national maternity client information system	<p>Work with regional ICT to develop implementation plan</p> <p>Participate in MCIS system development at the national level, working with the clinical reference group and CleverMed</p> <p>Implementation plan commenced in early adopter site</p>	<p>Regional implementation plan and timeframe available</p> <p>Users of the system provide feedback to influence system development</p>	MMAG representation on national Maternity Client Information system (MCIS)/working group to assist in developing New Zealand IS platform)	<p>MMAG</p> <p>MCIS still work in progress; more computers/wireless will be required for Taranaki DHB maternity services in the future and will be carried forward</p>

Performance against Clinical Indicators

Please see Appendix 4 for regional and local data tables and analysis

Taranaki DHB have analysed the clinical indicators provided by the MoH and data obtained by local and regional data analysts. Areas for improvement in practices and outcomes, as well as areas that we excel in, are identified.

Clinical Indicators

Indicator 1 Spontaneous Vaginal Birth

STRENGTH : Taranaki has a stable rate of 73.5% in 2011, 79.1% in 2010, and 76.6% in 2009; still above the national average of 70.0%.

Indicator 2 Instrumental Vaginal Birth

STRENGTH : Taranaki has a rate of 9.1% in 2011, 5.6% in 2010, and 8.8% in 2009; well below the national average of 13.9%.

Indicator 3 Caesarean Section among Primiparae

INVESTIGATE : Taranaki has an increasing rate of 17.4% in 2011, 15.3% in 2010 up from 14.6% in 2009 and above the national average of 15.4%. Benchmarked against the other Midland DHBs, Taranaki has the highest rate and this is an area for investigation. It is intended to audit all elective and emergency caesarean sections for clinician type, reason and gestation; please see Work Plan. It would be useful to know the caesarean section rates for private obstetricians around other areas of New Zealand to be able to compare/benchmark local data.

Indicator 4 Induction of Labour among Primiparae

STRENGTH : Taranaki has rates of 3.1% in 2011, 3.4% in 2010, and 2.9% in 2009 but under the national average of 4.3%.

Indicator 5 Intact Lower Genital Tract - Vaginal Birth

STRENGTH : Taranaki has consistent rates of 50.2% in 2011, 46.7% and 46.6% in 2009, 2010 against the average 33.1%.

Indicator 6 Episiotomy and No 3rd or 4th Degree Tear

STRENGTH : Taranaki has rates of 8.4% in 2011 which is well below the national average of 19.0%.

Indicator 7 3rd or 4th Degree Tear Sustained with No Episiotomy

STRENGTH : Taranaki has a consistent rate of 1.3%, national average is 3.2%.

Indicator 8 Episiotomy and 3rd or 4th Degree Tear Sustained

STRENGTH : Taranaki has rates of 0.6% in 2011, 0 in 2010, and 0.9% in 2009; well below the national average of 11%.

Indicator 9 General Anaesthesia for all Caesarean Sections

INVESTIGATE : Taranaki has rates of 11.6% in 2011, 11.9% in 2010 up from 10.7% in 2009 which is above the national average of 8.4%. The general operating theatres which are used for caesarean sections are a considerable distance from the maternity unit and until a location is found to house the maternity unit nearer to the operating theatres, this rate is unlikely to change. Following discussion at the MQC and anaesthesia team meetings, the result of the general anaesthesia audit conducted in 2013 highlighted there are differences in local data when compared to MoH data, the local data concluded that it is more in line with the average national data.

Indicator 10 Postpartum Haemorrhage (PPH) Blood Transfusion after Caesarean Section Birth

STRENGTH : Taranaki has rates of 2.1% in 2011, 2.8% in 2010, and 2.3% in 2009 whereas the national rate fell from 3.8% to 3.3%. This is currently being audited but due to very small numbers, no trends have been identified.

Indicator 11 PPH and Blood Transfusion after Vaginal Birth

STRENGTH : Taranaki has a rate of 1% in 2011, 1.7% in 2010, up from 1% in 2009, below the 1.6% national average.

Indicator 12 Premature Births (Delivery from 32-36 Weeks)

STRENGTH : Taranaki has a stable rate of 5.9% in 2011, 6.1% in 2010 up from 5.7% in 2009; the national average has risen to 6.1%.

Snapshot of Taranaki DHB Maternity Services 2013/2014

The recommendations of the National Monitoring Group have been taken forward by Taranaki DHB MQSP:

- Taranaki DHB Neonatal Unit (NNU) collects data on admissions to the unit, including preterm births as well as other admissions, and now regularly reports to Taranaki DHB MQSP for auditing purposes; see data section.
- The new clinical indicators have been integrated into the Maternity Outcomes Protocol for trend monitoring and case review to inform our practices.
- The Perinatal Mental Health Pathway is implemented and is currently being audited.
- Taranaki DHB is committed to “better help for smokers to quit target” and is working together with LMCs, GPs and stakeholders to plan a way forward to support pregnant women and families to reduce smoking.
- Consumer engagement has progressed with our consumer representative communicating with the wider community via a closed Facebook page. Our representative has also undertaken training in privacy and confidentiality and will conduct a face to face consumer survey this next year.
- National Referral Guidelines on Observation of the Mother and Newborn have been implemented and the local PPH Protocol is under review to come in line with the national guideline.
- New initiatives have been implemented to encourage early registration with an LMC.

Access to Maternity Services

There have been no reports of any eligible New Zealand women being unable to access an LMC in any geographical areas of Taranaki. A media statement was sent out as part of the MQSP encouraging pregnant women to access an LMC as early as possible after diagnosis of pregnancy. A stakeholder MQC newsletter was sent out to practitioners highlighting the current rates of early engagement with an LMC and encouraging all practitioners to work together to improve early access to LMCs and early pregnancy screening. Additionally the Taranaki DHB website has a link page providing information on how to access an LMC, including preferred contacts as well as links to the www.findyourmidwife.co.nz/midwives/taranaki and www.tdhub.org.nz/services/maternity/lmc_contacts.shtml sites. Women, GPs and LMCs are advised to contact the ADOM if there are any women reporting difficulties in accessing a midwife. In 2013, the ADOM/antenatal clinic coordinator assisted seven women to access an LMC after reported difficulties. Two ineligible non-resident women were attended by the secondary antenatal clinic (as provider at last resort) due to financial barriers in accessing an LMC.

There have been some reported delays for women who require transfer by ambulance from rural units to the secondary unit. Ongoing meetings are being held with the service, contract manager and ambulance services to improve communication and directives to come in line with the community and primary emergencies transfer protocol.

Taranaki DHB pregnancy ultrasound scanning services are stretched and there have been reports of delayed access due to a shortage of ultra-sonographers. Additionally the Nuchal Translucency (NT) services are provided by a private obstetrician at her private rooms. Unfortunately when the obstetrician is on leave, NT locum services have not been able to be accessed to cover this local service, resulting in the unavailability of this service during the leave periods. In the past four months, 178 local NT scans were performed, five of which had incorrect dating so were unable to be carried out, 33 local NT scans have been declined due to demand outweighing capacity. A total of 51.5 days in the past year have not had an available service due to the private Obstetrician being on annual leave, which means women and their families have travelled to the nearest DHB, which is at least three hours by road. This has been a barrier for some women where some elect not to have this test due to time and cost of travel. The alternative MSS2 screening test has been offered but there has been a noticeable increase in amniocentesis required for an “increased risk” result with MSS2 testing. All amniocentesis performed for MSS2 “increased risk” however have returned a normal amniocentesis result.

If families choose not to go out of the region for NT scanning, there is a potential impact on the Taranaki DHB perinatal mortality rates because in some cases diagnosis of fetal abnormality has not happened until the 20 week scan, which has delayed termination of pregnancy (TOP) where this is elected. Training Taranaki DHB employed obstetricians is a priority to be able to cover this service during leave.

Maternity equipment is due to be reviewed as some is aging and requires replacing in order to maintain future service provision and ongoing quality improvements, particularly fetal monitoring equipment in relation to the rising maternal BMI rates.

Antenatal Clinic

There are four antenatal clinic sessions per week which include referrals for consultation with a specialist, as well as secondary antenatal appointments. The ANC coordinator midwife triages all antenatal clinic referrals to ascertain the urgency of appointments.

These clinics are often full four weeks in advance due to an increase in both new antenatal consults, secondary referrals and the volume of follow-up visits which are required due to the increase of secondary women in this service. (If there are no allotted appointments available, the women are seen as an urgent outpatient case by the duty obstetrician on the antenatal ward). A further reason for the full clinics is the time allocated for each appointment which has changed from 15 to 20 minutes due to the previously allotted 15 minute appointment time being insufficient. The initiation of a fetal day assessment unit may relieve some of these appointments.

- Fortnightly vaccination clinics : 58 women have been vaccinated against flu and/or whooping cough in antenatal clinics since the initiative began in April 2014. More women have been vaccinated on the Labour Ward but unfortunately this data is not currently available. The antenatal clinic also achieved Cold Chain Accreditation in 2013.
- Fetal Day Assessment Unit (FAU) was initiated in March 2014 : After a trend of women were identified as needing urgent assessment following scanning, this has been implemented on a weekly basis to coincide with the high risk ultrasound scanning sessions provided by Fulford Radiology. Previously, if concerns were identified during ultrasound scanning, women were sent to the Labour Ward for urgent assessment which resulted in rising ward acuity levels and staffing levels being inadequate to deal with all the referrals. The FAU is coordinated by the antenatal coordinator and staffed by a core midwife and an obstetric registrar. The aim is to see women in a timely manner and by trained midwives who are known to the women and the antenatal clinic.



Antenatal Coordinator Karen Janes (left) and Midwife Sorcha Wolnik (right) with Gemma Neill who is 29 weeks pregnant, Fetal Assessment Unit

- A monthly joint diabetes/obstetric clinic is held but has irregular attendance by the Diabetes Clinical Nurse Specialists, sometimes resulting in fragmentation of services. Further discussions and plans need to be held to improve this service for women and investigate if a midwife trained specifically in diabetes in pregnancy would be more appropriate. Taranaki DHB now has an identified specialist obstetrician (Dr Viner) with an interest in diabetes in pregnancy.

Antenatal Clinic Data

- In 2012 the antenatal clinic had 803 visits, in 2013 there were 927 visits. This is a 15.4% increase.
- 58 women attended vaccination clinic in 2013 (new service).
- Hip check (held in the antenatal clinic) had 1,119 visits in 2012 and 1,193 visits in 2013.
- Amniocentesis : Two obstetricians offer this service. In 2013, 31 amniocentesis were performed. Almost 50% were performed for MSS2 “increased risk” results; none of these had chromosomal abnormalities (CA). Only one CA was found; a Trisomy 21 following an increased risk MSS1 result.

Improvements made

- Handheld maternity notes : Women under the secondary antenatal clinic services now have their own personalised handheld notes.
- New maternity management care plans : These have been approved by the Clinical Records Committee after being trialled for four months. They include a column for evaluation as recommended in our recent audit.
- The antenatal clinic has purchased a television and DVD player for the clinic waiting room for antenatal education purposes.

Issues for the Antenatal Clinic

- Clerical assistance has not increased with the additional workload, which has created a fall back of work on to the antenatal clinic coordinator. A temporary 0.4FTE ward clerk contract has recently been agreed as a temporary measure.
- Full clinics.
- Increasing requests for elective caesarean sections (CS) and less uptake of VBAC will require further education from the antenatal clinic and the obstetric team. The DVD and television mentioned above will be utilised in the waiting room to educate women on VBAC. It is noticeable that more women are requesting elective CS for reasons other than repeat CS. Examples include third degree tears, cystocele, big baby, previous haemorrhoids, Post Traumatic Stress Disorder (PTSD), In Vitro Fertilisation (IVF), increased age.
- Visiting Maternal Fetal Medicine(MFM) services : Visiting monthly MFM services have not been replaced since the resignation of Dr Jeremy Tuohy which means pregnant women and families who require MFM care have had repeated antenatal visits in Wellington or other tertiary hospitals. The Midland region does not currently have a MFM specialist so a five hour road trip is costly in terms of emotions, travel and time off work for pregnant women and their families. It is hoped that a visiting MFM service can be re-established or alternatively, further development in telemedicine to avoid repeated antenatal travel and disruption to families. This will require improved accessibility to high-tech ultrasound scanning locally and IT technology for tele-consultation.

Antenatal Clinic Plans for 2014/2015

- Establish the Fetal Assessment Unit every Wednesday to relieve the workload on delivery suite.
- Monitor/audit the increase in antenatal clinic services to ascertain why the ANC is having difficulty in accommodating all appointments in a timely manner.
- Continuity of care for high risk women.
- Establish relationships with a Maternal Fetal Medicine specialist to try and reduce women having to travel outside of Taranaki by having the Maternal Fetal Medicine specialist visit and/or develop telemedicine.

Obstetric Anaesthesia and Operating Theatres

The new hospital building at Taranaki DHB was opened in 2013 however it does not include a new maternity or neonatal unit. This means the distance to the operating theatre has extended to six to seven minutes fast walking pace time. The purchase of a battery powered cardiotocography machine has allowed continuous monitoring of the foetus where there are concerns for its wellbeing. It has also informed decision making for spinal or general anaesthesia for caesarean section. Following its purchase, a decline in general anaesthesia was noted in an audit conducted by the anaesthetic team. A summary of the results of general anaesthesia for caesarean section were as follows:

Incorrect reporting of general anaesthesia cesarean sections and therefore incorrect Ministry data; if we recalculate total general anaesthesia - 10.1% not 10.9%.

- What are the reasons for Category 1 delays
 - No theatre in maternity, need to transport patient to theatre.
 - No staff on-site after hours.
 - Possibly inaccurate time records; analogue clocks used throughout the hospital. (Time of decision making by the clock in maternity, time of delivery by clock in theatre).
- How can we make things better?
 - Consultant anaesthetist on-site - economically viable?
 - Improve communication between surgeon and anaesthetist, between maternity and theatre staff.
 - Synchronised digital clocks throughout the hospital; the new theatres have both analogue and digital clocks.
 - Meticulous record keeping is essential.
 - Theatre in maternity.
 - Repeat audit to see if things have improved.
 - Report data to Ministry and ensure correct data published.
- Conclusion
 - Rates of elective caesarean sections under general anaesthesia similar to national average.
 - Rates of emergency general anaesthesia – higher than national but overall appropriate especially in view of setting.

Access to Perinatal Mental Health (PNMH) and Services to Vulnerable Pregnant Women

The introduction of a PNMH pathway for stakeholder referral/entry and access to local services has been implemented along with the Edinburgh postnatal depression scale screening tool. This pathway is currently being audited to assess if further education is required and inform our services whether our clients are receiving optimal care, including meeting the referral pathway criteria and timeframes.

The introduction of a multidisciplinary Perinatal Mental Health (PNMH) meeting has been implemented (see appendix 7) to:

- Review all pregnancy and postnatal cases that present with maternal mental health issues in Taranaki DHB.
- Provide an MDT planning of care for pregnancy, labour and birth and for postnatal care.
- Collate and report feedback from PNMH clients' experiences in maternity/NNU services to identify any trends and assist in identifying and implementing improvements in practice.
- Assist in identifying areas for recommendations for further education of staff where appropriate.

Vulnerable Families

A pre and post pregnancy checklist and support directory has been devised following a meeting of key stakeholders who provide care to vulnerable pregnant women and their families. The meeting highlighted the need to format a checklist and directory to inform all practitioners of the services that are available within Taranaki DHB. It has recently been finalised, published and distributed to stakeholders and maternity practitioners. The checklist and directory provides names, contact details and preferred referral pathways including criteria for referral to practitioners/stakeholders to support maternity services in caring for vulnerable families. The checklist and directory has recently been finalised, published and distributed to stakeholders and maternity practitioners (see Appendix 5).

Perinatal Mortality

Taranaki DHB has seen an increase in the number of cases classified for perinatal mortality in 2013 (see data section and analysis section, Appendix 4). This could have been impacted by the later diagnosis of fetal abnormality/access to first trimester Nuchal Translucency screening, resulting in later gestation terminations, although Taranaki DHB numbers are small so are likely to fluctuate annually.

Information and Communications Technology

Information and Communications Technology (ICT) is outdated and has proved a challenge in sourcing information and data. Our data collection system has had changes made at unit level to try to improve its reliability but is still dependent on clerical staff manually entering data, with no specific maternity IT package being available in Taranaki DHB. This should improve in the future with the implementation of the national MCIS IT system following implementation by the early adopter DHBs. A closer relationship has been made with Midland and Taranaki DHBs' data analysts that has made better availability of data to present and display to staff and practitioners.

Discharge Summaries

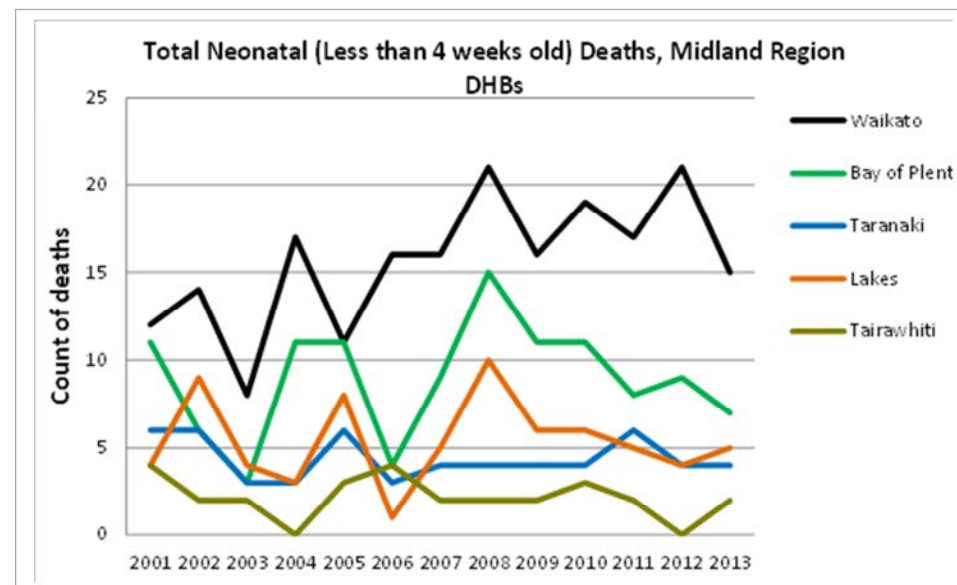
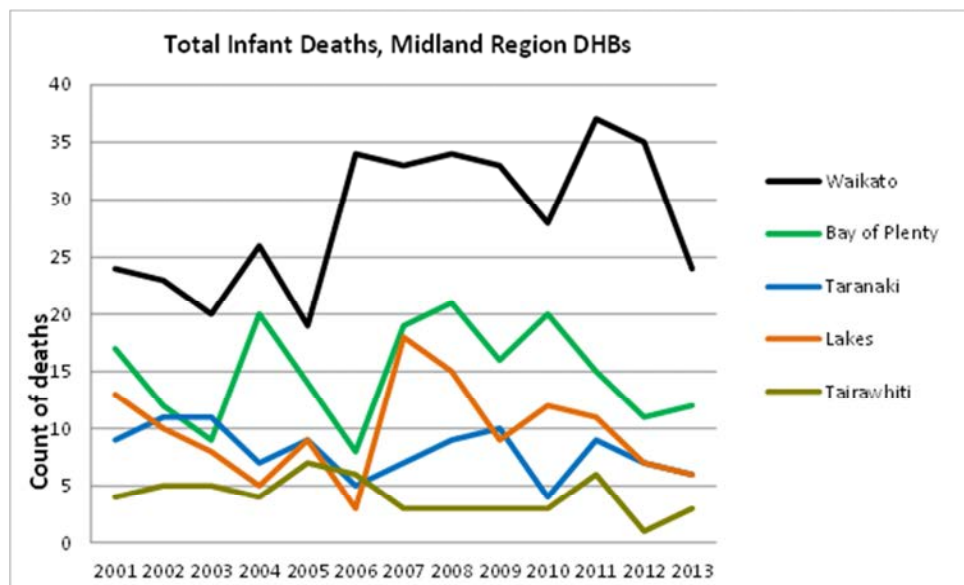
The timely completion of maternity discharge summaries has continued to be challenging with on-going investigations and strategies being implemented to try and improve this. All midwife LMCs have access to Concerto from their practice addresses so they can now access electronic discharge summaries once their clients are transferred back to their care, timeliness of completing the summaries has not met local protocol and was an identified risk. (However some discrepancies in inclusion criteria for the last audit have been identified which may have led to healthy newborns, who do not require a discharge summary, being included in the data). After recently implementing a process map on how/when and who is to complete maternity discharge summaries, we are already starting to see an improvement in the timeliness completion of them however the maternity unit requires further computers to assist this process.

Late Preterm Baby/Neonatal and Postnatal Services

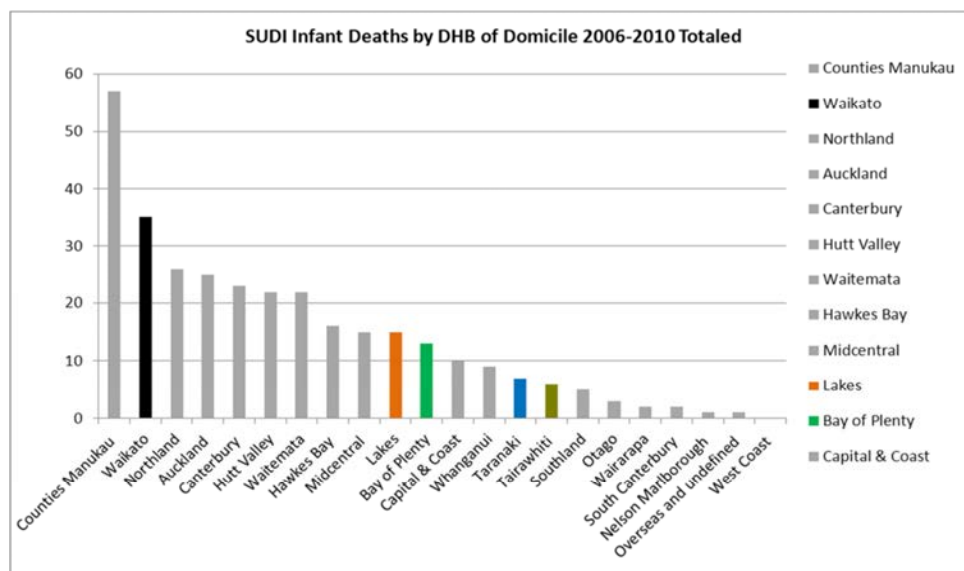
The goal to keep mother and late pre-term babies together has been hampered by the postnatal ward staffing shortages, despite the provision of guidelines for care provision. Midwives are prioritised to staff the antenatal and labour wards which mean that the postnatal ward does not always have a midwife rostered. It is dependent on staffing the postnatal ward with registered nurses, enrolled nurses and casual staff when there are insufficient midwives. This leads to inconsistencies in skills and practices when caring for the late pre-term baby. Having a new maternity unit that operates from one floor, and is co-located with the Neonatal Unit, will enable sharing of staff and facilities and will assist in the supervision and education of skills and practices, enabling more mothers and babies to stay together.

In the meantime, the position of postnatal coordinator is currently being appointed to coordinate, supervise and educate staff where the need is identified, with the focus for education of all staff this year on the care of the late preterm infant. Additionally, midwifery positions are also being advertised with incentive packages to aid recruitment.

Safe Sleep : Sudden Unexpected Death in Infancy (SUDI)



Taranaki and Lakes DHBs have similar population and birth numbers, however Lakes have a higher Maori population and similar SUDI rates. It is hoped the introduction of the Pepi Pod distribution programme will have an impact on Taranaki's SUDI rates.



A regional safe sleep policy has been implemented along with safe sleep education, both locally and regionally. The highlight of our Pepi Pod distribution programme and securing 180 Pepi Pods for our babies/Pepi through the MMAG, has been celebrated in an attempt to further reduce Taranaki's SUDI rate and promote safe sleep practices. A local company has donated funds to secure future replacement of Pepi Pods.

The first National Safe Sleep Day was promoted in Taranaki by the display of safe sleep resources and messages in our local shopping centre as well as the wards, which was supported by our local safe sleep champions and distributors.



Safe sleep day 6 December 2013

The purchase and use of clip-on cots has been received very positively by our consumers. These have enabled women and babies who are considered at risk of SUDI to have close contact safely; for example women who have undergone caesarean section, who are morbidly obese or overtired/under the effects of sedative drugs etc.

Pēpi-Pod® Programme Report: Summary for 2013

Period: Jan-Dec 2013

Summary of distribution and follow up data, by DHB region, for records entered between Jan 2013-Jan 2014.

Region	Distribution (N=1373)							Follow-up (N=1075)				
	Total	Maori		Smoking in Pregnancy		Uses CS Card		Yes		Want to keep pod		People spoken with
	n	n	%	n	%	n	%	n	%	n	%	n
Waikato	462	395	85	295	64	338	73	371	80	353	95	2073
Lakes	108	88	81	72	67	80	74	63	58	59	94	283
BOP	138	111	80	99	72	94	68	120	87	110	92	1014
Tairāwhiti	111	95	86	87	78	81	73	60	54	54	90	242
Taranaki	43	29	67	26	61	33	77	35	81	31	89	248
Midland Total	862	718	83	579	67	626	73	649	75	607	94	3860
Hawkes Bay	320	228	71	231	72	201	63	298	93	255	86	853
Counties Manukau	112	27	24	40	36	60	54	85	76	82	96	334
Northland	66	56	85	34	52	47	71	30	45	29	97	100
Other	13	8	62	11	85	12	92	13	100	13	100	41
Grand Total	1373	1037	76	895	65	946	69	1075	78	986	92	5188
												Ave = 5.8 people

NB: Provisional data for participating DHBs. Variations in service size and duration. Percentages are of total respondents (some missing data).

Region	Numbers of infant deaths (all causes)			IMR/1000 live births	% Maori births
	Neonatal	Post-neonatal	Total		
Northern	69-68	37-38	106-106	4.4	23.4
Midland	38-33	23-18	61-51	4.4	43.3
Central	20-27	22-23	42-50	4.5	32.8
Southern	28-27	16-21	44-48	4.0	18.9

Excerpt in response to media release from Stephanie Cowan Change for our Children (CFOC):

Te Puna Oranga has led the Pepi Pod Programme in Waikato in conjunction with the MMAG, and has worked in partnership with the other DHBs across the Midland area.

Infant mortality statistics (all causes) for 2013, released by Statistics New Zealand, show that Midland was the only region to see a continuing fall in infant deaths during 2013 (from 61 to 51 deaths).

There was no change in infant deaths for the Northern region (106-106) and an increase for Central (from 42 to 50) and Southern (from 44 to 48). Infant death rates are now similar across all four regions of New Zealand, regardless of Māori birth rates.

Midland has the most concentrated supply of Pepi Pod sleep spaces in New Zealand. It is also the region with the highest proportion of Māori births (43% compared to 23%, 33%, 19% for Northern, Central and Southern regions respectively) and therefore the greatest prevention challenge because Māori infants are more at risk of sudden infant death, more commonly exposed to smoking in pregnancy and to sleeping with parents.

"It cannot be claimed that the Pepi Pod Programme is the cause of the fall in deaths, for there are a lot of people working in various ways to protect babies, but it is heartening to see that the effort in Midland, in particular, by health teams and families, is in the right direction," said Cowan.

"It seems that the programme supported parents in practical ways as well as with safety. They liked being able to have their babies close by during the day, as well as in the night, loved the convenience when travelling, visiting and moving about the house, and 76% found pods helped with settling their babies for sleep. This simple concept has supported parents to provide safe sleep for their babies within the context of their social and cultural norms."

Baby Loss

Developments for stillbirths, terminations for fetal abnormality and second trimester (early pregnancy) loss within Taranaki DHB maternity unit

The Willow Suite is a room which is used for families suffering baby loss. A sofa bed, fridge, microwave, cups, plates and cutlery have been donated by RJ Eagers and SANDS New Plymouth (pregnancy, baby and infant loss support group). SANDS New Plymouth continue to provide memory boxes, blankets and clothing, teddies and information/care packs for all baby loss at every gestation for the maternity unit, emergency department and missed miscarriage clinics.

The midwife champion for baby loss works closely with SANDS New Plymouth who provide support by telephone and also hold monthly meetings. They hold an annual candlelit service and balloon release during Baby Loss Awareness Week and a Christmas remembrance service. A professional photographer has recently volunteered her services to provide families who experience baby loss with professional photography shots of their baby/family.



Above : Donations received for the Willow Suite

Lactation Consultant Service

Please see data section, Appendix 4 for current lactation consultant service provision.

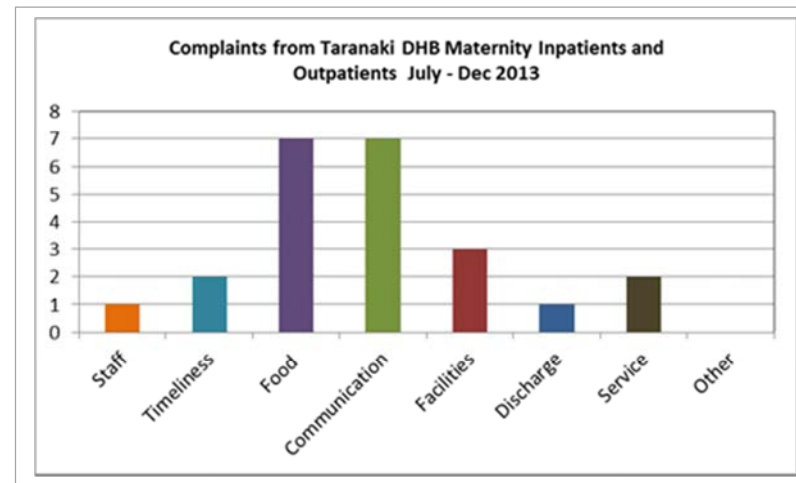
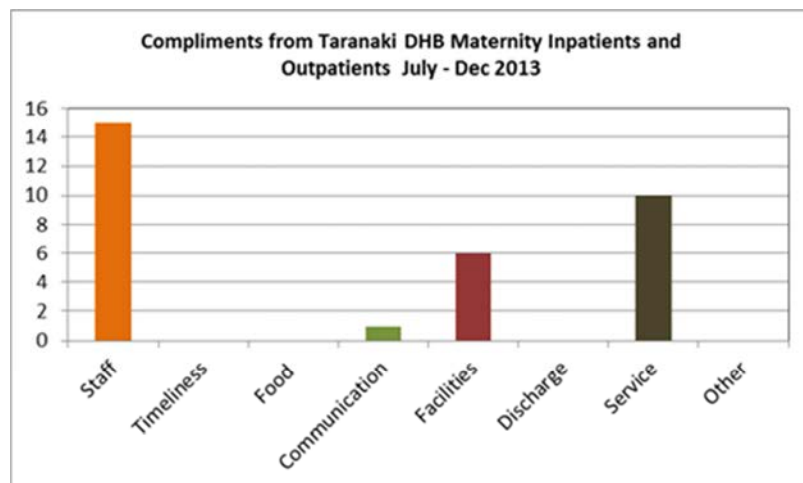
Four scholarships have been awarded to study and sit the International Board of Clinical Lactation Consultants exam this July. The scholars (a mix of midwives, neonatal nurses and well child nurses) meet monthly to share education sessions and plan how the new community lactation service will be provided. Discussions are currently being held to investigate how best to meet the needs of women in the community with a potential mix of support including group meetings, clinic times, home visits and using social networking as an avenue for answering questions. Once the four scholars are certified, it is hoped to have plans in place for the new Lactation Consultants to continue supporting current breastfeeding support groups as well as develop new community initiatives.

Consumer Feedback on Services

Consumer Report January 2014:

“From a consumer point of view, 2013 was a productive year for the MQC. Taranaki DHB maternity webpages have been updated with information on how to contact an LMC and access maternity services. A Facebook page for the Taranaki MQSP has been created and clip on cots have been procured for the postnatal ward. Additionally, vending machines have been situated in the maternity unit for consumers following a trend identified in the consumer feedback survey requesting more availability of snacks. Thank you Amanda, Belinda and Gemma for your help.

Looking forward to 2014/15, the consumer focus will be on communication. The Facebook page will be utilised to reach a greater number of consumers and share more information about what the MQC is doing as well as gain opinion from our consumers. Privacy/confidentiality and consumer training has been completed and now the consumer representative will coordinate consumer feedback surveys. The idea is to survey/reach a targeted group of woman to get their feedback on the entire maternity experience from conception to birth. The consumer representative is also working at establishing a greater awareness about the Taranaki DHB and NZCOM feedback processes amongst consumers”.



Summary of Consumer Feedback Survey Results : June 2013

40/100 surveys returned; the question of whether the services are culturally safe and appropriate is embedded in the survey and there was no negative feedback to this question.

What did we do well?	What could we do better?
<ul style="list-style-type: none"> Meals were on time and nutritious Lactation consultant services very supportive in time of need Great educational materials in booklets and DVDs Good to have car capsule checked before leaving hospital We found all the midwives and nurses that we dealt with exceptional The clip-on cot was excellent as it was difficult for me to get up and to reassure baby during the night Nice quiet room Doctors really listened The care and support and understanding and the speed of offering guidance Everything; bossy and kind at the right times, persistent, gave us options, allowed us to try ourselves 	<ul style="list-style-type: none"> Some advice was inconsistent Hip check delay and communication More availability of snacks Some staff attitudes Continuity of staff

The results of the survey are presented to staff and actions where appropriate are taken to improve the services. We are currently reviewing the process for hip check services.

Report on Accessing Continuity of Care from an LMC for Primary Maternity Care

98% of women access an LMC for primary maternity care. Taranaki DHB do not provide LMC services however they do provide midwifery care for labour and birth services for two private obstetricians. **Please see Appendix 4 data analysis section.**

Workforce

Medical Vacancies

Taranaki DHB has a new specialist O&G Consultant who has relocated from the UK and commenced in June 2014, following Dr Jackie Hanson's retirement. Additionally a second O&G registrar has recently been approved to improve work conditions for the other pre existing registrar post and allow better cover for leave periods.

Midwifery Vacancies

- 1.8FTE by the end of June 2014 for Taranaki Base Hospital
- Hawera primary maternity facility is currently recruiting midwifery staff to ensure the unit is covered 24 hours per day

Taranaki DHB is actively recruiting for both areas however there has been difficulties in filling midwifery positions despite the voluntary bonding scheme which is available for new graduate midwives. It is disappointing that midwifery has been withdrawn from the immigration skills shortages list because Taranaki DHB have recruited four overseas midwives in the last year due to a lack of New Zealand applications.

Following the retirement of Di Herbert in May 2013, the new CMM with 20 years' midwifery experience, commenced her role. Since joining the team, she is gaining an insight and understanding of her role and building on/developing relationships with the obstetric, core midwifery, LMC midwives and administrative staff. Maternity vacancies continue to be problematic with 1.8 FTE gap currently. The Postnatal Coordinator role is in the process of being appointed to enhance the effective coordination and management of the postnatal services and to attract midwives outside the DHB. The present deficit is being managed; we are offering registered nurses temporary contracts on the postnatal ward until permanent midwifery positions are filled. Maternity has seen an increased use of casual nursing staff as a result of the midwifery recruitment difficulties on the postnatal ward to fill the deficit including the daily swing shift.

It has become increasingly evident that maternity is in need of a new unit that is on one level in order that we can manage the available FTE more efficiently and effectively, especially during times of high acuity. This would also improve continuity of midwifery care and supervision for less skilled members of staff and student midwives. Having a unit that is closer to theatres or having its own obstetric theatre would be much more advantageous than the current situation. Auckland University of Technology continues to offer satellite midwifery training to undergraduate midwives, with seven new student midwives commencing training in 2014. It is hoped that training midwives locally will provide long-term sustainability of the midwifery workforce.

Table 1 : Age of Midwife Workforce

Age range	Headcount	Distribution
26-35	8	20%
36-45	9	23%
46-55	13	33%
56-65	8	20%
65+	2	5%
Grand Total	40	100%

Table 2 : Average Age of Midwife Workforce

Unit	Number of employees	Average age	Age from	Age to
Base Hospital	27	45	26	66
Hawera Hospital (Rural)	6	53	41	68
Casual Pool	7	48	40	63

Education of Staff

A Clinical Midwife Educator (CME) has now been appointed and is undertaking training in adult education. The CME is networking with the other Midland DHBs to devise shared education templates and resources to fall in line with the new requirements from the Midwifery Council of New Zealand (MCNZ).

An annual maternity education calendar can be viewed in Appendix 6. Additional to this calendar is ward based in-service education sessions and e-learning modules, as well as the online K2 cardiotocography (CTG) learning package. All education is offered to all maternity practitioners, both employed or self employed. Taranaki DHB is continuing to encourage employed midwives to engage with the Quality Leadership Programme (QLP) and participate in post graduate education.

Access Agreement Holders

There are 50 active access agreement holders throughout Taranaki DHB who claim through Section 88, an increase from 43 in 2013. These include midwives, GPs and private obstetricians. Taranaki DHB has not received any reports of eligible New Zealand women who are unable to access an LMC. Rural midwives have utilised the rural midwife locum service for leave.

Core Midwifery Services for Private Obstetricians

With the retirement of one private obstetrician, the unpredictable workload has decreased for core midwives providing labour and birth services to primary obstetricians' clients. This however has not been noticeable with an increase in women being seen for day assessment on the labour ward and an increase in complex women coming through our services. We are currently reviewing the provision of midwifery care to private obstetrician cases. In 2013, all private obstetrician cases ceased using Taranaki DHB hospital midwifery services for postnatal service and these services are now provided by self-employed midwives.

MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB AND THE MIDLAND REGION

List of Priorities, Deliverables and Planned Actions for 2014/15

Maternity Quality Committee (MQC) Work Plan

Chair: Belinda Chapman (Associate Director of Midwifery, TDHB)

Vision: To lead local maternity activity on behalf of Taranaki DHB that improves patient safety, quality of care, equity of access, and population health outcomes.

Key Objectives:

- Undertake an agreed local work programme that supports the implementation of the National Maternity Quality and Safety Programme (MQSP)
- Improve consistency of practices and coordination of responsive maternity services through working collegially and cooperatively to develop local and regional standards, guidelines, etc to enable the best use of resources
- Improve access to information sharing for LMCs, maternity service providers and consumers.
- Maternity workforce development to reduce vulnerability and increase sustainability

	Project	Expected outcome	Progress	Outcomes	Responsibility
1	Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance at TDHB to enable consumer informed decision-making	Consumer voice (via survey, individuals, focus group, complaints and compliments) is collected and informs the future direction of service delivery for TDHB. Local MQSP consumer representatives have a TDHB forum space to share ideas and connect with each other to strengthen consumer input into maternity services.	Training on confidentiality and customer services for consumer rep. Face to face survey piloted. Contract for consumer Facebook page activity.	Training completed in Apr 14 Pilot completed in May 2014 Contract received in June 2014	Consumer; ADOM
2	Improve LMC registration so that access to care is increased – increase the number of women registering with an LMC in their first trimester	Improved first trimester LMC registration across TDHB. Improved access to LMC maternity care across all ethnic groups.	April 2014 contacted GP Liaison & PHO0 manager to organise a Roadshow with GPs and Practice nurses. Bus display investigated. Fliers in progress of being drafted.		ADOM;ANC coordinator; Educator; CD O&G; LMC rep

	Project	Expected outcome	Progress	Outcomes	Responsibility
3	<p>Preterm and Late Preterm Births</p> <p>Monitor and evaluate underlying reasons for and the number (% of total) of preterm births</p> <p>Investigate any improvements that can be made to prevent preterm births</p>	<p>Data captured to benchmark regionally and nationally.</p> <p>Identify areas for improvement:</p> <ul style="list-style-type: none"> • Early enrolment with an LMC; • Healthy women and healthy babies. <p>Reduce the numbers of preterm births.</p>	Data being captured and reported to MQC.		CD O&G; NNU CNM; ADOM ; Educator
3A	<p>Neonatal Admissions</p> <p>Continue to monitor numbers of term, late preterm and preterm admissions to NNU</p> <p>Identify reasons for admission</p> <p>Monitor length of stay</p> <p>Explore reasons for admission</p> <p>Identify areas for improvement in the care of the late preterm infant so that mother and baby can remain together in the postnatal ward</p>	<p>Benchmarking – regionally and nationally.</p> <p>Keeping mothers and babies together; plan for co-location of Maternity, Neonatal and Child Health Services.</p> <p>Training and education of all Maternity and Neonatal staff in the care of the late preterm infant.</p>	<p>Care of the jaundiced baby protocol introduced with ongoing education of staff.</p> <p>Neonatal and Maternity study day being planned; to include casual staff too.</p> <p>Neonatal staff provide support to postnatal when a late preterm infant remains with his/her mother.</p> <p>Meeting arranged for 29 May 2014.</p>		NNU CNM; Educator; CD O&G; CMM
4	<p>Investigate co-location of Maternity (antenatal/postnatal/labour) and neonatal services (to be nearer to the child health services and operating theatres)</p> <p>Explore what the future maternity services will look like in TDHB (is a primary unit required in New Plymouth?)</p>	<p>Integrated Antenatal / Postnatal/Labour and birth services with Neonatal unit adjacent to improve continuity, effectiveness and efficient use of staff and equipment.</p> <p>Promote skill mix, education and learning environment.</p>	Security to the existing areas is to be improved with video surveillance and remote access.		CSM M&CHS; ADOM; CMM; NNU CNM

	Project	Expected outcome	Progress	Outcomes	Responsibility
5	Ensure secondary maternity Electronic Discharge summaries are completed on discharge from the secondary services and are accessible to primary maternity providers and GP's	Next audit of Maternity EDS' shows an improvement on recent audit results (last audit November 2013 showed a maximum of 25 days from discharge to EDS completion). Instructions for audit of Maternity EDS' clearly set out for future auditors (eg do not include well newborns).	Flowchart including definition of which people require an EDS drawn up. Draft poster on EDS for maternity in progress. Definition of which conditions are primary admissions and which remain secondary being developed.	New procedure on who requires ED's completed including definitions of primary/secondary conditions. Procedure posters displayed.	QEC; ADOM; CMM
6	Improve screening and services for vulnerable perinatal women, babies and families	A. Pre and post natal referral directory implemented and sent to all stakeholders of maternity. Maternity providers and stakeholders have knowledge of the support services available to antenatal and post natal clients.	22 April 2014 completed directory sent to communications finalise and workout a strategy for launching to stakeholders and maternity providers.	Final directory and screening tool published and circulated 12 May 2014; for quarterly updating.	Belinda Chapman (ADOM)
		B. FVIP screening and training on how to screen and refer is available to all maternity practitioners. 100% maternity patients screened for FVIP.	Progressing staff onto training days. SEM's have free NZCOM training organised for 3 June 2014.		CSM M&CHS; CMM; Educator; FVIP Coordinator
		C. Multidisciplinary Maternal and Child Health liaison meeting.			CMM; FVIP Coordinator; ADOM

	Project	Expected outcome	Progress	Outcomes	Responsibility
		<p>Perinatal Mental Health screening and pathways Planned audit of GP's.</p> <p>Planned audit of Clients discharged not seen.</p> <p>Planned audit of referrers re Referral pathway EPDS and blockages to referral.</p> <p>Encourage feedback if referrals rejected to improve the process.</p> <p>Address work around bypassing Intake process via maternal social work.</p> <p>Core midwifery have access to information on MMH.</p>	<p>Referral Pathway circulated to GP's via GP /PHO Liaison. New Intake Coordinator appointed and temp replacement prioritising PMH referrals.</p> <p>Discussion with Clinical director re dedicated Perinatal psychiatrist on going. Perinatal MH and Maternal liaison group Terms of Reference to address clinical governance issues of clients with MH problems bypassing Intake process via maternal social work as identified at Perinatal hui.</p>		Team Leader, PNMH
7	TDHB Ultrasound scanning for fetal assessment and screening in pregnancy have capacity to meet demand for ultrasound scans to be performed locally and in a timely manner (CAR)	<p>Referral pathway devised and implemented with expected timeframes/criteria.</p> <p>Fulford Radiology scanning has capacity to meet demand for ultrasound scans to be performed within expected timeframes.</p> <p>NT scanning services are locally accessible to all pregnant women who wish combined maternal screening in Taranaki.</p>	<p>Primary first trimester scans for dating and threatened miscarriage can be referred to private GP provider to alleviate wait time at Fulford Radiology.</p> <p>Monthly monitoring of NT scans that cannot be provided due to demand outweighing capacity.</p> <p>New O &G consultant to train in NT scanning.</p>		CSM M&CHS; ADOM; CD O&G; CD Radiology

	Project	Expected outcome	Progress	Outcomes	Responsibility
8	Explore how improvements can be made to ensure client privacy is improved during transfer to the operating theatre and improve timeframes for Level One caesarean sections to meet expected urgency codes (CAR)	Improvement on timings of Level 1 caesarean sections (last audit showed an average of 46 minutes); the decision for caesarean birth to delivery of baby time is within the recommended 30 minutes for Level One caesarean sections. Client privacy is maintained as much as possible during transfer in public corridors to the operating theatres. Individualised antenatal and postnatal care plans are implemented to guide and evaluate care in consultation with the woman and LMC.	Initial meeting to map process held; FMEA completed in second meeting. Audit of level 1 c/section continues. Flowchart for "out of hours" process complete. OT to audit the time it takes for on call staff to arrive out of hours. Audit of bed stocks. Consider battery back up beds as delays possible with transfer onto another bed.		Core midwife; QEC; CMM; CSM M&CHS; ADOM; CD O&G; Anaesthetist; OT CNM
9	Implement individualised antenatal and postnatal care plans based on the goals and desired outcomes of the consumer (CAR)	Individualised antenatal and postnatal care plans are implemented to guide and evaluate care in consultation with the woman and LMC.	Draft care plans for mother and baby devised and to be piloted June 2014.		Educator; PN Coordinator
10	Hip check services reviewed to improve consumer satisfaction	Hip check provides a service that is timely, accessible and satisfying to consumers.			CSM M&CHS; CMM
11	A. Antenatal Clinic Services : Antenatal clinic to establish a fetal day assessment unit to reduce acuity on labour ward for urgent antenatal outpatient reviews	FAU implemented to reduce labour ward acuity and provide timely assessment where urgent assessment or review is identified as required. Continuity of midwifery and medical care.	FAU commenced service in May 2014.	(?Resume previous services January 2015)	ANC coordinator; Core Midwife; CMM
	B. Timely access to Maternal Fetal Medicine (MFM) services by establishing relationships and developing telemedicine/ communication	MFM services are accessed within seven working days of referral with a focus on consultation being provided by telemedicine where appropriate.			Obstetrician; ANC coordinator

	Project	Expected outcome	Progress	Outcomes	Responsibility
	<p>c. Monitor/audit the increase in antenatal clinic services to ascertain why the ANC is having difficulty in accommodating all appointments in a timely manner</p> <p>Continuity of care for high risk women</p> <p>Investigate if a clinical midwife specialist in gestational diabetes would improve the services & outcomes for Gestational Diabetes Mellitus (GDM) clients</p>	<p>Identification of reasoning why the demand for antenatal clinic exceeds capacity.</p> <p>Future services planned around findings so that capacity meets demand and appointments are received in a timely manner, depending on reason for referral.</p> <p>Continuity of care for high risk women.</p> <p>GDM women have timely services for healthy eating, exercise monitoring and treatment in pregnancy, labour and birth.</p>			<p>CMM; ANC coordinator; ADOM; CSM M&CHS</p> <p>Diabetic and dietician services</p>
12	Investigate the rising caesarean section rate to benchmark and identify any trends in clinician type, reasons for and gestation of caesarean section	<p>Caesarean section rates among primiparae and multiparae compare to similar populations e.g. Lakes DHB.</p> <p>Caesarean sections performed only if clinically indicated prior to 39 weeks gestation.</p> <p>VBAC counselling and education is consistent and as per RANZCOG guidelines.</p> <p>Any trends identified are addressed e.g. education.</p>			CSM M&CHS; ADOM; Obstetrician
13	Review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres	All caesarean section cases have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre.			QEC; ADOM; NNU CNM; CMM; OT CNN; CSM M&CHS

Midland Maternity Action Group (MMAG)

Chair: Corli Roodt (Clinical Midwife Director, Waikato)

Vision: To lead regional maternity activity on behalf of Midland DHBs that improves patient safety, quality of care, equity of access, and population health outcomes.

Key Objectives:

- Undertake an agreed regional work programme that supports the implementation of the National MQSP
- Improve consistency of practices and coordination of responsive maternity services through working collegially and cooperatively to develop regional standards, guidelines, etc to enable the best use of resources
- Improve access to information sharing for LMCs, maternity service providers and consumers
- Maternity workforce development to reduce vulnerability and to increase sustainability.

Initiative 1	<p>Support the reduction of the smoking rates of pregnant women, support the reduction of the SUDI rates for Midland, and support the improvement of breastfeeding rates:</p> <ul style="list-style-type: none"> - Continue the implementation of the Midland safe sleep programme across Midland to reduce Māori SUDI rates, in alignment with national indicator (<0.5 per 1,000 live Māori births). - Enable training around best practice to support attainment of quit smoking support indicator for pregnant Māori women within Midland (95% of in-patient hapū woman offered quit support) - Pilot an initiative that incentivizes smoking quit support uptake amongst pregnant women in Waikato. Evaluation used to inform regional roll-out/ learnings. (95% of in-patient hapū woman offered quit support) - Complete Mama Aroha Breastfeeding training with key health practitioners inclusive of midwives, LMCs / Māori provider staff across Midland region (% of Māori infants fully and exclusively breastfed at 6 weeks (68%), 3 months (54%), 6 months (59%) improving trend evidenced) - Networking and sharing of resources throughout Midland re breastfeeding - Explore the development of IT applications and the use of the regional website to improve access to information for all parents, particularly Māori and vulnerable mothers. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	Q4 – 2014/15					
Measurable	<ul style="list-style-type: none"> • All providers of maternity services are trained in promoting safe sleeping messages, as part of the Midland Safe Infant Sleeping (Birth to 1 Year) Policy and the Midland Safe Sleep Programme • Progress towards a rate of <0.5 SUDI/1000 live Māori births. • All maternity providers have access to education around smokefree pregnancy • An increase in the educational resources that maternity providers are able to access ie online MoH ABC smoking cessation recommendations programme, and/or study sessions • Progress towards 90% of all pregnant women, particularly Māori women, who identify as smokers at the time of confirmation of pregnancy in general practice or booking with an LMC are offered advice and support to quit, eg MoH ABC smoking cessation recommendations programme • An improvement in accessible consistent breastfeeding information • Progress towards a 5% increase of infants fully and exclusively breastfed, particularly amongst Māori, for babies at 6 weeks. 					
Inputs & Resources	MMAG / Midland Regional Smokefree Programme / Midland Regional Training Network (MRTN) / Midland GPs Māori Health					
Responsibilities	MMAG/ MQSP sub group / Breastfeeding/BFHI sub group / Midland GPs Māori Health					
Enablers	Midland Regional IS					
DHB Contribution						

Initiative 2	Improve patient care, quality, and safety through establishing a robust maternity/neonatal transfer system – implement consistent system for maternity transfers and repatriations across Midland and beyond: <ul style="list-style-type: none"> - Midland Maternity Services: Transfer and Repatriation Standards - quality indicators and standards for maternity transfers developed and implemented to underpin transfers - Analysis and review of transfer system efficiency and repatriation numbers/ appropriateness. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	Q4 – 2014/15					
Measurable	<ul style="list-style-type: none"> Improved consistency of practices and systems through development of regional wide standards, procedures and processes Facilitating improved coordination and responsiveness of services to those requiring maternity services in Midland in a cooperative and coordinated manner Working collegially and cooperatively to make best use of resources and/or to implement regionally consistent systems and processes 					
Inputs & Resources	MMAG / Midland Regional IS					
Responsibilities	MMAG					
Enablers						
DHB Contribution						

Initiative 3	Workforce: <ul style="list-style-type: none"> - Intelligence – design a strategy for a sustainable maternity workforce across the region, including rural and remote rural areas with the skills and knowledge required to meet the needs of women within the Midland population. Ensure stronger engagement with workforce monitoring in conjunction with GMs HR to enable DHBs to understand maternity workforce issues, eg a pipeline supply, age, work, and preferences. - Utilisation – identify future maternity workforce requirements and develop plans to ensure ongoing, safe and appropriate maternity care provision. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	Ongoing					
Measurable	Workforce: <ul style="list-style-type: none"> - Intelligence: <ul style="list-style-type: none"> Robust data collected on numbers of health professionals working in maternity services across the Midland region to understand current workforce in primary care (both rural and urban), secondary, and tertiary settings. Birthing populations and their outcomes mapped against requirements for maternity care. Map the learning needs to each occupational group to identify gaps in knowledge, skill and number of health practitioners. - Utilisation – explore: <ul style="list-style-type: none"> Options for innovative models of service delivery to allow practitioners to work throughout the breadth and depth of their scope, enable role substitution where possible (e.g. midwifery-led clinics), collaborative models including allied health practitioners. Training and education models to facilitate the inclusion of General Practitioners into rural maternity services. 					
Inputs & Resources	MMAG / Midland Workforce Advisor/Midland Regional Training Network					
Responsibilities	MMAG / Midland Workforce Advisor/ Midland Regional Training Network					
Enablers	MMAG / Midland Workforce Advisor/ Midland Regional Training Network					
DHB Contribution	GMs HR					

Initiative 4	Improve access to pregnancy and parenting (P+P) classes, particularly for rural and Māori pregnant women, with the aim to increase the number of vulnerable pregnant women who enrol in P+P / antenatal classes, especially in rural and high deprivation areas: <ul style="list-style-type: none"> - MMAG to support and advise the implementation of P+P service specifications at a local level - MMAG to collaborate with Midland planning and funding divisions to receive regular information/data on P&P utilisation and ethnicity 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	Q4 – 2014/15					
Measurable	<ul style="list-style-type: none"> • P+P classes well attended • Increased number of Kaupapa Māori P+P / antenatal classes available across the region • Improved Māori attendance. 					
Inputs & Resources	MMAG					
Responsibilities	MMAG/ MQSP sub group / Midland GMs Māori Health					
Enablers	PFALT					
DHB Contribution						

Initiative 5	Improve LMC registration so that access to care is increased – increase the number of women registering with an LMC in their first trimester: <ul style="list-style-type: none"> - Each local MQSP governance board to consider how to improve LMC access and share initiatives/learning/strategies across the Midland region. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	ongoing					
Measurable	<ul style="list-style-type: none"> • Improved LMC registration across the Midland region • Improved access to LMC maternity care across all ethnic groups. 					
Inputs & Resources	MMAG					
Responsibilities	MMAG/ MQSP sub group					
Enablers	Midland Regional IS					
DHB Contribution	Midland DHB MQSP Governance Boards					

Initiative 6	Strengthen consistency of practices through shared educational activities and shared resources – maximise collaboration between Midland regional maternity educators, lactation consultants, BFHI coordinators, safe sleep champions: <ul style="list-style-type: none"> - Investigation into the use of Moodle as an electronic platform for e-learning modules to share education across the region - Regional education plan is developed, with activities and associated expenditure prioritised - Regional education calendar available on regional website for all maternity service providers, including LMCs and medical practitioners - Regional education arranged through MMAG, ie, offer of a workshop/s in each Midland DHB with a particular focus on perinatal and infant loss and perinatal and maternal mental health. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	ongoing					
Measurable	<ul style="list-style-type: none"> • Consistent and supported maternity education delivered across region • Increase in focus on the multi-disciplinary team's knowledge around perinatal and infant loss and maternal mental health. 					
Inputs & Resources	MMAG / Midland Regional Training Network (MRTN) / Midland Regional IS					
Responsibilities	MMAG/ ME&ML sub group / Breastfeeding/BFHI sub group					
Enablers	Midland Regional IS					
DHB Contribution						

Initiative 7	Inclusion of consumers in the MQSP governance boards at each Midland DHB to enable consumer informed decision-making: <ul style="list-style-type: none"> - Consumer voice (via survey, individuals, focus group, complaints and compliments) is collected and informs the future direction of service delivery for the Midland region - Local MQSP consumer representatives have a Midland virtual forum space to share ideas and connect with each other to strengthen consumer input into maternity services. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
Milestone	ongoing					
Measurable	<ul style="list-style-type: none"> • All Midland DHBs have a consumer representative on their local MQSP governance boards, and their maternity service improvement initiatives are underpinned and shaped by consumer input • Development of a virtual forum space for regional consumers commenced 					
Inputs & Resources	MMAG					
Responsibilities	MMAG/ MQSP sub group					
Enablers	Midland Regional IS					
DHB Contribution	Midland DHB MQSP Governance Boards					

Future for Taranaki Maternity Quality and Safety Programme

Taranaki DHB is mindful that the Maternity Quality and Safety Programme, the work being undertaken and the vision for the future will move to being business as usual in the coming months. We are reviewing our processes to support this transition, recognising that the programme is both valuable and important and that the work done to date is not diminished. It is planned that we will link with the Taranaki DHB wide hospital agenda within the Quality Committee, ensuring that the maternity focus is not reduced. We will continue to be reporting to the Clinical Board and monitoring improvements at service level, and working closely with stakeholders and departments associated with maternity services.

Appendix 1: Quality Audit and Reporting Grids

Taranaki DHB Maternity Quality Audit Grid 2014/15

	2014						2015					
	March	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb
MEWS <i>CME-I</i>	✓			✓			✓			✓		
Customer Satisfaction Survey <i>ADOM</i>				✓								
Documentation and Fluid Balance <i>QR Rep Maternity</i>			✓			✓			✓			✓
ISBARR <i>Postnatal Coordinator</i>		✓				✓				✓		
Appraisals <i>CMM</i>			✓			✓			✓			✓
Fetal Fibronectin <i>O&G</i>			✓						✓			
Antenatal steroids Audit <i>O&G</i>					✓							✓
Safe Sleep Audit <i>Safe sleep champion</i>					✓							
Level 1 c/sections decision to delivery times <i>O&G</i>							✓				✓	

Taranaki DHB Maternity Quality Committee Reporting Grid 2014/15

	2014						2015					
	March	April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb
PMMR and case review/trends/great saves <i>CME/ADOM</i>	✓			✓			✓			✓		
Maternal mental health <i>Numbers/Trends – MMH Team Leader</i>		✓						✓				
Neonatal Unit <i>Admissions/trends/issues</i> <i>CNM NNU</i>			✓			✓			✓			✓
Complaints/consumer feedback trends <i>Mat Child Health Manager/</i> <i>CMM</i>		✓				✓				✓		
Wound infections/general anaesthesia and blood transfusions (caesarean section) <i>CNS – Infection Control</i>				✓					✓			
Nuchal Translucency Screening <i>QR Delegate</i>										✓		
Inter-facility referral and transfer <i>CME</i>											✓	
Consumer report <i>Consumer Representative</i>											✓	
LMC Registration <i>ADOM</i>											✓	
Newborn Hearing Screening <i>Allied Health Manager</i>						✓						✓

Appendix 2 Alignment of Aims/Objectives with National Priority and Recommendations

Standard One:

Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.

8.2 Report on implementation of findings and recommendations from multidisciplinary meetings

Multi-disciplinary review processes/meetings that have been coordinated

- Monthly MQC meetings.
- Associate Director of Midwifery (ADOM) meetings with remote rural, rural and urban midwives.
- Weekly case review linked to the new Maternity Obstetric Outcomes: trend monitoring, case review, near misses and reportable events protocol (see Appendix 10 for data collection form).
- Bi-monthly self-employed and Taranaki DHB maternity/neonatal service meeting.
- Weekly core midwifery meetings.
- Monthly Perinatal Mental Health meetings (see Appendix 7).
- Monthly complex care meetings (includes maternity social workers, diabetes educators, obstetricians, registrars, obstetric house surgeons, NNU manager, paediatrician, antenatal clinic coordinator (ANC), Clinical Midwifery Manager (CMM) and ADOM).
- MMAG meetings : Sub-groups include midwifery leaders' meetings, midwifery educators and leaders, breastfeeding/BFHI and Midland MQSP.
- CMM and ADOM included in the monthly paediatric liaison meeting to discuss potentially vulnerable unborn babies.
- Maternal and Child Health Services meeting.
- Perinatal and Maternal Mortality meetings twice yearly.
- National MQSP forum.

Changes in clinical practice and quality improvements that have been driven by MQSP initiatives and above meetings

- Antenatal clinic midwife and two core midwives trained to capture and provide opportunistic immunisation of the flu vaccine and Boostrix.
- Dashboards for KPIs and information are displayed in Wards 14 and 15.
- Hand held records have been implemented for secondary antenatal clients.
- Maternity internet site has been initiated with a description of the maternity services including information on stakeholders and how to access an LMC including a contact list of LMC's in Taranaki, also provided is information on how to access a midwife through the link www.Findyourmidwife.co.nz site.
- Revised Quality Reporting Grids – draft (see Appendix 1).
- Revised Maternity Audit Grid – draft (see Appendix 1).
- Intravenous (IV) antibiotics given one hour prior to elective caesarean section to reduce the risk of wound infection.
- Maternal mental health draft pathways further developed with a proposed audit to test its implementation.
- Yearly maternity education calendar developed/updated (see Appendix 6).
- Newborn enrolment system for women with unknown GP to encourage early enrolment of the baby for timely immunisation.

- Smoking cessation KPI data collected.
- Diabetes nurse specialist attending secondary antenatal clinic appointments for women with known diabetes to promote integration of services and combine appointments means women only attend one appointment and are less likely to default.
- Implementation of audits to ensure adherence to MEWS protocol.
- Escalation protocol for times of high acuity and staff absence developed and linked with Care Capacity Demand Management.
- Regional Safe Sleep Policy and in-service education sessions, regional education implementation; audit to be implemented to ensure compliance.
- National observation of mother and baby guideline adopted locally.
- Breastfeeding : Antenatal Colostrum Expressing (ACE), mothers' quiet room area which enables privacy and quiet to feed or express if she wishes.
- Introduction of a new protocol 'Care of the Jaundiced Baby' with more education around assessment and care of the baby in the postnatal ward, in addition to how to use either the Bilibed or the Bilisoft.
- Fentanyl PCA protocol for women in labour who are not suitable for epidural anaesthesia.
- Jadelle contraceptive insertion prior to discharge for transient women at risk of repeated unwanted pregnancy.
- Furnishing of the 'The Willow Suite' for parents who suffer baby loss.
- Pre-mix Magnesium Sulphate infusion bags implemented.
- General anaesthesia caesarean section audit.
- Purchase of portable cardiotocography machine for continuous fetal monitoring to try and reduce general anaesthesia caesarean section rate.
- Maternity referral guidelines : Patient status boards reflect the new maternity referral guidelines (see Appendix 8) and in-service education/meetings to discuss the new referral guidelines.
- Maternity management care plans implemented for secondary antenatal clients.
- Perinatal mental health clients provided with 1:1 maternity and neonatal tour and discussion prior to expected due date.
- Lactation Consultant scholarships (four) to increase number of Lactation Consultants for community clinics.
- Rural maternity unit meetings via video conferencing facility implemented.
- Pepi Pod provision, referral process and named distributors.
- MQC stakeholder newsletter (see Appendix 9).
- Checklist and pre and postnatal services referral directory see Appendix 5.
- Fetal day assessment unit implemented in March 2014.
- Newborn hearing screening service – clinical governance provided by MQC.
- Fetal fibronectin audit.
- Review of the PPH protocol to come in line with the national guideline.
- Elective caesarean sections not booked prior to 39 weeks' gestation unless medically indicated (antenatal steroids recommended if booked prior to 38+6 weeks' gestation).

New meeting initiatives

Maternity Obstetric Outcomes: Trend monitoring, case review, near misses and reportable events protocol (see Appendix 10 for data collection form).

Weekly Multidisciplinary Meeting

Taranaki DHB has progressed with multidisciplinary meetings and increased the number of case reviews and debrief sessions since the implementation of the Maternity Obstetric Outcomes : Trend Monitoring, Case Review, Near Misses and Reportable Events Protocol. A weekly case review meeting enables the obstetric medical team, core and self-employed midwives and other related professions such as maternity social workers, neonatal staff and anaesthetic staff to discuss trends and cases in a collaborative, safe and non-punitive environment and provide an opportunity to apply the latest literature to practice and test our current knowledge and practices in an attempt to have best practice and outcomes within our units.

MDT Perinatal Mental Health Meeting (see Appendix 7)

Meetings to Discuss Potentially Vulnerable Unborn Babies

The monthly paediatric liaison meeting now includes an invitation to the CMM and ADOM and accepts antenatal referrals so that discussion, planning and support can be implemented. Relationships and networking with the services that attend these meetings are enhanced. It is hoped this will be developed further as the national tool boxes are released in 2014/15 and the recruitment of a new Family Violence Intervention Coordinator who commenced her position at the end of February 2014. A Taranaki pre and post pregnancy checklist and referral directory has been devised to inform practitioners of how and where to refer families with additional needs (see Appendix 5).

8.4 Produce an annual maternity report

Taranaki DHB produced its first Maternity Annual Report in June 2013 and will continue to report on the Taranaki DHB maternity services on an annual basis.

8.5 Demonstrate that consumer representatives are involved in the audit of maternity services at Taranaki DHB

Taranaki DHB is committed to training and ensuring consumer representation on the MQC. The Taranaki DHB consumer representative has completed Taranaki DHB training in confidentiality and customer services, in preparation for her liaison role in surveying consumers and targeted consumer groups to obtain feedback from the users of the maternity services.

The consumer representative has assisted in formulating a communication plan and a Taranaki MQSP Facebook page. This is used to obtain consumer feedback/opinion to gather information as well as dispersal of information to consumers. Additionally the annual consumer survey was conducted in 2013. One hundred (100) surveys were sent out over a one month period, with a return rate of 40%. One of the results of the survey was the installation of vending machines in the maternity area to provide the availability of snacks and refreshments. Consumers and practitioners were consulted in the preferences of items to be stocked in the machines.

9.1 Plan to provide and report on appropriate and accessible maternity services to meet the needs of the Taranaki region

Maternity Facilities

The Taranaki Region hosts both primary and secondary birthing facilities; these are Base Hospital (New Plymouth), Hawera Hospital (South Taranaki), and Elizabeth R Hospital and Maternity (Stratford, Central Taranaki).

Taranaki District Health Board Maternity Facilities

- Taranaki Base Hospital primary and secondary births
- Elizabeth R primary birthing unit, Stratford (Central Taranaki)
- Hawera Hospital (DHB) primary birthing facility
- Home birth, offered by midwife LMCs
- Total Taranaki approximate births 1,480 (down from 1,507 births in 2012)

Taranaki Base Hospital (2013)

- 1,307 (increase of 21 from 2012) total births
- 1,053 (increased from 939 in 2012), primary Midwife/LMC
- 42 primary obstetrician/LMC births (decreased from 136 in 2012)
- 212 secondary births (including transfer of care in labour, similar to 2012)
- Epidural service
- Level 2A Neonatal Unit

Taranaki Base Hospital Staff

Three employed Taranaki DHB obstetricians (two have full-time contracts and one has a part-time contract) plus one full-time senior MOSS works on the O&G roster. Additionally, one obstetrician (not contracted to Taranaki DHB) works privately and has an access agreement for Taranaki DHB.

- 1 MOSS (0.5FTE, additional to MOSS position above)
- 1FTE obstetric registrar
- 2FTE house surgeons
- ADOM (0.6FTE)
- MQSP project coordinator (0.2FTE)
- Clinical Service Manager, Child & Maternal Health (1.0FTE)
- Midwifery, nursing and administration staff (31.65FTE) which includes 0.8FTE
- Lactation Consultant and 1.0FTE CMM

Taranaki Base Antenatal Clinic

- Co-ordinated by antenatal clinic midwife coordinator
- Maternal Fetal Medicine specialist clinic no longer offered due to the shortage of Maternal Fetal Medicine specialists/resignation of previous specialist
- Outpatient specialist consultation clinics
- Secondary antenatal team clinics
- Amniocentesis clinics

The antenatal clinic coordinator provides continuity of midwifery care and education for secondary patients in the antenatal period. Additionally secondary patients have a nominated obstetrician for antenatal care to promote continuity of obstetrician.

Antenatal and Labour Ward

- 5 delivery rooms (for primary and secondary births)
- 1 pregnancy loss room named "The Willow Suite"
- 1 birthing pool
- 7 antenatal rooms
- Operating theatres (which are located in the main hospital block six to seven minutes' walking distance)

Postnatal Ward

- Located on a separate floor above the labour ward
- Total of 19 beds – nine single rooms plus two single rooms with ensuite, two four-bedded rooms
- Accommodates boarder mothers when no facilities available in NNU

Taranaki Base Hospital Neonatal Unit

- Approximately 240 admissions per year
- 6 cots
- 2 intensive care cots
- Accepts >1,000gms and >28 week gestation
- 8 paediatricians (6.7FTE total for maternal and child health services)
- 4 house surgeons
- 2 registrars
- Nursing staff (13.5FTE)
- Homecare and Lactation Consultant (0.8FTE)

Hawera Hospital Primary Maternity Facility (DHB)

- Hawera Hospital is a primary maternity facility with a rural health focus that is one hour by road from Taranaki Base Hospital
- 79 births in 2013 (down from 96 births in 2012)
- 1 GP LMC and five part-time midwife LMCs access this facility
- Hawera is supported and managed by the CMM, ADOM and the Clinical Services Manager; these staff cover both Base and Hawera sites
- 2 O&G consultants share outpatient, secondary care maternity and colposcopy clinics in Hawera, visiting at least fortnightly to achieve this
- Midwifery staff in Hawera consists of 2.7FTE midwives and 0.9FTE registered nurse, and are currently recruiting
- Taranaki DHB has an agreement with a private GP obstetrician in Hawera to support the Hawera maternity unit for obstetric emergencies

Proposed Changes for Staffing Hawera Hospital Maternity Unit (HMU)

HMU has undergone a staffing review in the past 12 months. The objective being to achieve a staffing model that was mutually agreed by the core staff and Taranaki DHB. The models discussed would have seen the core staff being paid in a manner that enabled them to be retained at work on-site if there were inpatients requiring care and on-call if the unit was not occupied. Statistically, the HMU is not fully utilised and at many times it does not have any patients receiving care in the facility. The proposal was rejected by the staff following discussions with the NZNO as it required staff to agree to a variation to their employment agreement in relation to their pay ie receiving a salary rather than an hourly rate. The proposal did not see any midwives receiving less salary than they currently earn.

HMU is now recruiting midwifery staff to ensure the unit is covered 24/7. The staff are putting themselves on-call under the provisions of on-call in the collective NZNO employment agreement. One registered nurse is expected to work in the Hawera inpatient area if there are inpatients and she does not wish to be on-call. Within the core FTE, the unit staff arrange and provide their own cover for all types of leave with some support, if and when required, from Base Maternity Unit. The staff have agreed to this, as recruiting additional midwives has the potential to dilute LMC work for those core midwives that are LMCs also. We are however currently having difficulty recruiting into the post and have extended the advertised position to include experienced registered nurses also.

Elizabeth R Maternity, Stratford (non-DHB Facility)

- 35 minutes by road to Base Hospital
- 65 births (down from 89 births in 2012)
- 1 delivery room
- 1 birthing pool
- 4 postnatal beds
- All midwife LMC cases

BUPA who own and operate the Elizabeth R Rest Home and Hospital (Elizabeth R) support the local community in the need for primary maternity services to be provided at Elizabeth R however they gave notice to exit the provision of maternity care by the end of June 2014. Following a request for proposal to contract the maternity facility and services at Elizabeth R, Taranaki DHB recently announced the new provider to be “Maternity Services Taranaki Limited”. They will commence services which will continue to be delivered from the existing Elizabeth R site from 1 July 2014.

Home Births

Approximately 30 births (down from 40 births in 2013) by self-employed midwife LMCs however there is difficulty in accessing accurate data.

Appendix 3 : Six Monthly Report of the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) to the Taranaki DHB Maternity Clinical Governance Group

Date of Report:	28 January 2014
Report number	1
Report period	1 July 2013-31 Dec 2013
Department	Newborn Hearing Screening, Allied Health, Scientific and Technical Services
Author	Mary Bird, UNHSEIP Coordinator/Allied Health Support Manager

Background and purpose of UNHSEIP

The Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) aims to identify permanent congenital hearing loss that is likely to impact on the development of a child's speech and language so that

- they can access timely and appropriate interventions;
- inequalities are reduced; and
- the outcomes for these children, their families, whanau and communities, and society are improved.

The goal is for all babies in New Zealand to have a hearing screen completed before the age of one month, diagnostic audiology testing for those without a clear response by three months, and early intervention services initiated by six months (1:3:6 goals).

The UNHSEIP is a partnership between the Ministries of Health and Education. The MoH has responsibility for funding screening, diagnosis of hearing loss, and medical interventions, including devices such as hearing aids and cochlear implants. The Ministry of Education has responsibility for early intervention education services. The UNHSEIP is overseen by the National Screening Unit (NSU) of the MoH and the programme is delivered by all 20 District Health Boards (DHBs).

Taranaki DHB implemented the newborn hearing screening programme throughout the province on 1 April 2009 as part of a three year DHB roll-out of newborn hearing screening. By 2009, 50% of DHBs had implemented the programme and by 2010, 100% of DHBs had completed implementation. The establishment of the Taranaki programme was lead by Mary Bird, Allied Health Support Manager, together with a Taranaki DHB clinical working group which included the CMM, and the roll-out was guided and supported by the NSU.

Essential elements of the UNHSEIP (from the UNHSEIP National Policy and Quality Standards June 2013):

- Coordination of all components of the programme
- An organised invitation for screening to families and whanau of all newborns
- A multidisciplinary approach to screening, diagnosis and follow-up
- Close links with treatment and early intervention services
- Operational policies and quality standards and ongoing monitoring
- A focus on continuous quality improvement

Universal Newborn Hearing Screening and Early Intervention Programme



How do you make a great screening programme?



A monitoring and evaluation report against the monitoring and evaluation requirements outlined in Clause 1 of Schedule C1 of the UNHSEIP Agreement for the period 1 July 2013 – 31 December 2013

A. Screening	Number of Newborns
Offered Screening	744
Declined Screening	3
Screening Completed	751
Screening Not Completed ¹	2
Babies Requiring Targeted Follow-Up ²	47
Babies Missed ³	1
B. Diagnostic Audiology	Number of Newborns
Referred for Audiology Assessment	9
Confirmed Sensorineural Loss (Total)	2
Bilateral	2
Unilateral	0
Confirmed Conductive Loss (Total)	2
Bilateral	2
Unilateral	0
Confirmed Mixed Loss (Total)	0
Bilateral	0
Unilateral	0
Confirmed Auditory Neuropathy (Total)	0
Bilateral	0
Unilateral	0
C. Referral to Intervention Services	Number of Infants
Referred to a Ear, Nose, Throat Specialist (Otolaryngologist)	3
Referred to Ministry of Education for Early Intervention Services	0
Referred for Hearing Aids	1
Referred for Cochlear Implants	1

Consumer Engagement and Feedback

Results of the Annual Survey:



2013 September
Customer Survey Summary

Taranaki Newborn Hearing Screening Programme Customer Survey and Complaints/Compliments Notification Procedure and Survey Form:



Procedure-customer
survey V 2.doc



Customer survey
Base-UNHSEI 11-02-1

How are we doing?

Note: This Information is benchmarked with national data

Statistics extrapolated from the most recent *UNHSEIP Monitoring Report April– Dec 2012*

http://www.nsu.govt.nz/files/ANNB/UNHSEIP_Monitoring_report_April_to_Dec_2012.pdf

Key Performance Indicators	National	Taranaki
Offered screening	98%	102%
Declined screening	1%	0.8%
Completed screening	86%	99.9%
Completed screening by one month	92%	98.9%
Referred to Audiology	1.7%	1.9%
Targeted follow up	5%	*10.3%

*The targeted follow-up rate has reduced following further training and education of screeners and neonatal staff

Key highlights for the service in the past six months

- Development of the first Service Delivery Plan in September 2013 and feedback from NSU (attached as PDF):



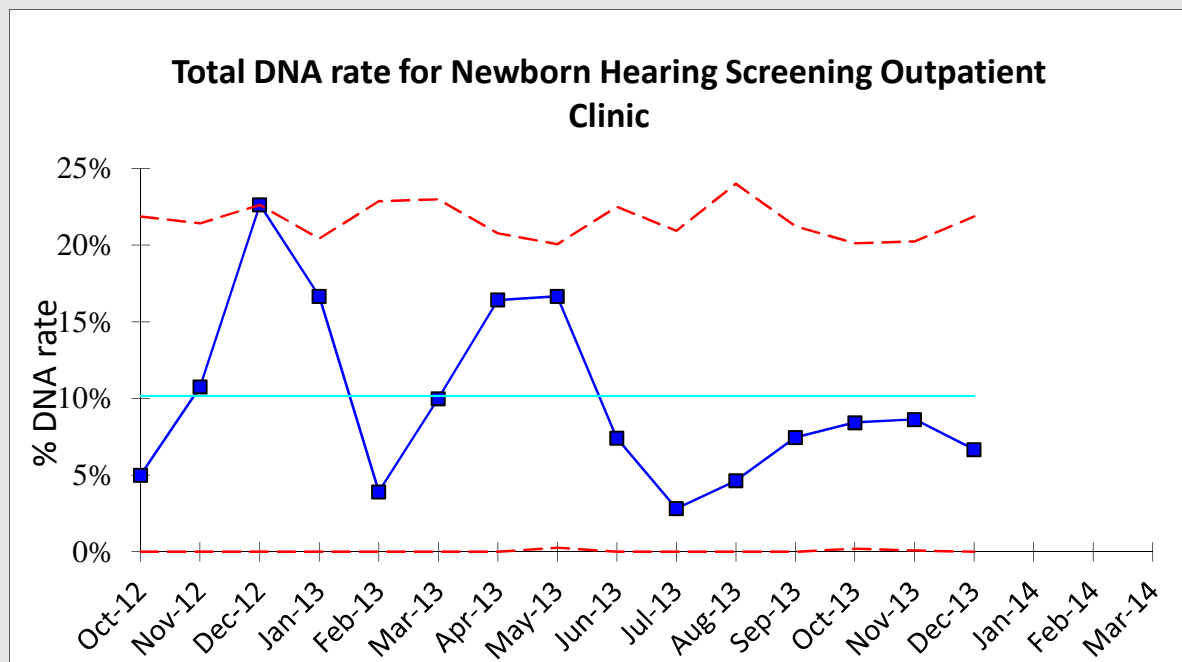
2013-09 TDHB
UNHSEIP service delivery

- Planning is underway for the external audit by Deloitte of UNHSEIP screening and audiology services which is scheduled for 3 and 4 April 2014. Auditing of UNHSEIP services in DHBs is undertaken over a three year cycle. This is the first audit round for Taranaki and our services are the last DHB to be audited. The audit team will assess the procedures and operations related to UNHSEIP in Taranaki DHB against the requirements of the:
 - MoH's contractual agreement for Universal Newborn Hearing Screening;
 - UNHSEIP National Policy and Quality Standards, including Appendix F : Diagnostic and Amplification Protocols.
- Distribution and review of the new screener training manual has provided a learning opportunity for screeners to review their practice to ensure they are working at best-practice level.

- Implementation of revised UNHSEIP National Policy and Quality Standards (distributed June 2013).
- A new quarterly DNA report has been set up following a request to the Management information Unit. This will improve the coordinator's ability to monitor DNA rates and also to evaluate the impact of service improvements.

The first chart is displayed below.

Table 1



This graph shows a pleasing reduction in the DNA rate from June 2013. This will be monitored and charts showing DNA rate by ethnicity (Maori and Non-Maori) will be added.

Note : A continuation of this result for one more month is a significant trend statistically; (eight points below the centre line shows a downward shift).

Key Issues for the service in the past six months

- Screener incident as detailed in sentinel events section (below).
- The screening service is continuing to trial an outpatient service with a weekly clinic operating every Monday from Hawera Hospital Outpatient Department. The clinic commenced on 17 June 2013 and is run by Faye Symes. Extra FTE is being used for her screener role while the coordinator identifies optimal staffing requirements when the Hawera maternity staffing model is finalised.
- It had been agreed that north services screener leave would be provided by the south screener. Following the new Hawera staffing model and midwife vacancies in the south, cover availability has been severely limited due to rostering issues. Review of leave cover arrangements will be a priority in the next six months (see below staffing model).
- Strategies are being implemented to reduce the targeted follow-up referral rate.
- The implementation in November 2013 of an 11am discharge time from maternity wards had an immediate impact on inpatient screening services. There were several incidents where midwives asked the screener to screen babies who were less than 24 hours old and still quite mucousy, which the screener appropriately did not act on.
- 2013/14 Variation to the Agreement between the MoH and DHBs requiring additional reporting:
 - Section 5 Monitoring of individual screener data on a quarterly basis
 - Section 6 1 programme specific financial reporting on a quarterly basis

Staffing model and issues (vacancies, recruitment plans, roster and leave)

The service is staffed during normal business hours of 0830-1700hrs Monday to Friday.

UNHSEIP coordination (0.2 FTE) is the responsibility of the Allied Health Support Manager who also manages Audiology Services. This ensures close audiology alignment and integration with newborn hearing screening services. The coordinator role does not include carrying out screenings. In July 2013 the coordinator was seconded to the programme office for 12 months while maintaining her operational management of UNHSEIP, audiology and podiatry services.

A screener FTE in Taranaki of 1.3FTE has been calculated based on the NSU guide ratio of 1.0FTE screener per 1,250 births. The newborn hearing screening staffing model takes into consideration the location of births with 1,286 births (2012) occurring at Taranaki Base Hospital also the location of the sole NICU. For this reason, the fulltime position is located in the maternity postnatal ward.

This model facilitates inpatient screening because both the inpatient service and outpatient clinics are provided in the same location by the screener based in the maternity postnatal ward. This provides flexibility to maximise screening coverage, enable patient-centred bookings for outpatients and ensures an efficient service and effective time management.

The central and south services are provided by an 0.3FTE screener. She is also employed as a registered nurse in the Hawera primary birthing facility at Hawera Hospital. Weekly outpatient screening clinics operate at Hawera Hospital and fortnightly outpatient screening clinics operate at the Stratford Health Centre. Inpatient screenings are provided when the screener is on duty as a registered nurse in the maternity unit. This model ensures effective and timely identification of babies while they are inpatients.

There are no vacancies. The last vacancy occurred in 2010 and retention in this small service is excellent.

Issues

The change in staffing model at maternity services in Hawera has required a reorganisation of south screening services and additional FTE within this report period. A temporary increase of FTE for the central/south screener has not been made permanent until the Hawera nursing roster is finalised.

It had been agreed that the north screening services screener leave would be provided by the south screener. Following the new Hawera staffing model and midwife vacancies in the south, cover availability has been severely limited due to rostering issues. Review of leave cover arrangements will be a priority in the next six months (see above Key Issues).

The coordinator role and responsibilities have grown due to the implementation of a number of recommendations following the 2012/13 screener incidents in a number of DHBs. In particular, there are new standardised individual screener monitoring and reporting requirements which were implemented in 2012/13 and must be adhered to. There has been no additional funding to increase the coordinator FTE.

Facilities/plant - current and future issues, replacement, planned purchases and funds required

- Replacement screener equipment has been planned for in the capital budgets. The two Taranaki DHB accuscreeners were purchased in 2009 and will potentially require replacement within the next three years. They are calibrated annually. Selection of suitable new equipment will be dependent on the national protocol review which is underway at present, as the protocol may change to AABR only.
- The screener office at Base maternity is not the best environment for screening due to size and noise.

Sentinel event reporting

- **Number of sentinel events reported in last six months (July to December 2013)**

One sentinel event. In September 2013, an audit was undertaken of the well child screening data for the period 1 April 2009 to 5 May 2010 as requested by NSU. This audit specifically focussed on screenings of screeners who had left Taranaki DHB employment. At Taranaki DHB, this involved auditing screenings of two screeners who left in 2009 and 2010. The results of this audit identified a sentinel event because 60 children now aged between three and a half and 4 were identified. In these cases, the screener had not followed protocol and the children, as babies, had been incorrectly screened. Notification to the MoH of a sentinel event occurred. A recall was immediately initiated as a high priority with 57 children being offered a B4School Check, two children being offered audiology testing and one child, already known to audiology and ENT services, continuing to be routinely followed up.

- **Have the issues highlighted been dealt with**

Yes, the new NSU individual screener monitoring protocol has been implemented and a retrospective audit of all screenings is underway.

This incident created additional workload from September-December 2013 in order to manage the recall and hearing tests for the 60 children identified as being incorrectly screened in 2009. The staff of the B4School Check Programme, Audiology, HR, Quality/Risk, Media and Communications Manager and senior hospital management worked together supportively and effectively with the Newborn Hearing Screening Programme Coordinator in order to facilitate the best possible outcome for affected children and families.

Outcomes of B4School Check or, where appropriate, hearing tests of the children who are being tracked following the 2009/10 Taranaki DHB hearing screening incident, are being actively followed up and further patient outcomes will be notified to NSU in February 2014. Two children have not been located and the remainder have all been offered screenings and outreach as appropriate.

- **Are there any unresolved issues?**

No.

Budget - current or future issues?

- **14/15 budget**

There is a potential need to train a third screener to cover leave because having two screeners is a risk to the service. This will result in additional training costs.

Staff morale

- Despite the 2009 screener incident, identified in September 2013 which resulted in a recall of 60 children for further screening and/or testing, screener morale remains positive. The screeners and coordinator are highly motivated to provide an excellent service. Working as a sole screener in a busy maternity ward can be challenging. Good communication, role-modelled by coordinators and managers, is essential to prevent misunderstandings.

UNHSEIP National Policy and Quality Standards

- The National Policy and Quality Standards form part of the contract between the MoH and DHBs for the provision of services for the UNHSEIP. They are intended to increase knowledge and understanding about the programme, outline requirements of service and assist DHBs to achieve high standards of practice that support the programme's aims.

Top three most important issues to attend to this next year

Issue	By whom	By when
1) Recruitment of an additional screener	Mary Bird	December 2014
2) Reduction of targeted follow-up rate	UNHSEIP and neonatal teams	July 2014
3) Successful external audit	UNHSEIP team	May 2014

Are these issues recurrent from previous years?

N/A

If so why, what is preventing resolution?

N/A

What support do you require from the Maternity Clinical Governance Group to achieve the objectives in this plan?

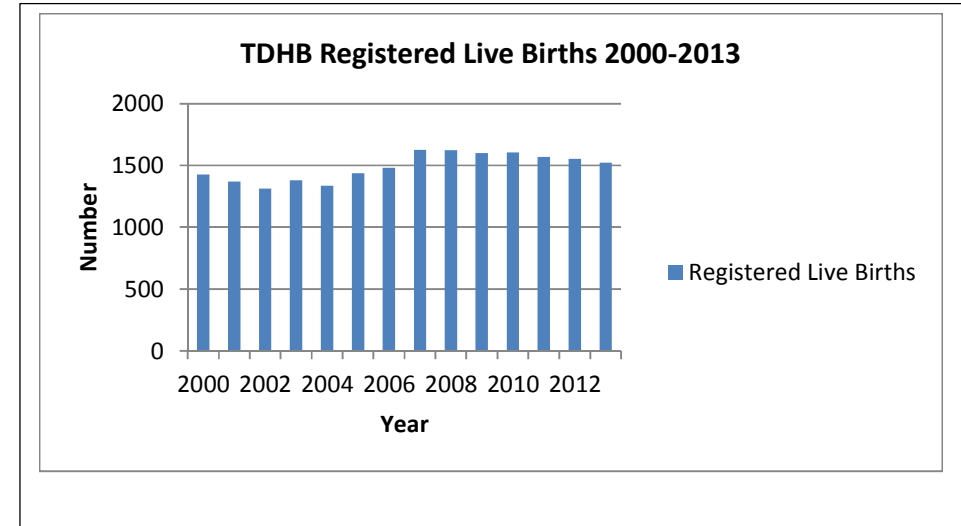
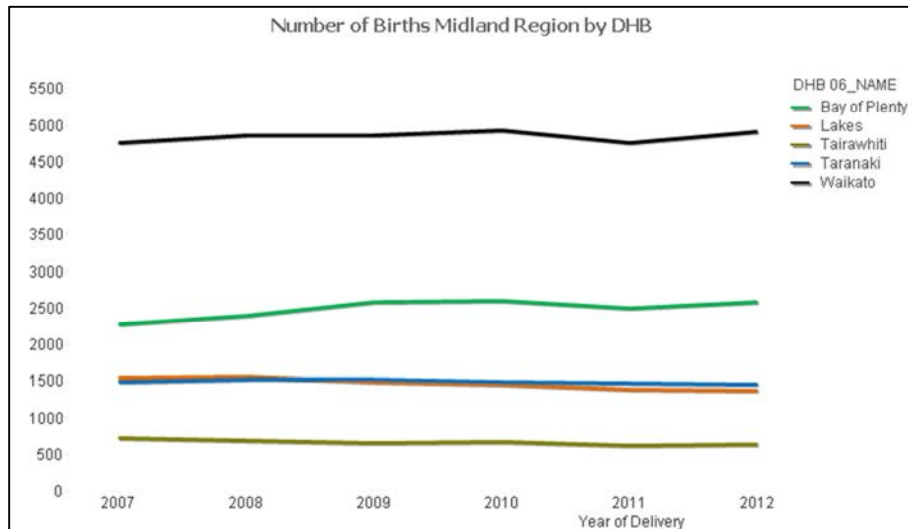
Support and advice regarding the issues.

Additional comments:

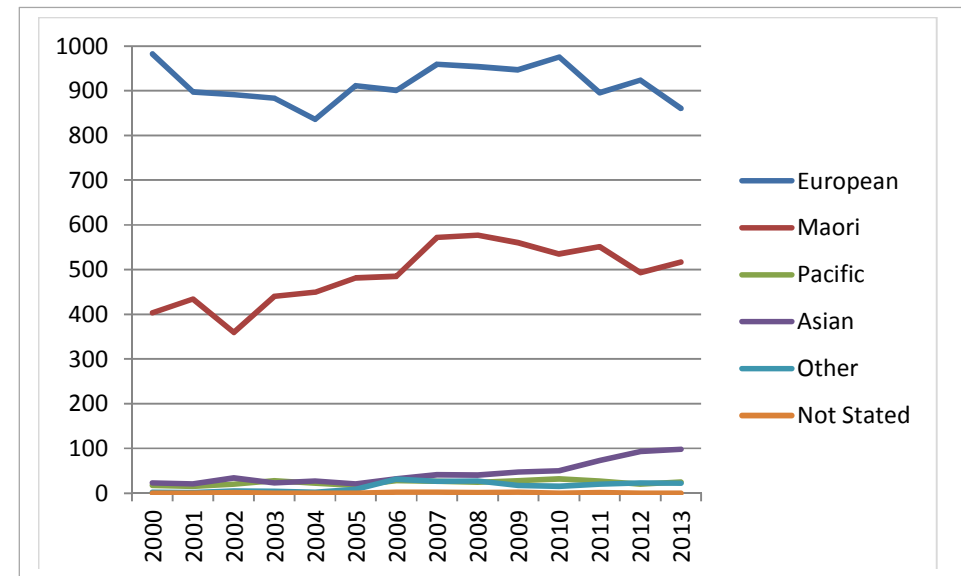
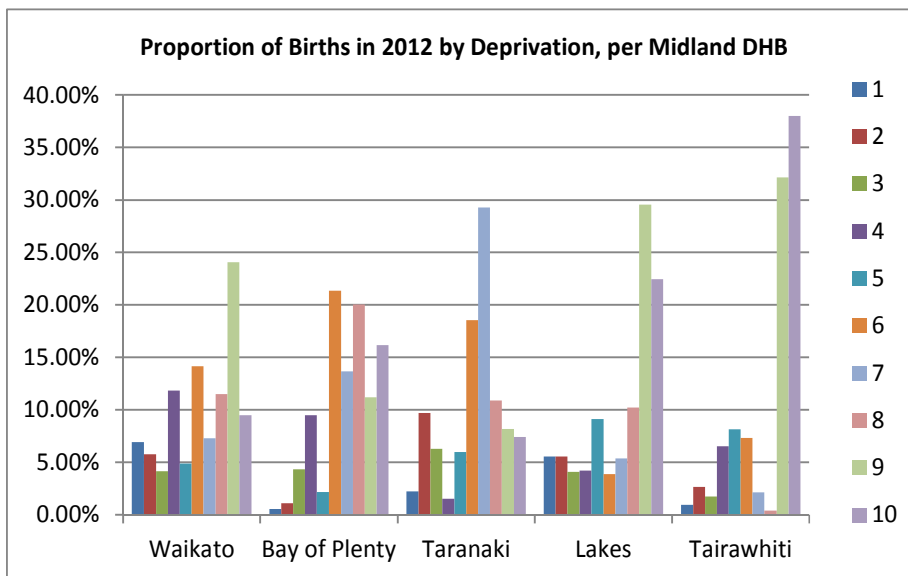
- This has been a challenging six months due to the impact of the unexpected and unplanned additional workload from the screening incident.

Appendix 4 : Data Tables and Analysis

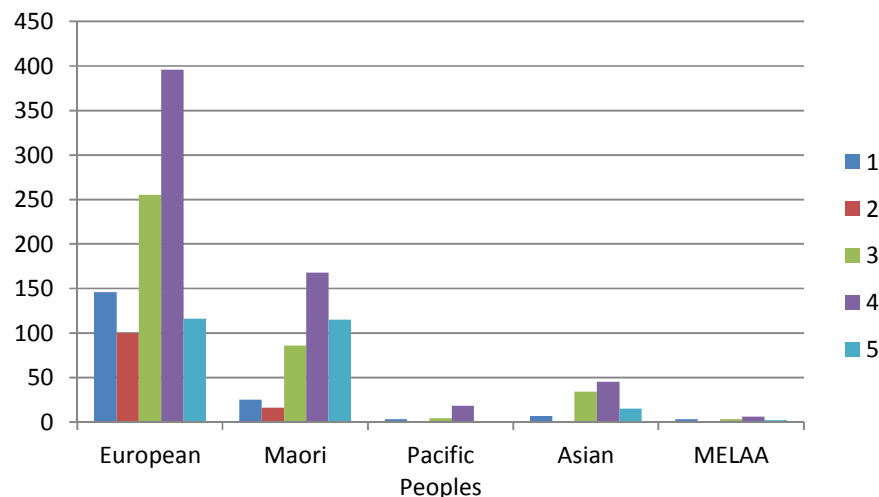
Midland Data: Please note that all data for Taranaki DHB is presented in **turquoise within the** Midland DHB data



Comment: Taranaki DHB has similar birth numbers to Lakes DHB if comparison is required within this document where numbers are relevant.

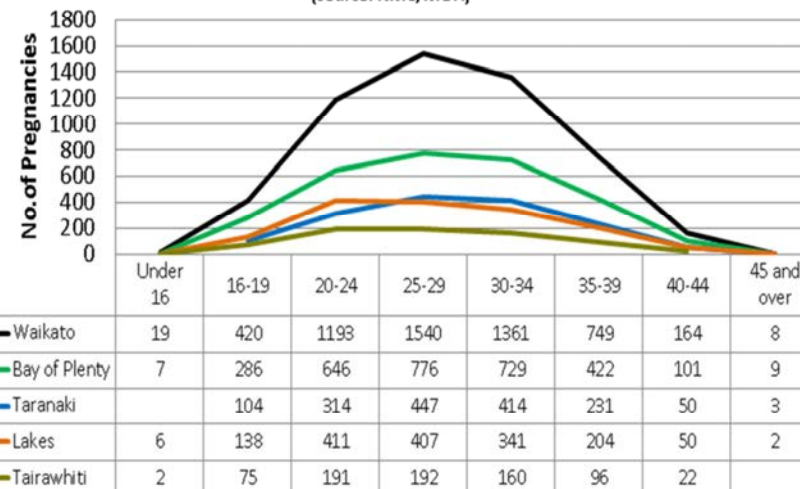


Taranaki Births by Deprivation Scale and Ethnicity, 2012



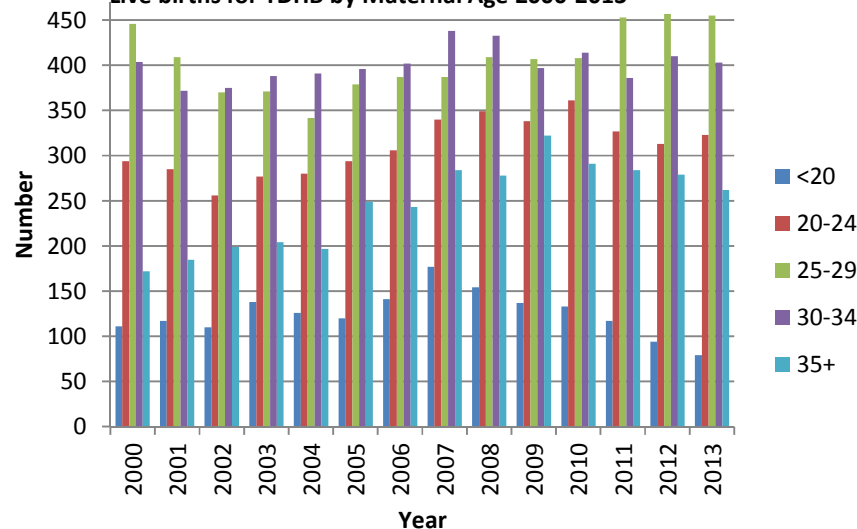
Number of Pregnancies by Age Bands per Midland DHB, 2012

(Source: NMC, MOH)

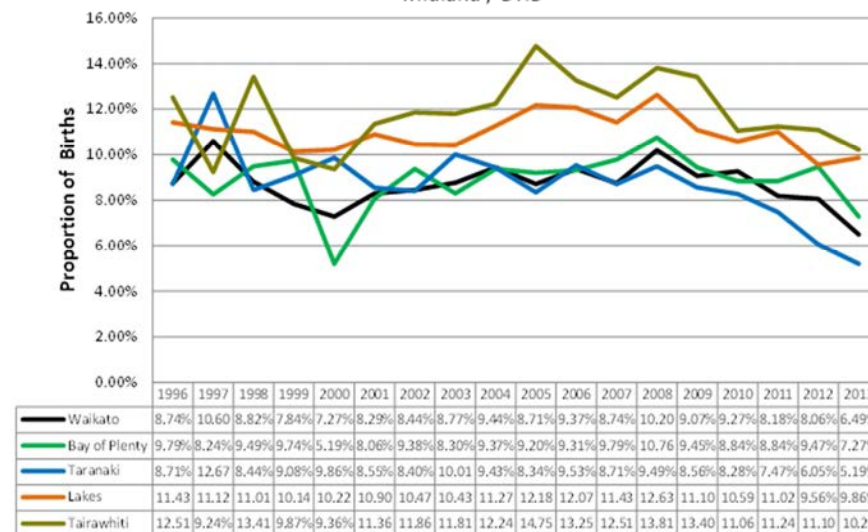


Comment: Taranaki DHB's birth rate is consistent and there are less teenage pregnancies in Taranaki in proportion to total births when compared with other Midland DHBs.

Live births for TDHB by Maternal Age 2000-2013



1996 -2013 Age under 20 by % of total. Trend lines graph for each DHB: Midland / DHB



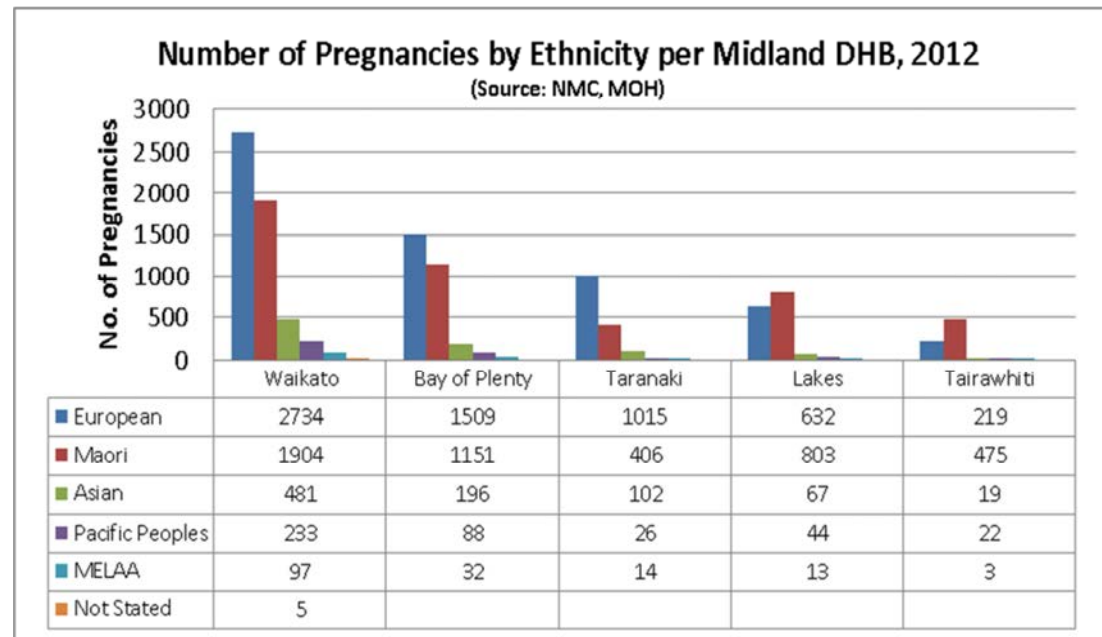
Age and Demographics

The most common age group delivering their first child (Primiparae) in Taranaki is the 25-29 age group for European (rural or urban) and 20-24 age group for Maori (rural or urban) and for all ethnicities, 25-29 age group is the most common; this is closely followed by the five years above or below this. So most women are having their first baby between 24-34 years of age. This is consistent with our falling teenage pregnancy rate, possibly due to better education and access to contraception such as the Jadelle.

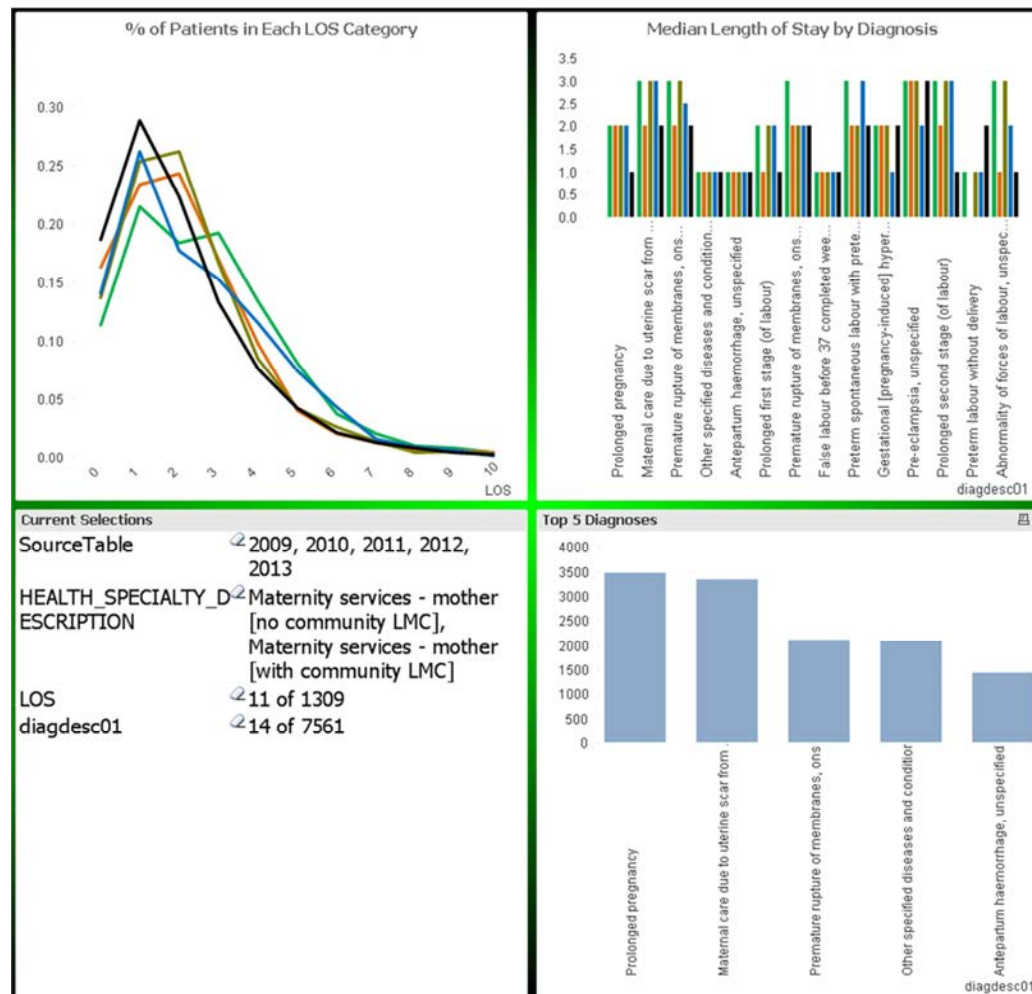
Taranaki has the lowest teenage pregnancy rates in Midlands (largely due to fewer Maori teenage births - from the highest in 2009 to second lowest in 2011).

The "Midlands **Rural** Crude Birth Rate per 10,000" graph shows the Taranaki Rural Crude Birth Rate is higher than for any other DHB.

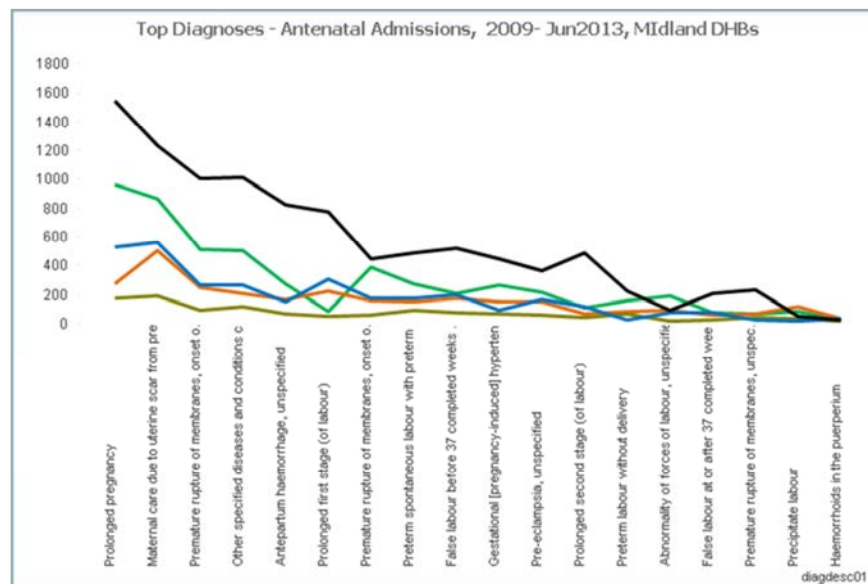
The total "Births Rural Urban Taranaki" graph shows that over the last few years actual urban and rural births have remained surprisingly constant and equal around 65 per month for each category.



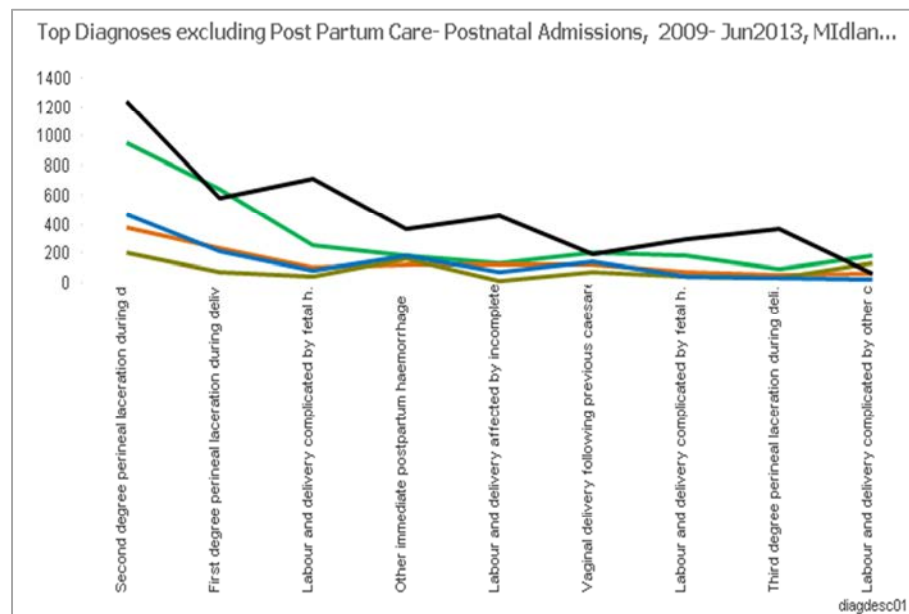
Comment: The majority of pregnant women in Taranaki DHB come from New Zealand European and Maori ethnicities, however there is a noticeable increase in Asian ethnicity within the region. This has the potential to have an impact on family support, language, cultural beliefs and post natal support services. This ethnicity is also at increased risk of gestational diabetes and complications that are associated with this.



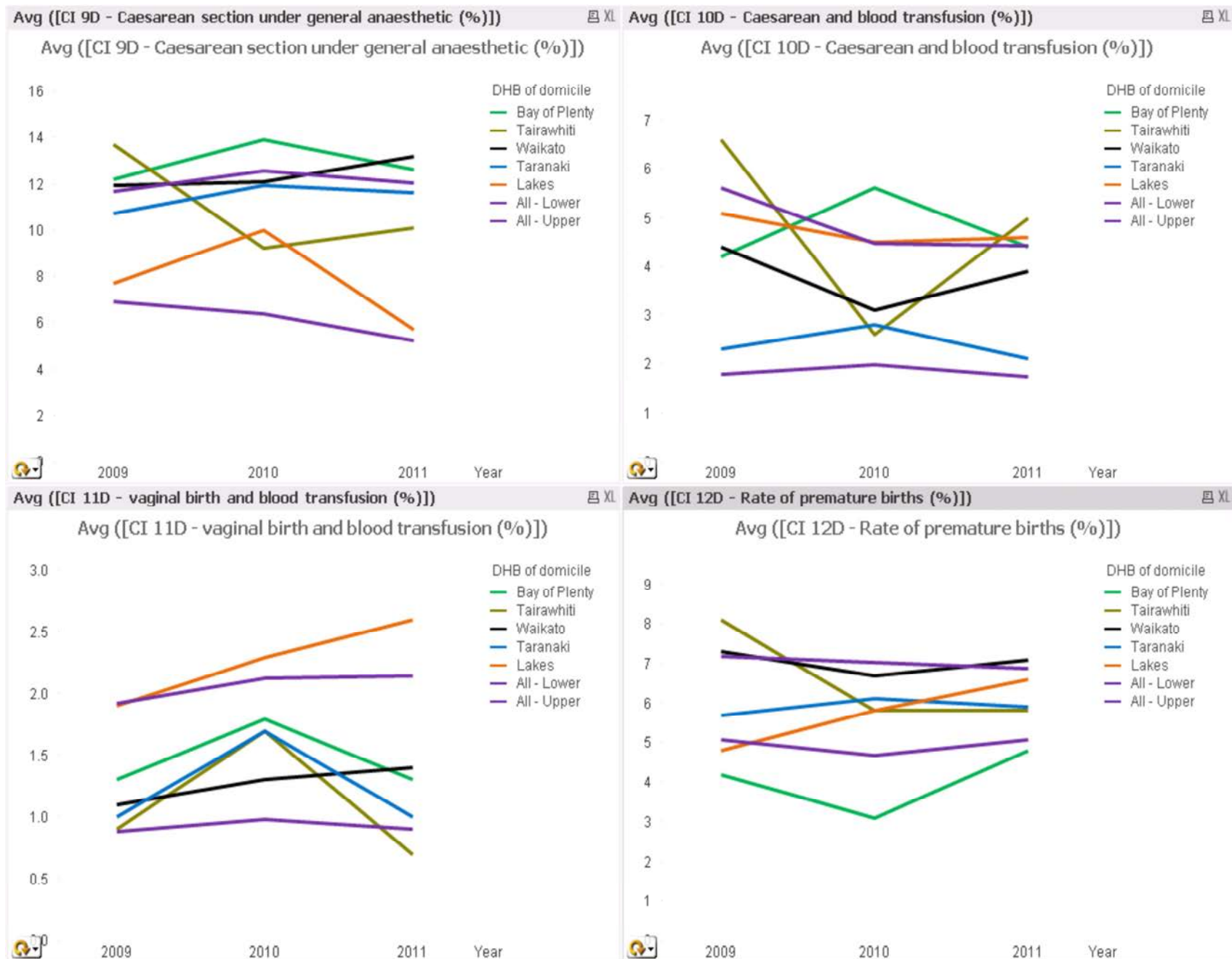
Comment: Taranaki DHB's average Length of Stay (LOS) peaks at similar lengths to the other Midland DHBs' LOS but falls more rapidly between days one and three but then expands to day seven. This could be linked to coding or boarder mothers who have babies in the Neonatal Unit. LOS following caesarean section and preterm birth appear longer than some of the other Midland DHBs and may be worthy of investigation of processes with a focus on education of staff on local discharge policy and boarder status.



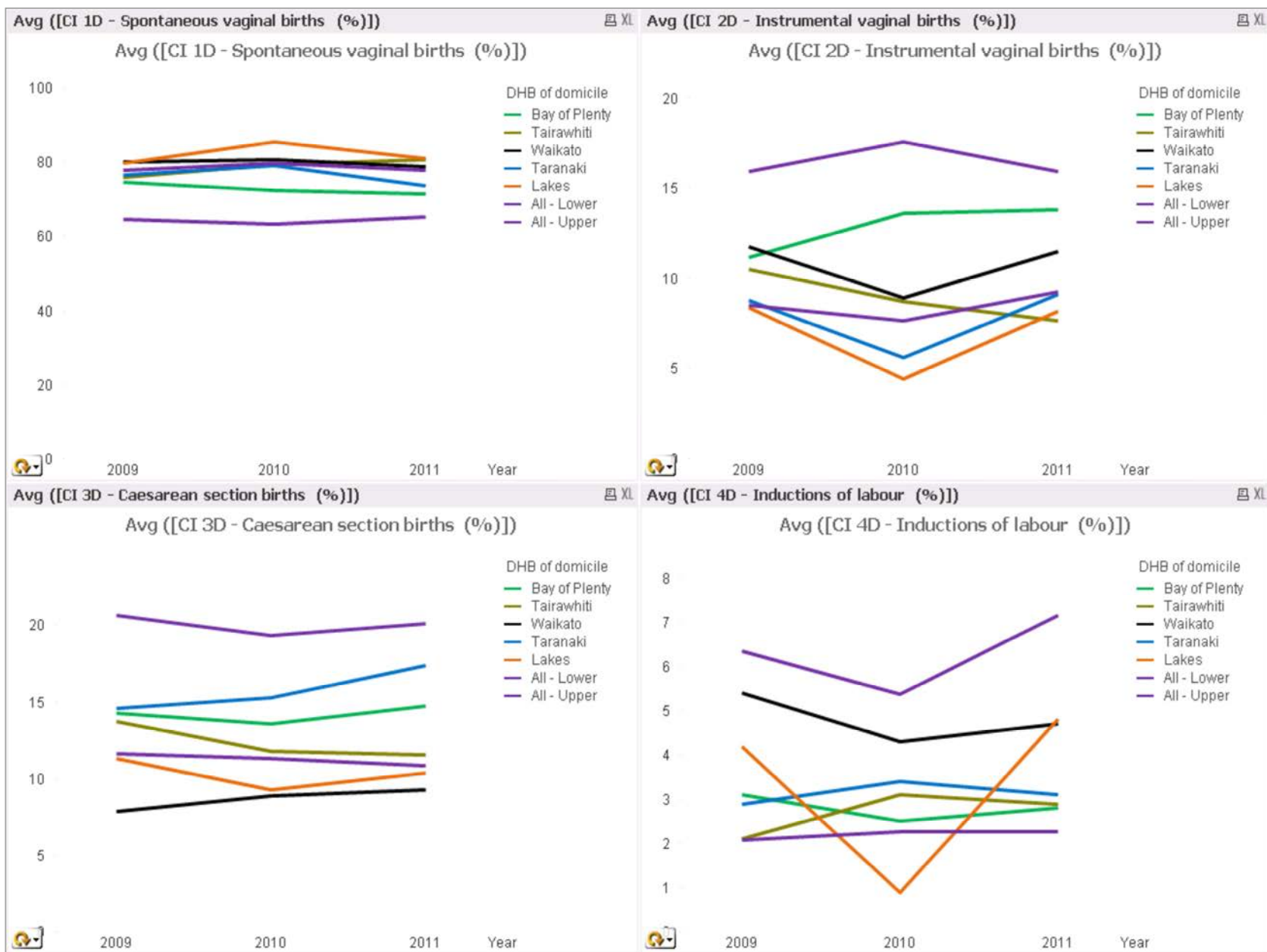
Comment: Prolonged pregnancy/induction of labour/caesarean section appears to be the top diagnosis for antenatal admissions. The induction of labour and caesarean section rates however are similar when compared with the other Midland DHBs. The implementation of the local fetal assessment unit may reduce some admissions.



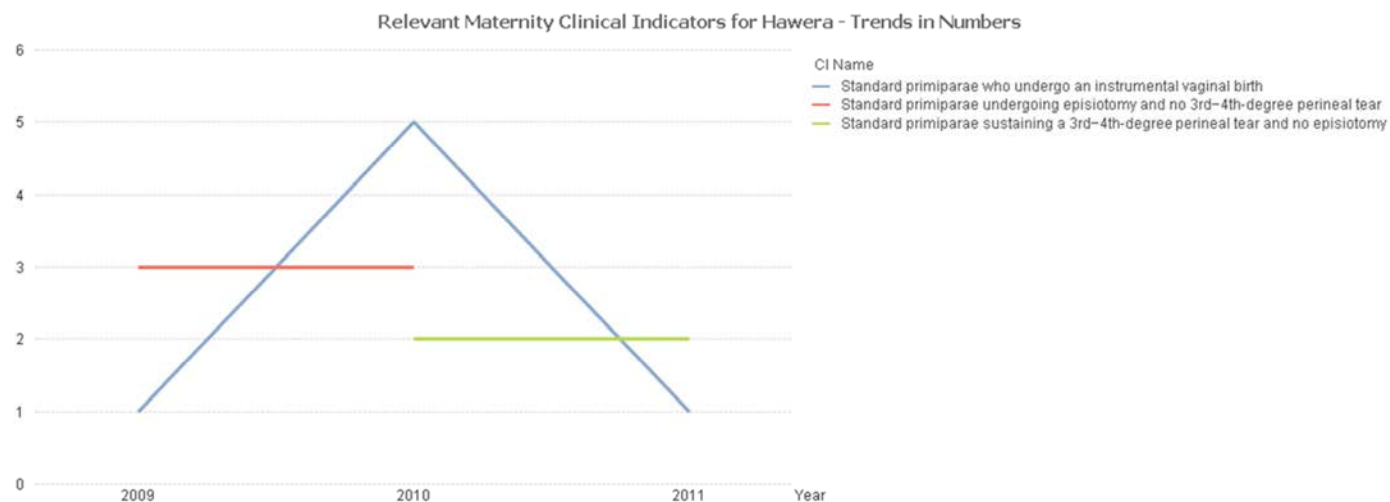
Comment: Taranaki DHB follows a similar trend to Lakes DHB (similar birth numbers) for postnatal admissions.



Comment: Taranaki caesarean section rates under general anaesthesia are towards the upper limits and could be related to the location of the operating theatres (see previous comments under general anaesthesia caesarean section audit). Local audit also identified a difference in % between the number submitted by the coders to the number of the audit. The rate of blood transfusions following caesarean and vaginal births are falling and the rate of premature births are comparable to similar sized DHBs.



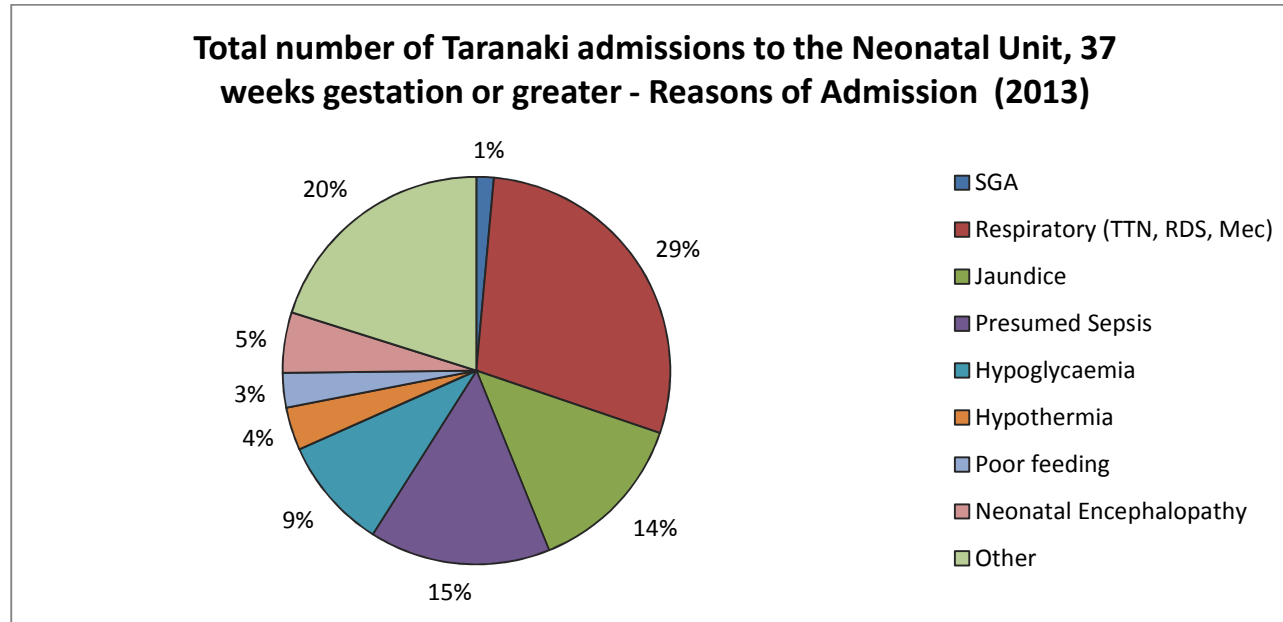
Comment: Taranaki's caesarean section rate is rising and the vaginal birth rate is falling. All cases of Level 1 caesarean section are discussed at case review sessions surrounding decision making and timing. The antenatal clinical coordinator has however identified an increase in consumer requests for caesarean section. This warrants further investigation into the education and counselling of women in the antenatal clinic and by LMCs. A local retrospective audit will be carried out on Induction of labour per clinician and gestation and also on all elective and emergency caesarean sections for clinician and gestation. Instrumental vaginal birth is the second lowest in the Midland DHBs and the induction of labour rate is just above average when compared to the other Midland DHBs.



Comment: The small birthing numbers at Hawera Hospital make it difficult to analyse, however having a GP obstetrician based at Hawera Hospital facilitates expedition of birth by forceps where there are concerns for fetal wellbeing.

Local Taranaki Neonatal Unit Data

Reasons for admission

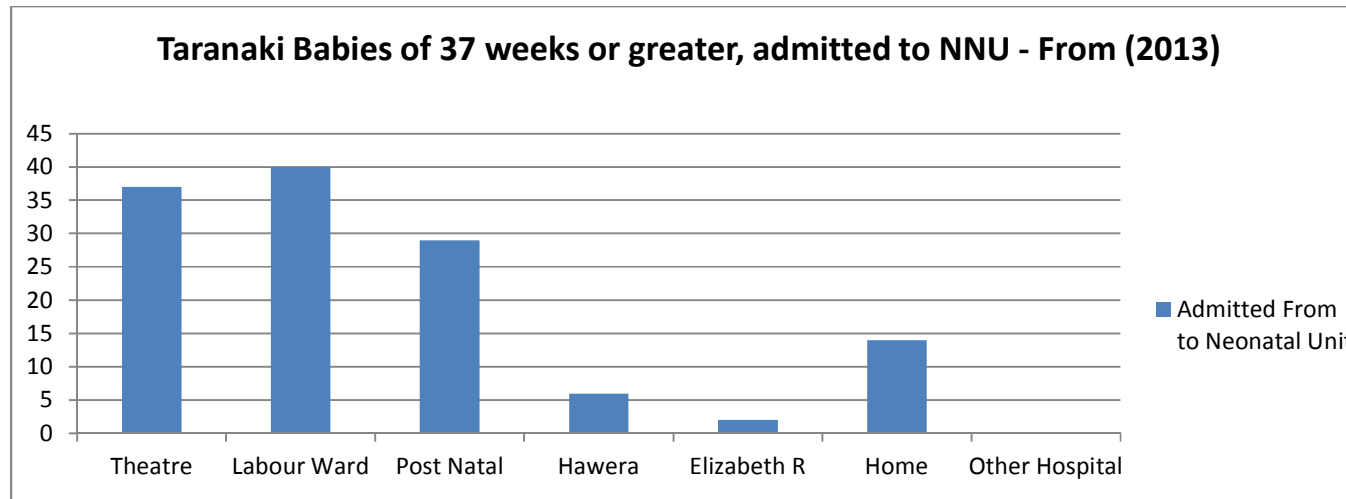


Comment: Respiratory includes all babies with delayed transition to extra-uterine life i.e. delayed onset of regular breathing, Transient Tachypnoea of the Newborn (TTN), grunting, meconium exposure, respiratory distress, cyanotic episodes. A large proportion of these babies are admitted from Caesar Theatre for a few hours for monitoring.

Jaundice is another leading cause for admission. Taranaki DHB is currently launching a new protocol, 'Care of the jaundiced baby'. With the increased education and training of staff, the aim is to reduce the number of babies who need to be admitted to NNU for treatment of jaundice, and thus increasing the number of babies that can be nursed at the mother's bedside or in the community, if the condition allows. This is dependent on the staffing, education and skill mixes available on the postnatal ward, plus additional phototherapy units.

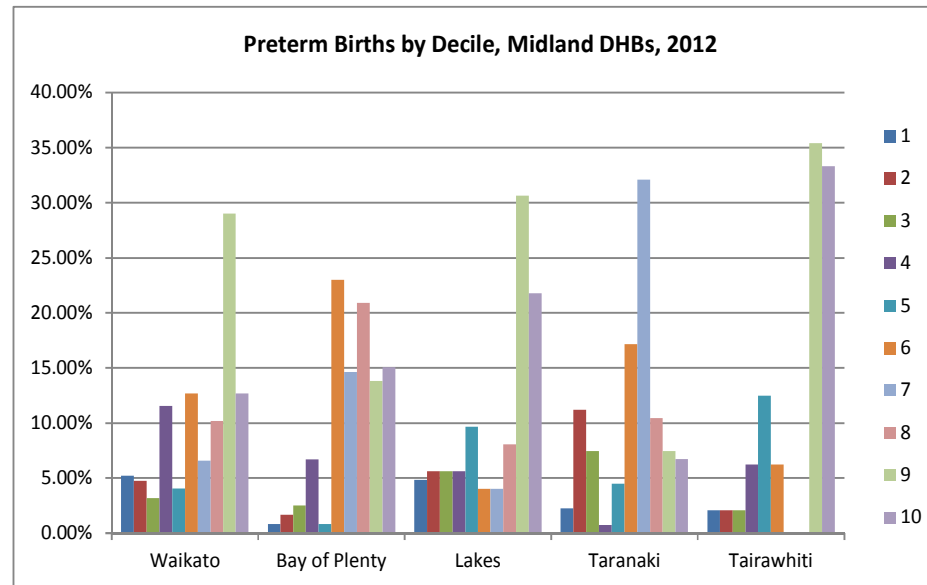
Training and education in 'Care of the late preterm', and improved staffing, would also improve the care of babies and reduce the number admitted to NNU for poor feeding, hypoglycaemia and hypothermia. Tube feeding education and assessment sessions have been carried out for maternity staff.

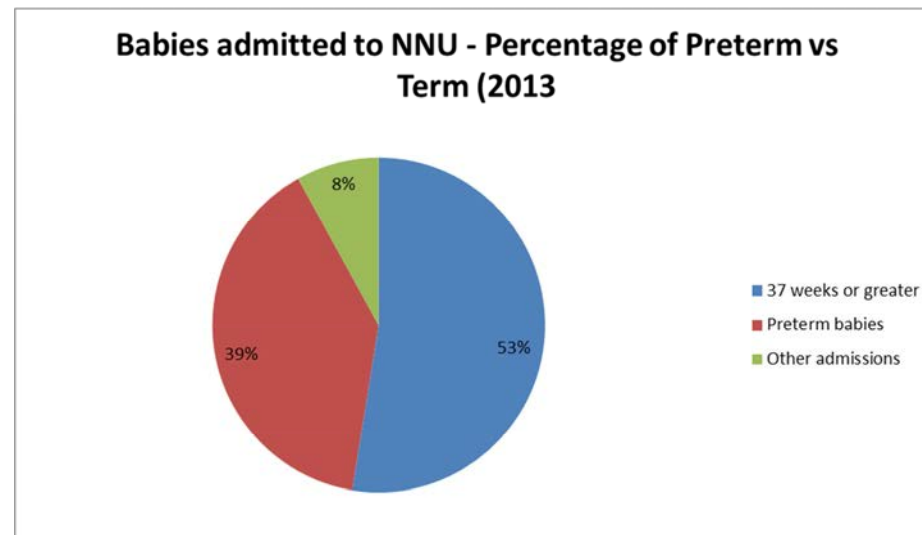
Taranaki Neonatal Unit Admissions



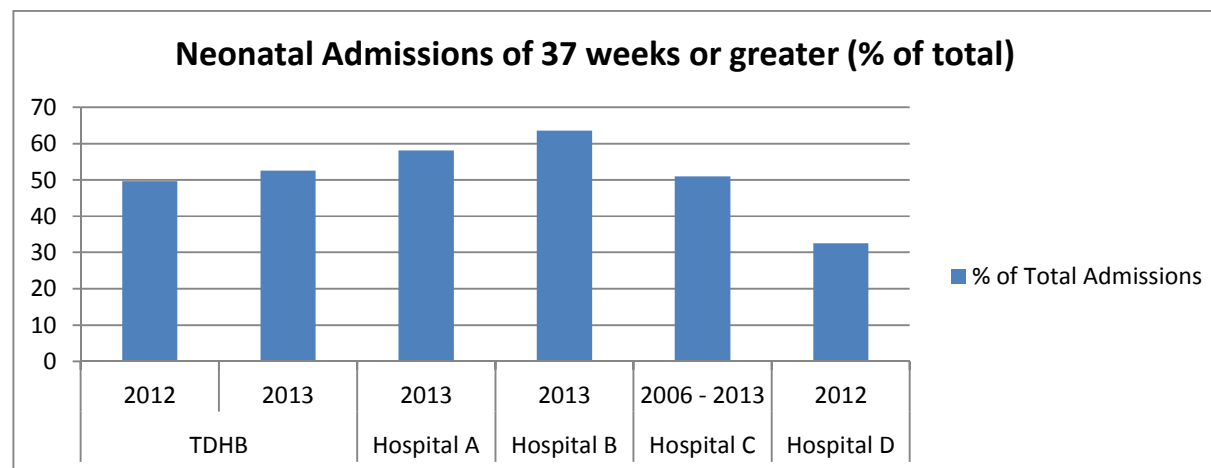
Comment: The majority of admissions are from the labour ward and operating theatre, followed by postnatal ward and home. Exploration of how and where babies are observed as they transition to extra-uterine life, whilst maintaining baby with mum, may require examination of current staffing as well as further education. The co-location of NNU with Maternity (as is proposed in the future) may allow this to happen.

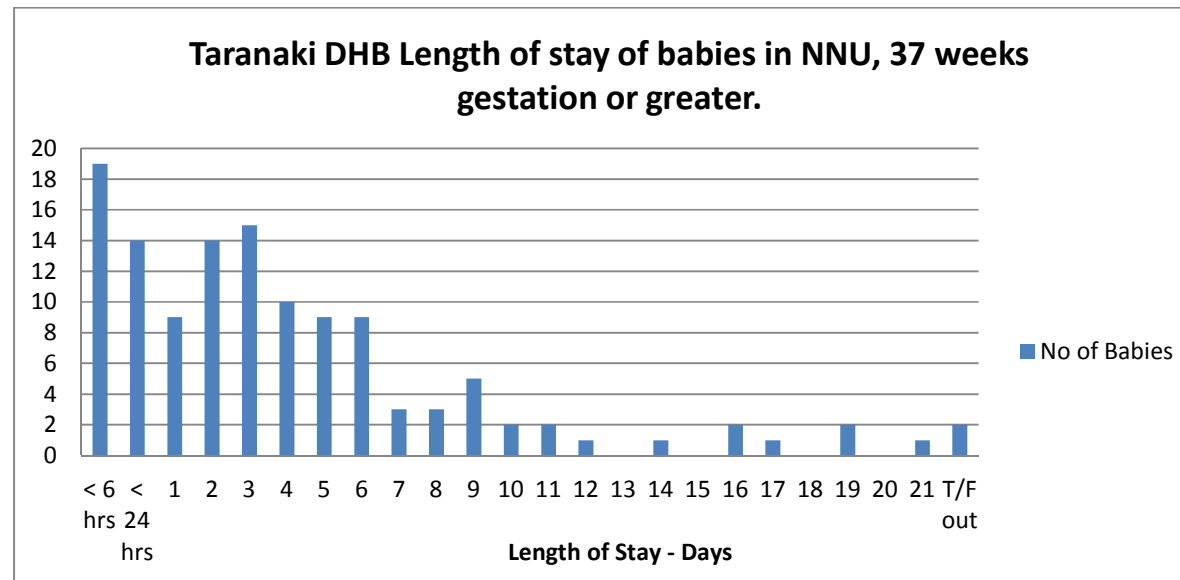
Percentage of Preterm vs Term Babies admitted to Taranaki Base NNU





Comment: The high number of Taranaki term babies admitted to NNU includes all babies, even those with a minimum stay. This data has been compared with four other similar neonatal units in New Zealand.





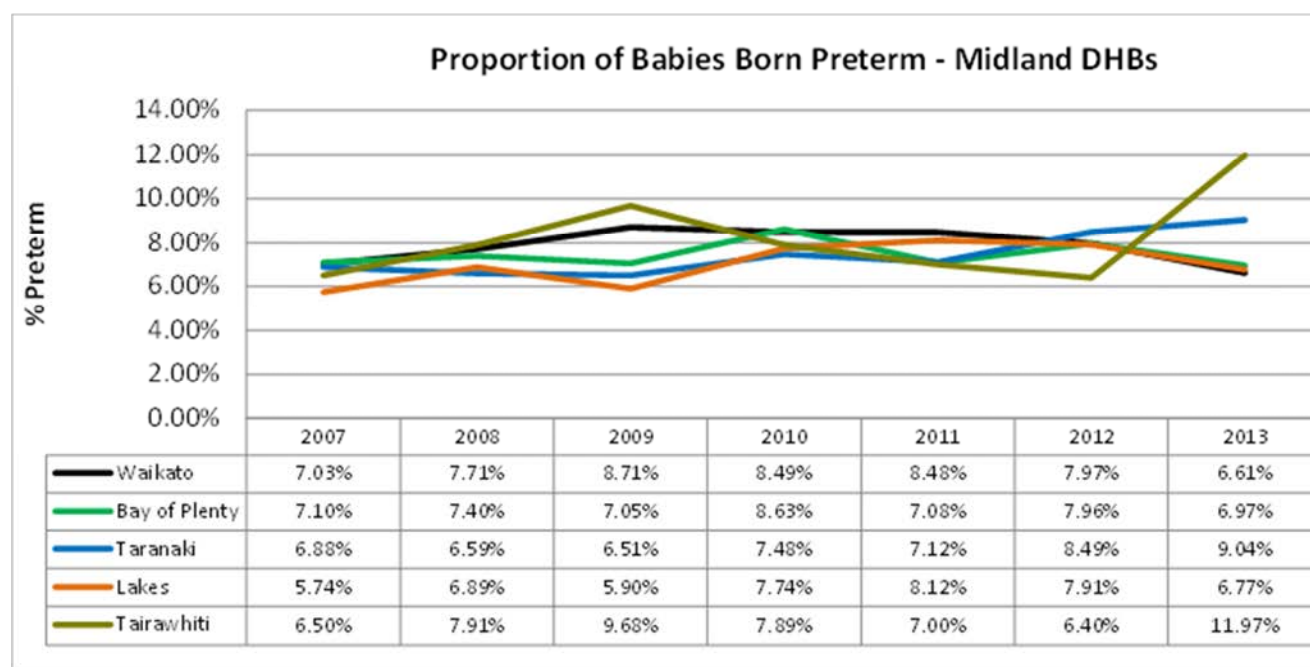
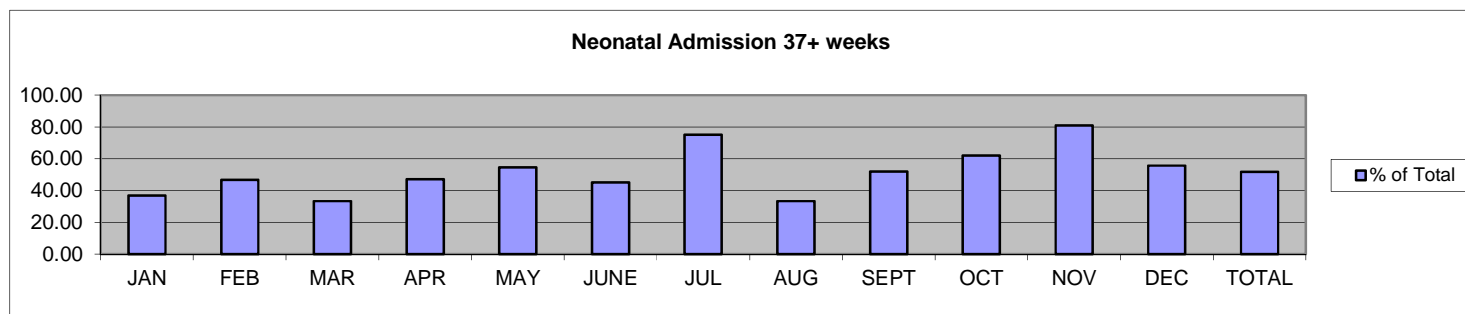
Comment: 27% of babies were admitted for less than 24 hours, and of these, the majority were in the Neonatal Unit for less than 6 hours. Whilst there is a valid reason for these babies being admitted for such a short time, further investigations may be carried out to see if these babies can stay at the mother's bedside under observation, particularly following caesarean birth.

A working group will be setup to investigate the feasibility of a core midwife attending all caesarean sections to keep mother and baby together and observe in the immediate newborn period, aiming to reduce newborn short admissions to the NNU. (Currently, a neonatal nurse attends caesarean sections and will continue to attend Level 1 caesareans and preterm births).

Taranaki has an increasing rate of preterm births and a higher rate than Waikato (tertiary) centre. Preterm births are currently being audited.

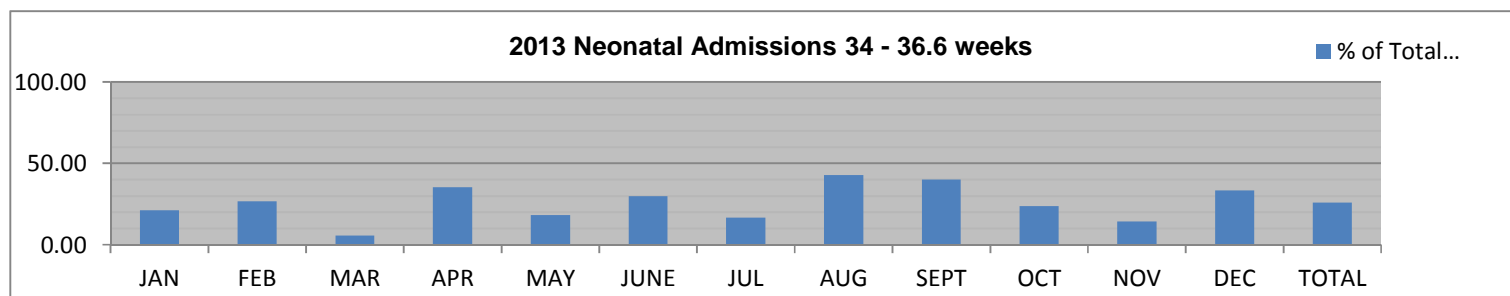
Neonatal admissions of babies 37 weeks gestation or greater

2013	JAN	FEB	MAR	APR	MAY	JUNE	JUL	AUG	SEPT	OCT	NOV	DEC	TOTAL
Total admissions	19	15	18	17	33	20	12	21	25	21	21	18	240
37 and 37+ weeks	7	7	6	8	18	9	9	7	13	13	17	10	124
% of total	36.84	46.67	33.3	47.05	54.55	45	75	33.33	52	61.9	80.95	55.6	51.67

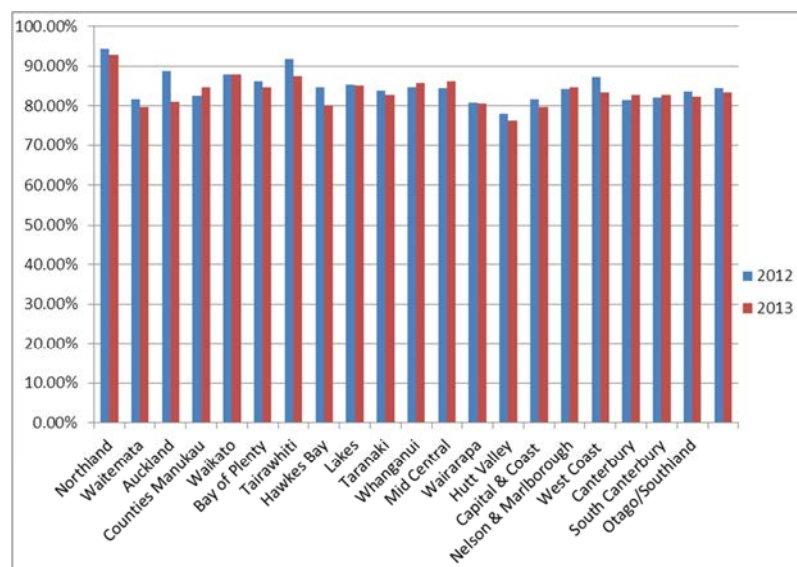


Neonatal admissions of babies 34 – 36.6 weeks gestation

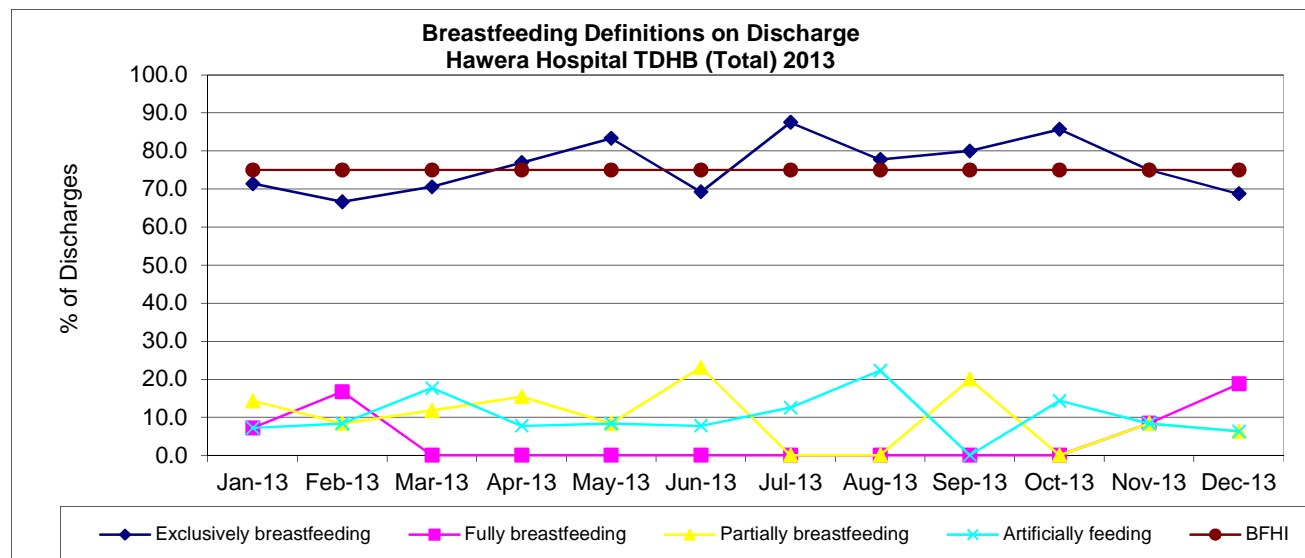
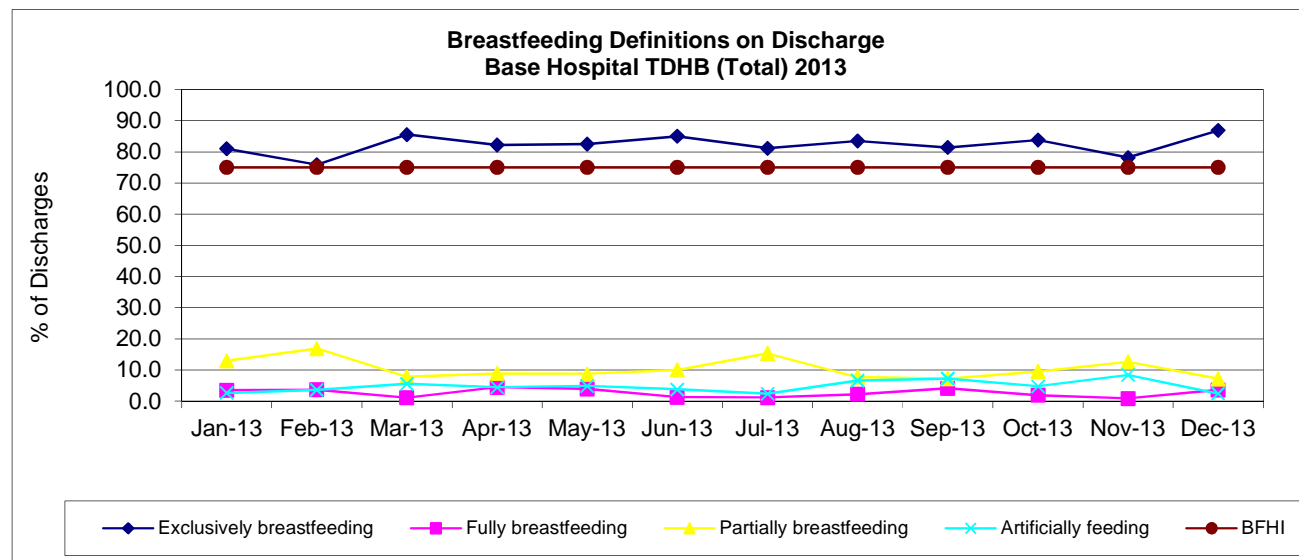
2013	JAN	FEB	MAR	APR	MAY	JUNE	JUL	AUG	SEPT	OCT	NOV	DEC	TOTAL
Total Admissions	19	15	18	17	33	20	12	21	25	21	21	18	240
34 - 36.6	4	4	1	6	6	6	2	9	10	5	3	6	62
% of Total	21.05	26.67	5.56	35.29	18.18	30.00	16.67	42.86	40	23.81	14.29	33.33	25.83



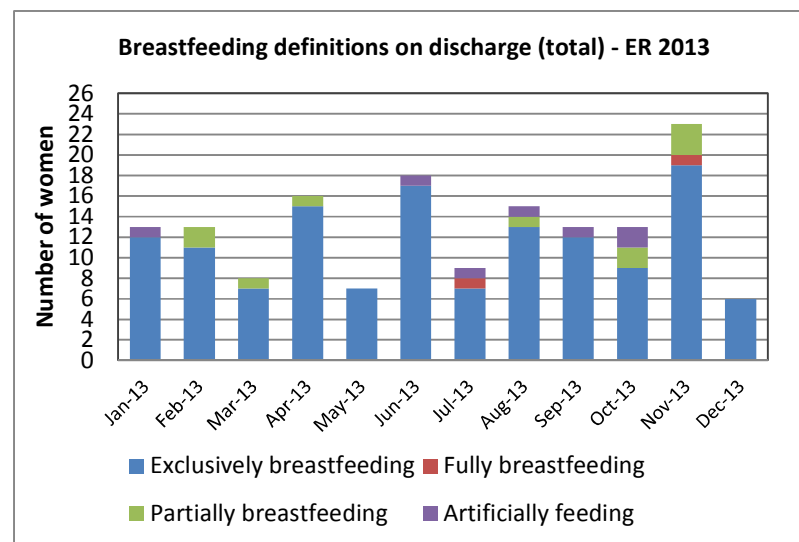
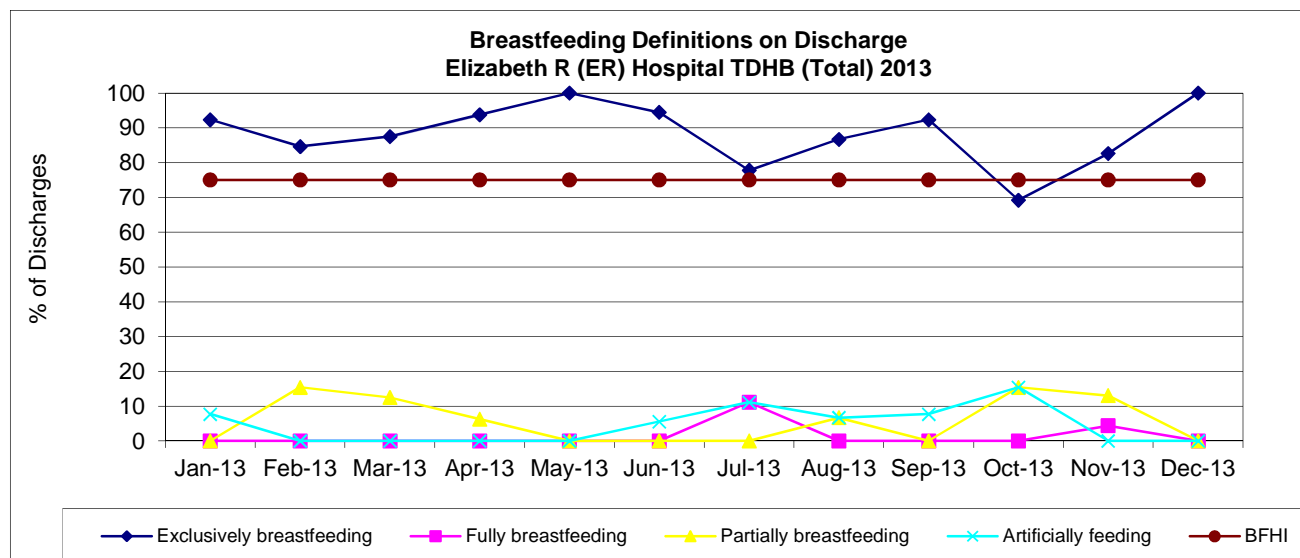
Comparison of the exclusive breastfeeding rates at discharge by DHB : 2012 and 2013



The numbers of women who were partially breastfeeding or artificially feeding on discharge at Base Hospital was much larger than those in Hawera or ER. Due to larger overall numbers of women, this did not affect the overall percentages. Even in November 2013, when there was a total of 25 women on discharge who were partially breastfeeding (15) or artificially feeding (10), the percentage of women who were exclusively breastfeeding was still above 75%.

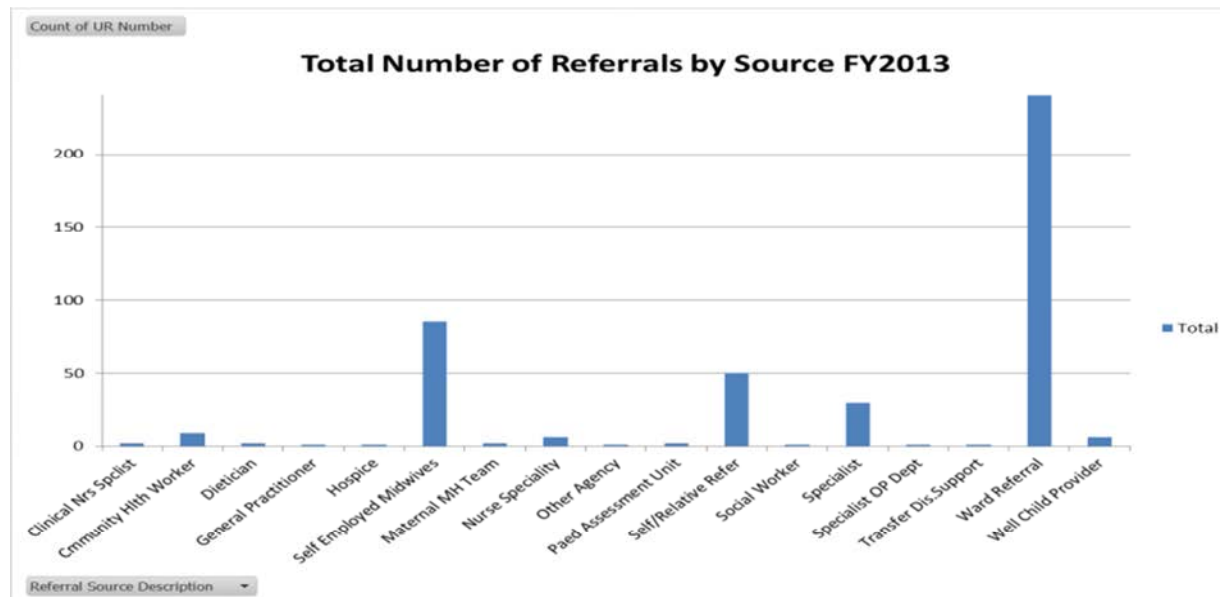
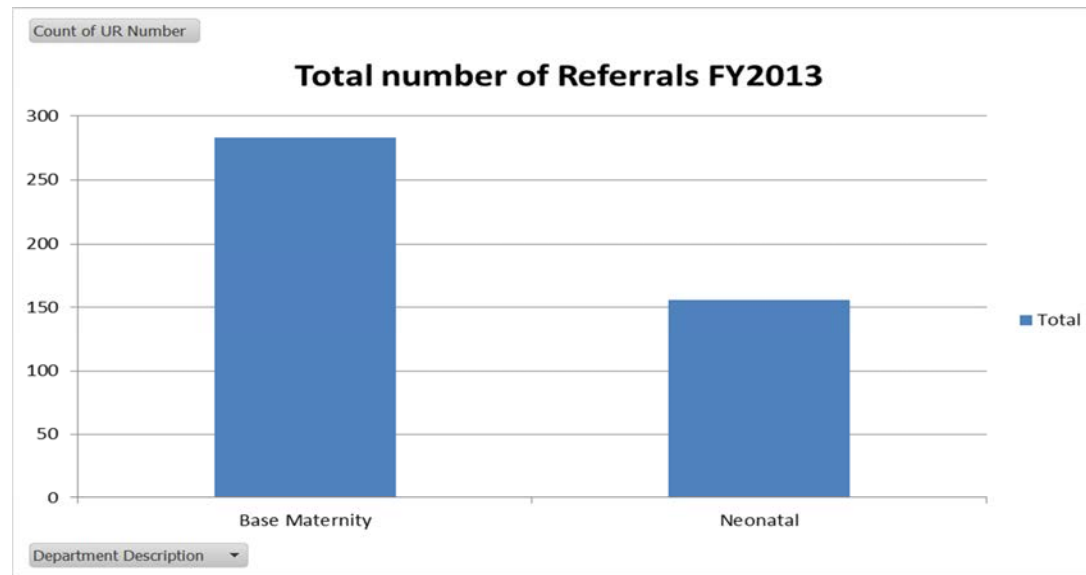


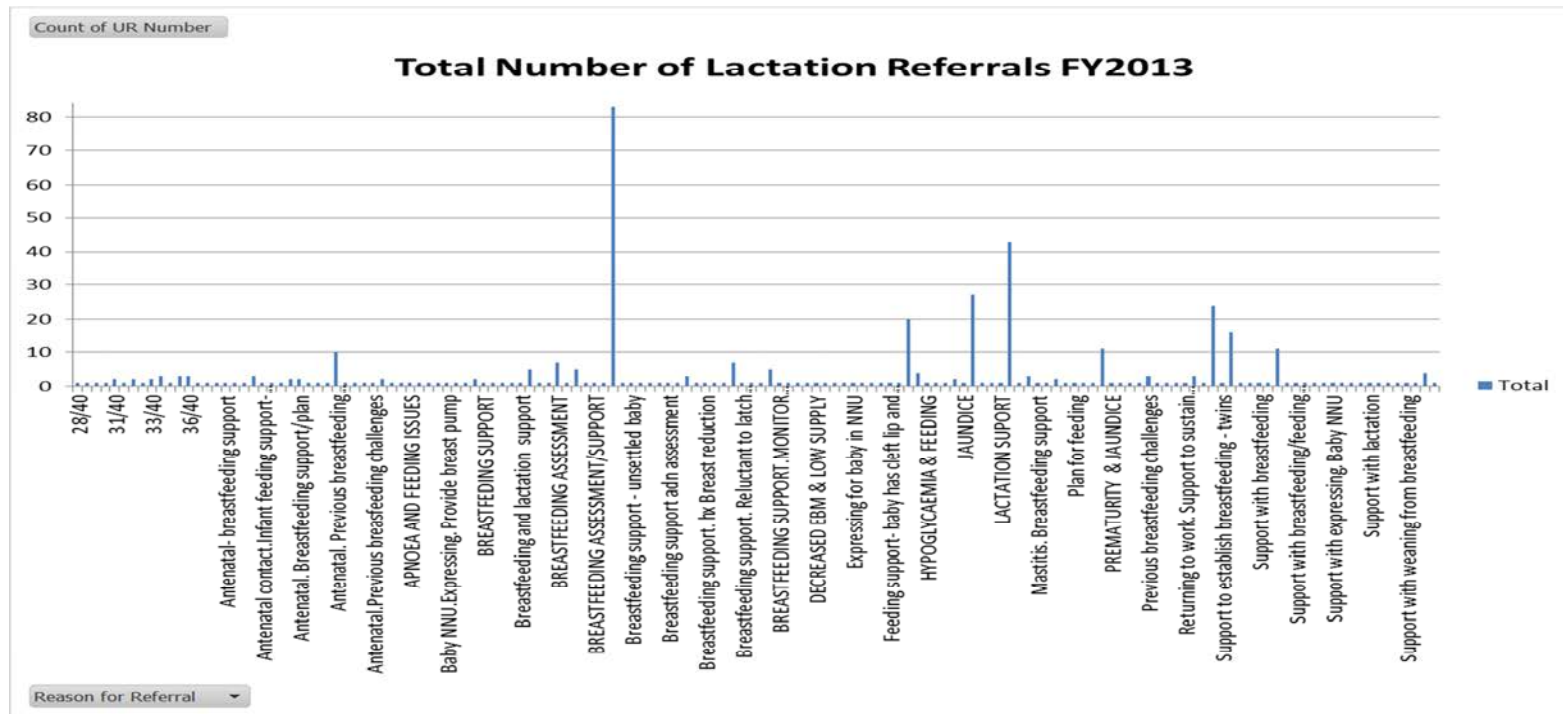
The combined numbers of women who were partially breastfeeding or artificially feeding on discharge at Hawera Hospital did not exceed five during 2013. Due to small numbers of overall discharges, even an additional one or two women who were not exclusively breastfeeding on discharge, resulted in the overall percentage of exclusively breastfeeding women falling below 75% in February, March, June and December 2013. It is also noted that in February and March 2013 there were slightly higher numbers of infants who were transferred from Base Hospital to Hawera who were not exclusively breastfeeding i.e. three to four compared to one to two.



In October 2013, the percentage of mothers who were exclusively breastfeeding fell below 75%. This was due to a very small increase i.e. two women who were partially breastfeeding or artificially feeding.

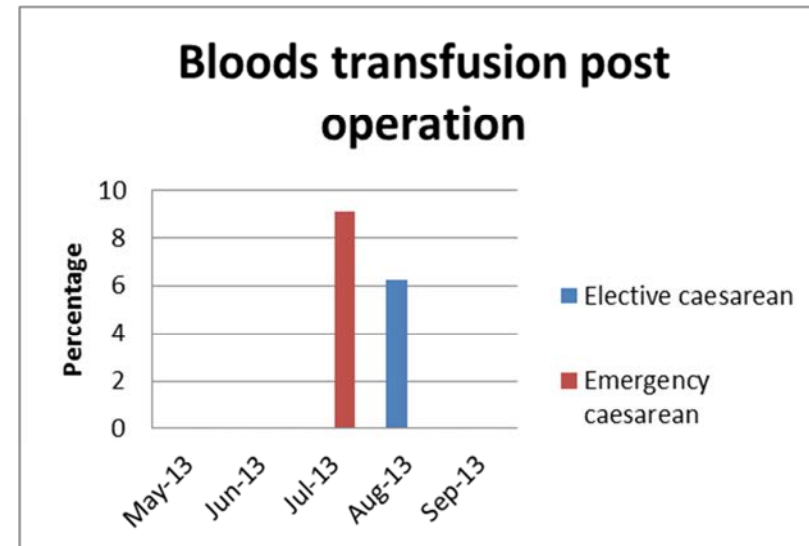
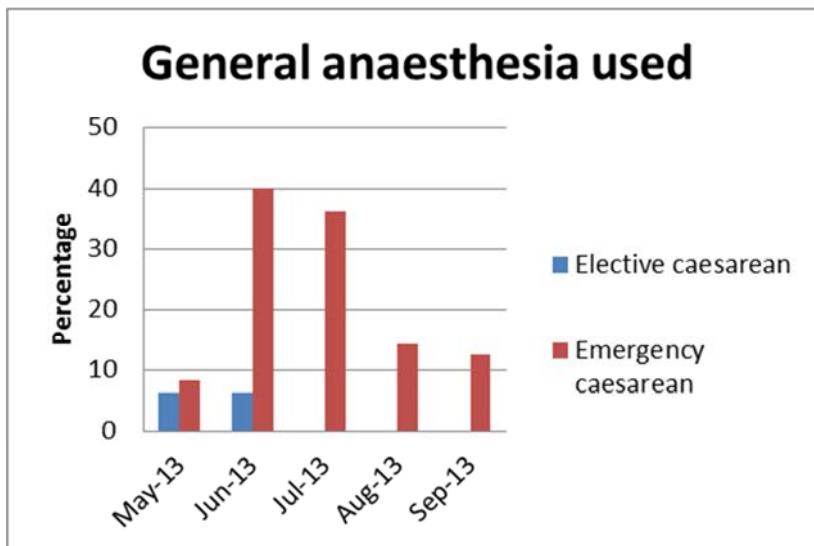
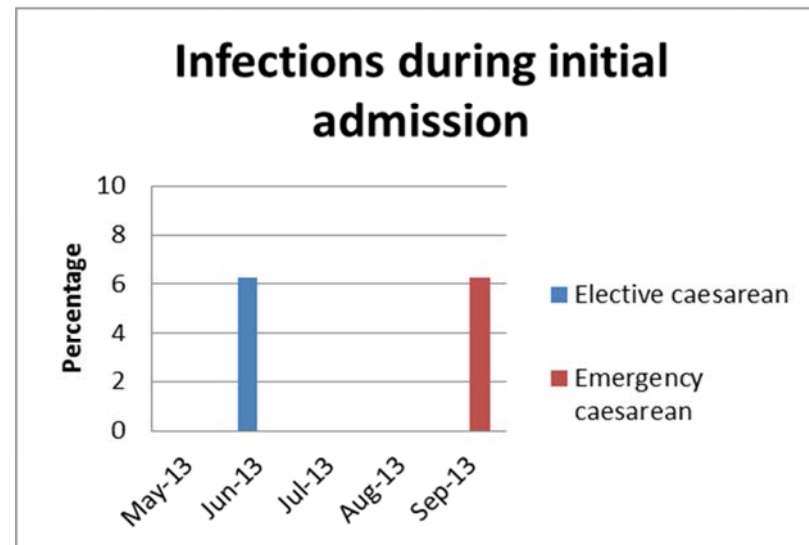
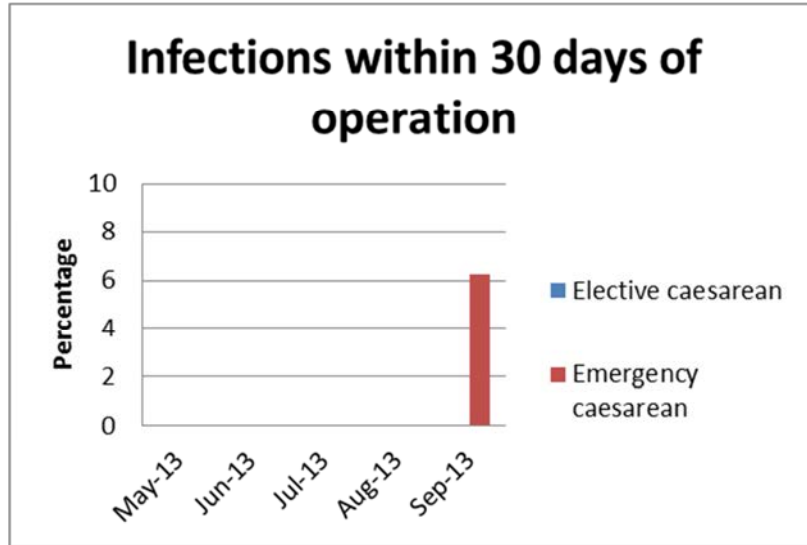
Taranaki DHB Lactation Consultancy Referrals





The above chart has highlighted the need to modify the reasons for referral. All lactation consultants to agree on set criteria for referral for data input to allow a better interpretation of the results in the future.

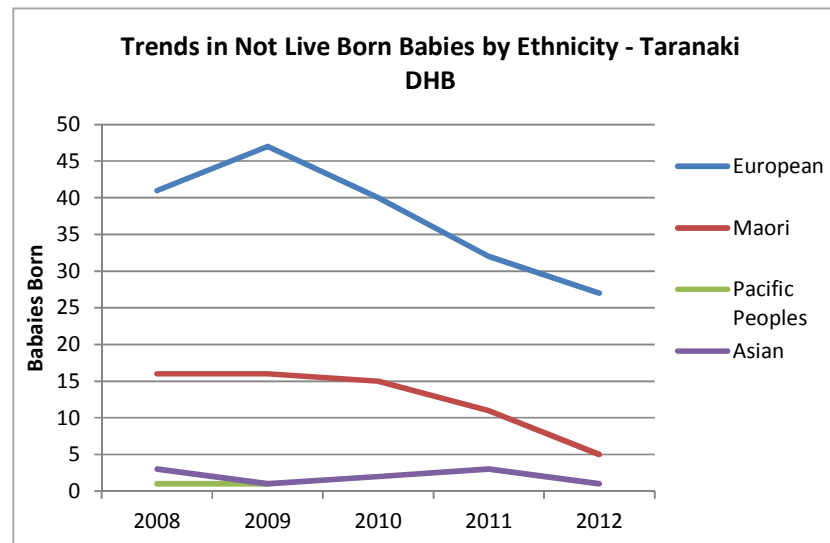
Taranaki Infection Control Dashboard Post Caesarean Section



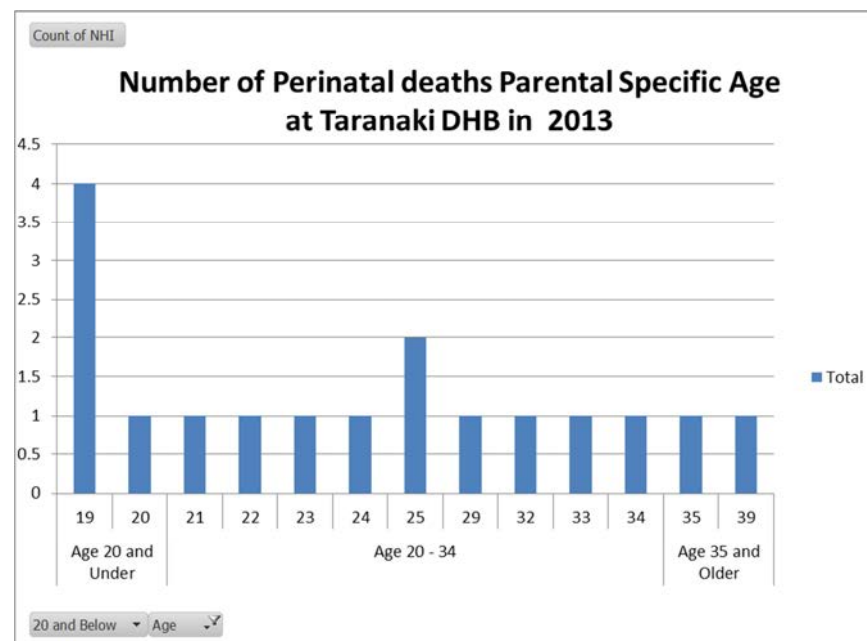
Comments: The numbers for wound infection and blood transfusion are low and therefore difficult to analyse. It may be useful over a wider time period to monitor these and investigate if there are other compounding factors such as raised BMI, age, medical reasons such as diabetes. The PICO wound dressing has recently been introduced to try to reduce wound infection and hospital readmission rates.

The fall in general anaesthesia caesarean section rates coincides with the introduction of a portable CTG monitor to accompany the woman to the operating theatre and has informed decision making for spinal/general anaesthesia caesarean section.

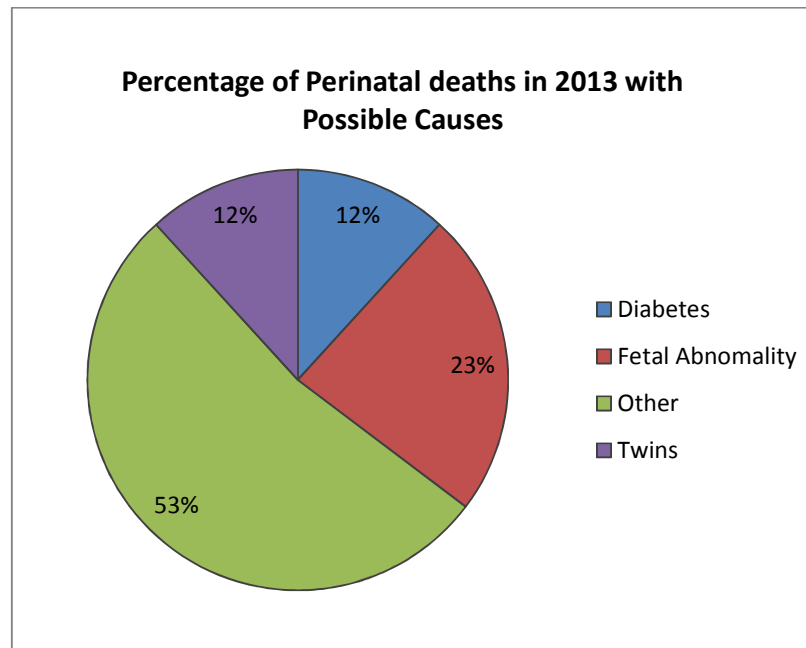
Perinatal Deaths



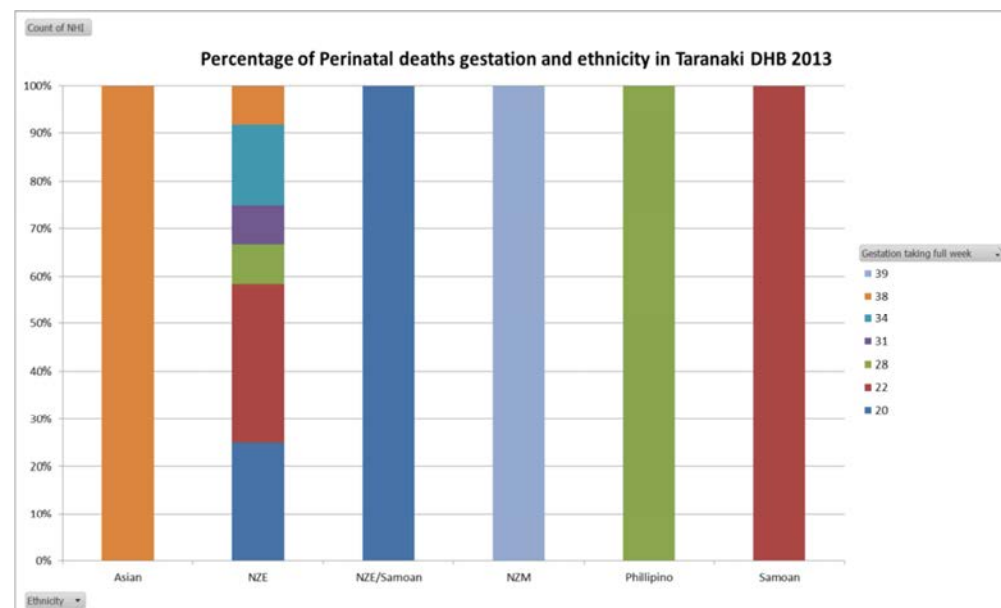
The trend is declining in the European and Maori populations, the numbers are very small for Pacific and Asian ethnicities.

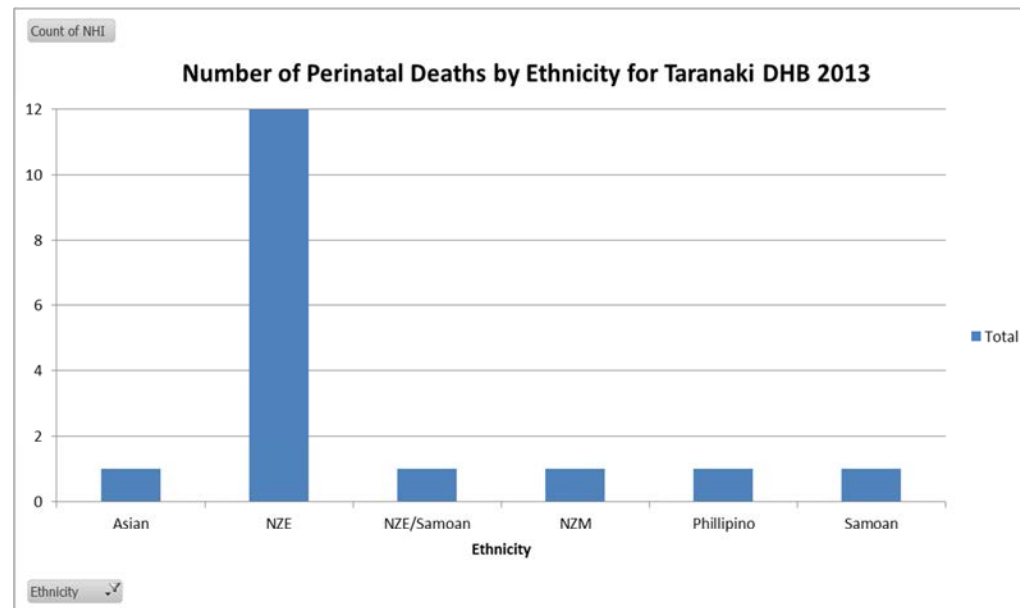


The highest number of deaths were in teenage pregnancies

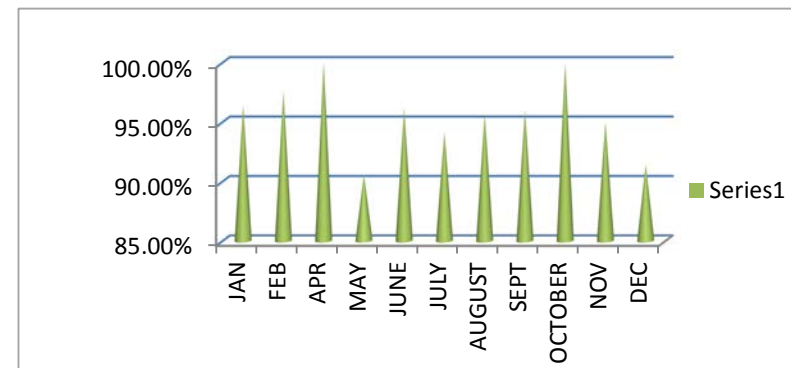
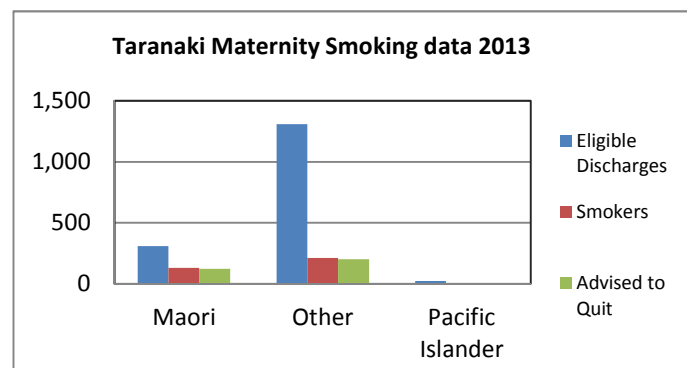


Comments: Fetal abnormality, diabetes and twins have been the leading risks identified. Late termination for fetal abnormality needs further discussion, including early diagnosis and access to Maternal Fetal Medicine services.

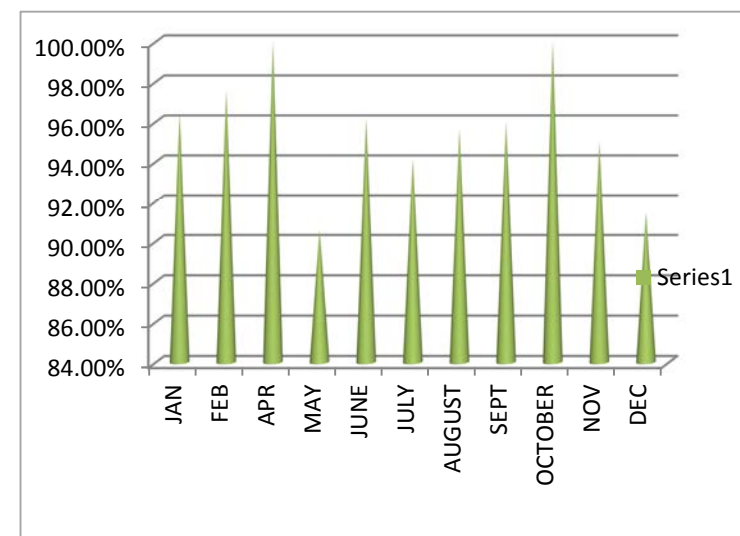
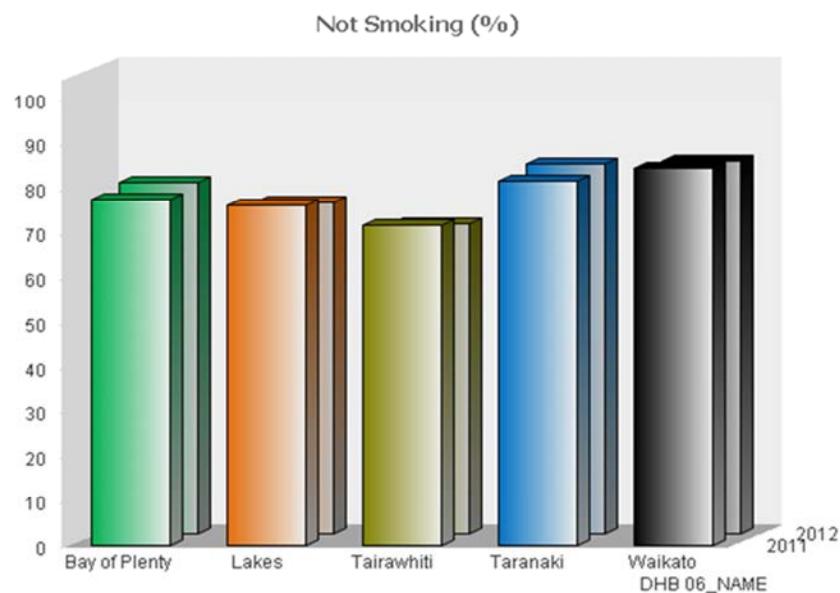




Comments: New Zealand European is the largest ethnicity of Taranaki DHB and also largest ethnicity identified for perinatal mortality in Taranaki DHB in 2013.

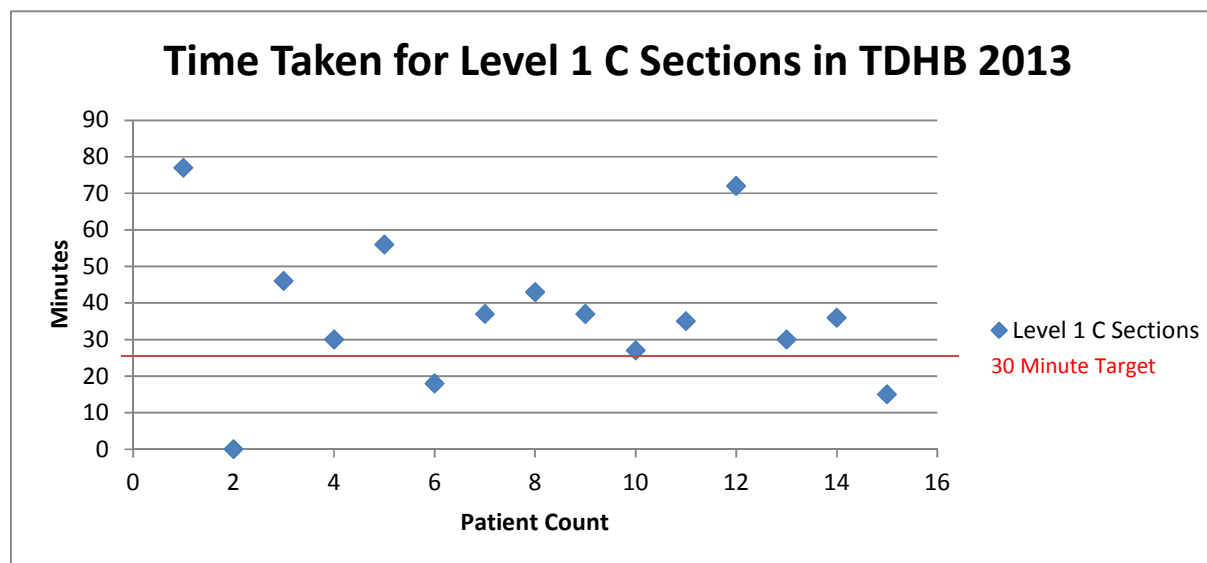


Above: Smokefree Health Target for Taranaki Base Maternity Unit



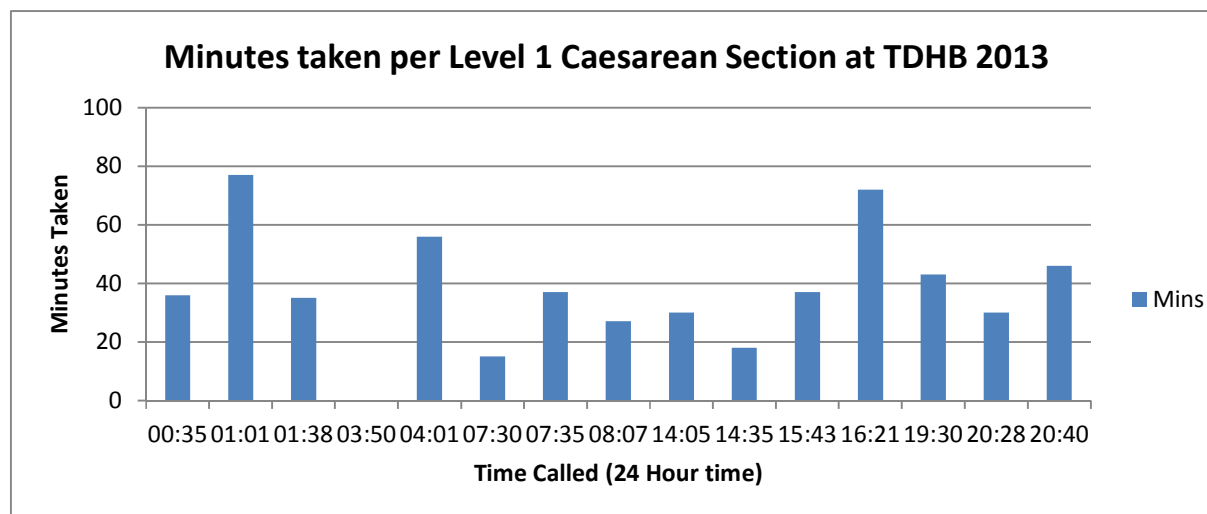
Above: Smokefree Health Target for Hawera Maternity Unit

Comments : Both Taranaki Base and Hawera units are overall achieving above 95% target. Taranaki DHB have the highest Midland % of mothers not smoking; the majority of mothers who smoke have been advised to quit.

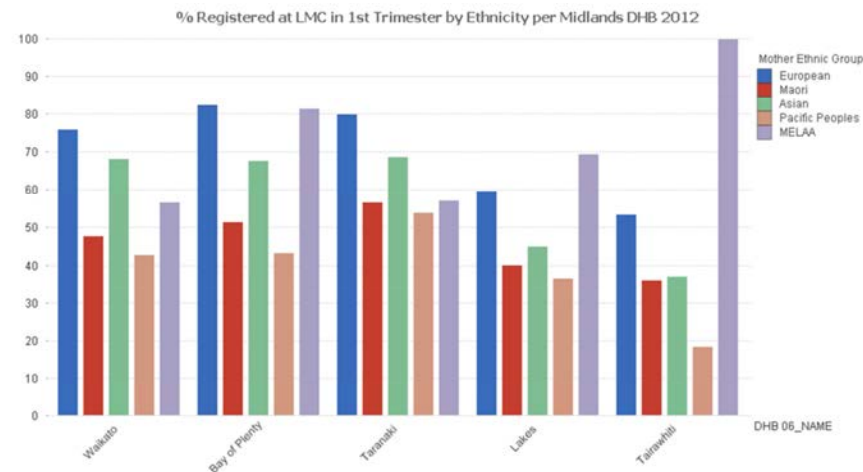
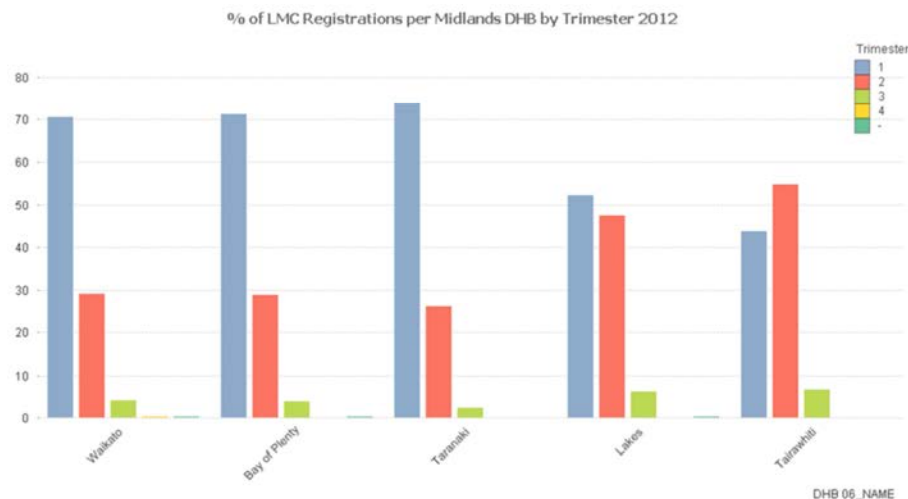


Comments: The majority of Level 1 caesarean section are not achieving the 30 minute target from decision to birth of the baby.

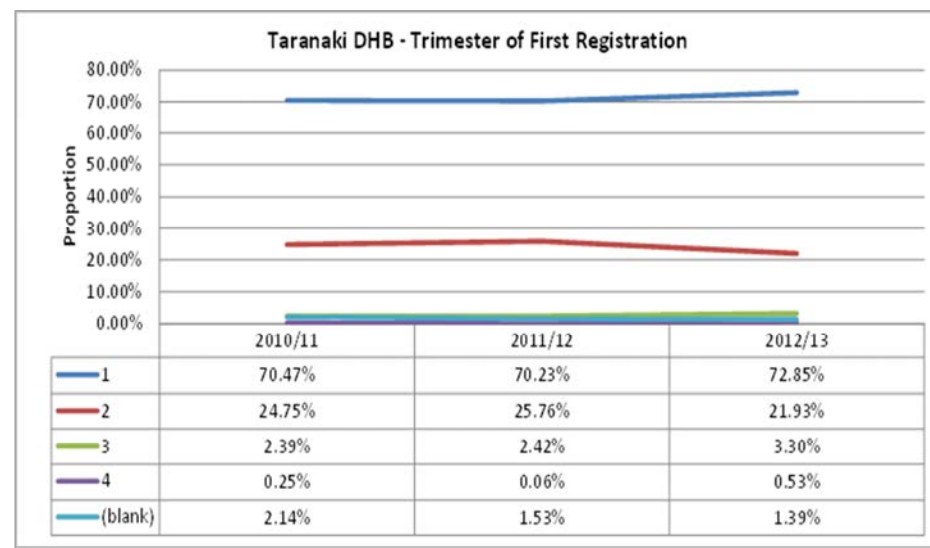
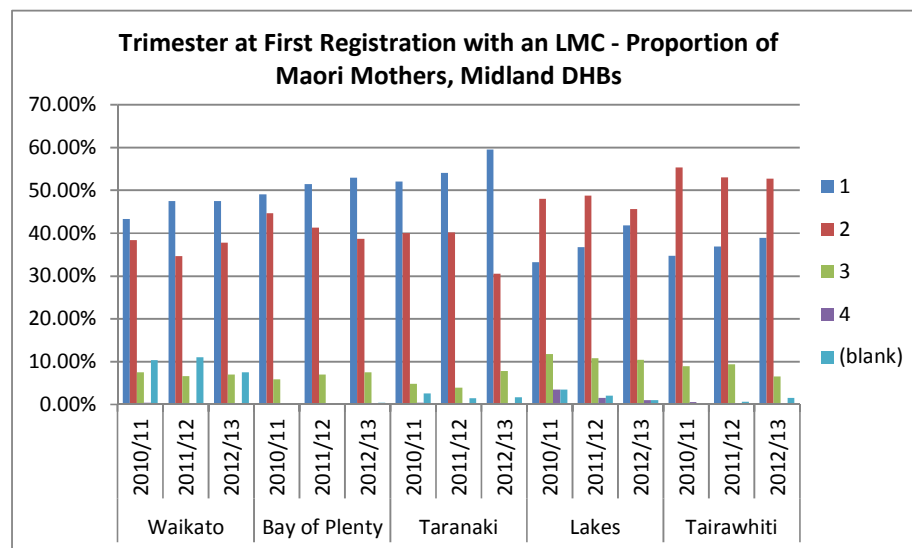
The target times have been more likely to be achieved during day time hours (0700-1600 hours) rather than after hours. The operating theatres are a considerable distance from the maternity unit and theatre staff are on-call from home during the night, however further investigation by conducting a Failure Mode Effects Analysis exercise has been completed and actions to improve timings have been implemented (see planned service deliverables section).



Data - Proportion of Women who Register with an LMC



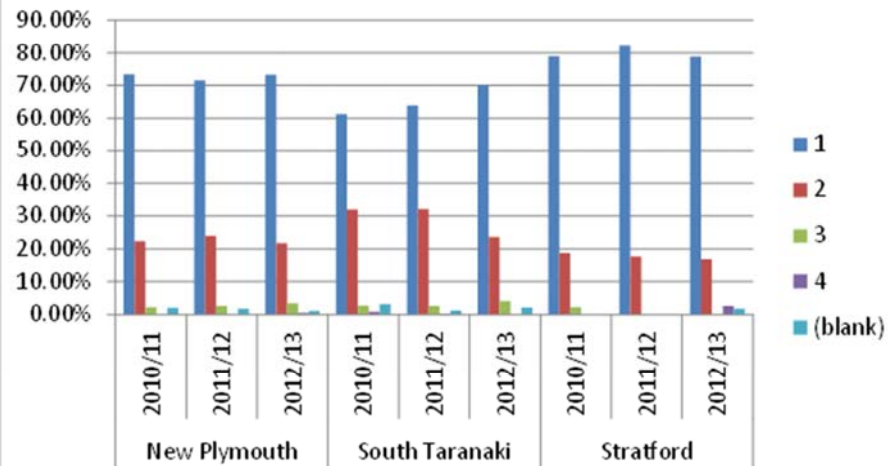
Comment: Out of the five Midland DHBs, Taranaki has the greatest engagement with an LMC in the first trimester. Further work is being carried out to improve these rates.



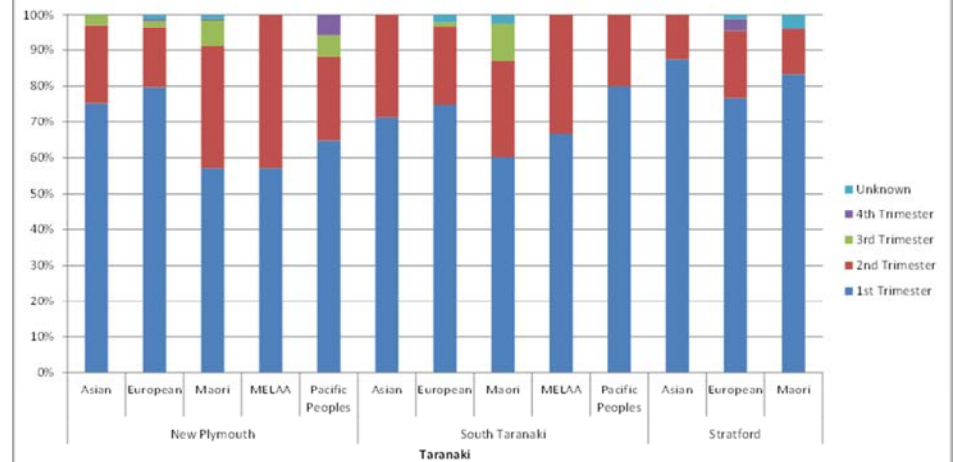
Timing of Registration with an LMC

Analysis of the data provided by the MoH indicates that Taranaki has 98% of women registered under an LMC; 72.85% (increased from 70%) of these register with an LMC in the first trimester which is above the national average and by the end of the third trimester, 97% are registered. When comparing age and geography, further investigation is required to explore how pregnant women in the 16-19 year age group and South Taranaki pregnant women can access an LMC at an earlier gestation. Additionally, it is intended to look at ways of encouraging GPs to initiate first trimester screening and facilitate women to expedite booking with an LMC early.

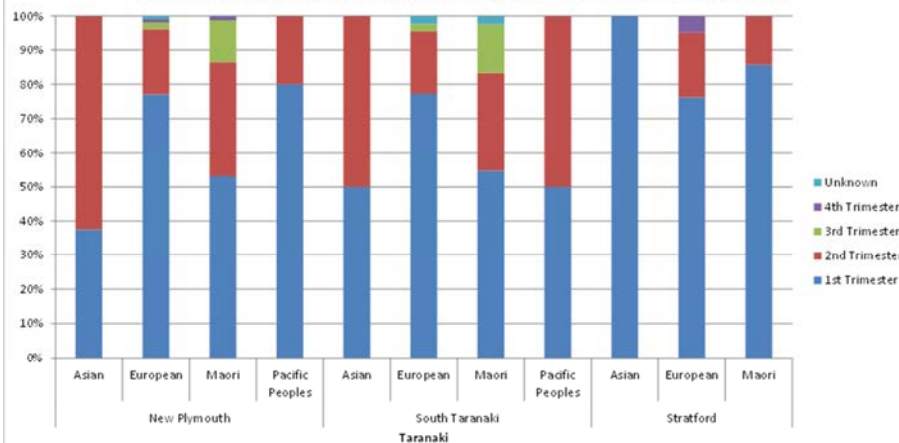
Taranaki DHB - Trimester of registration by TLA



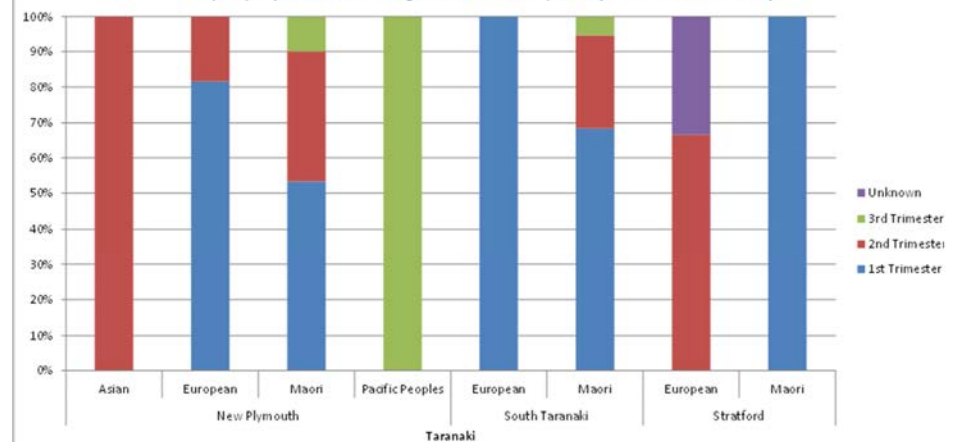
Percentage of Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA), by Trimester of Registration in FY 2012/2013 (Source: NMC, MOH 2014)

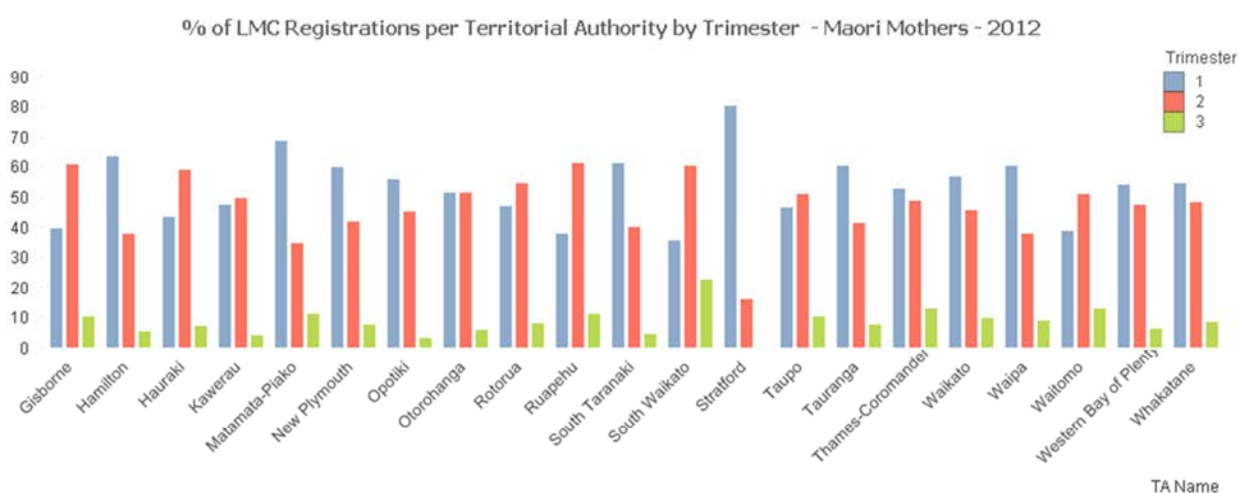


Percentage of 20-24yrs Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA) by Trimester of Registration in FY 2012/2013 (Source: NMDC, MOH 2014)

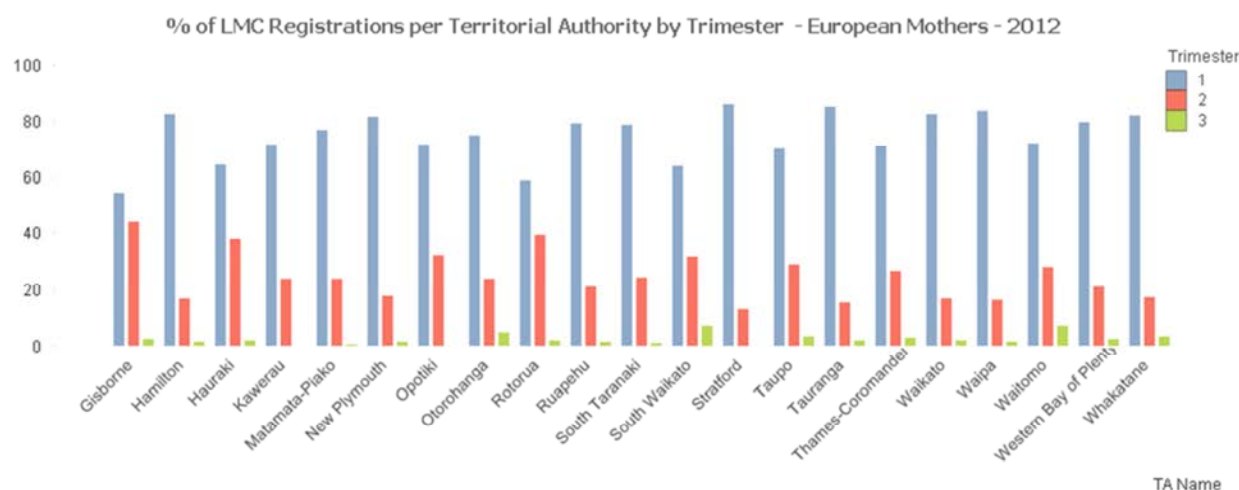


Percentage of 16-19yrs Mother LMC Registrations in Taranaki DHB Territorial Local Authority (TLA), By Trimester of Registration FY 2012/2013 (Source: NMDC, MOH 2014)

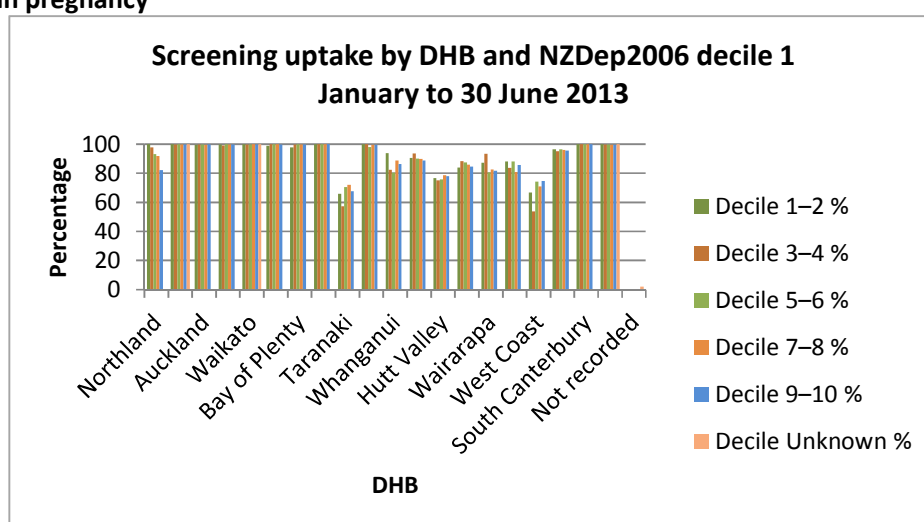




Comment: Further work needs to be done to investigate/communicate with consumers and stakeholders to encourage non New Zealand European ethnicities (Maori, Asian and Pacific) to engage with an LMC earlier in the pregnancy, in the first trimester.



HIV screening in pregnancy



Taranaki has one of the lowest levels in the country. This will be discussed with local Obstetricians, GPs and LMCs to encourage a greater uptake for this screening. The data shows that Obstetricians have the lowest screening uptake in Taranaki, however the data does not capture how many decline screening.

Appendix 5 : Pre and Post Pregnancy Support Services Checklist and Directory

During your, or the kaimahi hauora interactions with the mother, you will be able to fill in this simple checklist below. Be sure **not** to make this a question/answer form but more of an informal discussion during the time of stay in hospital.

Checklist	Tick for yes
Mother or baby Maori	
Baby born with low birth weight	
Mother under 20 years old	
Come from or will live in a high deprivation area	
Baby will be formula fed	
Addiction issues	
• Smoking	
• Drugs	
• Alcohol	
• Gambling	
Requiring Pepi Pods or wahakura	
Are they experiencing or have experienced:	
Extreme budget restraints (income not covering outgoings)	
Domestic violence	
CYF involvement of either parent or partner	
Family violence concerns	
Criminality or offending behaviour concerns	
Mental health concerns (MMH Pathway)	
Concerns regarding previous trauma (TABs/?)	
Cognitive or developmental impairment	
Concerns parenting ability or life skills	
Concealed/unwanted pregnancy	
Attachment concerns	
Transient lifestyle	
Poor engagement with maternity care	
Do they have poor social supports	
Living alone	
Estranged from family/whanau	
Or from another district and have no family/whanau support close	
Obesity BMI over 40	
Poor housing conditions	
Vulnerable Women and Babies	

If you have ticked any of the above, please see the Pre and Post Pregnancy Support Services Directory for referral pathways

Pre and Post Pregnancy Support Services Directory

The below directory will help you refer your patient or client to the appropriate health worker or organisation.
Please ensure you have consent to refer before making contact. Many of these contacts also allow self-referral.

Support needed because	Ante Natal		Post Natal		How to refer
Mother or baby Maori	TKM Alliance GP services		Maori Health Team	Raana or Denise 06 753 7777 ext 7587 or 6707 raana.solomon@tdhb.org.nz denise.smith@tdhb.org.nz	By phone with details of patient
	Tui Ora Tamariki Ora Service	Leonie.brown@tuiora.co.nz Team Leader Well Child Service 06 759 4064 ext 6320 027 706 4032	Tui Ora Tamariki Ora Service	Leonie.brown@tuiora.co.nz Team Leader Well Child Service 06 759 6064 ext 6320 027 706 4032	Contact Leonie Brown or Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799
	Tui Ora Mama & Pepe Kaiawhina	06 759 4064	Tui Ora Mama & Pepe Kaiawhina		As above
Mother under 20 years old	Young Parent Programme	Tania Judson 06 758 3666 ext 848	Young Parent Programme	Tania Judson 06 758 3666 ext 848 (TMCA) Tania.judson@mpymca.org.nz	No referral template Phone or email contact for self referrals
	Stratford Teen Parent Unit	Tracey Burnell	Stratford Teen Parent Unit Youth Service (under 19 years) (Benefit administration and SW support) SWITCH – Young Mums Peer Support (for those on a benefit and under 19)	Tracey Burnell 06 765 0402 027 857 8590 tpu_tracey@stratfordhigh.school.nz Sara Bright 027 210 3221 sara.bright@tuiora.co.nz	No referral template Phone contact for self referrals Requirements: <ul style="list-style-type: none"> • Under age of 19 at start of that year • Pregnant or primary caregiver • Desire for further education
	Tui Ora Tamariki Ora Service and Tui Ora Mama & Pepe Kaiawhina	Leonie.brown@tuiora.co.nz Team Leader Well Child Service 06 759 4064 ext 6320 027 706 4032 06 759 4064	Tui Ora Tamariki Ora Service Tui Ora Mama & Pepe Kaiawhina	Leonie.brown@tuiora.co.nz Team Leader Well Child Service 06 759 4064 ext 6320 027 706 4032 06 759 4064	Contact Leonie Brown or Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799 As above

Support needed because	Ante Natal		Post Natal		How to refer
Come from or will live in a high deprivation area	Community Kaiawhina South Taranaki NAV Team C/- Ruanui Health	Patu, Hone, Lou, Jane Jo Larsen (youth) 06 278 1310 Marilyn is overseer	Kaimahi Hauora	Marilyn@ngatiruanui.org	
	North Taranaki Tui Ora Young Parent Programme	Tania Judson 06 758 3666 ext 848	Young Parent Programme	Tania Judson 06 758 3666 ext 848 Tania.judson@npymca.org.nz	No referral template Phone or email contact for self referrals
Barriers to breastfeeding	TDHB Lactation Consultant	Deb Wright 06 753 7777 ext 8750	Lactation Consultant	Deb Wright - Taranaki DHB Debbie.wright@tdhb.org.nz Lynne.legge@tdhb.org.nz	Referral forms: Tui Ora Referral Form – Breastfeeding
	Mama Pepi Hauora Tui Ora	Lynn Legge (Hawera) 06 278 7109 ext 6891 Julie Foley 06 759 4064 ext 6123		Julie.Foley@tuiora.co.nz	Lactation Consultancy Referral Form
Addiction issues					
Smoking	Smokefree Pregnancy Tui Ora	Emma Dillon 06 759 4064 ext 6018	Cessation Services GP services	06 278 1310 ext 7016 Emma.Dillon@tuiora.co.nz Fax : 06 759 1799	
Drugs	Alcohol & Drug Team	06 753 7777 ext 8555	Alcohol & Drug Team	06 753 7777 ext 8555 Rose.taylor@tdhb.org.nz	Community Services – Mental Health and Addictions Referral Form Referral template using email Walk-ins or phone conversations in regard to potential referrals
Alcohol	Alcohol & Drug Team	06 753 7777 ext 8555	Alcohol & Drug Team	06 753 7777 ext 8555 Rose.taylor@tdhb.org.nz	Community Services – Mental Health and Addictions Referral Form Referral template using email Walk-ins or phone conversations in regard to potential referrals

Support needed because	Ante Natal		Post Natal		How to refer
Gambling	Problem Gambling Foundation	Sandy Cummings 06 769 6020 027 787 1817	Problem Gambling Foundation	Sandy Cummings 06 769 6020 027 787 1817 scummings@pgfnz.org.nz	Referral form: Problem Gambling Referral Form Explains preferred contacts as well
Requiring pepi pods or wahakura	LMC, well child providers		LMC, well child providers Requires an exchange card obtained from LMC/well child provider	Pepi Pod Distributors: Taranaki DHB Ward 15 06 753 7777 ext 7750	There is an exchange card system for Pepi Pods, obtained from the LMC, well child provider or Neonatal or paediatric wards. Then an appointment is made (via contacting the post natal ward on 06 753 7777 ext 7750) for an appointment to get the pepi pod from a pepi pod distributor and the education on safe sleep. For Hawera, contact Hawera Maternity – Bernadette Winks for an appointment.
			Contact Marianne George or Lynette Gilligan or Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799	Tui Ora Contact (Tamariki Ora Nurse) 06 759 4064 Marianne.george@tuiora.co.nz Lynette.gilligan@tuiora.co.nz	Contact Marianne George or Lynette Gilligan or Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799
	Safe Sleep Champion		Safe Sleep Champion – see above	Merry.sorensen@tdhb.org.nz	
Extreme budget restraints (income not covering outgoings)	Work and Income	0800 559 009	Work and Income	Query email (no names) NPY_Client_Query@msd.govt.nz Karen.Coleman008@msd.govt.nz (for further info about Work and Income services) Kelly Kemp Integrated Services Case Manager 06 968 6695 Kelly.kemp001@msd.govt.nz	No template, refer with a description outlining situation and reason for referral, through email
	Budget advise	06 758 5996	Budget Advice	06 758 5996 np.budget@xtra.co.nz	

Support needed because	Ante Natal		Post Natal		How to refer
CYF involvement of either parent or partner	CYF Liaison	Rein Reinfeld 06 968 3337	LMC, Maternal and Child Health Social Worker	Rein Reinfeld 06 968 3337 Rein.reinfeld001@cyf.govt.nz	Referral template Telephone 0508 FAMILY 0508 326 459 Also need to be clear that Taranaki DHB staff/LMCs should follow the Taranaki DHB policy/process when making a notification to CYF (you could check this with Carol Shenton at the hospital). Note the above is only for non Taranaki DHB staff.
	Maternal & Child Health Social Worker	Lydia Rae	Maternal & Child Health Social Worker	Lydia Rae Lydia.rae@tdhb.org.nz Vivien.jones@tdhb.org.nz	
Family violence or domestic violence concerns	Tu Tama Wahine	06 758 5795	Social Worker/Police	reception@tutamawahine.org.nz	
	Taranaki DHB Family Violence Co-ordinator	06 753 7777 ext 8973	Relationship Aotearoa Maternal & Child Health Social Worker HRC Hawera Work & Income	Marianne Pike Marianne.Pike@tdhb.org.nz Lee Haskell Family Violence Response Co-ordinator 06 968 6699 lee.haskell001@msd.govt.nz	Refer through Work & Income
Behaviour concerns leading to prison	Youth Justice Service if under 17	0800 559 009	Youth Justice Social Worker	Meryn Wright meryn.wright@police.govt.nz 06 759 5500 1	
	Tui Ora		New Plymouth Police		
Perinatal Mental Health concerns (MMH Pathway)	Perinatal Maternal Mental Health Pathway	Patrick Morris, Team Leader 06 753 7749 ext 8547 Patrick.morris@tdhb.org.nz Intake Co-ordinator Mentalhealth.referrals@tdhb.org.nz	MMH Pathway GP Services	Patrick Morris, Team Leader 06 753 7749 ext 8547 Patrick.morris@tdhb.org.nz Intake Co-ordinator Mentalhealth.referrals@tdhb.org.nz	Perinatal Mental Health Pathway
	Police if life in immediate danger otherwise Mental Health Crisis Team	Crisis Team via hospital switchboard 06 753 6139 or cell 0508 277 478 Leave message, usually reply in 20 minutes	Police if life in immediate danger otherwise Mental Health Crisis Team	Crisis Team via hospital switchboard 06 753 6139 or cell 0508 277 478 Leave message, usually reply in 20 minutes	

Support needed because	Ante Natal		Post Natal		How to refer
Tui Ora Mental Health concerns (including perinatal and infant mental health)	Infant mental health in development – current perinatal mental health as per Maternal Mental Health Pathway	Intake Co-ordinator Mentalhealth.referrals@tdhb.org.nz Sally Phillips and Carolyn Ravek 06 759 4064	Infant mental health in development – current perinatal mental health as per Maternal Mental Health Pathway	Intake Co-ordinator Mentalhealth.referrals@tdhb.org.nz Sally Phillips and Carolyn Ravek 06 759 4064	Via DHB Maternal Mental Health Pathway Perinatal Mental Health Pathway
Family concerned about mental health	Supporting Families-Whanau in Mental Health Taranaki	Main Office – 06 757 9300 North Taranaki – Catherine Heaven 027 555 1503 South Taranaki – Bernie Kira 027 555 6808	Support, Advocacy, Information and Education for loved ones of someone who has a mental health concern	info@sftaranaki.org.nz or Catherine@sftaranaki.org.nz Or Bernie@sftaranaki.org.nz	Self-referrals accepted, referrals from other organisations via referral form; contact main office
Concerns regarding previous trauma (Trauma After Birth)	Trauma After Birth information	http://www.tabs.org.nz	Trauma After Birth Pathway	Lydia Rae Lydia.rae@tdhb.org.nz	
Language barriers	Kaumatua	South Taranaki Aroha Wharemate ext 6707 North Taranaki Matua Ramon Tito ext 7482	Kaumatua	South Taranaki Aroha Wharemate ext 6707 Aroha.wharemate@tdhb.org.nz North Taranaki Matua Ramon Tito ext 7482 Ramon.tito@tdhb.org.nz	
	Language Line		Language Line	Helen Burley Mike Burr Helen.Burley@tdhb.org.nz Mike.Burr@tdhb.org.nz	
Concern regarding parenting ability or life skills	Barnardos Child and Family Services	John Parry John.parry@barnardos.org.nz 06 968 8536	Parents as First Teachers (PAFT)	PAFT Criteria Angevahn@barnardos.co.nz	PAFT Referral Form
	Open Home Child & Youth Health Programme		Plunket	Jo Malcolm-Black Jo.malcolm-black@plunket.org.nz 06 768 3601 ext 67601 027 238 6318	Open Home Child & Youth Health Programme:
	Triple P Programme			Becky Jenkins (Open Home) Becky.Jenkins@tdhb.org.nz	Open Home Child & Youth Referral Form
	Mothercraft Waikato				Triple P Programme Information
	Maternal social worker		Maternal social worker	Lydia Rae Lydia.rae@tdhb.org.nz	Mothercraft Waikato Referral

Support needed because	Ante Natal		Post Natal		How to refer
	Tui Ora Youth Services parenting courses – Tui Ora		With child under 5	Currently being replaced 06 759 4064 ext 6330 patsy.bodger@tuiora.co.nz	
Concealed/unwanted pregnancy	Maternal Social	Lydia Rae	Adoptions?	Lydia.rae@tdhb.org.nz Vivien.jones@tdhb.org.nz	
	Associate Director of Midwifery	Belinda Chapman	Same	06 753 7864 Belinda.Chapman@tdhb.org.nz	
	Family planning – Sexual Health Unit if termination requested			Sexual Health Clinic 188 Powderham Street New Plymouth Free phone 0508 739 432 Option 1	Patient's name, up to date address, DOB, NHI, current phone numbers are included Fax : 06 757 8316
Transient lifestyle	Find your LMC/Midwife website	Taranaki DHB accessing an LMC site	Kaiawhina	www.findyourmidwife.co.nz Belinda.Chapman@tdhb.org.nz http://www.tdhub.org.nz/services/maternity/lmc_contacts.shtml	If transient woman and is in advanced pregnancy with no LMC, please contact Belinda Chapman so the woman can be followed up
			Tui Ora Tamariki Ora Service	Leonie.brown@tuiora.co.nz Team Leader Well Child Service 06 759 4064 ext 6320 027 706 4032	Contact Leonie Brown or Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799
			Tui Ora Mama & Pepe Kaiawhina	Phone 06 759 4064	As above
Poor engagement with maternity care	Tui Ora Mama & Pepe Kaiawhina	Phone 06 759 4064	Maori Health Team	Raana or Denise 06 753 7777 ext 7587 or 6707	Tui Ora email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799
	Maternity social worker		Tui Ora Mama & Pepe Kaiawhina	Phone 06 759 4064	Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799
Poor social supports	Mama Pepi Hauora Tui Ora		Parents as First Teachers	PAFT Criteria	PAFT Referral Form
Living alone	Mama Pepi Hauora Tui Ora		Parents as First Teachers	PAFT Criteria	PAFT Referral Form

Support needed because	Ante Natal		Post Natal		How to refer
Estranged from family/whanau or from another district and have no family/whanau support close	Mama Pepi Hauora Tui Ora		Parents as First Teachers	PAFT Criteria	PAFT Referral Form
Obesity BMI over 40	Dietitian	Clinical Dietitians, Taranaki DHB	Dietitian	Clinical Dietitians, Taranaki DHB Please fax the referral to 06 753 7709 or dietitians@tdhb.org.nz	Referral from either a medical practitioner or an allied health worker <u>Information required:</u> Name, DOB and NHI Medical diagnosis and past medical history EDD Reason they have been referred to the Dietitian Whether a translator is required
Poor housing conditions	Housing Corporate, Work & Income (screening)		Work & Income, Social Workers	Updated in February	Contact Leonie Brown or Tui Ora via email or fax Email: reception@tuiora.co.nz Fax : 06 759 1799
	WIZE Better Homes	Glenarr Huntley 027 706 8463	WIZE Better Homes	Glenarr Huntley 06 759 4064 ext 6065 027 706 8463	

Appendix 6 : Midwifery Professional Development 2014

REGISTRATION: Bookings only accepted once course has been advertised
Check Intranet page - Services/Education Centre/Training Courses to view registration details

COURSE NAME	HOSPITAL RN, MW	PRIMARY SECTOR	DATE(S)	FACILITATOR	APPROX. TIME
Advanced Life Support Levels 5, 6, 7	RN RM ONLY		12 Feb, 5 March, 2 April, 7 May, 4 Jun, 2 July, 6 August, 3 Sept, 5 Nov, 3 Dec	Kareen McLeod	0830-1730
CPR Level 4 NZRC Modular Core Course	✓		19 Feb, 19 Mar, 16 April, 21 May, 18 June, 23 July, 20 August, 24 Sept, 15 Oct, 19 Nov, 17 Dec	Kareen McLeod	AM – 0730-1100 PM – 1200-1530 offered on each date
Epidural (1/2 day)	RM only		4 April, 17 Oct	Sharon Howe/ Tom Lupton/Emma Patrick	1230-1700
Immunisation Course	MIDWIVES ONLY		TBC		1200-1400
Neonatal and Breastfeeding study day	✓	✓	25 Feb, 18 Nov	Sharon Howe	0830-1630
NNU Resus – full day	RN RM & Paed Dr's ONLY		23 May, 14 Nov	Abi Webber	0900-1600
NNU Resus – refresher	RN RM & Paed Dr's ONLY		7 March	Abi Webber	0900-1100/1200-1400 Offered on each date
Paediatric Advanced Life Support	RN RM ONLY		17 Feb, 9 June, 1 Dec	Kareen McLeod	0830-1630
Pain Management	✓		4 Feb, 18 March, 13 May, 10 June, 1 July, 9 Sept, 21 Oct, 25 Nov, Hawera – 25 March, 4 Nov	Eileen Davey	0830-1200
Perineal Suturing	RM only		13 Feb, 16 Oct,	Sharon Howe/ Eddie Williams	1230-1630
Perinatal Mortality Meeting	O&G, NNU, Paeds, LMC's, Maternity	✓	4 Feb, 2 Sept	Finola Mooney/ Belinda Chapman	7-9pm

PROMPT Course	RM, Obst, Anaesthetists	✓	28 Feb, 29 August	PROMPT FACULTY	0800-1630
Midwives Practice day	RM only		20 August	Sharon Howe	0830-1630
Midwives Emergency Refresher workshop	RM only		19 August, 9 Sep, 4 Nov Hawera 10 June	Sharon Howe	0830-1630
Wintec Preceptor Day	RM only		13 March 2014		0830-1630
Te Hapu Ora	RM,RN,		19 March 2014	Alys Brown	0830-1300
FVIP NZCOM WORKSHOP	RM		3 June 2014	NZCOM	0845-1630
TDHB FVIP WORKSHOP	RM RN		23 May, 27 June, 25 July, 22 August, 26 Sept, 24 Oct, 28 Nov	Marianne Pike	0830-1630
DOTTING THE I'S AND CROSSING THE T'S	RM		TBA	NZCOM	0830-1630
AUT PRESENTATION	RM, RN, O&G		TBA	AUT	0830-1630

Midwives compulsory education requires:

- Annual TSW emergency day training which includes adult CPR level 4, Neonatal resuscitation and emergency drill training. PROMPT training day will cover an annual TSW emergency day (once in every 3 years only, remaining 2 years must be TSW emergency day)
- TSW education/Practice day every 3 years
- NBLS full day (recommended to be attended 3 yearly but not compulsory)
- 3 yearly attendance at a Breastfeeding approved workshop (minimum 4 hours), in addition must attend another education session to a minimum of 4 hours which can be a conference, on-line learning or other activities (cannot be the second half of a workshop)
- Midwifery standards review 2-3 yearly
- Professional and elective education as stipulated by Midwifery Council

Any questions please contact Belinda Chapman (ADOM) ext 8918 or Sharon Howe Midwifery Educator ext 8257

Appendix 7

PERINATAL MENTAL HEALTH (PNMH), MATERNITY & NEONATAL (NNU) MEETING TERMS OF REFERENCE

Date Issued:	October 2013
Review By Date:	October 2015
Responsibility:	Team Leader for PNMH
Authorised By:	PNMH/Maternity/NNU
Version:	1
Page:	1 of 2

Purpose

To provide an MDT forum to ensure optimal communication and collaboration between clients who require PMMH and Alcohol and Drug (AOD) services during pregnancy, labour and birth and the postnatal period.

Definitions

MMH:	Any woman who has been referred to PNMH in pregnancy via PMH local pathway
AOD:	Any woman who has been referred to Alcohol and Drug services in pregnancy
Maternity:	Any woman with a confirmed pregnancy and up to 6/52 PN
NNU:	Any potential pregnancy that may result in a NNU admission

Terms of Reference

- The PNMH, Maternity and NNU meeting will review all cases that present with maternal mental health issues in Taranaki DHB and who are pregnant or up to 6 weeks postnatal
- To provide a MDT planning of care for pregnancy, labour and birth and for PN care
- PNMH will collate and report trends of PNMH clients' experiences in maternity/NNU services to identify trends and implement improvements in practice
- The meeting will make recommendations for further education of staff where appropriate

Chairperson

The Team Leader for Adult Mental Health will act as Chairperson.

If the Chairperson is unavailable at any meeting, the members present shall appoint an Acting Chairperson for that meeting.

Membership

- Team Leader for Adult Mental Health
- CMM
- NNU Clinical Nurse Manager
- PN Coordinator
- Community Mental Health Nurse
- PNMH Social worker and Maternity Social workers case specific
- PNMH Psychologist case specific

Co-opting Power

The Committee/Meeting shall have the power to co-opt members of staff as required. This may include:

- LMC
- Antenatal Coordinator
- AOD case worker
- Paediatricians
- Obstetricians
- Clinical psychologists
- Key workers for the women known to PMMH
- Midwife educator
- ADOM

Quorum

A quorum shall consist of not less than four members.

Meeting Time Frame

Monthly on a Tuesday morning 09.30 am until 10.30 am in the PN meeting room

Conflict of Interest

Conflicts of interest are to be declared when a potential conflict exists with an agenda item. The Committee will determine the appropriate response.

Reporting Relationship

Reports to the Maternity Quality Committee

Minute Circulation

Minutes will be circulated to all members of the group. Also a copy to be circulated to ADOM.

Appendix 8 : Inpatient Status Board

	Name	P/S	G	P	Gest	Clinical responsibility of	LMC	Core	NNU	Diagnosis/Progress	Review due
1											
2											
3											
4											
5											
6											
7											
A											
B											
C											
D											
E											
F											

P/S= Primary or Secondary: In the event a Primary Obstetrician/GP is clinically responsible then this name will also be in the LMC column and this column will identify "P" which means the LMC or back-up will be contacted 24/7. Same if a Midwife/GP LMC In the event of a named secondary obstetrician being clinically responsible for care then an "S" will be indicated in this column which means the named obstetrician will be responsible for continuity of care and daily care planning Mon-Fri 8am-4.30pm (realistically this will mainly be done at the daily morning ward round). Out of hours, the duty Obstetrician will be contacted (this name is indicated in the "on-call" section of the notice board). If there are times of unavailability of the named obstetrician eg in theatre the duty obstetrician should be contacted).

G=Gravida

P=Parity

Gest=Gestation

The Maternity Quality Committee is a clinical governance group that monitor and manage standards of clinical care, and are committed to ensuring a quality maternity service exists for the women and families of Taranaki.

SEPTEMBER 2013

Welcome to the first quarterly newsletter of the Maternity Quality Committee

The Committee was established in December 2012. It is a clinical governance group that has been set up to monitor and manage standards of clinical care. The group meets every four weeks.

Over the past eight months the monthly meetings have brought together people who are involved with, and committed to, ensuring that a quality maternity service exists for the women and families of Taranaki.

Group Members

- Associate Director of Midwifery (Chairperson)
- Clinical Services Manager: Maternal & Child Health
- Head of Departments; Obstetrics & Gynaecology (O&G), (Paediatrics)
- Clinical Managers; Neo Natal Unit (NNU), Maternity
- Representatives from; Consumers, Infection Control, Maori Health, Mental Health, Quality Risk, Social Work, Mental Health
- Lead Maternity Carer (LMC) Midwives: Rural, Urban, Core Midwife/ Quality Risk Delegate, Midwife Educator

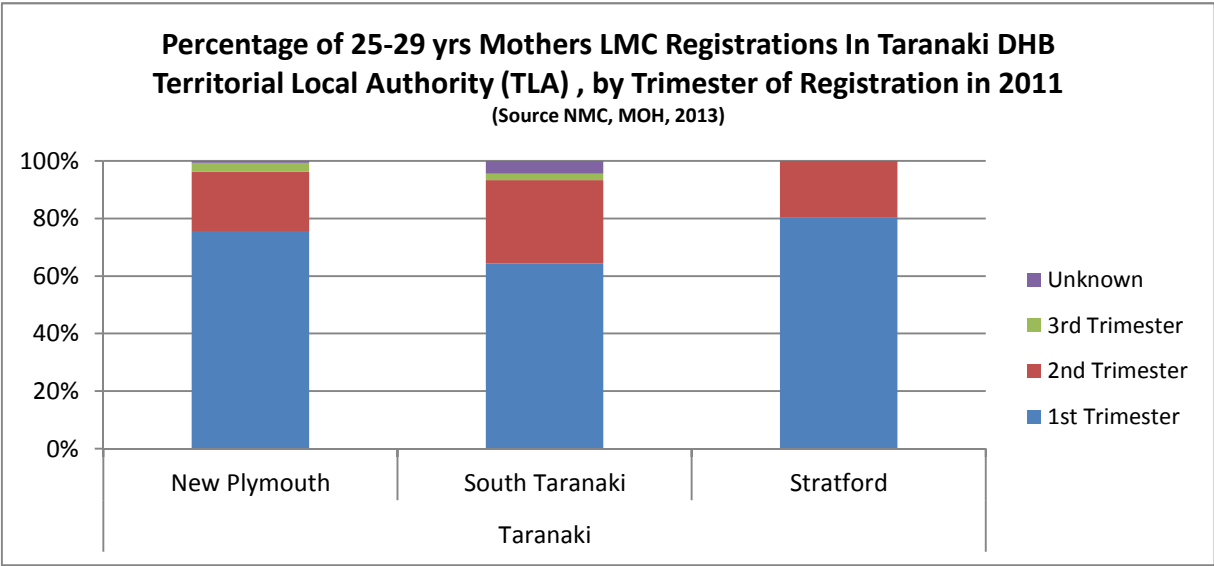
The monthly meetings focus on working with the national Maternity Quality and Safety Programme. As a framework a Maternity Quality Audit and Reporting Grid have been developed. This encompasses the multi-disciplinary services and personnel.

News from our recent meetings:

- Statistics show that > 50% of admissions to the NNU are of babies born at > 37 weeks gestation. A proportion of these are for neonatal jaundice. Some of these are admitted from the community. A new protocol is being developed that will incorporate the use of "bilisoft" phototherapy treatment in the community. The need for staff training and updates prior to implementing this was recognised as well as the purchase of a new bilisoft bed.

- Fetal Fibronectin (FFN) is a test that is used where there is threatened pre-term labour and can determine whether a woman will deliver her baby within the next 7 days. Dr Jeremy Smith (Head of Dept O&G) has commenced a retrospective audit of the use of this test to look at FFN use over the past 2 years. The aim is to confirm the cost-effectiveness of this expensive test as it may save an unnecessary transfer to a tertiary hospital. This is also advantageous to the family unit.
- Belinda Chapman (ADOM/MQC Chairperson) attended the first face-to-face National Maternity Quality & Safety Programme meeting in Wellington. Belinda was able to present Taranaki DHB's draft Maternal Mental Health (MMH) Pathway.
- Patrick Morris (Team Leader MMH) presented an update of the MMH Pathway and ways to implement it into the service. An in-service on the Edinburgh Postnatal Depression Scale was held on Ward 14 on 3rd September at 3pm.
- A trial of clip-on cots has proved very popular with mothers and staff. A great quality improvement that supports safe-sleeping for babies and has resulted in the purchase of 5 clip-on cots for Ward 15 and 1 for Hawera Maternity Unit.
- Another safe-sleep initiative was the launch of pepi-pods. Those mothers eligible are given a pepi-pod exchange card by their LMC or care provider and can then collect their pepi-pod by arrangement with our pepi-pod distributors.
- The final Maternity Quality and Safety Programme Annual Report has been accepted by the Ministry of Health. This document highlights quality improvement initiatives, one of which is to improve the number of women registering with a Lead Maternity Carer in the first trimester.

There are annual targets to be met with an aim of 90% of women engaging early with an LMC by 2016. The diagram below shows our previous details of access to Lead Maternity Carers.



To access a midwife, the following websites may be used;

www.findyourmidwife.co.nz/midwives/taranaki
www.tdhub.org.nz/services/maternity/lmc_contacts.shtml

- The Annual Report recommends the inclusion of consumer input at all levels of maternity service decision-making. Taranaki MQC has a consumer representative who brings ideas and feed-back to the monthly meetings.
- The goal over the next year is to put in place a community consumer liaison position.

The Maternity Quality Committee welcome comments, ideas and feedback. The email address for any enquiries related to this newsletter or MQC activities can be found at the foot of each page.



All enquires to : maternityqualityinfo@tdhb.org.nz

Appendix 10 : Maternity Obstetric Outcome Data Collection Form

Patient Bradma

Database Record:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Date of Delivery: ☐☐ ☐☐ ☐☐ Time of Delivery: ☐☐ ☐☐ ☐☐ Delivery Location: _____

Mode of Delivery: ☐ Spontaneous Vaginal Birth ☐ Assisted Vaginal Birth ☐ Caesarean Section

Category	Fetal & Maternal Outcome	Comments/Indication/Gestation		
		Circle	Yes	
Trend Monitoring (discussed at weekly case review forum meeting)	Transfer to or from tertiary centre	DS/W		
	Second tri TOP for fetal abnormality	DS		
	Preterm birth <37 weeks gestation	DS		
	PPH ≥ 500 mls (vaginal birth)	DS/W		
	PPH ≥ 1000 mls (caesarean birth)	OT/W		
	Decision-to-delivery interval >30 minutes for Level 1 caesarean cases	DS		
	Caesarean section elective	DS		
	Caesarean section emergency	DS		
	General anaesthetic caesarean section	DS		
	Epidural in labour	DS		
	Uterine death/TOP > 20 weeks	DS		
	3 rd or 4 th degree tears	DS		
	Induction of labour	DS		
	Wound infections post caesarean	W		
	Postnatal readmission	W		
	Number of days postatal inpatient stay ≥ 5 days	W		
Case Review	Unexpected maternal transfers to ICU	DS/OT W		
	Eclamptic seizure	DS/W		
	Visceral trauma; uterine scar rupture/dehiscence, urinary system or bowel trauma; 3 rd and 4 th degree tear	DS		
	Caesarean hysterectomy	DS		
	Level 1 caesarean section	DS		
	NND/intrauterine death/TOP > 20 weeks	DS		
	Transfer to or from tertiary centre	DS		
	Transfer in from primary unit/home by ambulance	DS		
	Maternal blood transfusion	DS/W		
	Unexpected admission to the NNU from delivery suite/OT and PN when ≥ 37 weeks gestation and excluding fetal abnormality	DS/W/ OT		
	Apgar score <5 at 5 min and/or <7 at 10 min, and/or	DS/OT		
	Postnatal readmission	DS/W		

Mandatory Reporting	Intrapartum fetal demise	DS		Reportable event must be completed and copy attached Line Manager must be informed
	Maternal death	DS/W		Report event must be completed and copy attached
Other concerning outcome – requesting review				Detail and comment:

Signed: _____ **Print Name:** _____ **Date:** _____

Form to be forwarded to Midwife Educator and ADOM on discharge