



TARANAKI DISTRICT HEALTH BOARD

MATERNITY ANNUAL REPORT

1 JULY 2015 - 30 JUNE 2016

ACKNOWLEDGMENTS

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Rosemary Darby, Core Midwife
Sadie Walker, Baby Loss Midwife Champion
Sharon Howe, Midwife Educator
Stephanie Cowan, Change For Our Children
Suzanne Andrews, Project Manager (Midland Maternity Action Group)
Tesa Pilkinton, Antenatal Clinic Coordinator

MATERNITY QUALITY COMMITTEE MEMBERS



Belinda Chapman,
MQSP Coordinator/
Associate Director
of Midwifery



Leigh Cleland,
Child & Maternal
Health Clinical
Services Manager



Amanda Antoine,
Clinical Midwifery
Manager



Sharon Howe,
Quality Rep and
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Jenny James,
Portfolio Manager
for Maternity,
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Karmin Erueti-
Thatcher, Tobacco
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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, CHILD & MATERNAL HEALTH)

Taranaki DHB's Maternity Quality & Safety Programme (MQSP) remains an integral part of the service provided to the women and families/whanau of Taranaki. Taranaki DHB remains committed to this programme, its benefits and the significant improvements it has achieved for the maternity services, consumers, families/whanau, practitioners and stakeholders within the Taranaki region. It is recognised as a valuable and important programme which has become embedded into the Taranaki DHB wider Quality Committee which it reports to the Taranaki DHB Clinical board annually.

The Maternity Quality Committee (MQC) was established in 2012 and has continued to meet on a monthly basis. It has wide representation from maternity practitioners, managers, consumers and stakeholders of maternity care. The Committee has continued to progress and review the work plan set out for 2015/16. It has also enhanced stronger relationships with other services within Taranaki DHB and in the community such as quality and risk, perinatal mental health services, operating theatres, smoke free coordinator, child protection and family violence coordinators and stakeholders of maternity care both in the hospital and community.

The Taranaki DHB consumer role is seen as a vital role, it brings the consumer view and provides a link between the community, hospital practitioner and stakeholder services, so much so that a second consumer position has been appointed this year.

Taranaki DHB has seen an improvement in the ability to recruit midwives to both the community (self-employed) and employed workforces across the region. We have enjoyed this for over a year now, however are mindful that this has been an area of risk and has not always been sustained in the past. A group of senior midwives,

managers and unions are currently reviewing how Taranaki DHB is best to manage staffing in the peaks and troughs of the day to day variance of patient numbers and acuity in the maternity units. This is a challenge that other units of a similar size face and finding a solution that is viable and meets the needs of the services and the staff work-life balance is proving difficult. The unit is currently trialing a staff model aimed at staffing the unit in a more sustainable way.

Taranaki DHB is now staffed with four senior medical officers and are currently in the process of recruiting a fifth senior medical officer, this will better support on call and cover for leave. Having a full complement of experienced and capable obstetricians enables us to provide an excellent service to women and families of Taranaki as well as support teaching and development of our staff. The service has benefitted from the addition of a Registrar to the RMO group, Taranaki DHB now employs two Registrars and two House Officers.

Service progress has been guided by the Maternity Quality Committee, which has given some clarity about where we wish to head and areas that the team needs to focus on. This has resulted in recognition of national issues such as prevention and management of haemorrhage, also local issues such as obstetric outcomes and the Taranaki caesarean rate for first baby.

Dr Jeremy Smith, Mrs Belinda Chapman and Mrs Leigh Cleland

MESSAGE FROM CHAIR, MIDLAND MATERNITY ACTION GROUP

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

- **BOP DHB:** Matthias Seidel (SMO rep.), Thabani Sibanda (SMO rep.), Marg Norris (Midwifery Leader), Karen Palmer (Senior Lactation Consultant; Chair, Breastfeeding/BFHI Sub Group), Sachit Gagneja (MQSP Programme Manager)
- **Lakes DHB:** Simon Ewen (O&G HOD), Sue Finch (Clinical Midwife Manager/ MQSP)
- **Tairāwhiti DHB:** William Weiderman (SMO rep.), Mary-Clare Reilly (Midwifery Leader/MQSP), Liz Lee-Taylor (Maternity Educator ex officio)
- **Taranaki DHB:** Anene Chukwujama (SMO rep.), Belinda Chapman (Assoc. Director of Midwifery/ MQSP), Sharon Howe (MQSP/Maternity Educator)
- **Waikato DHB:** Penelope Makepeace (Clinical Director - Obstetrics) - resigned part way through this term, Corli Roodt (Associate Director of Midwifery; MMAG Chair), Pip Wright (Maternity Educator; Chair, Maternity Educators, Clinical Midwife Managers, & Midwifery Leaders Sub Group), Ruth Galvin (MQSP Project Manager; Chair, Midland MQSP Sub Group)
- **Director, Nursing/Midwifery rep.:** Sue Hayward (Waikato DHB)
- **Māori Health rep.:** Jade Chase (Waikato DHB) – resigned part way through this term
- **Public Health Service rep.:** Louise Harvey (Toi Te Ora)
- **Planning & Funding rep.:** Becky Jenkins (GM Planning & Funding, Taranaki DHB), Jenny James (Portfolio Manager, Taranaki 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.

MMAG's main focus over the past 12 months has been the development of a breastfeeding mobile phone application, BreastFedNZ. This project was supported by the findings of the NZ Institute of Rural Health's 'Midland Region Rural Maternity Services Consumer Engagement Study' (June 2014) recommending that Midland maternity services look to develop a pregnancy phone app.

BreastFedNZ was launched in late August 2015 and offers free and timely information and support for consumers on iPhone and android. The app is supported by a 'Breastfed NZ' Facebook page and a website www.breastfednz.co.nz, offering free print design files. Working with Midland Public Health and Population Health Services has enabled the incorporation of breastfeeding accredited spaces into the app's GPS activated map function. As at 30 May 2016 there have been over 4,600 app downloads, with positive feedback received from consumers, LMCs and maternity staff.

Other MMAG regional initiatives and collaboration has focused on:

- the development of the Midland Maternity Transfer and Repatriation Standards – improving communication and care of Midland women transferring to and from the Waikato tertiary service
- the Midland Safe Sleep Programme has had success in reducing SUDI rates; "...in the 12 months ending March 2016, Midland saw equal Post Perinatal Mortality rates for Māori and non-Māori. This is significant given the disparities of March 2002, and even March 2012." Stephanie Cowan, Director, Change for our Children
- the joint purchase of CO monitors and distribution across Midland to support smokefree pregnancies
- the continued close working of Midland midwifery educators and lactation consultants has supported their practice.

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

Corli Roodt, Associate Director of Midwifery, Waikato DHB
Chair, Midland Maternity Action Group

TARANAKI DISTRICT HEALTH BOARD VISION

Our Shared Vision / Te Matakite

Taranaki Together, a Healthy Community
Taranaki Whanui, He Rohe Oranga

Our Mission / Te Kaupapa

Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki

Our Aims

- To promote healthy lifestyles and self-responsibility
- To have the people and infrastructure to meet changing health needs
- To have people as healthy as they can be through promotion, prevention, early intervention and rehabilitation
- To have services that are people-centred and accessible where the health sector works as one
- To have a multi-agency approach to health
- To improve the health of Māori and groups with poor health status
- To lead and support the health and disability sector and provide stability throughout change
- To make the best use of the resources available

Our Values

How We Work Together With Others / Nga Tikanga

The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, whanau, funded agencies, staff and members of the public. Therefore, we will work together by:

- Treating people with trust, respect and compassion
- Communicating openly, honestly and acting with integrity
- Enabling professional and organisational standards to be met
- Supporting achievement and acknowledging successes
- Creating healthy and safe environments
- Welcoming new ideas

Maternity Services Vision

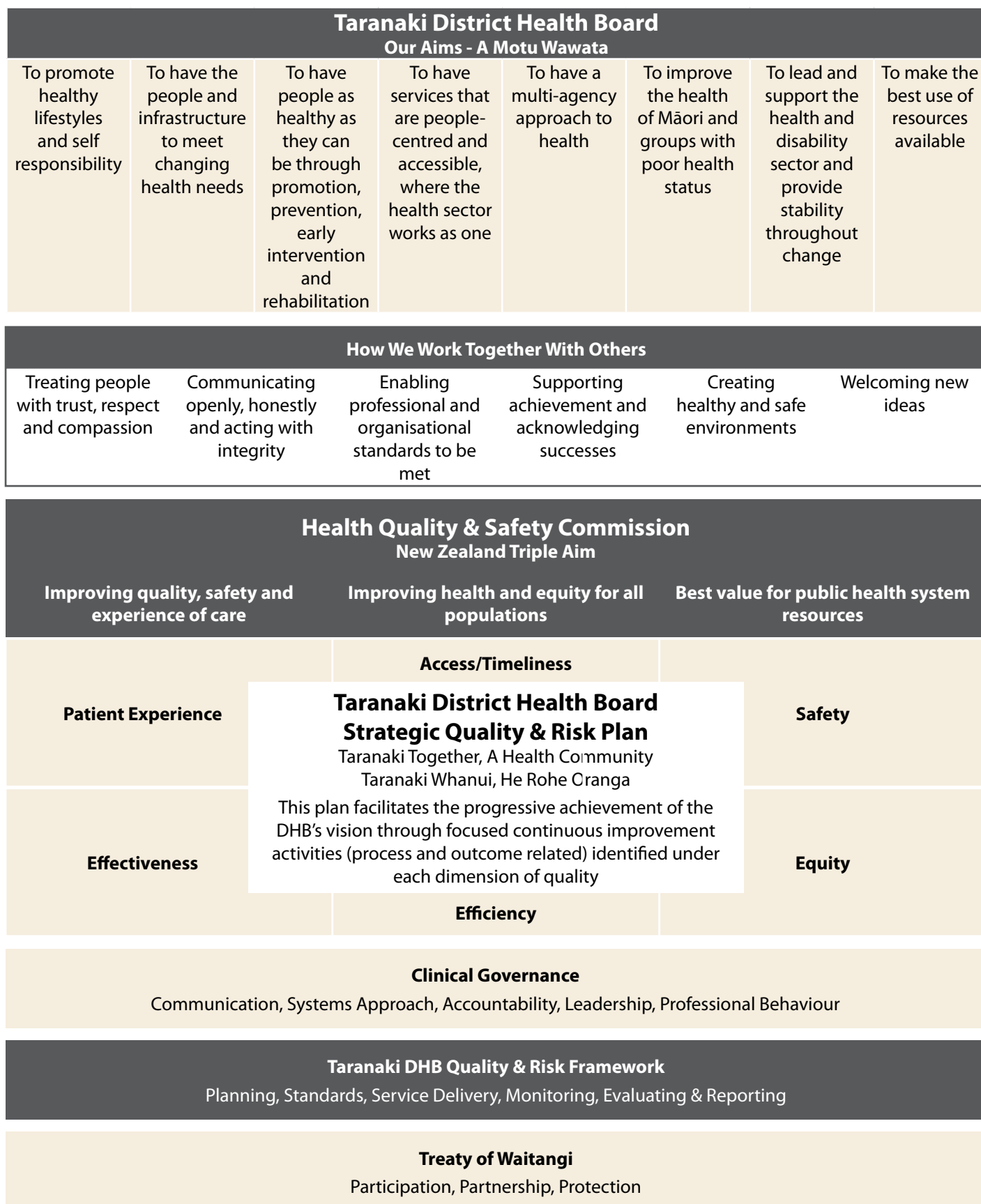
Taranaki Together, committed to caring in pregnancy, birth and beyond, for a Healthy Community:

- HE URUNGA WHENUA
- HE URUNGA TANGATA
- HE URUNGA OHI
- HE URUNGA TARANAKITANGA
- KI TE TAI AO
- MAU TONU



SETTING THE SCENE

To set the scene, the following diagram demonstrates the relationship between Taranaki DHB's vision, missions and aims, the Health Quality & Safety Commission's Triple Aim, our defined dimensions of quality that are then supported by Clinical Governance behaviours, our Quality & Risk Management Framework and the Treaty of Waitangi principles.



PURPOSE AND EXECUTIVE SUMMARY

This annual report meets the requirements of the service specifications for the Maternity Quality and Safety Programme (MQSP): Excelling DHB. It will be accessible to all maternity stakeholders, practitioners of maternity care and consumers via the Taranaki DHB website (www.tdhb.org.nz), hospital library, maternity and neonatal departments as have past MQSP reports.

This annual report demonstrates Taranaki DHB's delivery of the expected outputs of an excelling MQSP DHB and outlines the progress that Taranaki DHB is making with the three year plan 2015-2018.

The report describes Taranaki DHB's activities undertaken in 2015/16 and those intended to be undertaken to improve maternity quality, safety and clinical outcomes of its maternity services in 2016/17.

- Consumer has been actively involved for three years and is highly engaged and participates in the programme including improvement priorities and projects, a second consumer has been recruited who identifies as Māori ethnicity. Training and support is integral to the roles.
- The programme uses national, regional and local data to inform and assist in priority setting. Dashboards are available and also information is circulated via email and presented at meetings.
- Taranaki DHB quality team are linked to and engaged with the programme.
- Maternity Quality Committee (MQC) is linked to Taranaki DHB's Executive Management Team and reports to the Clinical Board annually.
- Taranaki DHB MQSP has delivered meaningful improvements for women and their families/whanau.
- Taranaki DHB networks and collaborates with the four other Midland Regional DHBs, sharing quality improvement initiatives and supporting each other, examples are the BreastFedNZ App, the transfer and repatriation guidelines, and the Quality and Leadership Programme for midwives.
- Taranaki DHB has received positive feedback from the National Maternity Monitoring Group (NMMG) in relation to the progress of the perinatal mental health Service.
- Taranaki DHB meets all of the New Zealand Maternity Standards audit criteria.
- Taranaki DHB continues to develop relationships and alliance with other maternity primary care providers.
- This annual report includes consumer feedback and how this has been responded to.
- Taranaki DHB facilitates information on how to contact Lead Maternity Carers (LMC) and provides information on the Taranaki DHB website www.tdhb.org.nz.
- The proportion of women accessing continuity from and LMC for primary care is reported in this report.



PROFILE OF TARANAKI

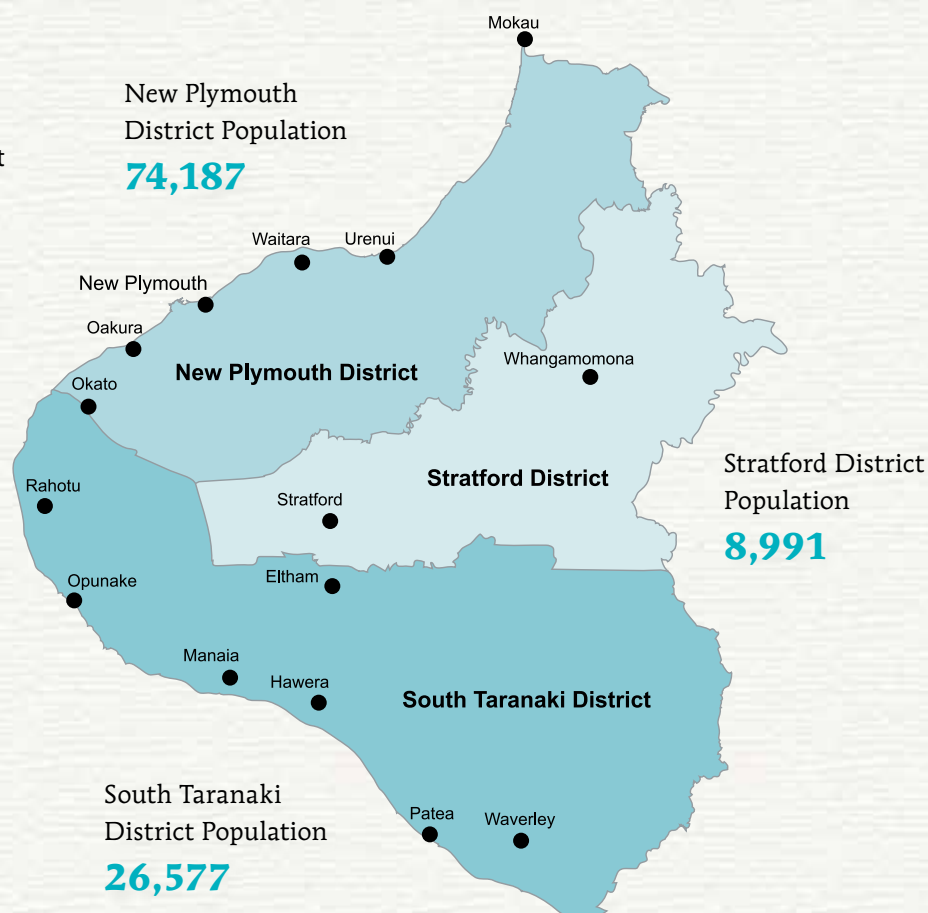
Taranaki DHB delivers health services in Taranaki and in the Mokau area, which is part of the Waikato District Health Board. The district covers more than 7,000 square kilometres. There are a few densely populated centres in Taranaki such as New Plymouth, Stratford and Hawera. The rest of the population is scattered in and around small rural centres.

POPULATION PROFILE

According to Statistics New Zealand, in 2014/15 Taranaki DHB served a population of 109,608* people.

The Māori population is projected to increase to 20.6% of the total population by 2026. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2013 Census. Taranaki has 86.2% identified as European and other, 17.4% as Māori, 1.6% as Pacific and 3.5% as Asian.

Note: Where a person reported more than one ethnic group, they have been counted in each applicable group. As a result percentages do not add up to 100%.

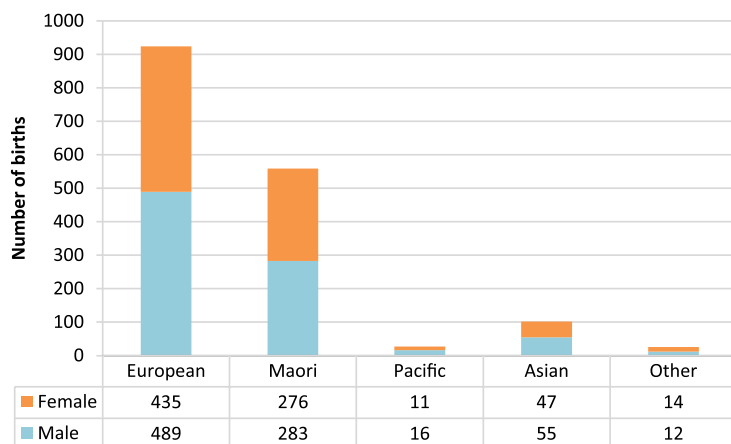


*Based on updated information received from Statistics New Zealand Population Projection 2013

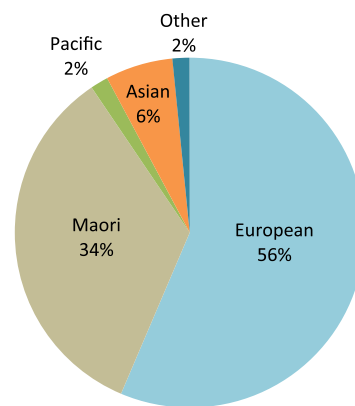
SOCIO-ECONOMIC INDICATORS

The Taranaki population sits towards the centre of the socio-economic range. There are higher percentages of people living in NZDep2013 deciles 5, 6, 8 & 9 and lower in decile four compared to the New Zealand average. Approximately 74% of the Māori population is resident in deciles 6-10 compared to 57% of non-Māori. Māori in Taranaki have six to seven years less life expectancy than non-Māori.

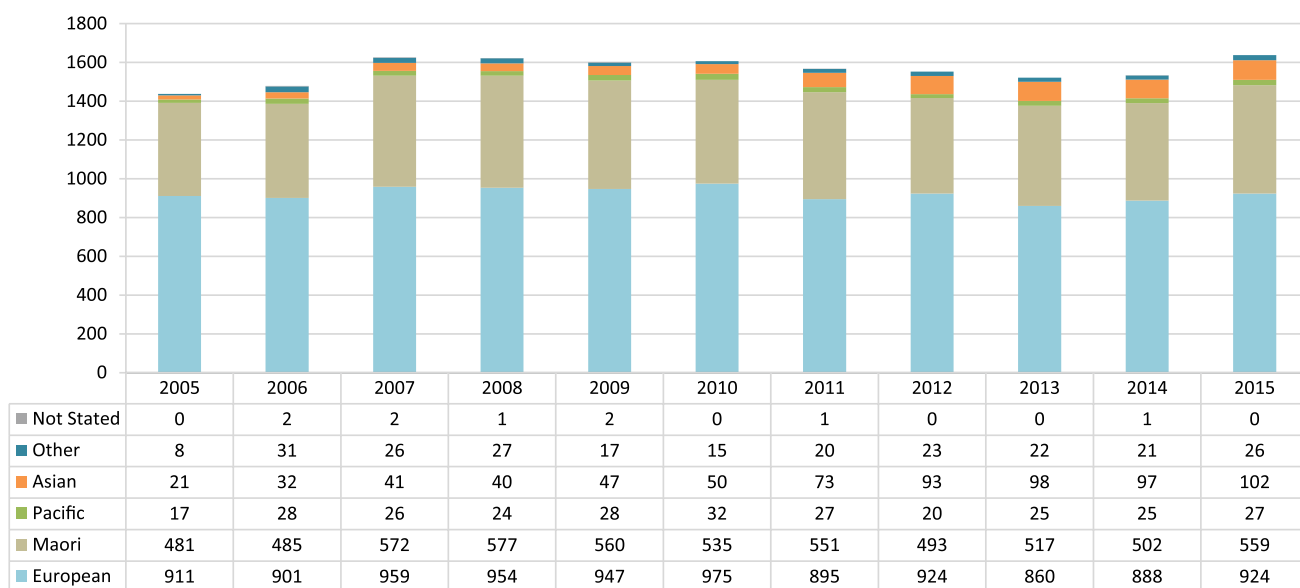
**Number of Taranaki Births in 2015
by Gender and Ethnicity
(based on registration date)**



**Taranaki Births in 2015 by Ethnicity
(based on registration date)**



**Movement in Taranaki birth rates from 2005 to 2015
(based on registration date)**



BIRTHING AGE POPULATION

Over an 11 year period Taranaki has seen an overall increase in the birthrate of 13.9%. There were 200 hundred more births in Taranaki in 2015 compared with 2005.

Over a six year period the increase is 1.9%, an increase of 31 births in 2015 compared to 2010.

There has been an increase in births across all ethnicities over an 11 year period, the biggest changes are seen amongst the Asian ethnicity (385.7% over an 11 year period), a smaller increase of 16.2% in Māori births over the

same period. However over the last six years there has been a decline in babies that identify as European (down 5.2%) and Pacific(down 15.6%), whereas the babies who identify as Māori, Asian, and "other" have increased.

The highest birth numbers identify as European, followed by Māori and then Asian, Pacific and other.

Teenage births are continuing to decline, with the 25-29 year age group having the largest numbers of births,

followed by 30-34 year and then 20-24 year age groups. Woman over the age of 35 years accounted for 15.8% of births.

The largest number of births reside in the New Plymouth district 65% (982 in 2015), where as 410 (27%) were identified from the South Taranaki region, interestingly only 89 (21%) of these birthed in the local primary maternity unit.

120 (7.8%) women from the Stratford region birthed in 2015, these women birthed either at home, in the primary

unit in Hawera hospital or at Taranaki Base Hospital, not all of these women would have been suitable to birth in a primary maternity unit or at home.

A total of 55 (3.6%) women had a homebirth in Taranaki and 51 (3.4%) women from a Taranaki domicile birthed outside of Taranaki which could include a tertiary unit or neighboring DHB.

603 births were from decile >8 which is equal to 40% of the total births in Taranaki.

Demography of women living in Taranaki who birthed in 2014, regardless of DHB of birth

Source: MOH - National Maternity Collection (MAT)

Maternal Age	Number	%
<20	83	5.5%
20-24	313	20.7%
25-29	457	30.2%
30-34	420	27.8%
35-39	191	12.6%
40-44	45	3.0%
45-49	3	0.2%
	1,512	100.0%

Territorial Local Authority (TLA)	Number	%
New Plymouth	982	64.9%
South Taranaki	410	27.1%
Stratford	120	7.9%
	1,512	100.0%

Place of Birth (baby)	Number	%
Taranaki (excl homebirths)	1,399	92.5%
Homebirths	55	3.6%
Outside Taranaki	51	3.4%
Unidentified	7	0.5%
Taranaki Total	1,512	100.0%

Ethnicity	Number	%
European	987	65.3%
Māori	391	25.9%
Asian	81	5.4%
Pacific Peoples	35	2.3%
Middle Eastern/Latin American/African (MELAA)	18	1.2%
	1,512	100.0%

Distinct number of Pregnancies	Year of Delivery					
Delivery Outcome	2009	2010	2011	2012	2013	2014
Other multiple births (liveborn)		2		1		
Single live birth	1,599	1,546	1,528	1,519	1,482	1,480
Single stillbirth	11	17	11	6	10	11
Twins (live and stillborn)		2	1		3	1
Twins (liveborn)	16	19	23	30	20	20
Twins (stillborn)					1	
Grand Total	1,626	1,586	1,563	1,556	1,516	1,512

Taranaki birthing demography in comparison to the rest of New Zealand:

- Slightly younger than in New Zealand overall.
- Less often Pacific.
- More often European.
- More often of average socio economic status opposed to extreme high or low deprivation.

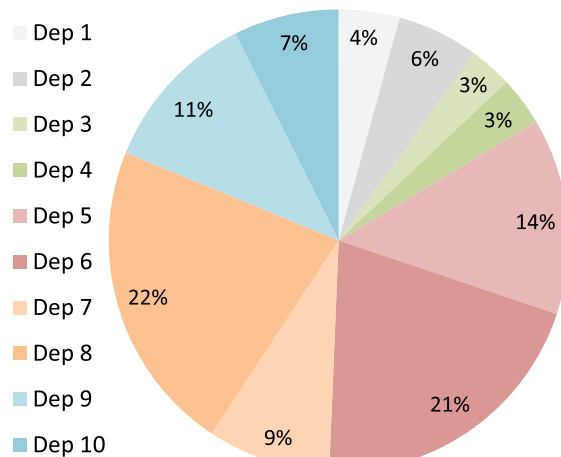
Place of Birth (baby)	2009	2010	2011	2012	2013	2014
Taranaki (excl homebirths)	1,503	1,484	1,468	1,466	1,416	1,399
Homebirths	71	64	50	42	49	55
Outside Taranaki	44	34	29	42	38	51
Unidentified	11	7	17	7	17	11
Taranaki Total	1,629	1,589	1,564	1,557	1,520	1,516

Place of residence	Number	%	Decile
New Plymouth			
Barrett	19	1.3%	1
Bell Block	92	6.1%	5
Bowden	6	0.4%	3
Carrington	4	0.3%	1
Egmont Village	7	0.5%	2
Fernleigh	3	0.2%	1
Fitzroy	31	2.1%	5
Frankleigh	65	4.3%	6
Glen Avon	9	0.6%	4
Highlands Park	20	1.3%	1
Inglewood	49	3.2%	6
Kaimata	19	1.3%	3
Kaitake	25	1.7%	2
Kawaroa	23	1.5%	7
Lepperton	37	2.4%	2
Lynmouth	34	2.2%	8
Mangaoraka	9	0.6%	2
Marfell	42	2.8%	10
Marsland Hill	19	1.3%	7
Merrilands	36	2.4%	6
Moturoa	42	2.8%	9
Mount Bryan	11	0.7%	6
New Plymouth Central	54	3.6%	7
Oakura	19	1.3%	1
Okato	21	1.4%	6
Okoki - Okau	16	1.1%	5
Omata	4	0.3%	2
Paraite	2	0.1%	4
Spotswood	26	1.7%	7
Struan Park	60	4.0%	6
Upper Westown	13	0.9%	3
Urenui	5	0.3%	7
Waitara East	42	2.8%	9
Waitara West	51	3.4%	10
Welbourn	12	0.8%	6
Westown	55	3.6%	8
New Plymouth Total	982	64.9%	
South Taranaki			
Eltham	38	2.5%	9
Hawera North	41	2.7%	8
Hawera South	110	7.3%	8
Hawera West	5	0.3%	2
Kahui	37	2.4%	5

Place of residence	Number	%	Decile
Kaponga	10	0.7%	9
Kapuni	20	1.3%	5
Makakaho	11	0.7%	6
Manaia	15	1.0%	9
Mangatoki - Moeroa	11	0.7%	5
Normanby	16	1.1%	6
Ohangai	4	0.3%	4
Ohawe Beach	5	0.3%	6
Okaiawa	7	0.5%	6
Opunake	15	1.0%	9
Patea	19	1.3%	10
Rahotu	4	0.3%	7
Tawhiti	7	0.5%	3
Waingongoro	8	0.5%	4
Waitotara	1	0.1%	8
Waverley	11	0.7%	9
Whenuakura	15	1.0%	6
South Taranaki Total	410	27.1%	
Stratford			
Douglas	7	0.5%	4
Midhurst	3	0.2%	6
Pembroke	12	0.8%	4
Stratford East	22	1.5%	8
Stratford West	65	4.3%	8
Toko	10	0.7%	4
Whangamomona	1	0.1%	8
Stratford Total	120	7.9%	
Grand Total	1,512	100.0%	

Breakdown of deprivation decile for mothers who gave birth in 2014

(Depn decile sourced Census 2013, Statistics NZ)



MATERNITY SERVICES IN TARANAKI



BASE HOSPITAL

PRIMARY & SECONDARY MATERNITY UNIT

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 private obstetrician LMC (labour and birth)
Newborn hearing screening
Level 2A neonatal services

ANTENATAL CLINIC

Outpatient specialist consultation clinics
Secondary antenatal team clinics
Secondary midwife clinics
Fetal Day assessment
Amniocentesis



DELIVERY AND ANTENATAL WARD

1 pregnancy loss room
"The Willow Suite"

5 primary and secondary birthing rooms

7 antenatal single rooms

1 birthing pool room



POST NATAL WARD

19 beds which include boarder mother facilities

LEVEL 2A NEONATAL UNIT



6 cots

2 intensive care cots



HAWERA HOSPITAL

PRIMARY MATERNITY UNIT

Normal delivery
Inpatient primary postnatal care
Outpatient specialist consultation and secondary clinic
Orthopaedic hip checks
Lactation consultant services
Newborn hearing screening
Homebirth is offered by Lead Maternity Carers in Taranaki

1 birthing room

4 postnatal beds

All Maternity Staff

We have...

6 REGISTERED
NURSES

42 Midwives

**1 Associate Director
of Midwifery**

2 SENIOR
HOUSE
OFFICERS

1 Post Natal Coordinator

1 LACTATION
STATE CERTIFIED
NURSE

**1 Antenatal
Clinic Coordinator**

3 OBSTETRICIAN/
GYNAECOLOGISTS

1 Head of Department O&G

8 PAEDIATRICIANS

2 Medical Officers O&G

1 CLINICAL MIDWIFE
EDUCATOR

5 Healthcare Assistants

*2 Ward Administrators
1 Clinical Midwife Manager*

1 Midwifery New Graduate

*1 ENROLLED
NURSE*

2 Registrar O&G

ALL MATERNITY STAFF

O&G = Obstetrician/Gynaecologist

SUMMARY OF THE AIMS AND OBJECTIVES OF THE MATERNITY QUALITY & SAFETY PROGRAMME (MQSP) IN 2015/16

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 (MDT) meetings including access holders.
- 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.
- 9.4 The proportion of women with additional health and social needs receive continuity of midwifery care.
- 10.1 Clinical audit demonstrates effective communication among maternity providers.
- 10.2 The number of sentinel and serious events in which poor communication is identified is monitored and decreases over time.
- 11.1 National evidence informed clinical guidelines are implemented. (National PPH and observation of the mother and newborn implemented, working forwards with implementation of the GDM guidelines).
- 21.1 100% maternity service specifications are implemented in each funded DHB-funded maternity service.

STANDARD TWO:

Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage

- 16.1 Taranaki DHB provides access to pregnancy, childbirth and parenting information and education services.

- 17.2 Demonstrate in the annual maternity report how Taranaki DHB have responded to consumer feedback on whether services are culturally safe and appropriate.
- 18.1
- 18.2 Consumer feedback demonstrates that consumers consider the services to be culturally safe and appropriate. Taranaki DHB to report on how they have responded to consumer feedback.
- 19.1
- 19.2 Taranaki DHB provides information about local maternity facilities and services and facilitates women's contact with Lead Maternity Carers (LMC) and primary care. Taranaki DHB report on the proportion of women accessing continuity of care from an 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

- 22.1 Local services are consistent with the national and regional plans and are accessible and appropriate for the local population.
- 23.1 Clinical audit demonstrates women and babies have access to levels of care that are clinically indicated.
- 24.1 Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility (reported in 2012/13 annual report).
- 24.2 Clinical audit demonstrates effective linkages between services.
- 25.1 Report on local and regional maternity and neonatal emergency response plans.
- 25.3 Clinical audit demonstrates effective communication among maternity providers in cases of clinical emergency.
- 26.1 Taranaki DHB provide a model of continuity of midwifery and obstetric care when secondary services are responsible for the woman's care.
- 26.2 Consumer feedback shows that women requiring secondary level care are satisfied with the continuity of midwifery and obstetric care received.

MQSP GOVERNANCE AND OPERATIONS

The Maternity Quality & Safety Programme (MQSP) Governance Group is known as the Maternity Quality Committee (MQC) and is chaired by the Associate Director of Midwifery (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
- The Universal Newborn Hearing Screening Programme

An example of priorities for the MQC is to review, monitor and recommend improvements for:

- Actions and themes arising from adverse events submitted to the Serious & Sentinel Events Committee (SSEC), Reportable Events Committee (REC) and the Perinatal Mortality & Morbidity reviews
- Clinical Indicator Reviews
- Actions and themes arising from complaints submitted to Customer Services and the REC
- The National MQSP
- The National Maternity Standards
- Maternity service specifications
- Actions and themes arising from Newborn Hearing Screening audits
- Overseeing quality improvement, quality assurance and risk management activities within the maternity services and Newborn Hearing Screening.
- 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.

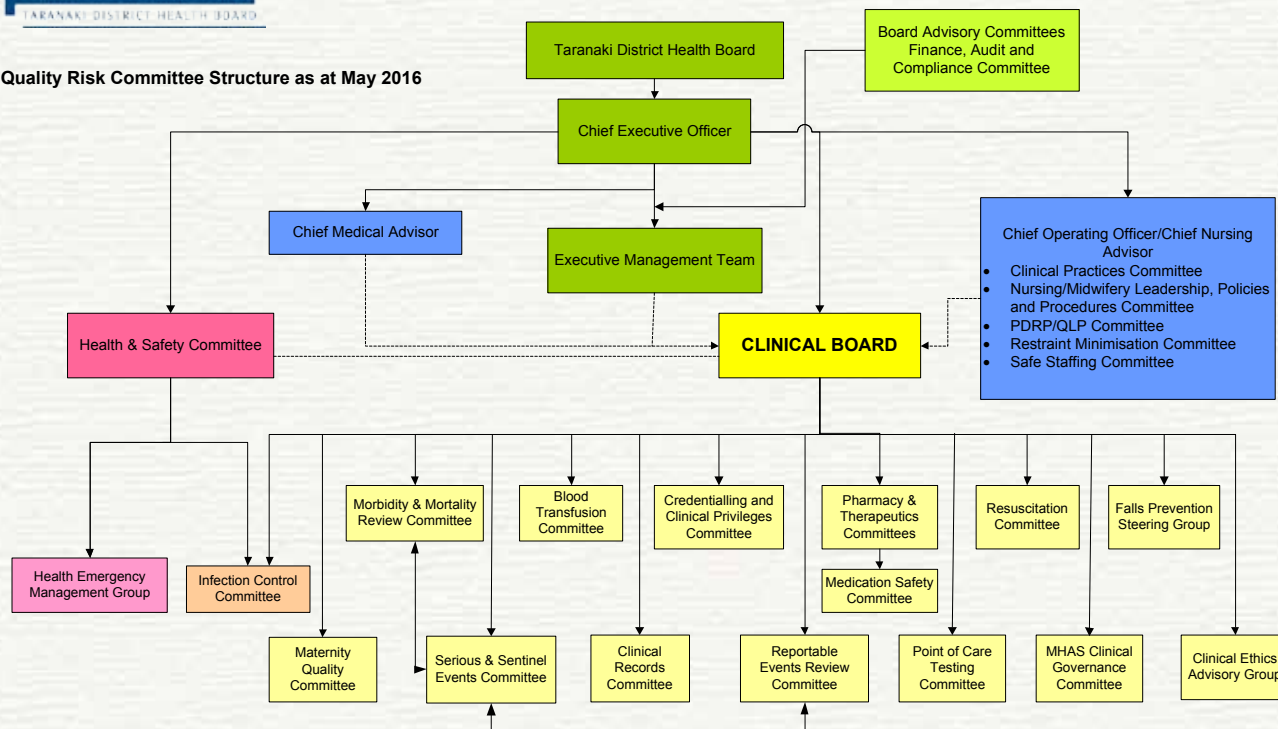
- To report these activities to the Taranaki DHB Clinical Board.

- To manage obstetric clinical risk.

Membership consists of:

- Clinical Directors or their representative: Obstetrics & Gynaecology and Paediatrics
- ADOM
- Clinical Midwifery Manager (CMM)
- Four stakeholders:
 - › Clinical Nurse Manager, Neonatal Unit
 - › Maternal & Child Health Social Worker
 - › Maternal Mental Health Intake Coordinator
 - › Clinical Nurse Specialist (CNS) - Infection Control & Quality and Risk
- Clinical Services Manager for Maternal & Child Health (CSM, M&CH)
- Quality and risk advisor
- Midwife Educator (ME)/Quality Risk delegate
- Two LMC representatives
 - › Rural
 - › Urban
- Māori Health representative
- Consumer representatives (one and currently recruiting a second)
- Core midwife/New Zealand College of Midwives (NZCOM) representative
- Planning & Funding Maternity Portfolio Manager representative.

Quality Risk Committee Structure as at May 2016



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 SSEC and REC, and the Perinatal Mortality & Morbidity reviews
- Clinical Indicator Reviews
- Actions and themes arising from complaints submitted to Customer Services and the REC
- The National MQSP
- The National Maternity Standards
- Maternity Service Specifications
- The National Perinatal & Maternal Mortality Review Committee.

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 CSM, M&CH and CMM or other relevant units:

- The activities/minutes are submitted monthly to the Chief Operating Officer/Chief Nursing Advisor and Quality & 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 formal contract with Taranaki DHB and has signed an agreement of confidentiality and the Taranaki DHB Code of Conduct. She has completed Taranaki DHB training in confidentiality and consumer service and is remunerated for her attendance at meetings.

The consumer 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 Léche League. The committee is currently recruiting a second consumer who identifies as Māori ethnicity following the resignation of our new consumer who started in December 2015.

Community Practitioner Representation on Taranaki MQC MQSP

Please see membership above for stakeholder and LMC representation.

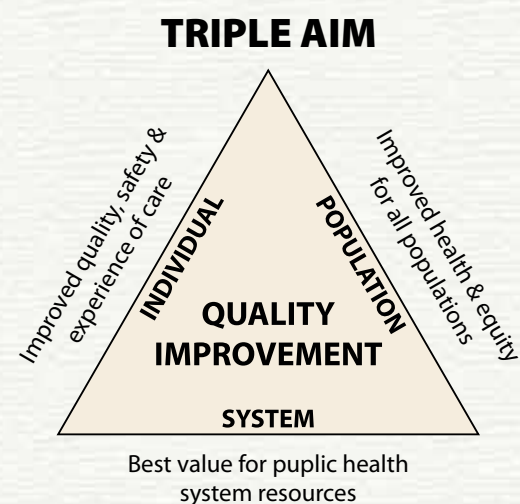
A newsletter is circulated electronically to GPs and stakeholders to update on Maternity Quality news, progress and data.

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

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

What has the MQSP funding been utilised for:

- Staffing and coordinating MQC project
- Consumer and LMC attendance and projects
- Early engagement with an LMC marketing; designing and formation of an electronic advert aimed at women who identify as Māori
- Staffing trial; planning and implementation
- Continuity of care to mothers and babies undergoing caesarean section project
- Improving the birthing environments in Taranaki Base Hospital and Hawera Maternity
- Carbon Monoxide (CO) Monitors
- Maternity consumer roadshow and maternity GP practice roadshow



Who does MQC link with locally?

MQC and Taranaki DHB consider our local and national population when reviewing or considering changes and quality improvements by building on the guiding principles of the NZ Health Strategy and the five themes below:



Taranaki DHB MQC has links with other teams within the DHB but also stakeholders who are linked to the project. Taranaki DHB work is on going with the aim to align with the triple aim. The MQC have continued to update and circulate the pre and post pregnancy support services directory to update service providers on the support services that are available around Taranaki, including how and who to refer to.

- Paediatric and neonatal services
- Newborn hearing
- Perinatal mental health, alcohol and drug and maternity social worker services
- Family Violence Intervention Programme
- Child Protection, Child Youth & Family (CYFS) through the Maternal and Child Wellbeing Multidisciplinary Advisory Group and paediatric liaison meetings
- Pregnancy ultrasound services in the community and the DHB
- Taranaki Immunisation Strategy Group
- Māori Health Services
- Communications and information technology services
- Better help to stop smoking/smoking cessation providers including Taranaki smoking coalition alliance
- Breast feeding groups through the Baby Friendly Community Initiative; support/welcome here/health promotion/community groups/ Tiaki Ūkaipō Governance Group (TUGG) - focusing on physical activity, healthy nutrition and breast feeding through the Mama Pepe Hauora programme
- Child Health Service Level Alliance Team (SLAT), Child Health Improvement Project (NCHIP) newborn enrolment, National Immunisation register, GP and WCTO, oral health registration, Primary Health Organisation.
- New Zealand College of Midwives alliancing project
- Diabetic educator and dietician teams
- Quality and Risk, including Datix reporting, protocol and procedures
- Well Child (WCTO) providers eg Tui Ora and Plunket.



WORKFORCE AND STAFFING

The midwifery and medical workforce has been stable over the last year. Taranaki DHB have managed to fill the temporary registered nurse (RN) positions with registered midwives (RM). The RN's were recruited temporarily as we were unable to fill the positions with midwives, this has been a recurring theme each year, however we are currently fully staffed with all permanent midwifery positions appointed to.

Midwives

There has been an increase in our younger Māori midwifery workforce.

There has been a reduction in the percentage of midwives over 55 years of age however Taranaki DHB are aware of the number of midwives who will be nearing possible retirement and are working together with the Auckland University of Technology (AUT) satellite midwifery training programme to try and predict and balance how many midwives that are accepted for training to ensure we have sufficient midwives but not too many that we are unable to employ or sustain positions for them either in the hospital or the community.

Midwives employed now have a contract that covers both base maternity and Hawera primary maternity units so that in times of sickness or shortages midwives can be deployed to either area to cover, reducing the fragility of services.

The Voluntary bonding scheme is available to midwives in the Taranaki region and has attracted midwives to train and move to Taranaki. Additionally Taranaki DHB offer a one year new graduate midwifery position.

Access Agreement Holders:

There are currently 60 access holders however approximately 34 of these advertise Lead Maternity Carer (LMC) services (both doctors and midwives) with the remainder identifying as locum midwives or midwives who carry a very small caseload and do not advertise their services. There does not appear to be a shortage of LMCs in Taranaki as there have been no reported cases where the

secondary services have provided services as "provider as last resort" to women that are unable to access an LMC.

Core Midwifery Services For Private Obstetrician

Taranaki DHB continue to provide core midwifery services for labour and birth only to one private obstetrician and one primary GP obstetrician. This can create unpredictable workloads for the midwives in both the community and base maternity hospital birthing suites.

Education of Staff and Quality Leadership Programme (QLP)

The sharing of education templates and programmes with the other Midland DHB's has continued with the midwifery leaders, midwife educators and health share Midland Maternity Action Group (MMAG) coordinator working together to improve, access, equity, efficiency and quality of education programmes. A copy of the maternity education calendar can be found in Appendix 4.

Taranaki DHB has coordinated and worked with the Midland DHB's to develop the regional draft QLP workbooks, guideline and processes for application and assessment.

Health Care Assistant (HCA) Role in Maternity Review

The HCA role in maternity has been reviewed in the past 12 months, with the objective of enhancing the effectiveness and efficiency of the service as a whole. It was deemed important to ensure that the HCAs were utilised to assist midwifery and nursing staff to their full potential and within their scope of practice rather than just for housekeeping duties. The objective was to match skills to

tasks and increase the practice for HCAs to better support the midwife and registered nursing team in maternity.

HCAs were supported to undergo additional training to assist midwifery and nursing staff to provide delegated patient care duties such as bathing, bed bathing assisting woman to the toilet or mobilisation as well as food service duties. With a result in the freeing of midwifery and nursing staff time to provide quality care.

A trial was run in maternity for three months. A survey was put out to staff to gauge staff feedback on the reviewed HCA role.

The results were:

1. 88.3% of feedback stated that they felt that the HCAs were more integrated into the maternity team over the last three months;
2. 88.3% of feedback said that they felt they were mostly or always able to obtain support from the HCAs across a broader range of tasks;
3. 76.5 % said that there was mostly or always more team work in the unit now;
4. 58.8% of staff responded that they would support HCAs receiving additional training in attending emergency bells, Trendcare, involving them in handover, blood pressure recordings using a Dinamap and breastfeeding education.

Maternity Staffing Trial

Maternity staff were reporting an increase in acuity and difficulty in meeting the peaks and troughs of the service demands. A working group was set up including representatives from MERAS, NZNO core midwives, neonatal unit (NNU), midwifery leader and DHB management. One of the difficulties of staffing the maternity unit is that the antenatal and delivery suite is separate from the post natal ward and again the NNU is also separate from the other two wards, all requiring a minimum base of two staff members on each shift.

Meetings occurred fortnightly to discuss staffing issues, increasing acuity of labour and postnatal wards, recruitment and how these issues were influencing workload within the unit. Discussions focused on how best to manage these to ensure safe patient care with staffing levels that support the peaks and troughs of patient volumes and acuity on the ward.

Approval was gained to trial for a six month period an additional staff member on night shift, Wednesday to Sunday following the examination of local data in relation to staffing and acuity:

Data showed that:

- 49% of shifts staff were being asked to work over and above their employed FTE.
- Casual or pool staff were called to work as the third

member of staff, or the on-call staff member was called in to work.

- Between 20% and 80% of this time, the third staff member was required to work afternoon or night shift.
- The third staff member was required due to the increased volumes of patients or increased acuity of patients on the ward.

Acuity:

In the past 12 months admissions to ICU and HDU have increased, also our caesarean section rate is currently 27% (for all births); nationally the caesarean section rate is 25%. The national target is 15% for first time mothers, Taranaki base hospitals rate is 21.4% (the third highest in New Zealand).

Below is a summary of agreed initiatives that we hope will better support staffing the maternity and NNU.

- The Base Maternity Unit (BMU)/NNU trial commenced in April 2016 for a six month period.
- The appointment of a registered midwife to work the Wednesday to Sunday night shift to work across the Labour Ward, Postnatal Ward and NNU. Orientation to support this will occurred prior to commencement.
- It is expected that both RMs and RNs are appointed to the maternity/child health unit and that registered nurses in the units are flexible to work across other areas in the hospital when and if required for this to be successful.
- It is expected that on the night shift where a third staff member is rostered, a midwife or NNU nurse will attend all caesarean sections to care for the mother and provide newborn life support if required and remains with them until they are returned to the ward to improve the quality and safety of mothers and babies at caesarean section and in the post operative recovery area.
- There is no longer an on-call system in place for BMU for the trial night shifts where a third person is rostered on.
- On-call is still required on afternoons and for morning shifts over the weekend throughout the trial period.
- In addition the swing shift, when rostered, commences at 1000hrs to better support cover for dinner breaks. On-call therefore commences at 1830 to 2245hrs on the afternoon shift Wednesday to Sunday.
- The Duty Manager works with staff to co-ordinate staff allocation.
- Weekly meetings to monitor and discuss how the trial is progressing are underway to facilitate evaluation of the trial and to agree any actions that may be required

This trial will work best if there is a team approach to staffing the areas, working as a supportive and well-functioning team that assists each other in their respective roles and include a focus on continuity of care.

Table 1: Age of Midwife Workforce

Age Grouping	2016 Headcount				2015 Headcount			
	Non Māori	Māori	Total	Dist	Non Māori	Māori	Total	Dist
26-35	7	4	11	26%	5	3	8	20%
36-45	7	2	9	21%	7	2	9	23%
46-55	11	3	14	33%	12	3	15	38%
56-65	6	1	7	17%	8	0	8	20%
65+	1	0	1	2%	0	0	0	0%
Total	32	10	42	100%	32	8	40	100%

Table 2: FTE and Age Statistics of Midwife Workforce

Unit name	Headcount		Total FTE*		Average Age		Min Age		Max Age	
	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
Base Maternity	32	29	22.1	20.5	46	45	29	28	62	61
Hawera Maternity Service	4	5	2.7	2.2	54	51	46	42	59	58
Pool/Casual Staff	6	6	0	0	44	54	32	42	66	65
Total	42	40	24.8	22.7						

*FTE is only for Primary position, does not include additional positions

Table 3: Age of Maternity Workforce

Age Grouping	2016 Headcount				2015 Headcount			
	Non Māori	Māori	Total	Dist	Non Māori	Māori	Total	Dist
26-35	12	4	16	24%	10	3	13	20%
36-45	9	2	11	16%	8	2	10	15%
46-55	17	4	21	31%	19	4	23	35%
56-65	15	1	16	25%	20		20	30%
65+	2		2	3%			0	0%
Total	55	11	66	100%	57	9	66	100%

Table 4: Age Statistics of Maternity Workforce

Unit name	Headcount		Total FTE		Average Age		Min Age		Max Age	
	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
Base Hospital	54	52	40.6	38.9	48	48	28	28	66	65
Hawera Maternity Service	6	8	4.0	3.4	57	55	46	42	67	66
Pool/Casual Staff	6	6	0.0	0.0	44	54	32	42	66	65
Total	66	66	44.6	42.3						

PERFORMANCE AGAINST THE CLINICAL INDICATORS

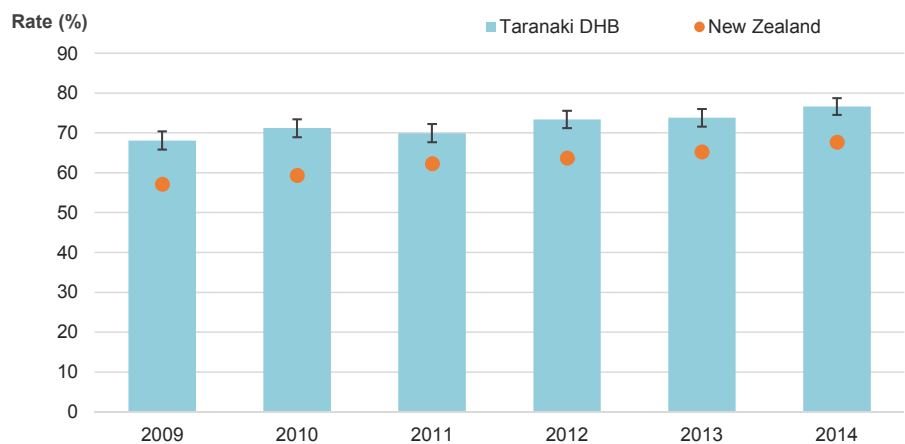
Taranaki DHB have analysed the clinical indicators provided by the MoH and data obtained by local and regional data analysts. Areas for improvement in practices and outcomes, as well as areas that we excel in, are identified.

It is disappointing to see the decline in spontaneous vaginal births and the increase in instrumental and caesarean birth rates. Case review and examination of out of hours caesarean section births suggests there could be a benefit to having a senior midwife coordinator with excellent labour management skills on duty out of hours. This may provide support and clinical coordination to midwives and senior medical officers and may have a positive impact on clinical outcomes and relationships.

Indicator 1: Registration with an LMC in the First Trimester of Pregnancy

STRENGTH: Taranaki has increased in rates over the last four years - 98% of women are registered under an LMC. The national rate has increased to 67.7%. Taranaki Base has a rate of 76.7% and overall Taranaki has a rate of 73.7 in 2013 and 73.4% in 2012.

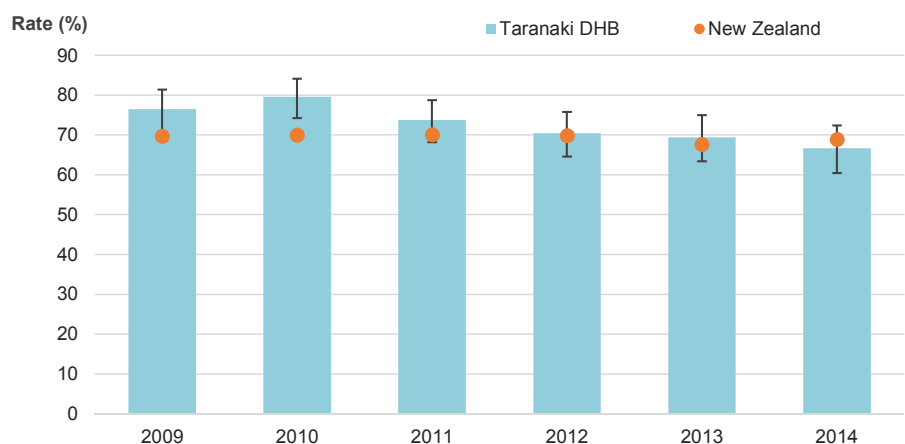
Indicator 1: Registration with an LMC in the First Trimester of Pregnancy



Indicator 2: Spontaneous Vaginal Birth

Decreasing INVESTIGATE: Taranaki's rate is declining and has a rate of 66.7% in 2014, 69.3% in 2013, 70.2% in 2012, 73.5% in 2011, 79.1% in 2010, and 76.6% in 2009; it is now sitting just below the NZ average of 68.9%, which has also seen a downward trend. Taranaki DHB continue to review all caesarean section cases to try and identify any trends or areas to target to try to improve our spontaneous vaginal birth rate in the standard primiparae. A caesarean section audit looking at cases where failure to progress and non reassuring CTG were identified as being the reason for caesarean section is evaluated in the audit section of this report.

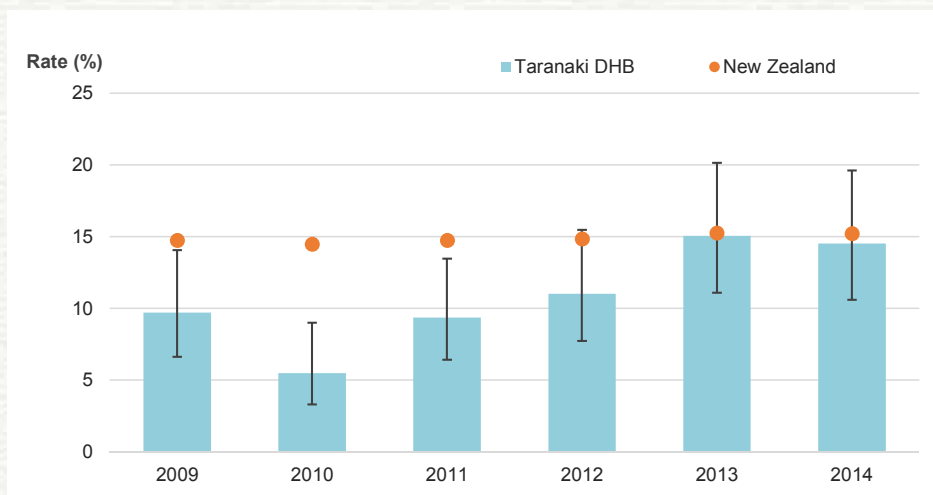
Indicator 2: Spontaneous Vaginal Birth



Indicator 3: Instrumental Vaginal Birth

Increased: Taranaki has an overall rate of 14.5% in 2014, 15.1% in 2013, 11.1% in 2012, 9.1% in 2011, 5.6% in 2010, and 8.8% in 2009; only just below the national average of 15.2%. However Taranaki Base hospital has an increased rate of 16.4%, the national average being 15.2%. Findings from case review sessions has identified that education on indications to commence active management of labour should be a focus in 2016/17.

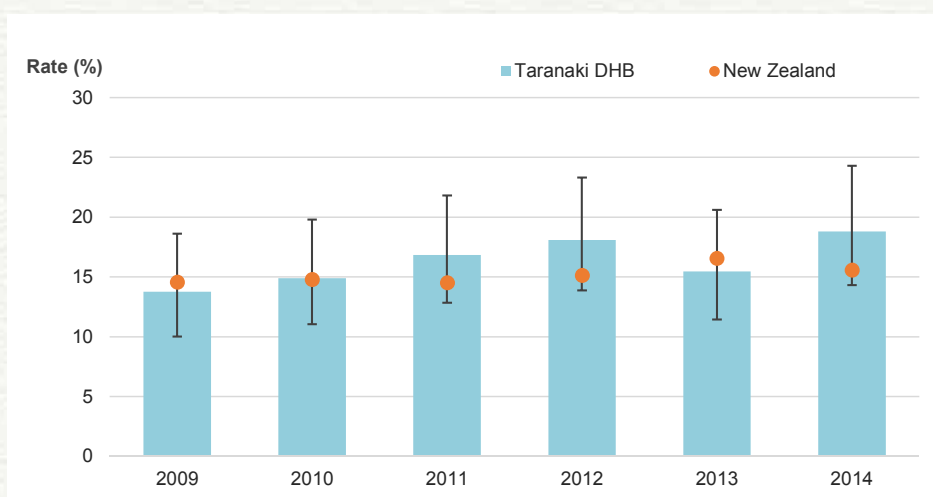
Indicator 3: Instrumental Vaginal Birth



Indicator 4: Caesarean Section among Primiparae

Increased: Taranaki has increased to 18.8% in 2014 up from 15.5% in 2013, however Taranaki base hospital rate has had a significant increase to 21.4% from 18% in 2013 and from 18.3% in 2012, 17.4% in 2011, 15.3% in 2010 up from 14.6% in 2009 against the national trend of an increase to 15.6%. With the Maternity Obstetric outcomes and case review protocol and meetings to review all cases we are hoping to have an impact on reducing this rate by the time the 2015 Clinical Indicators are published.

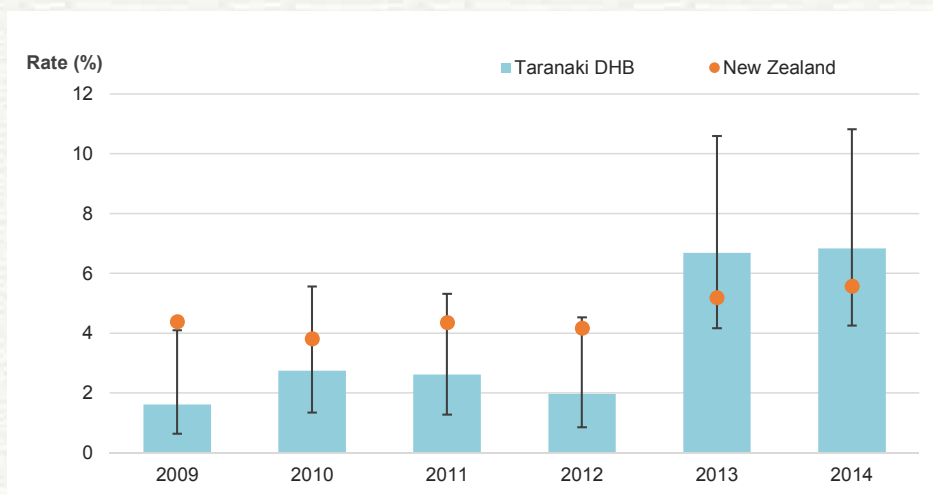
Indicator 4: Caesarean Section among Primiparae



Indicator 5: Induction of Labour among Primiparae

INVESTIGATE: Taranaki has a significantly increased rate of 6.8% in 2014, 6.7% in 2013, with Taranaki Base hospital having a rate of 8%, up from 7.8% in 2013 increased from 2% in 2012, 3.1% in 2011, 3.4% in 2010, and 2.9% in 2009 and above the rising national rate of 5.6%. It is proposed this is audited in the 2016/17 year.

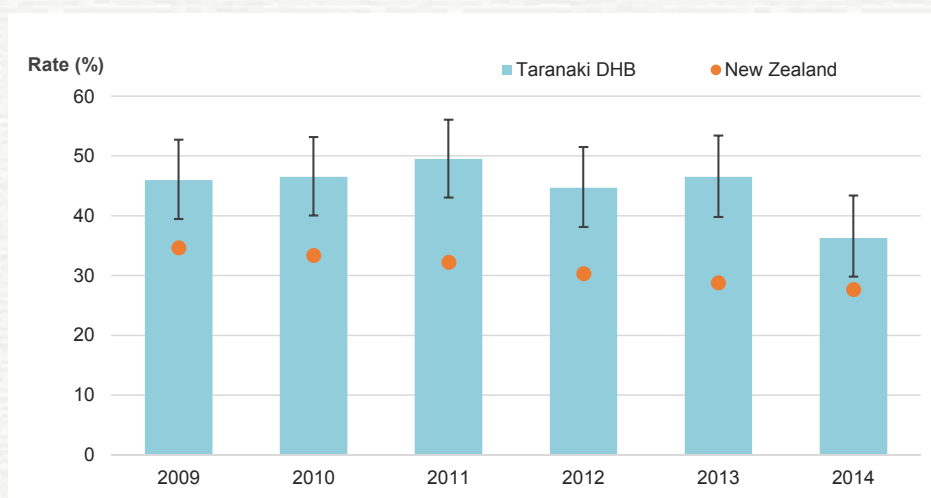
Indicator 5: Induction of Labour among Primiparae



Indicator 6: Intact Lower Genital Tract - Vaginal Birth

Decreasing: Taranaki has decreasing rates of Intact genital rates; 36.3% in 2014, 46.3% (Taranaki base is 29.1% down from 41.4% in 2013) in 2013, 45.1% in 2012, 50.2% in 2011, 46.7% and 46.6% in 2009, 2010 against the average 27.7%.

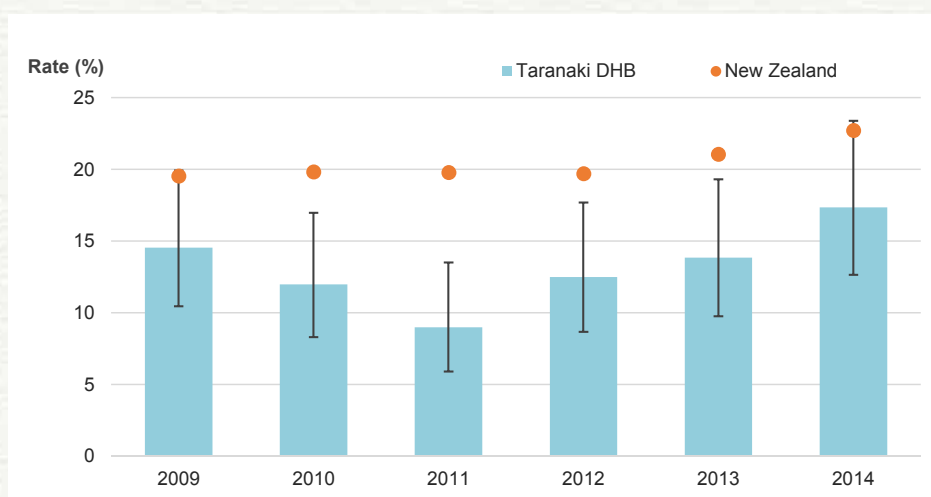
Indicator 6: Intact Lower Genital Tract - Vaginal Birth



Indicator 7: Episiotomy and No 3rd or 4th Degree Tear

STRENGTH: Taranaki has increasing rates of 17.4% in 2014, up from 13.9% (Taranaki Base rate is 15.4%) in 2013, 12.6% in 2012, 8.4% in 2011 which is well below the national average of 22.7%.

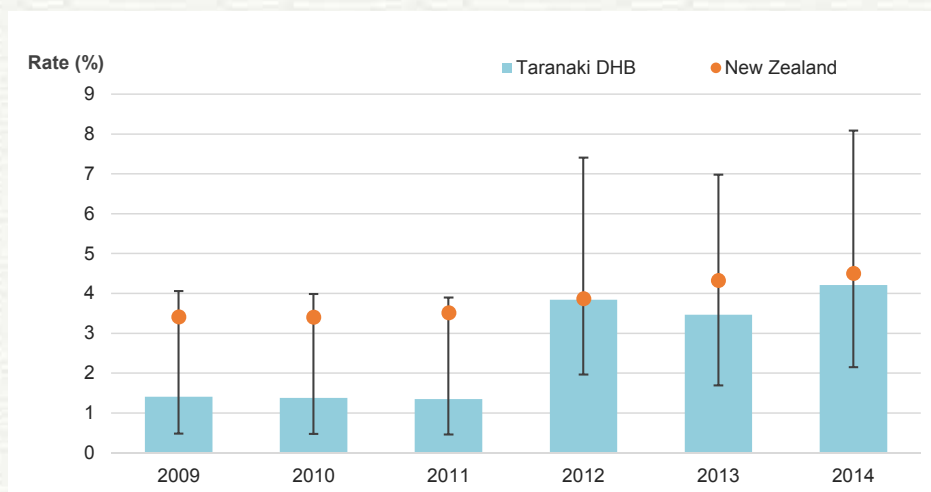
Indicator 7: Episiotomy and No 3rd or 4th Degree Tear



Indicator 8: 3rd or 4th Degree Tear Sustained with No Episiotomy

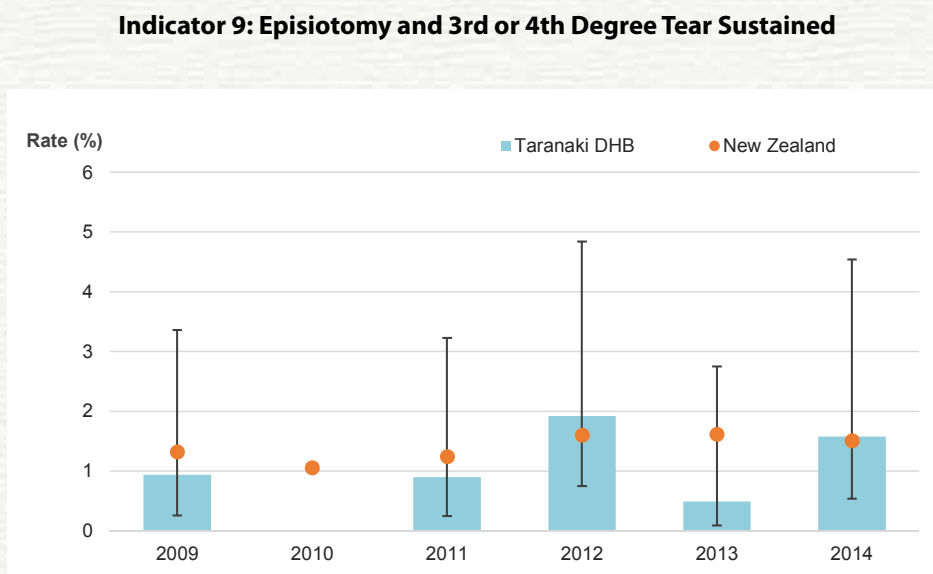
STRENGTH: Taranaki has a rate of 4.2% in 2014, up from 3.5% (Taranaki Base 4.4, up from 4.1% in 2013) in 2013, 2.4% in 2012, 1.3% in 2011, national average is 4.5%. Numbers are low so confidence is low

Indicator 8: 3rd or 4th Degree Tear Sustained with No Episiotomy



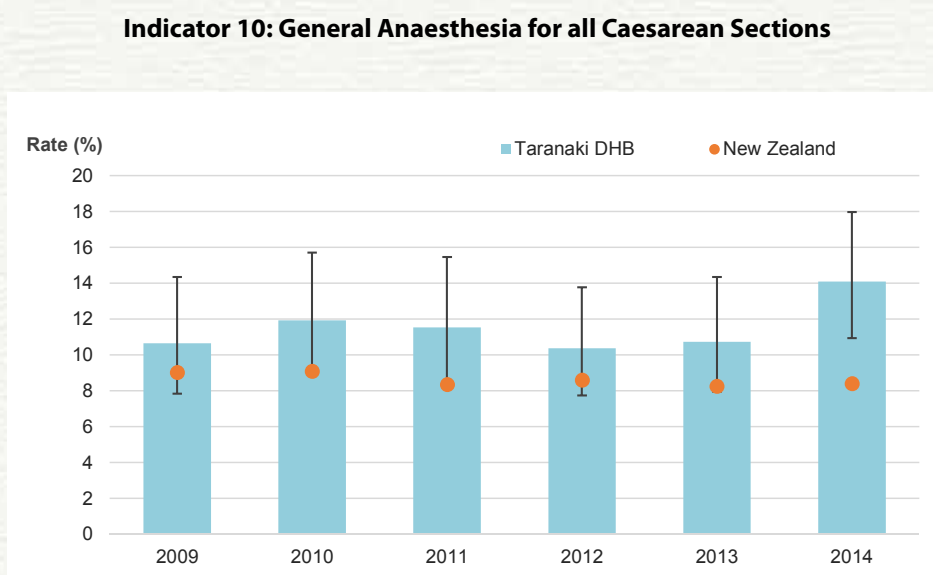
Indicator 9: Episiotomy and 3rd or 4th Degree Tear Sustained

Taranaki has a rate of 1.6% in 2014, up from 0.5% (1.3% up from 0.6% in 2013 in Taranaki Base) in 2013, 1.9% in 2012, 0.6% in 2011, 0% in 2010, and 0.9% in 2009; above the national average of 1.5%. Numbers are very small to have confidence in these figures but will be highlighted to the practitioners.



Indicator 10: General Anaesthesia for all Caesarean Sections

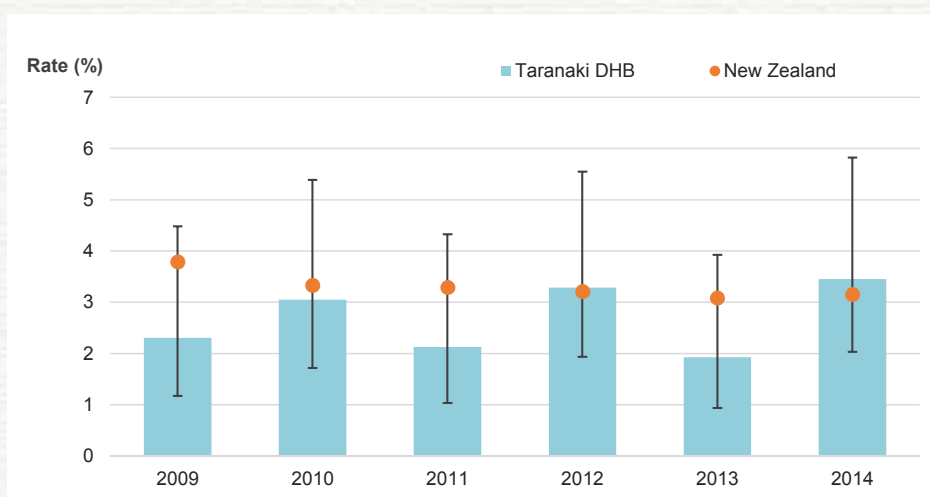
INCREASED: Taranaki has an increased rate of 14.1% in 2014 up from 10.7% (Taranaki Base is 14.2%) in 2013, 10.4% in 2012, 11.6% in 2011, 11.9% in 2010 and 10.7% in 2009 which is above the declined national average of 8.4%. The general operating theatres which are used for caesarean section are a considerable 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 significantly. However audits have been undertaken by the anaesthetic team and a portable CTG monitor and delivery beds with battery backup have been introduced as a quality improvement to try and reduce these rates, these did seem to have an impact the years following but the rate has increased again. This could be due to the increased distance between maternity and the operating theatre since the new Acute Services Building (ASB) was erected which now houses the operating theatres.



Indicator 11: Postpartum Haemorrhage (PPH) Blood Transfusion after Caesarean Section Birth

INCREASED: Taranaki has an increased rate of 3.5% in 2014, up from 1.9% (Taranaki Base up to 3.3% from 2% in 2013), 3% in 2012, 2.1% in 2011, 2.8% in 2010, and 2.3% in 2009, around the national average of 3.2%. Numbers are low to be able to have confidence in these rates however PPH has been audited in 2015/16, results are in the audit section of this report.

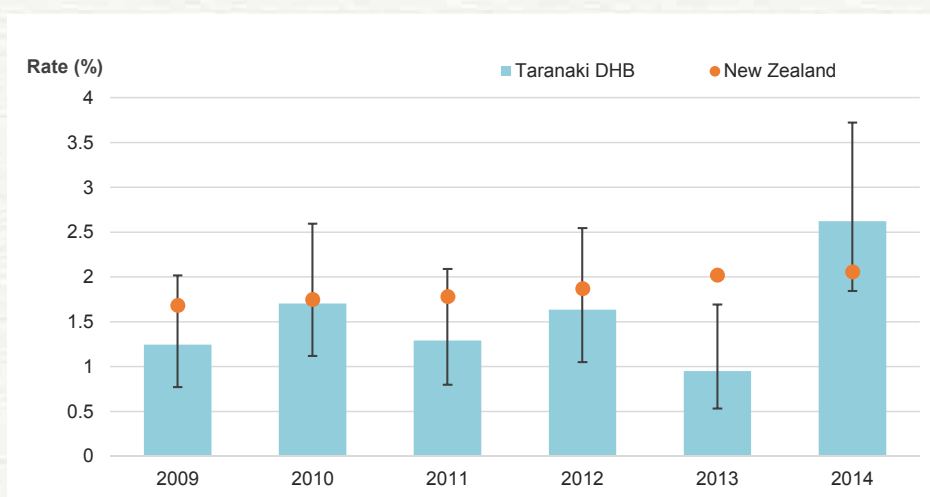
Indicator 11: Postpartum Haemorrhage (PPH) Blood Transfusion after Caesarean Section Birth



Indicator 12: PPH and Blood Transfusion after Vaginal Birth

INCREASED: Taranaki has an increased rate of 2.6% in 2014, up from 0.9% in 2013 (Taranaki base 3% up from 0.8% in 2013), 1.4% in 2012, 1% in 2011, 1.7% in 2010, up from 1% in 2009, around the 2.1% national average.

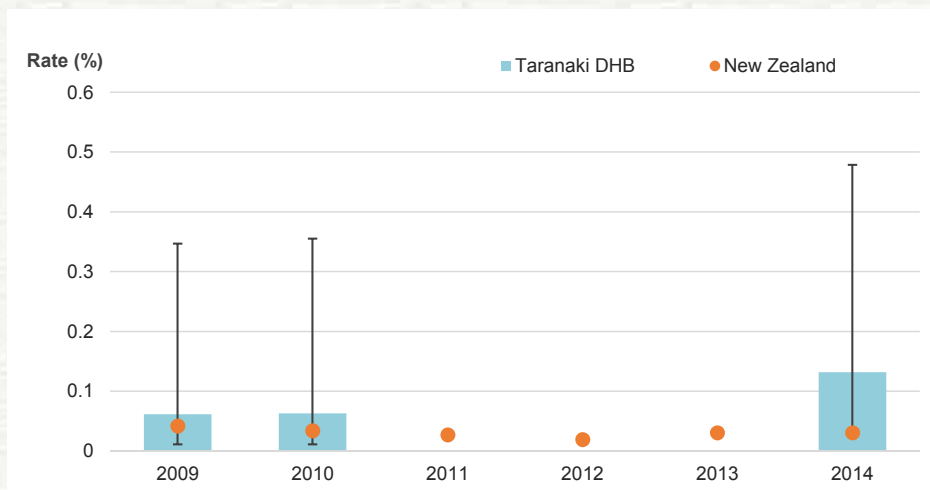
Indicator 12: PPH and Blood Transfusion after Vaginal Birth



Indicator 13: Diagnosis of Eclampsia at Birth Admission

Taranaki had 2 cases in 2014 whereas no cases were reported in 2013.

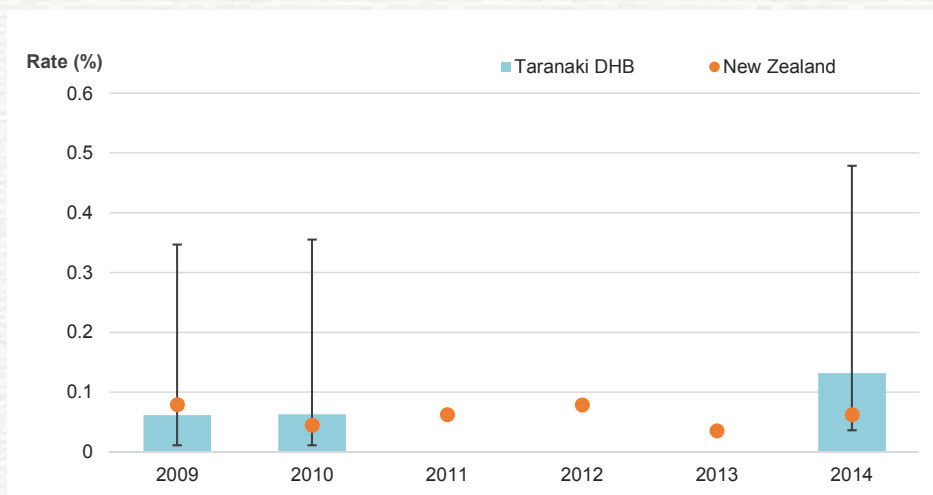
Indicator 13: Diagnosis of Eclampsia at Birth Admission



Indicator 14: Peripartum Hysterectomy

Taranaki had 2 reported cases in 2014 whereas no cases were reported 2013

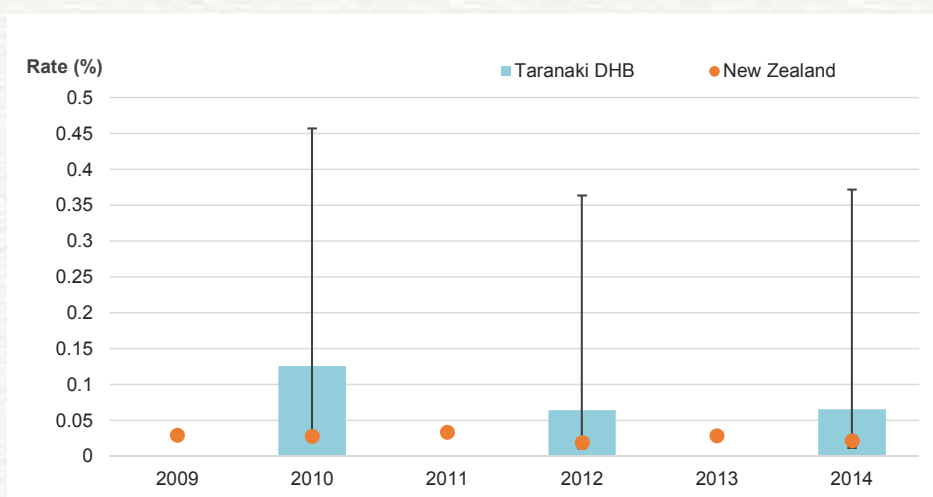
Indicator 14: Peripartum Hysterectomy



Indicator 15: Mechanical Ventilation during pregnancy or postnatal period

Taranaki had 1 case reported in 2014 and no cases in 2013

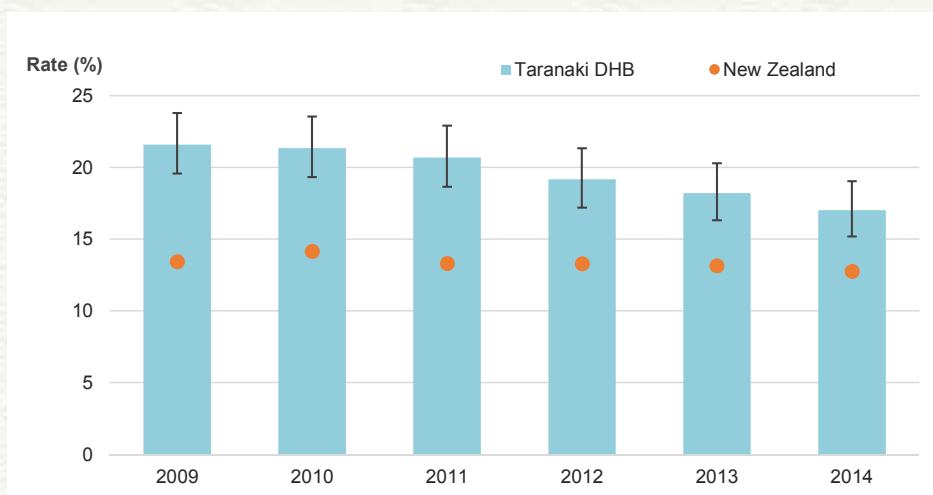
Indicator 15: Mechanical Ventilation during pregnancy or postnatal period



Indicator 16: Maternal Tobacco use during the postnatal period

DECREASED: Taranaki has a continued decreased rate of 17% in 2014, down from 18.3% (Taranaki Base rate down to 15% from 17% in 2013) in 2013 and 19.1% in 2012 this is above, above the declining national average of 12.8%. This needs to be further broken down into domicile, ethnicity and age to see if there are local areas of the population that can be targeted (see the smoking among pregnant women section).

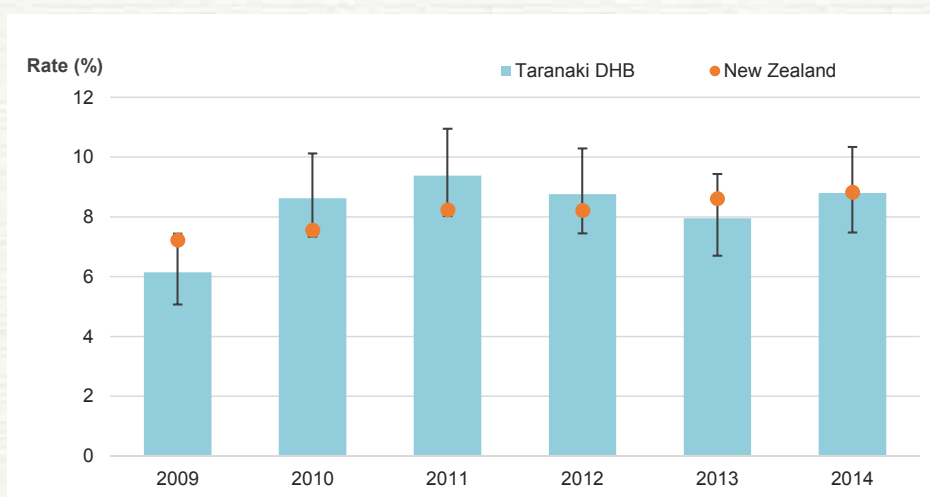
Indicator 16: Maternal Tobacco use during the postnatal period



Indicator 17: Maternal Obesity (BMI over 35 at registration)

Taranaki has a rate of 8.8% in 2014, up from 8% in 2013 (Taranaki Base rate 9.2% up from 8.5% in 2013) in 2013, around the national average rate of 8.8%

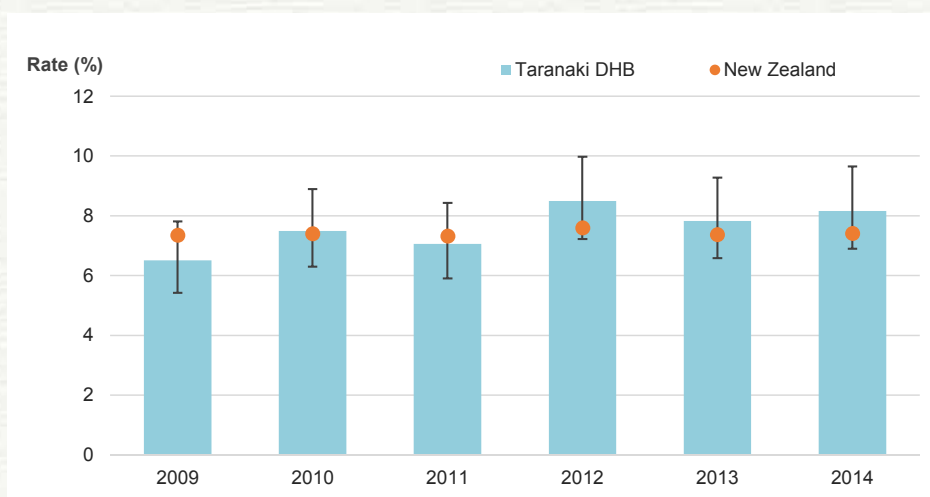
Indicator 17: Maternal Obesity (BMI over 35 at registration)



Indicator 18: Premature Births (Delivery from 32-36 Weeks)

INCREASED: Taranaki has an increased rate of 8.2% in 2014, up from 7.8% in 2013 (Taranaki Base static at 8.1% in 2013 and 14) in 2013 compared to 8.5% in 2012 and 5.9% in 2011, 6.1% in 2010 up from 5.7% in 2009; the national average is fairly consistent at 7.4% in 2013 and 7.6% in 2012. An audit has been undertaken in 2014/2015 and the NNU manager continues to monitor the rate. Further audit is planned for NNU admissions (2016/17)

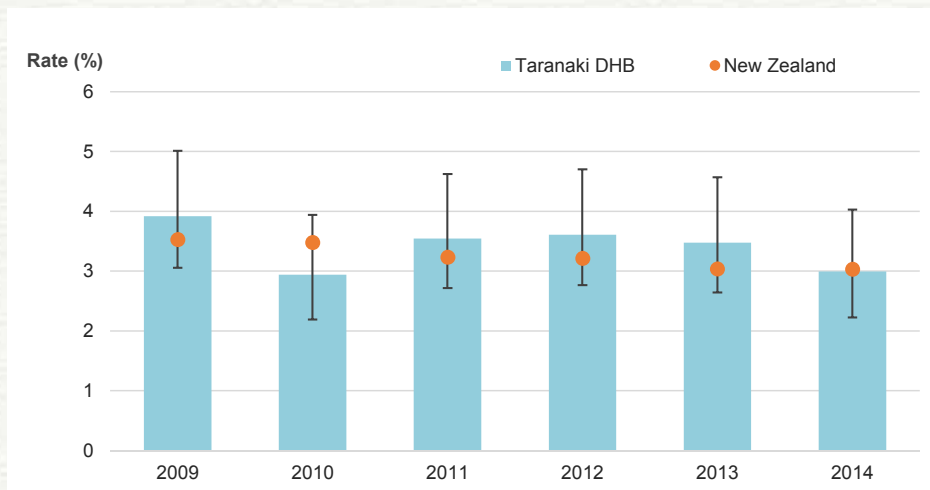
Indicator 18: Premature Births (Delivery from 32-36 Weeks)



Indicator 19: Small babies at term (37-42 weeks gestation)

Taranaki has a reduced rate of 3% in 2014 down from 3.5% in 2013 (Taranaki Base has a reduced rate of 3.1% in 2014 down from 3.7% in 2013) with an overall national rate of 3%. We are encouraging the use of the GROW tool in pregnancy and the use of the birth weight centile calculator on the newborn weight to help identify babies at risk. We are also monitoring these babies in the weekly case review/ maternity obstetric outcomes monitoring meetings. The rate is around the national average.

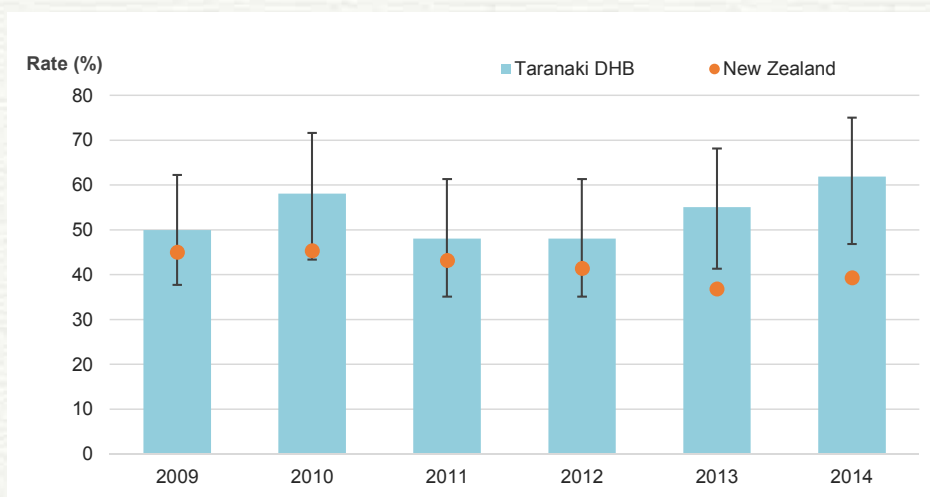
Indicator 19: Small babies at term (37-42 weeks gestation)



Indicator 20: Small babies born at term (40-42 weeks gestation)

INVESTIGATE: Taranaki has the highest rates in the country at 61.9% in 2014 up from 55.1% in 2013, (Taranaki Base rate is 65.8% up from 53.3% in 2013) the national average is 36.7%. The rate requires continued investigation as this is a reflection that cases of SGA may be undiagnosed. The expectation is that diagnosed SGA are likely to be induced before term. Also SGA can be linked with smoking in pregnancy. Carbon monoxide (CO) monitors have been purchased to use as a tool to help pregnant women quit in pregnancy. We are currently reviewing all undiagnosed cases of SGA that are identified in the weekly case review sessions to try and help identify any trends/ areas that can be improved. An audit is being prepared to investigate if risk factors for SGA have been identified at booking and appropriate care planning/ treatment eg aspirin. Whether SGA is diagnosed and appropriate care pathways followed eg consultation, monitoring and planned delivery.

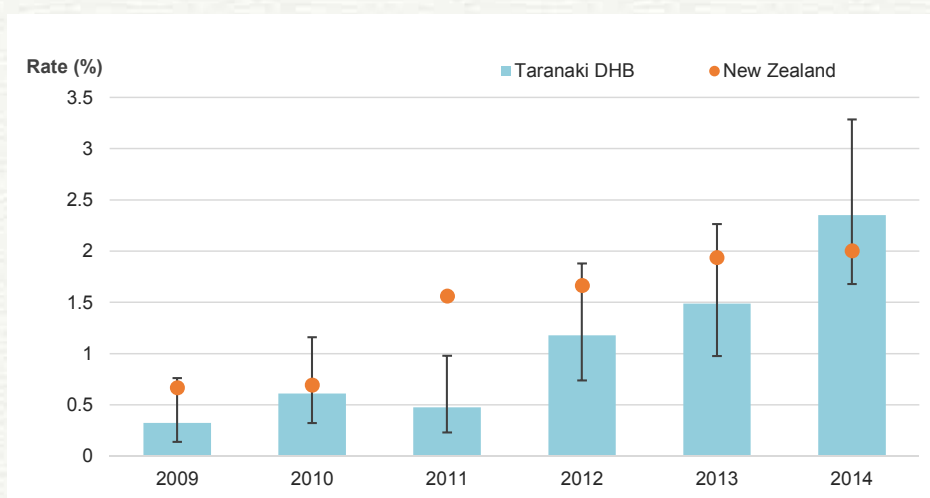
Indicator 20: Small babies born at term (40-42 weeks gestation)



Indicator 21: Term babies requiring respiratory support

Taranaki has an increased rate of 2.4% up from 1.5% in 2013 (Taranaki Base rate is 2.4% up from 1.6% in 2013) in 2013, around the national average of 2%. The number is small, however all unexpected term baby admissions to the Neonatal Unit are case reviewed.

Indicator 21: Term babies requiring respiratory support



SNAPSHOT OF 2015 - 16 INCLUDING QUALITY IMPROVEMENT



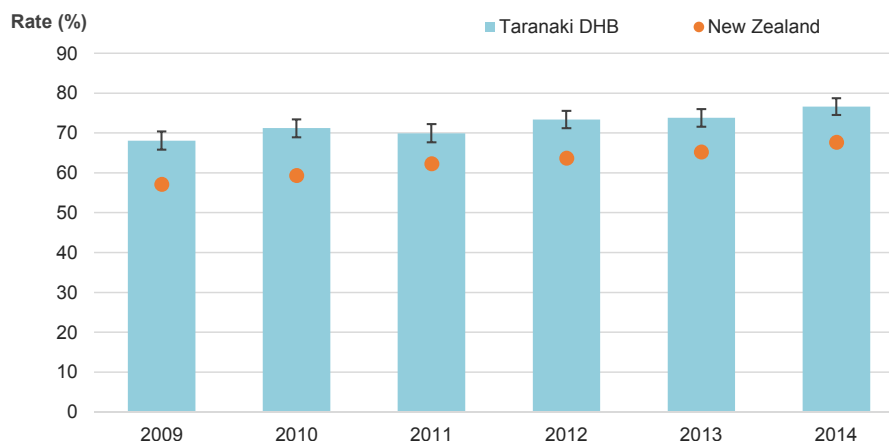
Summary of 2015-2016:

- Examination of recommendations made regarding the need for a maternal and child health hub for Stratford and the surrounding districts, and strengthening the model of care provided at the Hawera Primary Maternity Unit
- Promotion of a primary birth campaign (use of primary facilities and homebirth where appropriate)
- Continue to monitor and audit preterm births and neonatal admissions to explore reasons for admissions and help identify areas for improvement in care
- Investigate co location of the Maternity and Neonatal services to be nearer to the child health services and operating theatres
- Improve screening and access to wrap around services for vulnerable perinatal women, babies and families
- Review the responsibility and care of mothers and babies during transfer, delivery and return from the operating theatres
- Improve the referral process and pathways for stop smoking support for pregnant women, partners and whanau
- Implement a trial for a new staffing model to try and better meet the requirements of ward acuity and variance of wards
- Ensure full implementation of the Gestational Diabetic guidelines have been implemented.

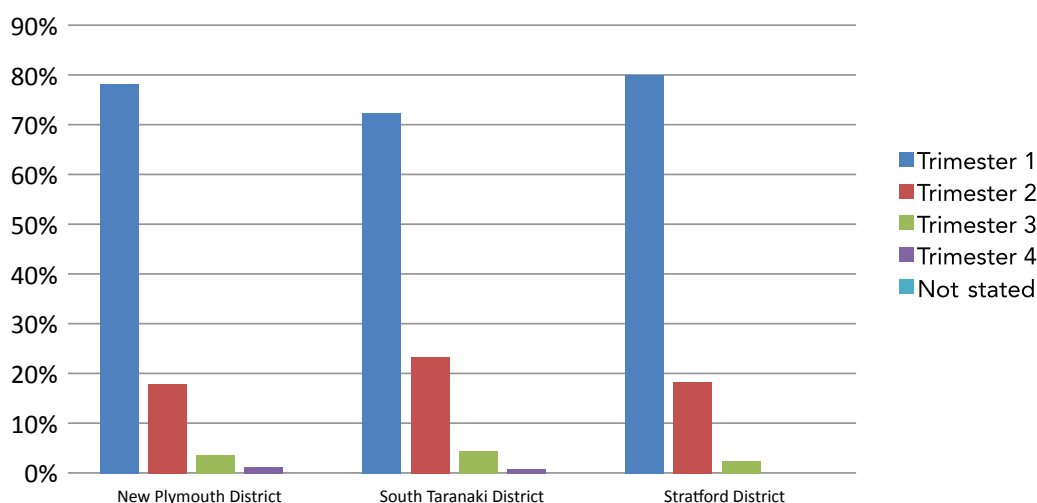
REGISTRATION WITH A LEAD MATERNITY CARER AND EARLY PREGNANCY CARE

Taranaki has seen another increase in the number of women engaging early with an Lead Maternity Carer (LMC):

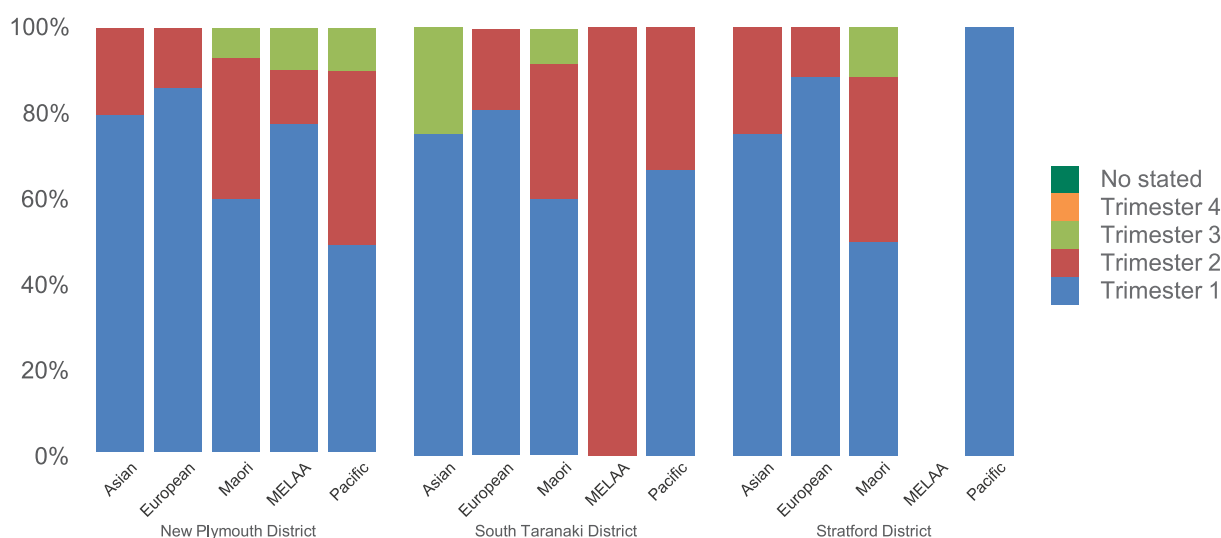
Indicator 1: Registration with an LMC in the First Trimester of Pregnancy



Taranaki DHB - Trimester of registration by territorial local authority (TLA) for 2014



Taranaki DHB - Trimester of registration by territorial local authority (TLA) and ethnicity for 2014



Initiatives that Taranaki MQC have participated in 2015/16 are:

- Updating of the pre and post pregnancy services directory twice yearly which is circulated to maternity stakeholders.
- Circulating of the Maternity Quality Newsletter with the information on how to best access an LMC via the Taranaki DHB and Find Your Midwife websites.
- Revamping the Taranaki DHB maternity internet pages to include consumer friendly information on our maternity, neonatal and immunisation services.
- Distributed business cards, rack cards and posters to GP practices, schools, pharmacies and other maternity consumer related businesses on the 'Top 5 things to do in the first 10 weeks of pregnancy'.
- Met with GPs in South Taranaki and some urban GPs to discuss early engagement and pregnancy assessment care with the intention to continue this road show around GP practices in the province.
- Met with the Emergency Department (ED) manager to discuss ways to improve capturing women who first present to ED who are pregnant to encourage early engagement with an LMC.

- Communications worked with maternity to initiate an information tent that was furnished by Hospice Taranaki at the World of Music Art and Dance (WOMAD). This tent promoted early engagement with an LMC, the BreastFedNZ App and how to ensure your baby gets the best start in life in the breastfeeding family friendly facility.

2016/17

In 2016/17 we have planned a consumer road show to be held in target communities where we would like to get the early engagement and 'Top 5 things to do in the first 10 weeks' messages out further. The first roadshow is planned to be held in Waitara and will invite local stakeholders in pregnancy and early post natal care to participate.

Taranaki DHB has also developed a two minute digital advert that is currently in its final draft to promote early engagement with an LMC in Taranaki and is focused on reaching the Māori population.



Taranaki DHB maternity stall at WOMAD

Expecting
Pregnant
Hapu

TOP 5
things to do
in the first
10 WEEKS

- ☐ Find a Lead Maternity Carer
- ☐ Consider early pregnancy screening
- ☐ Take iodine and continue folic acid
- ☐ Eat well and exercise
- ☐ Avoid smoking, drinking and other drugs

Find a Lead Maternity Carer:

- www.findyourmidwife.co.nz / 0800 MUM2BE (0800 686 223)
- Taranaki DHB Associate Director of Midwifery 06 753 7864
- www.tdhub.org.nz



Top 5 things to do in the first 10 weeks flyer

RURAL AND PRIMARY MATERNITY FACILITIES AND SERVICES

Stratford

Taranaki DHB have explored if a maternal and child health hub would be feasible to be based in the Stratford district following the closure of the Stratford primary maternity unit. Taranaki DHB has worked with the Stratford Community stakeholders on options for the hub (virtual or physical) and in March 2016 engaged the Bishops Action Foundation to explore whether there was the interest or demand for a greater level of collaboration between service providers. A coordinated consultation proceeded which included extensive dissemination of surveys to an agreed stakeholder group of providers and potential users. The responses of which were limited with five provider responses and three potential user responses. Results indicated that there is a strong sense that the concept of a Maternal and Child Hub is not what is wanted, with little momentum or demand for a hub.

Hawera

As part of the closure of Stratford primary maternity unit at Elizabeth R hospital it was agreed to strengthen the model of care at Hawera primary maternity unit to align it more to the model of the past Stratford unit, hoping to attract woman from the Stratford district to utilise the Hawera primary maternity unit rather than go to the combined secondary/primary unit at Taranaki Base hospital. Key members of staff visited three primary maternity units in the Waikato to gather information and ideas to present to local staff and assist future planning.

The environment at Hawera primary maternity unit has been examined as part of the birthing environment review at both Base and Hawera (see birthing environment section page 61).

A marketing leaflet has been drafted on the Hawera primary maternity facility to help promote its use with a focus of it being a low tech homely environment that is whanau/family friendly and meets the needs of the local population for low risk birthing (see Appendix 12).

Items of furniture and furnishings have now been priced and agreed, the purchases will be processed in the not too distant future. This will include facilities for partners to stay, new cots, beds, lockable lockers, feeding chairs, soft furnishings, decoration and garden deck areas.

Rural emergency response:

Increased communication and collaboration has taken place between St John and maternity, including primary maternity unit transfer. Cases of concern or where issues have been raised have been reviewed and sharing of education and resources has taken place. As part of the Taranaki DHB maternity obstetric outcomes protocol all cases where an inter hospital transfer has taken place has been reviewed to examine timing of response and transfer. As a result of the reviews it has been agreed to upgrade the Base hospital Maternity and Neonatal ambulance entrance to have 24 hour swipe access and emergency communication facility incase urgent help is required.

Practical Obstetric Multi-Professional Training (PROMPT) has been implemented in Hawera primary maternity unit involving community midwives, core midwives, Emergency Department (ED) doctors and St Johns ambulance staff. Basing the training in a rural setting allows for realistic scenarios in real time for midwives, ambulance officers, ED doctors and ED nurses from Hawera to practice their emergency skills. All who attended the training thoroughly enjoyed the day and two more workshops have been set up for 2016 to ensure all staff have a chance to participate. Team building was a really important section and focus of the day. All who participated now have an appreciation for each others roles within their practice. The day received positive feedback from all practitioners who attended.



Hawera staff at PROMPT training

PERINATAL MENTAL HEALTH

The Community Mental Health Team Leader and Midwife Educator have continued to present education on the Edinburgh Post Natal Depression Scale (EPDNS) screening tool and Taranaki DHB referral pathway at the midwives practice day.

Referrals have continued to flood in for Perinatal Mental Health Issues, many of which have been triaged as not requiring assessment.

The Medical Director and Service Manager have notified referrers that a completed assessment tool must accompany all referrals. If the practitioner is concerned they should annotate the EPDS score as underscored as referrals will still be accepted. Referrals need to identify the symptoms being experienced by the client as highlighted in the in service education sessions. Referrals are being returned to referrers if they are incomplete and practitioners are advised to amend and include the screening tool if they are not included in the original referral.

The community mental health team leader has agreement that Plunket / Well Child Tamariki will complete an EPDS if their initial screening tool (PHQ-3) is positive for Post Natal Depression (PND). It is anticipated that refreshers on the use of screening tools, the referral Pathway and the signs and symptoms of perinatal mental health problems will be ongoing annually and available for individual practitioners if their need arises.

The Midlands region infant perinatal clinical network has endorsed a perinatal support worker core competency learning package. This is due to go live in June 2016 as funded by the MOH.

With the resignation of both the Infant Child and Adolescent Mental Health Services (ICAMHS) coordinator and community manager the perinatal network / ICAMHS network have lost a degree of momentum. However as our new community manager settles into her post and with the return of Child and Adolescent Mental Health Services (CAMHS)/ICAMHS to the Community Mental Health (CMH) fold from maternity/child services it is hoped that new life will be breathed into the network.

Training for ICAMHS related therapy which has been uncoordinated since the split will hopefully be restored with the return of CAMHS/ICAMHS to CMH.

The forum between maternity and perinatal CMH teams will continue to meet monthly. The Terms of Reference (TOR) for this forum is currently being reviewed and needs to be finalised and signed off by the departmental heads.

Currently the proposed revised TOR has gone to the Medical Director and Service Manager of PMH for their input / approval.

Access to Mental Health Services for Pregnant Women and New Mothers (see Appendix 2 for Perinatal Mental Health Referral Pathway)

- The 0.6 FTE Acute Perinatal Registered Nurse (RN) position was successfully appointed in May 2015. After an extended period of orientation the role has impacted very positively in the numbers of clients being referred to the perinatal team. This has caused problems in terms of capacity however additional FTE time has been allocated as necessary by the Service Manager to help clear the backlog. Additionally the Team Leader has utilised his prior experience and has helped with initial assessments. The acute component of this role in providing brief intense intervention has been assisted by the acute home based team who do intensive work over a two week period.
- The Midland's five DHBs are working together through the Midland Health Network (MHN) to ensure there is alignment with the region's needs. Some of the funding is being allocated to the development of a perinatal clinical network and regional training.
- In 2013, a Midland Hui was held to discuss our local PNMH services including pathways, access to the services, priorities and actions to be made. The PNMH services are taking on board some of the feedback from the referrers and stakeholders present at this Hui which included maternity, LMCs and paediatric staff. The MMAG is working alongside the Midland Regional Network Team to produce a Primary Mental Health-Primary Care Map of Medicine Pathway and this is currently in draft format.
- 2016/17 Taranaki DHB will continue to promote integration with maternity services, Drug and Alcohol, WCTO and PNMH services.
- Client satisfaction surveys have commenced via our consumer advisor. Real time feedback is also due to go live. This will see clinicians using IPADs to allow the clients to complete a comprehensive electronic satisfaction survey. The use of modern media means that this can take as little as three minutes.
- We have initiated a draft patient information leaflet which will be distributed to all patients.
- We have initiated a draft referrer information Leaflet which we will distribute to all referrers.
- We continue to monitor
 - › access to maternal mental health services
 - › timing of referral to face-to-face meeting
 - › how many referrals are accepted
 - › how many are not and reasons for this
 - › gestation/age at referral
 - › referral problem
 - › age
 - › ethnicity
 - › parity/gravidity
 - › who referred
- This monitoring is currently done manually – we hope to have a report which will extract this data from the patient management system by June 2017
- We have adapted our referral tracking system to include some targets around time till first contact, time to be seen. However the volume of referrals has made it difficult to achieve the targets. Thus the most recent analysis will hopefully trigger a review of workload and processes.



GESTATIONAL DIABETES, OBESITY AND GREEN PRESCRIPTIONS

The Gestational Diabetes (GDM) guideline has been rolled out to all maternity practitioners throughout Taranaki. The information was circulated in the MQC newsletter and presented at the Perinatal and Maternity Mortality meeting education session, which included distribution of a copy of the GDM flow chart. The initial antenatal laboratory and GP blood request slips will be updated on the next print to include HbA1C on this request slip.

Audit shows that 75.8 % of patients are having an HbA1c requested at the initial antenatal screening. This is a significant increase from the first six months of 2015.

Of these 116 HbA1c requests 73 were requested by midwives and 43 by GPs or Specialists. The Lab has no way of knowing how many woman are being followed up with an Hb1Ac at three months postpartum.

Meetings with local GP's have included discussion on early pregnancy screening for GDM which has resulted in the GP systems being updated to request this as part of the initial antenatal bloods.

Women diagnosed with GDM are referred to our dietician services, a starting up guide is in Appendix 11 for guidance on diet while awaiting the dietician appointment. Additionally women are also referred to the secondary

antenatal clinic and the diabetes nurse specialist. Investigations have continued to explore the idea of having a specialist midwife in diabetes who would cover diet, education and the secondary core midwifery for women with GDM to promote continuity of care and reduce fragmentation of appointments.

Guidance for healthy weight gain in pregnancy:

An estimated one third of women of normal weight and 60% of obese women gain more weight than recommended in pregnancy. Guidelines for Healthy Weight Gain in Pregnancy (published June 2014) supports a reduction in the incidence of inappropriate weight gain in pregnancy, during pregnancy and post-partum. This Information and the healthy weight gain in pregnancy tool tear off pads (for completion at booking the booking visit) have been distributed to all maternity practitioners in Taranaki.

Green Prescription (GRx) for LMC's:

LMCs of women with, or at risk of, gestational diabetes are encouraged to refer to the GRx initiative. In service education has been given to our core and community maternity staff on the availability of and the referral process for the GRx so that pregnant women have access to healthy exercise and nutrition in pregnancy.

VARIATION IN GESTATION OF BIRTH

Our daily morning maternity meeting allows robust and professional discussions on care planning and management with a particular focus on timing of delivery. Any planned Induction of labour or elective caesarean section is questioned if it is planned before 39 weeks gestation: Is it clinically indicated? If it is clinically indicated antenatal steroids are recommended to be administered where appropriate with a focus on the best/safest outcome for baby and/or mother. At times there have been noted challenges in obtaining theatre slots to line up with timely delivery for caesarean section, our antenatal clinic coordinator is involved in the booking of elective caesarean sections and raises this to management level if it becomes an issue. Taranaki DHB maternity does not have any input into private obstetrician's clinical decision making or entry of their women into our systems for early delivery, this data is included in Taranaki DHB data reports locally and nationally.

Number of women giving birth by elective caesarean or induction at 37, 38, 39 and total weeks' gestation at Taranaki DHB

	Total weeks' gestation	2009				2010				2011				2012				2013				2014			
		37	38	39	All	37	38	39	All	37	38	39	All	37	38	39	All	37	38	39	All	37	38	39	All
Elective Caesareans	Number of women giving birth by elective caesarean section at 37, 38, 39 and total weeks' gestation by DHB of residence, 2009–2014																								
	Taranaki	10	51	47	162	12	47	61	179	10	52	60	161	21	42	90	205	20	42	85	183	17	41	106	194
	National	561	2038	2630	6663	610	2099	2670	6865	587	1868	2918	6783	629	1970	3064	7146	595	1981	3054	7004	626	1923	3157	7050
	Proportion (%) of women giving birth by elective caesarean section at 37, 38, 39 and total weeks' gestation by DHB of residence, 2009–2014																								
Inductions	Taranaki	13	25	13	10	18	23	17	11	13	24	17	10	30	22	23	13	20	24	23	12	17	19	28	13
	National	16	22	17	10	17	22	17	11	17	20	18	11	17	21	19	11	17	21	20	12	17	20	20	12
	Number of women who had an induction and gave birth at 37, 38, 39 and total weeks' gestation by DHB of residence, 2009–2014																								
	Taranaki	19	24	27	283	15	35	31	262	19	42	48	307	16	30	44	258	24	37	52	323	30	60	52	340
Inductions	National	831	1698	1705	11138	818	1987	1748	11342	902	2173	2025	11983	1027	2193	2258	12281	1074	2428	2309	12462	1111	2463	2423	12506
	Proportion (%) of women who had an induction and gave birth at 37, 38, 39 and total weeks' gestation by DHB of residence, 2009–2014																								
	Taranaki	25	12	8	17	22	17	9	16	24	19	13	20	23	16	11	17	24	21	14	21	31	28	14	22
	National	24	18	11	17	23	21	11	18	25	24	13	19	28	23	14	20	30	26	15	21	30	26	15	21

Above table supplied by the National Maternity Monitoring Group, April 2016

DONATION OF HANDMADE HATS

Olivia Sharpe as part of her services and duties school badge handmade and donated 65 colourful hats to Base maternity to keep the newborn babies warm.

Moerangi Tamati, Mark Luff, Olivia Sharpe, Amanda Antoine, Carol Wells, Kirsty Loveday



CONSUMER REPORT AND ACTIVITIES

I have been an MQSP consumer representative for more than three years now. This role has evolved so much in that time. As a consumer rep I sit on the Maternity Quality Committee (MQC) which is the governance group for maternity. My role seems to be a very fine line between advocating for consumers, giving consumer feedback as well as establishing and fostering relationships between consumers and the maternity service as a whole. This is still a role I find challenging at times, but most certainly I enjoy doing this. I feel appreciated and supported by all the members of our governance group as well as the wider Taranaki DHB.

In August 2015, I was very fortunate to be able to attend Matcon 2015 in Wellington. Around that time our DHB was dealing with community consultation around the closure of the only stand alone primary birthing facility in our area. With this in mind our MQC supported me to attend two days of this three day conference. On the second day the topic of primary and rural birthing was discussed. I was the only consumer to be present for this day. To me this shows the amazing support I have from my DHB and MQSP. Attending the second day gave me the opportunity to see how other regions approach primary birthing this was very helpful in my own understanding. This was an experience beyond measure, giving me a moral boost that keeps my passion alive. Meeting and networking with other consumers gave me a great feeling of unity and a greater understanding of this very varied role.

During 2015 I have conducted consumer surveys for the MQC. These surveys have been focused on receiving consumer feedback, with a view of the entire pregnancy journey. A target of collecting 100 responses was set, this target was seen as optimistic as previous paper based surveys only got around 30 responses out of 100 mailed out. As of May 2016, 80 responses have been obtained and reported upon in this report. Survey Monkey was used as the survey medium, with consumers being contacted directly with survey information and background. Direct contact allowed me to ensure consumers understood the questions as well as giving me the opportunity to build more relationships within the community. The survey evaluation is extensive. A copy can be obtained on the Taranaki DHB website www.tdhb.org.nz.

My main consumer focus for 2015 was to engage a second consumer to the MQC. This proved to be a difficult task due to variability in the role. Ideally we had in mind to engage a consumer with a Māori or rural background as this was areas we felt were under represented. After a number of expressions of interest and advertising were posted to stakeholders as well as the situations vacant section of the Taranaki DHB website and facebook pages, four candidates were invited to attend for an interview. An applicant was appointed, however, resigned after one month. I personally found this hard as I was really looking forward to having a 'buddy' to work with. Further more extensive community consultation led to another consumer stepping showing an interest in this position, she is currently in the process of

signing contracts and confidentiality agreements. She will undergo orientation and training before she commences.

The closure of the Elizabeth R primary birthing unit in Stratford district was a large part of my workload in 2015. After Taranaki DHB's decision to stop all services at this unit due to the contractors being unable to fulfil their contract due to staffing issues. Stratford community leaders wished to explore options for primary maternity services. To this effect a core group of stakeholders was formed, the group was supported by Taranaki DHB and included DHB planning and funding reps, Stratford community midwives, pregnancy and parenting, NGO reps, consumers of Stratford maternity services as well as myself and the Associate Director of Midwifery (ADOM). This group was given the mandate of considering the implementation of a maternal and child hub in Stratford. Consideration included location, size, participating services as well as logistics of such a unit. The conclusion after engaging Bishop's Action Foundation as a mediator and project manager was that at this point in time there was not enough traction within the community to continue along this path.

As a consumer I have administrated along with the MQC coordinator the Taranaki MQSP consumer facebook page which has 137 members as of 12 May 2016. This page has grown in leaps and bounds in the past year in members as well as use. We view this page as a community notice board of sorts, where information on pregnancy and parenting related events from any not for profit organisations can be shared. I create events for regular vaccination clinics at the antenatal clinic, this way members can show interest and get updates of the event.

Thank you so very much to Belinda Chapmen for all her support; emotional, professional and administrative. You are a true inspiration.

Looking ahead to the next year there are a number of projects I am working on with the MQC Committee, some of these include:

Meet your maternity services road show

The date for this has been set for the last week of July 2016. This is a very exciting project.

NCHIP

This is due to be rolled out 22 June 2016 within the Taranaki DHB area. As a consumer I am giving feedback on the information gathering process as well as a leaflet on the service.

VBAC

The NMMG have requested feedback on information consumers receive when considering a VBAC. I am gathering consumer experiences as well as any leaflet, brochure and other information consumers view during this time.

COMPLAINTS

Maternity services have halved the number of complaints received in the last year, however the graph below shows the highest number of complaints received are for attitude, these have increased from three from the previous year to six. When examining the complaints for attitude there is no trend, with the complaints made against nursing, midwifery and medical staff. Complaints related to competence have reduced from nine to three in the past year where as the other categories are similar.

All complaints are fully investigated by the clinical midwife manager or service manager and the complainant is responded to in writing. The focus when investigating complaints is to review how our consumers experience could have been improved with a focus on quality, safety and implementing change to improve our services.

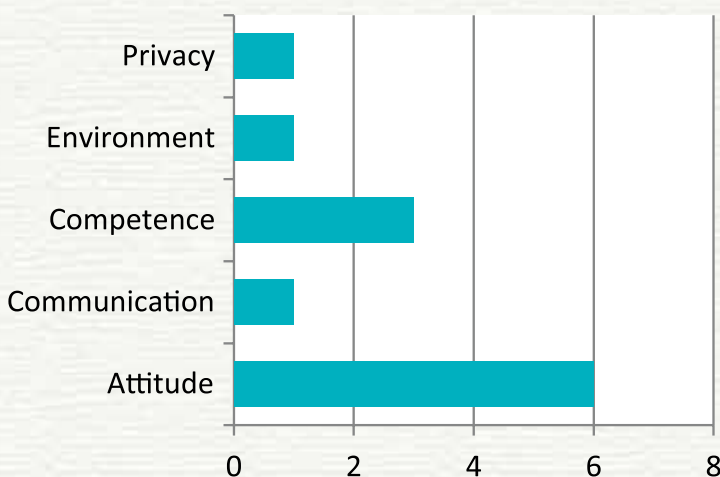
A new Datix reporting system was implemented to Taranaki DHB in December 2015. This system captures and registers complaints received, and this should improve our reporting in the future.

How are we doing forms are available in all of our maternity facilities which are used to capture consumer feedback which includes compliments, suggestions and complaints.

Health and Disability Commissioner (HDC) Cases:

There are four open HDC cases that are awaiting further feedback from HDC. These cases came through Taranaki DHB maternity services between 18 months and four years ago. There have been no new cases within the last year.

Maternity Complaints 1/7/2015 to 30/4/2016



FEEDBACK

Below are some examples of our consumer feedback:

Great staff, super friendly, was helpful with all my questions. Gave me advice when I needed it, supportive breast feeding.

Cannot thank staff enough for care during labour and afterwards. Support during a tricky situation gave us confidence that everything was OK. Midwife was exceptional.

Great support, excellent knowledge, very reassuring. Quick to provide additional expertise if needed. Good facilities and provisions. All round a very caring and supportive professional service.

Staff friendly, encouraging, helpful and displayed a genuine caring attitude to myself, baby and partner. Great information re breast feeding and other tests and procedures.

Staff at Hawera Maternity are absolutely lovely. They all took every opportunity to help me and baby and without their help I never would have gotten so far with my breast feeding.

Hawera's Maternity midwives are exceptional.

Staff amazing at Hawera Maternity. They checked on me constantly and provided me with 24 hour support and advice.

PERINATAL AND MATERNAL MORTALITY (PMMR) AND THE NATIONAL PMMRC RECOMMENDATIONS

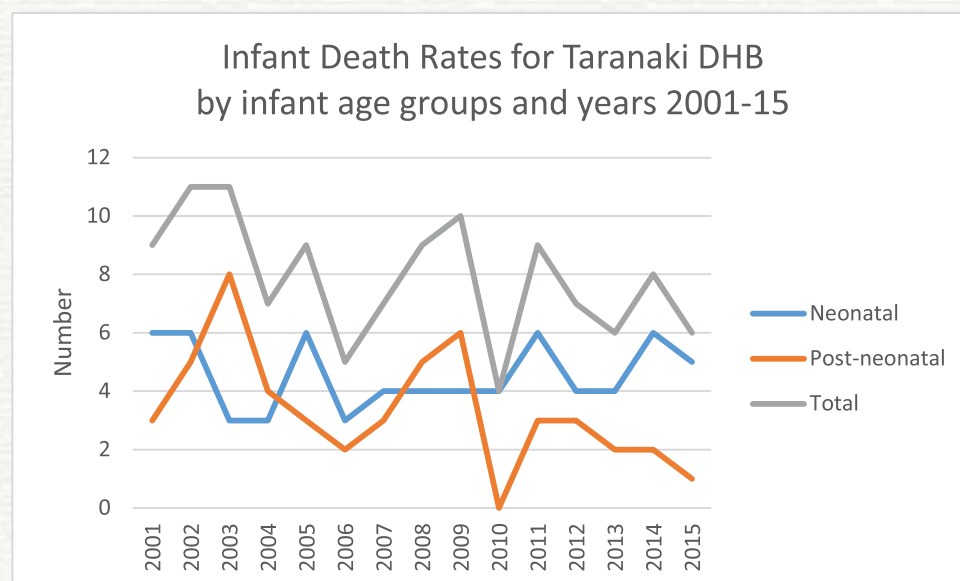
Infant Mortality in Taranaki

Prepared for Rebecca Madden, Pepi-Pod coordinator, Taranaki DHB on 27 May 2016

Caution

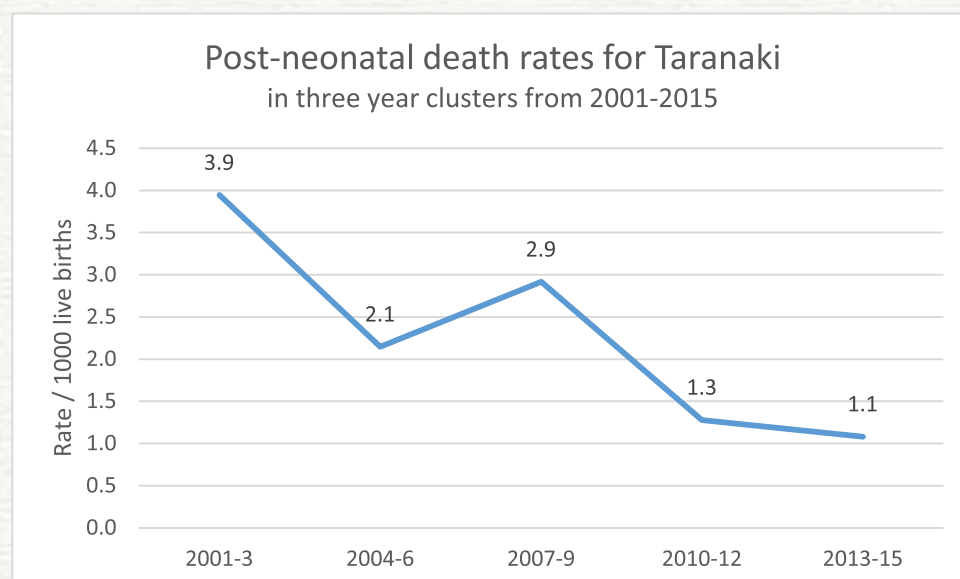
Where small numbers are involved statistics can vary from year to year and mislead as to improving or worsening outcomes. Caution is needed with interpretation. The data below are from birth and death registration, by year of registration, supplied by Statistics New Zealand. They describe deaths from all causes.

By number



Comment: Post-neonatal deaths (1-12 months) have been trending downwards in recent years while neo-natal deaths (<1 month) have remained unchanged. Most preventable deaths (including SUDI) are in the post-neonatal group.

By rate



Here is the same post-neonatal data calculated as rates per 1000 live births and presented in three year clusters to show the downward trend. The Sleep Space work started in 2013.

In 2015 Taranaki DHB had no maternal deaths. There were a total of 12 maternal cases leading to perinatal death. Two cases resulted from termination of pregnancy, three cases from Neonatal death and seven cases resulted from intrauterine death. Statistically the numbers are small so it is difficult to draw any trends or themes from them, however Taranaki DHB do take into account the recommendations from the national PMMR committee and continue to present all cases to maternity practitioners at the local perinatal and mortality review meetings, this includes perinatal mortality and cases of babies with Neonatal encephalopathy that are cooled. These meetings are combined with education presentations on subjects related to perinatal mortality and national recommendations, which includes presentation of local data. A recent PMMR meeting gave out an information pack and presented the importance of utilisation of the GROW tool for identification of small for gestational age babies, healthy weight gain in pregnancy tool, smoking cessation guidelines, drug and alcohol guidelines, GDM flowchart, preterm birth prevention and treatment guidelines, multiple pregnancy recommendations, recommended use of aspirin in early pregnancy, flu and Boostrix vaccination in pregnancy information and the PMMR information sheet on early Identification and treatment of a baby

with Neonatal encephalopathy.

Taranaki DHB have continued to progress work as recommended by the PMMRC ninth report. This includes the implementation of annual fetal surveillance training and is available for all practitioners involved in intrapartum care.

An audit has taken place on High Dependency Unit (HDU) admissions (please see audit section page 72) to ascertain areas of risk for maternal morbidity. All cases of unplanned admission to HDU are reviewed as part of the local obstetric outcomes protocol.

Antenatal detection of fetal growth restriction has been highlighted as an on going concern (see Indicator 20 from the maternity clinical indicator section), these cases are now an indicator for case review in an attempt to try and address the number of cases that have been undiagnosed prior to the birth. An audit of small for gestational age (SGA) is currently underway.

The maternity quality coordinator, antenatal clinic coordinator and obstetrician have met with local rural and town GP's (photo below) to discuss the PMMR recommendations, early engagement and access with an LMC, top 5 things to do in the first 10 weeks of pregnancy and early pregnancy assessment.

This included a presentation on:

- Pre pregnancy care and early referral for medical disease, including the process.
- Folic acid pre pregnancy or as soon as presents, including 5mg dose for women who are morbidly obese, or on medication where 5mg is indicated and iodine supplementation
- Smoking cessation

Enhanced communication has resulted from these meetings and areas identified for improvement have been made, including HbA1C testing at pregnancy booking and communication links between the community midwives and GP's.

Cold Cuddle Cot donation gives Taranaki families more time to grieve:

Taranaki families who suffer the loss of a baby in pregnancy or early infancy now have the opportunity to spend more quality time with their deceased baby, thanks to the donation of a Cold Cuddle Cot from the Emerikus Land Foundation.

In situations where baby loss occurs, the time available for families to share special moments, bond and form memories with their baby is limited. The addition of a Cold Cuddle Cot to Taranaki DHB's resources provides more time to do this and assists with the grieving and healing process for those families.

The Cot is welcomed by the staff as it helps better support families when a baby loss occurs. The personal and cultural needs of patients and visitors who use our services are so varied; the cot allows greater capabilities to meet those needs.

The cot is used in Taranaki Base Hospital's 'Willow suite', a facility that was set up with the support of SANDS New Plymouth (a pregnancy, baby and infant loss support group). The 'Willow suite' provides a comfortable and private environment for parents who are grieving from the loss of a baby.



Care First GPs with MQC members



Baby loss awareness week. The local SANDS group hosted an afternoon tea in the delivery suite lounge and the "The Willow Suite" was accessible for any consumers wishing to visit

Back left to right: Raewyn Land (Emerikus Land Foundation), Sadie Miller (Midwife and SANDS representative), Sharon Pengelly (Emerikus Land Foundation), Don Mackie, Belinda Chapman (Associate Director Midwifery), Leigh Cleland (Clinical Services Manager Maternal & Child Health) Front left to right – Linda Mackie, Sharon Howe (Midwife).

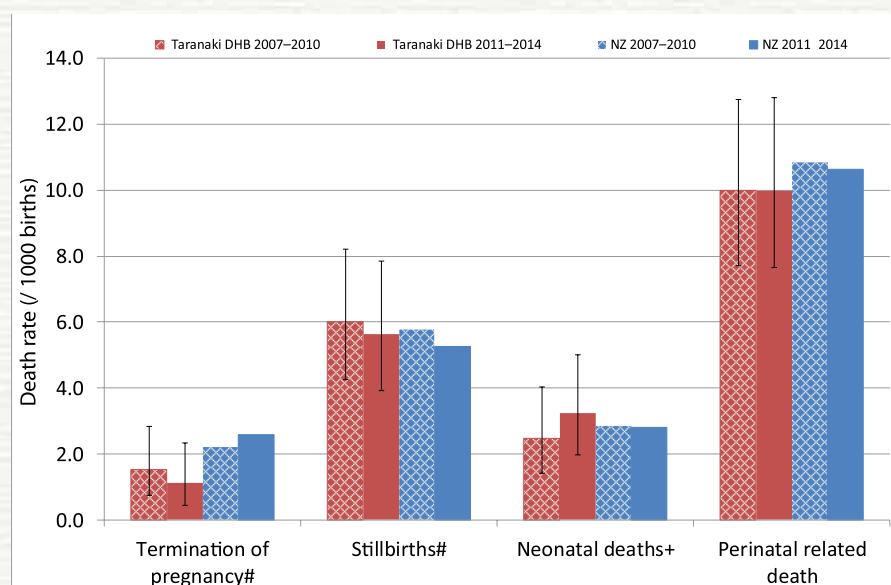


The PMMRC 10th Annual Report and Analysis of Findings

The PMMRC 10th Annual Report and Analysis of Findings, published (June 2016) shows the following for Taranaki DHB between the years of 2007-2014:

- There are no significant differences in perinatal related mortality by age, ethnicity or socioeconomic deprivation quintile in Taranaki.
- There is no significant difference between Taranaki and NZ stillbirth, neonatal or total perinatal related mortality rates; however there is a lower rate of termination of pregnancy in women residing in Taranaki compared to the NZ rate.
- There has been a non-significant reduction of mothers who smoke among Taranaki mothers of perinatal deaths, unlike the significant reduction seen nationally.

Figure 1: Perinatal related mortality rates Taranaki DHB (with 95% CIs) compared to New Zealand 2007-2014



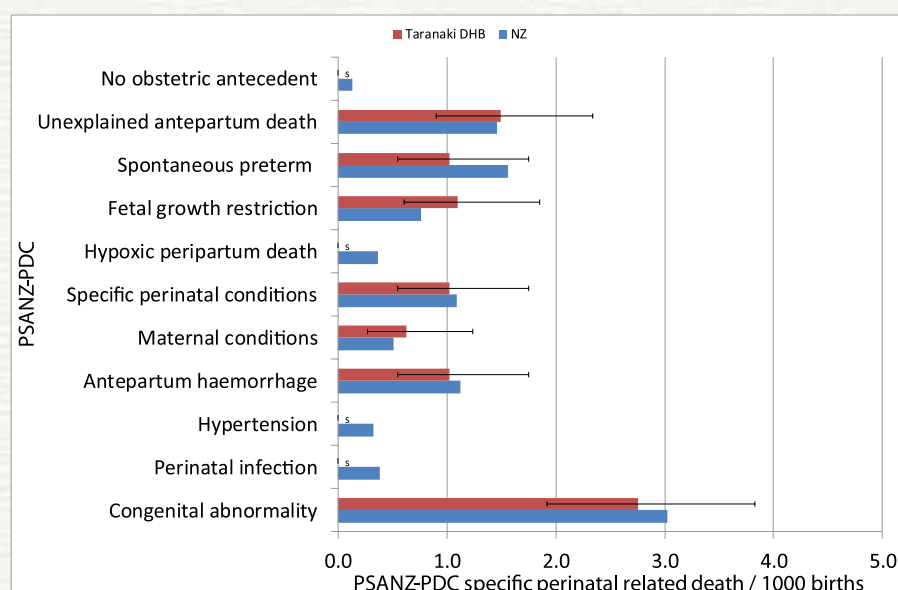
Rate per 1000 babies born. + Neonatal death rate per 1000 live born babies

- There has been a significant increase in the proportion of mothers of perinatal deaths who were eligible for screening and screened for diabetes.
- There has been an increase in optimum investigation rates of perinatal deaths, however they are consistently lower than national rates, but the difference is not statistically significant.
- Babies who died in Taranaki were more likely to have partial rather than optimum investigations when compared to NZ overall. Rates of no investigations were consistent with national rates. The PMMRC recommend that Taranaki DHB investigate this.
- The rate of Neonatal Encephalopathy at term among babies of Taranaki mothers is higher than the national average, the PMMRC recommend that TDHB investigate local cases of Neonatal Encephalopathy.

On examining the data for Neonatal encephalopathy (NE) It seems the peak of cases were in 2012, these cases were probably responsible for Taranaki DHB's overall findings. This aligns with the number of Health and Disability Commissioner (HDC) complaints we received that same year. Taranaki DHB introduced the Maternity Obstetric outcomes protocol in 2013/2014; unexpected admission to NNU is a key indicator for case review so all cases of NE are captured and reviewed. A decline in the number of cases will likely be seen in the 2015/16 data.

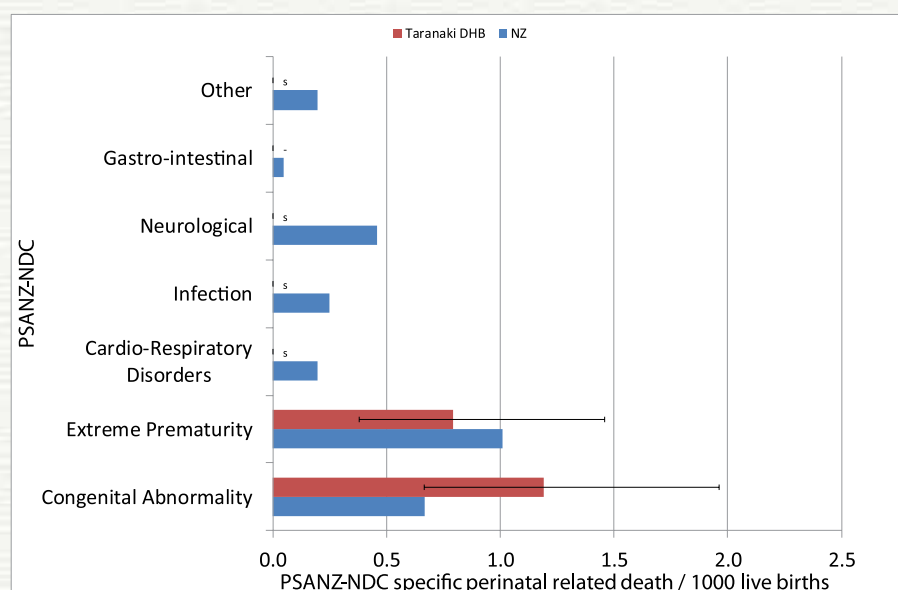
In relation to optimum investigation of perinatal death babies one of the barriers for parents is that their baby is flown to Auckland to be examined by a perinatal pathologist. This can be a deciding factor to decline investigation, however if a parent wants to go and doesn't have funding Taranaki DHB will now fund the parent to accompany their baby.

Figure 2: Perinatal death classification (PSANZ-PDC) specific perinatal related mortality rates (per 1000 births) for Taranaki DHB (with 95% CIs) compared to New Zealand 2007-2014



s indicates rate suppressed due to small numbers.

Figure 3: Neonatal death classification (PSANZ-NDC) specific neonatal death rates (per 1000 live births) for Taranaki DHB (with 95% CIs) compared to New Zealand 2007-2014



s indicates rate suppressed due to small numbers.

Some areas to focus on in the future are smoking in pregnancy and contributory factors; failure to follow recommended best practice, infrequent care or late bookings (this may improve with the Maternal

wellbeing and child protection multi agency group meetings now meeting fortnightly to try and wrap around services for women to engage with pregnancy care).



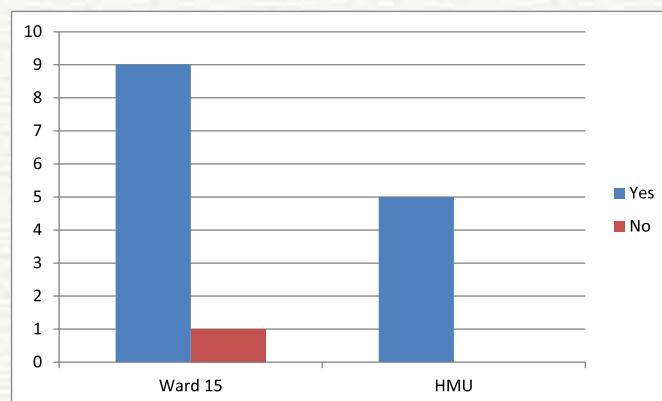
SAFE SLEEP AND SUDI

Taranaki DHB is committed to reducing the post perinatal mortality rates in Taranaki. By educating all families on the six principles of safe sleep and providing a Safe Start programme, the goal is to continue the current downward trend in post perinatal mortality. The six principles of safe sleep are:

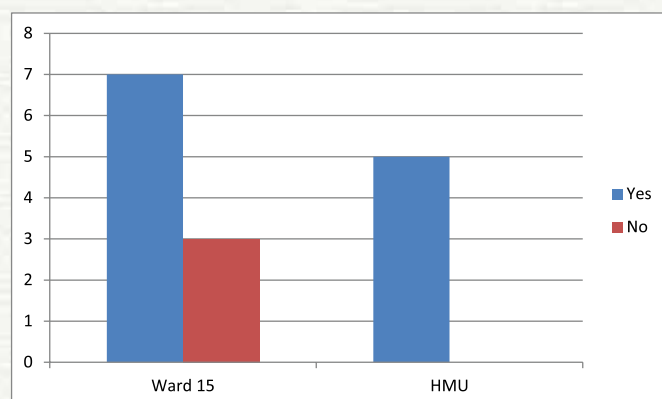
- Face up
- Face clear
- Smoke, drug and alcohol free
- Breastfed
- Close to mum
- Handled gently

These are considered essential information for all families with new borns and are included in the compulsory education section of the Taranaki DHB Maternal Care Plan. To ensure information is being adequately passed on to families, a five question, random spot audit was conducted during March 2016 of 10 inpatients on ward 15 (postnatal) and five inpatients at Hawera Maternity Unit (HMU).

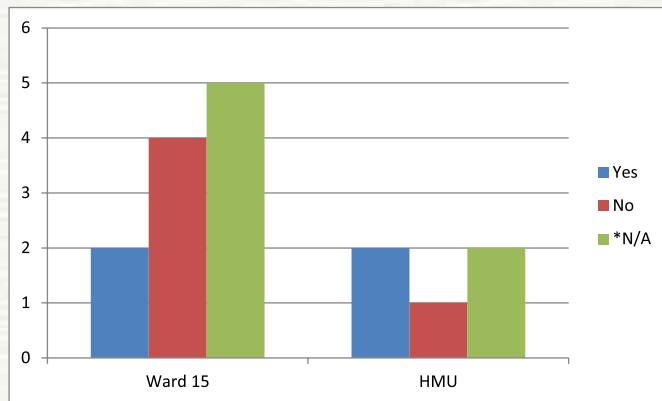
1. Are the correct client details on all documentation



2. Were all six principles of safe sleep discussed

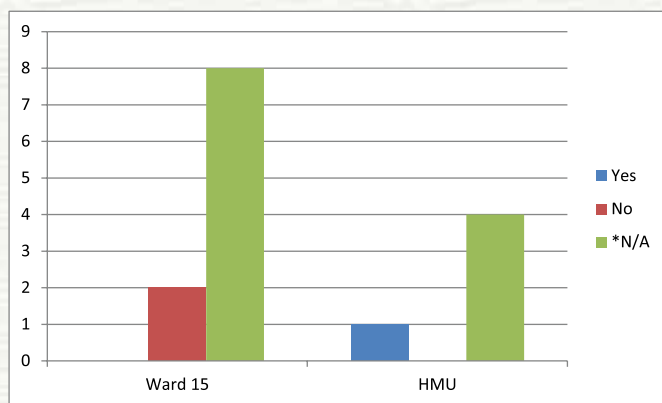


3. Were the relevant pamphlets given



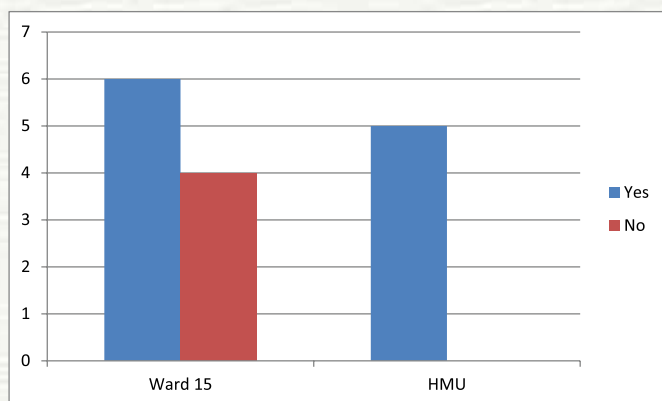
*Not applicable (N/A) where further discussion or referral was not required

4. Were follow up referrals done as appropriate (ie Pepi pod/Smokefree)



*N/A where no referral was required

5. Was the appropriate documentation completed in the Maternal Care plan



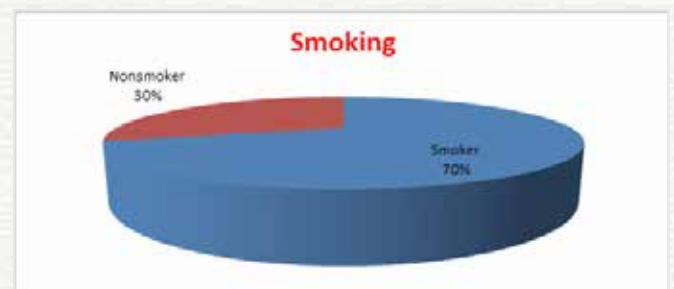
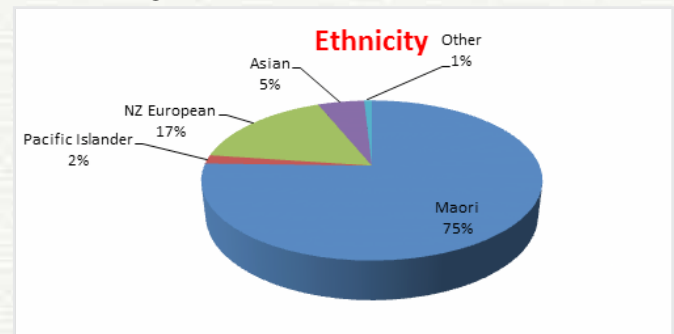
The Safe Start programme is a partially Government funded initiative of Change for Our Children that has been running successfully since 1994. The Pepi pod scheme was introduced in response to the need for safe, cost effective sleep spaces for infants following the 2011 earthquakes. Taranaki DHB joined the Pepi pod programme in 2013. Pepi pods are manufactured by Change for Our Children and funding is managed by the distributing agency. The referral criteria to receive a fully funded Pepi pod are;

- Newborn (unless referred by Paediatrics or Neonatal Unit) and two of the following -
 - › New Zealand Māori
 - › Exposed to smoking in pregnancy
 - › Premature (<36 weeks) or low birth weight (<2500 grams)
 - › Regular smoking, drug use or alcohol in the baby's household.

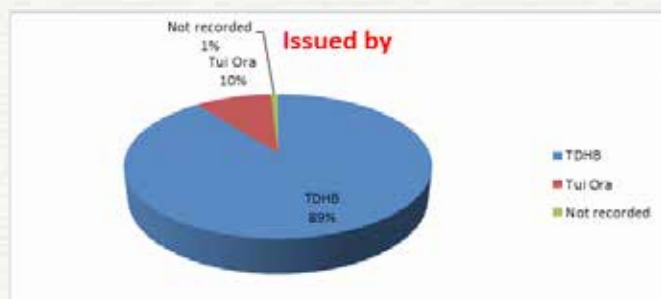
- › Exposed to smoking in pregnancy
- › Premature (<36 weeks) or low birth weight (<2500 grams)
- › Regular smoking, drug use or alcohol in the baby's household.

In Taranaki the Safe start programme and Pepi Pod scheme is managed by Taranaki DHB and involves maternity, neonatal and paediatric departments and Well Child providers Plunket and Tui Ora. 114 Pepi pods were issued by Taranaki DHB and Tui Ora in 2015. Currently statistics are only available on referrals that continued on to receive a Pepi pod. We have revitalised our information gathering to include all referrals received for the 2016 year.

The following is a breakdown of referrals received:



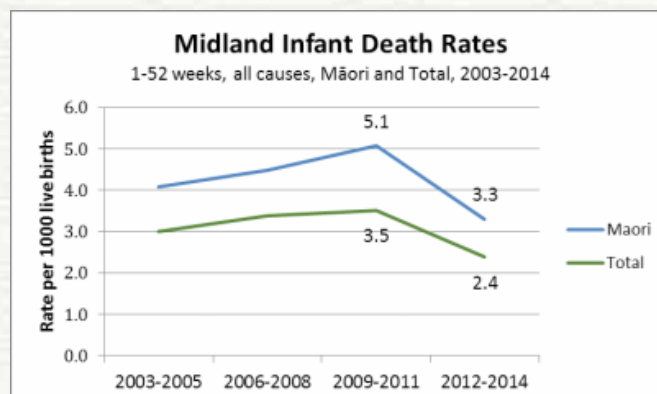
In 2015 the range of referral to action was between same day (70%) and 22 days with the majority of referrals actioned within 24 hours of the referral being received (81%). While this is an excellent result, some of our success may be falsely reported due to incorrect data gathering around referral dates. With the push in 2016 for antenatal referral, referral to action dates may increase, however antenatal issuing of Pepi Pods means reduced vulnerability for at risk new borns. Currently the majority of at risk babies are being identified either antenatally or during their inpatient stay at one of the DHB facilities, either by the core staff or LMC referral.



The number of unidentified at risk babies in the first 48 hours of life has reduced with anecdotal reports from Well Child providers that the significant numbers of their referrals are now due to a change in circumstances or unsafe sleeping habits identified within the home (66%). Tui Ora are provided with a stock of Pepi Pods by the DHB and issue them as appropriate, where as the Plunket identified and referred at risk babies to the DHB. The following is an excerpt from The Rainbow Report, Change for our Children, May 2015:

Fact: Infant death rates were rising in Midland from 2003 to 2011 and fell sharply in the 2012-2014 period. There were 47 fewer deaths overall during 2012-2014 compared to the previous period, and 33 less for Māori (70% of the recent change).

Fig. Changing infant death rates in the Midland health region, Māori and Total

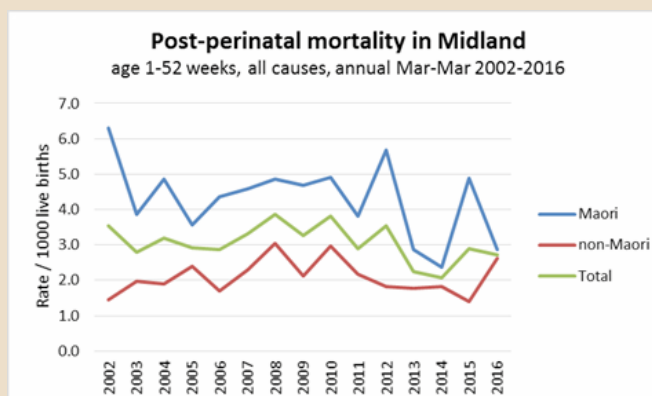


Our goal for 2016 is to ensure the continuation of the Pepi Pod programme, early identification of at risk infants and availability of safe sleep spaces. While the available data is not definitive, post perinatal mortality rates have significantly decreased in the Midlands region since the introduction of the Pepi Pod programme and we feel this programme is valuable in identifying at risk babies and opening doors to the difficult conversations around safe sleep, gentle handling, smoking cessation, the importance of breastfeeding and immunisations. By having a dedicated team available to address the larger picture of infant health, the core DHB midwives and nurses are released to provide more thorough clinical care. The Pepi Pod programme is not funded and we are currently looking for interim and hopefully ongoing funding to continue.

Post-Perinatal Mortality in Midland Region

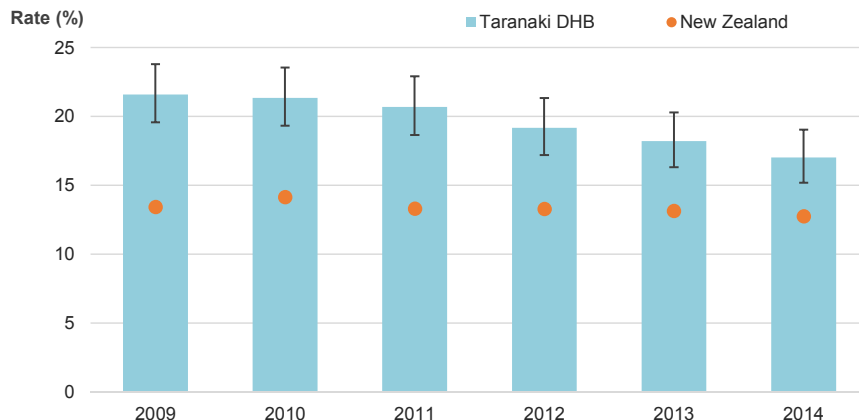
The graph (right) tracks annual post-perinatal mortality (1-52 weeks, all causes of death) rates for the Mar-Mar years 2002-2016. This gives the most recent feedback about how well our infant protection work is going, as a region. As numbers get small, graphs jump about so we need to be cautious. However, in the twelve months ending Mar 2016, Midland saw equal PPM rates for Māori and non-Māori. This is significant given the disparities of Mar 2002, and even Mar 2012. Yes, we still have infants to protect but reducing inequalities as well as infant deaths has always been a goal of the Pepi-Pod Programme, and all safe sleep work.

The improvements could be a reflection of the work that has been carried out by the Midland Maternity Action Group on the Midland safe sleep policy and the Pepi Pod distribution programme



SMOKING AMONGST PREGNANT WOMEN

Indicator 16: Maternal Tobacco use during the postnatal period



midwives have been offered and attended training on how to use the CO monitors as well as attend clinical training on how to support pregnant women who want to stop smoking. The training includes screening, advising, supporting and referring to specialist stop smoking services.

Taranaki DHB MQSP now has a representative who attends the Taranaki Smokefree/Auahi Kore Coalition coalition group which meets quarterly. This groups roles and responsibilities are to:

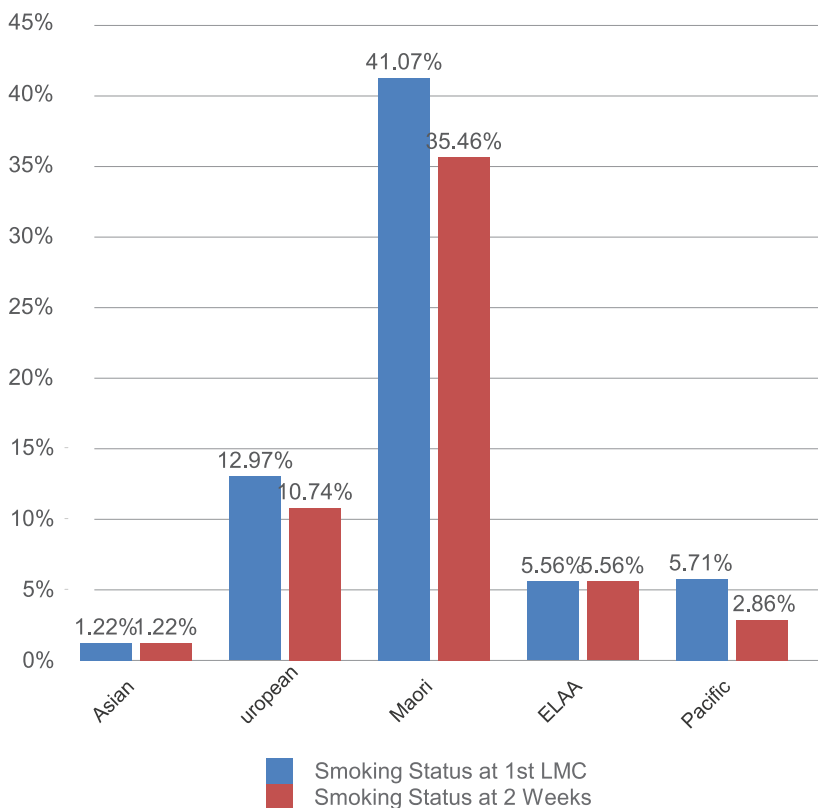
- Increase the number of people quitting smoking = increased quit attempts + increased use of pharmacotherapy and specialist stop smoking support especially our priority population groups
- Prevent the initiation of smoking - Reducing the demand for and supply of tobacco
- Protecting children from harm – no exposure to second or third hand tobacco smoke (includes pregnancy) and tobacco product
- Contribute to improving whanau ora and reducing health inequalities for Māori in Taranaki
- Advocacy and policy development
- Legislation, regulation and monitoring
- Raise awareness of smokefree Aotearoa 2025

Training has continued twice this year and is promoted and offered free to all midwives in Taranaki from Te Hapū Ora. This training is designed to support the ABC (Ask, Brief advice, Cessation support) model in midwifery practice and encompasses 'best practice' standards for cessation support, essential skills for approaching the topic of smoking with pregnant women and referring to a local stop-smoking service.

What we are doing in 2016/17:

- Update the ABC screening data collection sheet and process for all women admitted to hospital to include all smoking cessation provider details

% of Total Pregnancy Smoking Status by Ethnicity for 2014



Better help for smokers to quit

For the year end of 2015 94.2% of pregnant women were offered brief advice and/or support to stop smoking. Taranaki DHB has increased their national rank to 10th out of 20 DHB's.

The Midland Maternity Action Group

(MMAG) have worked together to purchase smokerlyzers to monitor breath carbon monoxide (CO) levels in pregnant women who smoke. Taranaki DHB maternity services have purchased three monitors which are situated in Hawera Maternity Unit, Base Maternity Unit and the secondary antenatal clinic.

Maternity staff and community

- Update the Taranaki DHB website to include Quitline and local services details
- Provide maternity practitioners with information on local providers and services they offer, including a pathway and feedback to LMC
- Review eLearning and training

- activities for staff and new staff orientating to Taranaki DHB, to include a section on pregnancy
- Investigate setting up peer group support sessions for pregnant women who want to stop smoking.
- Explore options of incentivizing packages for pregnant women

- who wish to stop smoking
- Discussing and setting local Key Performance indicators eg pregnancy referral time to smoking cessation support provider first face to face contact.

Te Hapū Ora

Clinical training for midwives, to support pregnant women who smoke

**Monday 2 May 2016
10.00pm – 2.00pm
Lecture Theatre
Education Centre
Taranaki Base Hospital**

Contact your local Clinical Link Champion to register:
Alys Brown
alys.brown@waikato.dhb.health.nz
or 022 340 0123

Or register online at
www.tehapuora.org.nz

Designed to support the ABC (Ask, Brief advice, Cessation support) model in midwifery practice, encompassing 'best practice' standards for cessation support, essential skills for approaching the topic of smoking with pregnant women and referring to a local stop-smoking service.

- 3 NZ Midwifery Council elective education points allocated
- Free to attend
- Facilitated by your local Clinical Link Champion (specifically trained practicing midwife)
- Interactive activities, video clips, group discussion
- Receive exclusive take-home resources for your midwifery practice
- Travel assistance available (conditions apply)
- Morning or Afternoon Tea provided

Innov8 Smokefree
Smokefree Pregnancy Specialists

Contact: Programme Service Co-ordinator: Mary Jane Newman, maryjane@innov8smokefree.co.nz Mobile phone: 027 252 2013

Smokerlyzer®

Breath Carbon Monoxide Monitors Helping people to stop smoking

Adult %COHb

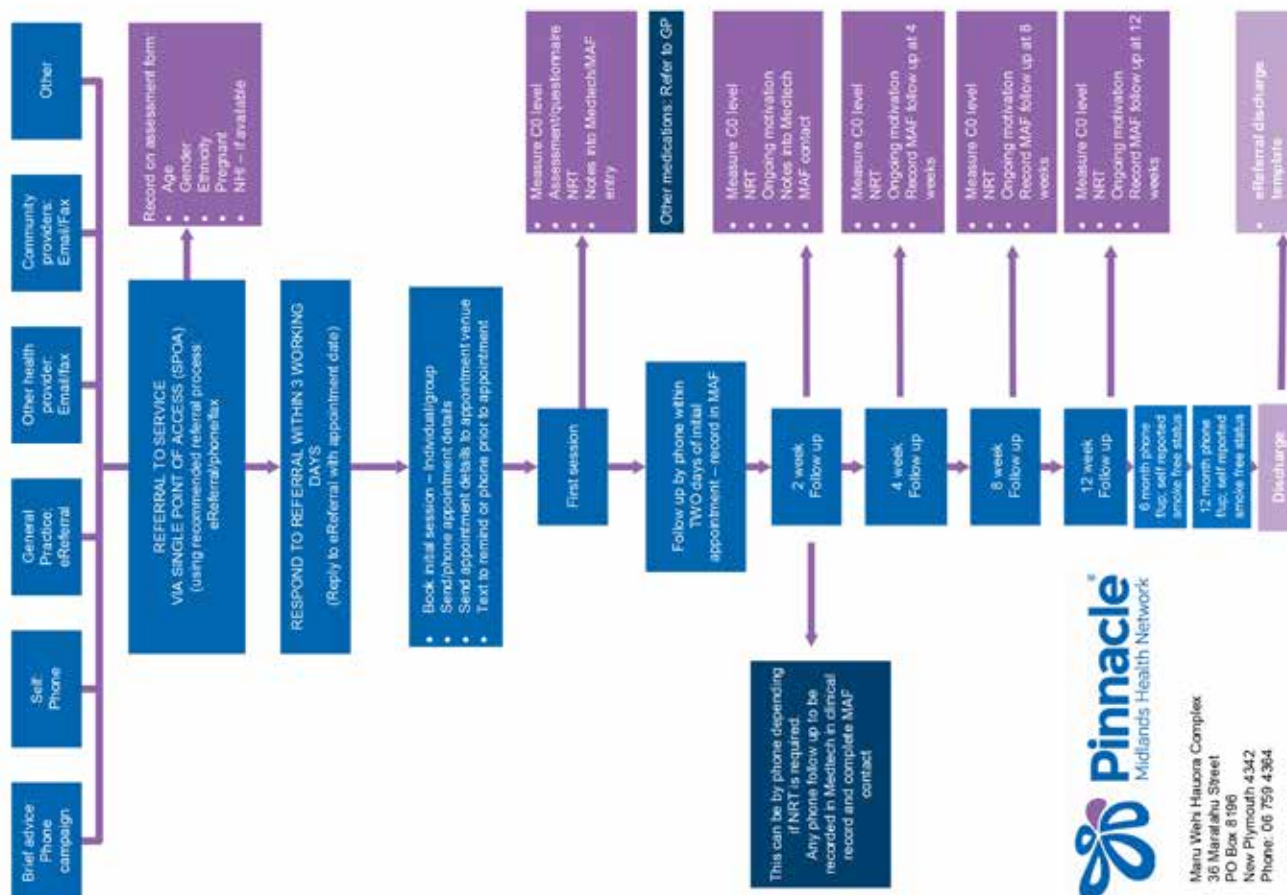
30	5.43
29	5.27
28	5.11
27	4.95
26	4.79
25	4.63
24	4.47
23	4.31
22	4.15
21	3.99
20	3.83
19	3.67
18	3.51
17	3.35
16	3.19
15	3.03
14	2.87
13	2.71
12	2.55
11	2.39
10	2.23
9	2.07
8	1.91
7	1.75
6	1.59
5	1.43
4	1.27
3	1.11
2	0.95
1	0.79

Adolescent/ Maternity %COHb

20+	5.65
19	5.38
18	5.09
17	4.81
16	4.53
15	4.25
14	3.96
13	3.68
12	3.40
11	3.11
10	2.83
9	2.55
8	2.26
7	1.98
6	1.70
5	1.42
4	1.13
3	0.85
2	0.57
1	0.28

This is where you really need to be!
If pregnant and have been told you have a COHb level of 10% or more, you need to stop smoking now. High COHb levels can harm your baby and your health. Stop smoking now to protect your baby and your health.

www.bedfont.com



ANTENATAL CLINIC SERVICES

At Base Hospital, there are:

- Seven obstetric, secondary antenatal/consultation clinics per fortnight.
- A weekly fetal assessment unit clinic
- A weekly midwife clinic at Base Hospital for women under specialist care whose LMC midwife does not provide care for
- A weekly midwifery and secondary antenatal/consultation clinic held in South Taranaki. This clinic provides a service to our rural women and their families.

Number of antenatal clinic visits:

2014 - 881

2015 - 967

In 2015 there were 218 visits through Fetal Assessment Unit (FAU) which gives a combined total of 1179. This again shows a further increase in clinic appointments through our services.

The antenatal clinic co-ordinator runs a weekly drop-in vaccination clinic. This clinic offers Boostix and Influenza vaccinations (seasonally prior to the flu season). Our community midwives inform their women as does the Maternity Quality Facebook page. Women can come to Antenatal Clinic (ANC), 2-3pm every Tuesday.

As at the beginning of May 2016, 77 women have been immunised through ANC. These are very encouraging numbers as the total number of women immunised in 2015, was 93 women.

Hip Check Clinic

This continues to be held twice weekly in the antenatal clinic. It is co-ordinated by our Health Care Assistants and the babies are seen by a visiting orthopaedic doctor.

Amniocentesis

This is performed by Dr Eddie Williams. A quality improvement is that the procedure is now being performed at Fulford Radiology at Base Hospital as they have superior ultrasound scanning equipment. After the referral for amniocentesis is received, the specialist will meet with the woman/partner, the day prior to the procedure in order to discuss the process, provide informed choice and answer any questions they may have.

In 2015, 10 women had an amniocentesis performed. So far in 2016, Dr Williams has performed five amniocentesis:

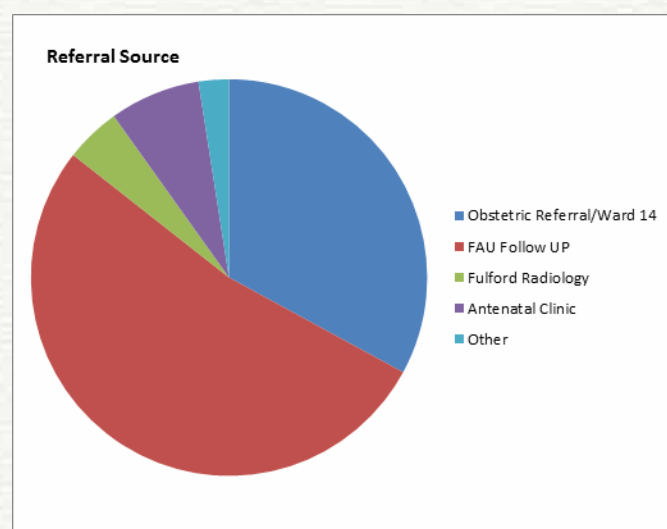
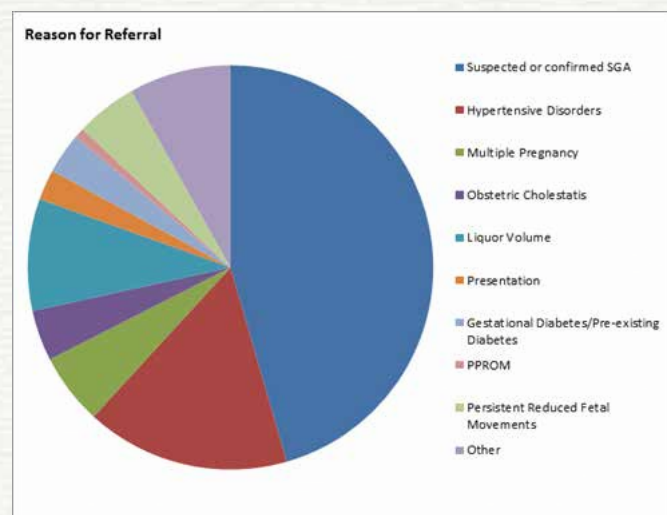
- 3 x for increased risk MSS1
- 2 x for increased risk MSS2.

All results have been normal. MSS2 testing has been done where women cannot afford to pay the nuchal screening ultrasound scan (there are no free providers locally) or they have not booked with an LMC in time to get this screening test.

pre-natal testing). This is a screening blood test that can be taken at 10-11 weeks gestation, however it is quite expensive. For some women who do not wish to have an amnio, this may be an option for them.

Fetal Day Assessment Unit

This is a weekly clinic that was initially developed for women who are under the secondary team who require extra surveillance in between appointments such as twice weekly Cardiotocography (CTG) monitoring, blood pressure and blood testing checks. Additionally it was also intended to capture women who had abnormal ultrasound scan results in the high risk scanning clinic who required immediate review, assessment and care planning. A draft guideline has been developed to guide referrers and improve communication.



Improvements made and what's going well in the antenatal clinic:

The vaccination clinic is very well attended. There is now clear documentation by way of a stamp to highlight those women who have been vaccinated in the maternity clinical notes. Labour ward are aware that if they see a woman antenatally, who has not been vaccinated, then we

can 'seize the moment/opportunistically offer antenatal immunisation for Flu and/or Boostrix' and hopefully capture women who may be considered 'high-risk' or may not be engaging well with services antenatally. Women who have been immunised are being recorded on the National Immunisation Register (NIR) which can be accessed by their GP also.

Within the last year we have visited two GP practices to provide a GP road show. This is very effective in ensuring good communication between GPs and the maternity services re the referral system and also refresh on early antenatal assessment, screening and how to assist the woman in finding an LMC.

Complex Care meetings have been reinstated and held every four to six weeks to discuss women who are under the clinical responsibility of an obstetrician/secondary care and/or women that have required Maternal Fetal Medicine (MFM) services. This is a multi-disciplinary meeting that aims to discuss complex/high-risk women to ensure all aspects of their care is well-planned and provided. There are currently 31 women in our secondary antenatal services.

The need for women to birth in High Dependency Unit (HDU) because they require cardiac monitoring in labour has continued despite Wi-Fi now being situated in our delivery suite, however the IT services will not guarantee that it is 100% reliable due to the old structure of our maternity unit building. Birthing in HDU involves a great deal of planning, there has been a protocol developed to ensure that a detailed labour and birth and postnatal care plan is in place for these women.

What needs to improve

An increase in the number of antenatal clinics per week is needed in order to cope with the amount of antenatal referrals to ANC. This of course comes down to money and staffing issues.

The development of a virtual consultation clinic for LMCs to refer to for non urgent advice on secondary recommendations such as aspirin in pregnancy, previous preterm labour advice and Low PAPP-A (biochemical marker from the combined early pregnancy screening test) was implemented but is not consistently used by the specialist's and will need further work for it to be successful.

The fetal day assessment unit has a draft guideline which has been developed following identified issues with communication and responsibility lines when women are referred directly after an ultrasound scan and who are not currently under the secondary services.

SUPPORT FOR YOUNG VULNERABLE PREGNANT WOMEN

Early Start Programme - New Initiative starting in May/June 2016

Te Puna Early Start is a police led early intervention programme, sought in response to The TSB Community Trust Child and Youth Wellbeing Report (2014).

Early Start is a research founded and fully evaluated, long term home based service, aimed at vulnerable families caring for children from birth to five years of age. Early Start is offered to families from 12 weeks antenatal, where social and family circumstances may put the health and well-being of children at risk. The service provided is voluntary, free, long term and home based. The objective of the programme is the promotion of healthy child development within a nurturing family environment, with long-term aspirations being to break the cycles of poverty, abuse and family dysfunction by promoting early preventative intervention strategies that improve the wellbeing of our children and raise their opportunity to become positive and contributing members of society.

"Learn and apply nurturing parenting practices; discover personal strengths and abilities; develop new skills and practices; and challenge negative and destructive life habits."

Early start is currently at a 'start up' stage and looking for an initial six to eight mothers-to-be, to work with.

Criteria for referral:

1. Family lives in the North Taranaki area (at this early stage)
2. Family is willing to participate
3. Mother is pregnant with her first child
4. Parent faces two or more of the following challenges:
 - Young parent under 18 years of age
 - Mother started late antenatal care
 - Mental health issues; i.e. depression, anxiety etc.
 - Difficulties with drugs, alcohol or gambling
 - Family relationships can be problematic and stressful
 - Child Youth and Family are currently or have previously been involved with the family
 - Parent/s experienced abuse as a child or young person
 - Partner relationship is difficult at times
 - Difficulties with housing, transport and/or meeting day-to-day living expenses
 - Family has been in trouble with the Police
 - Parent/s struggled at school and left early
 - Moved at least twice in the last 12 months
 - Minimal or inadequate social skills
 - Lacks confidence and experience in parenting
 - Limited support networks

Maternity Care, Wellbeing and Child Protection Multi-Agency Group

Maternity Care, Wellbeing and Child Protection Multi-Agency Group (MCWCP) is a team of people involved in maternity or child care who meet every two weeks to discuss pregnant women or infants who have been referred who may need extra support.

Who is on it?

The group changes depending on what support a family needs but may include:

- Midwives
- Social workers
- Alcohol and drug keyworkers
- Child, youth & family social workers
- Mental health workers
- Well Child & Tamariki Ora providers
- Kaitakawaenga (Māori health services)
- Representatives from community support agencies such as Family Start

What do we do?

The purpose of the group is to support and strengthen families. We discuss any issues a family is facing and suggest ways to help. Because there are many services on the group we have good knowledge of the help available.

Who can refer to the group?

Anybody involved in the pregnancy care can refer to the group.

This may be:

- Lead Maternity Carer/community midwife (midwife, obstetrician or GP)
- Social worker
- Well Child Provider – Plunket or Tamariki Ora nurse
- Practice nurse or GP
- School health nurses
- Public health nurses
- Child, Youth & Family
- Mental health service
- Addictions service
- Police or probation officers

Benefits of referral to the group

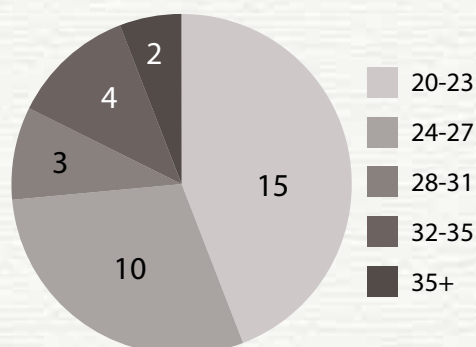
The group provides an opportunity for the team that provide direct care to the pregnant woman to work closer together to ensure the woman and her whanau have access to all the services available in relation to what she may need.

The inaugural meeting was commenced in August 2015 following a period of local planning with the Multidisciplinary advisory team.

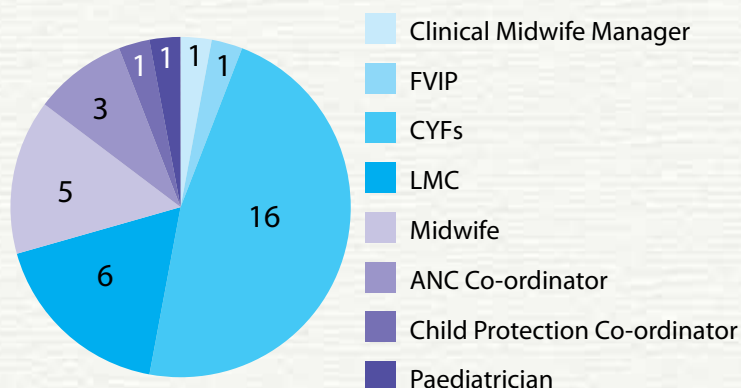
There have been increasing referrals since this group has been initiated, below are some tables highlighting the referrals that have been received.

October 2015 – March 2016 Maternity Wellbeing and child protection multidisciplinary agency group referrals.

Referrals by Age

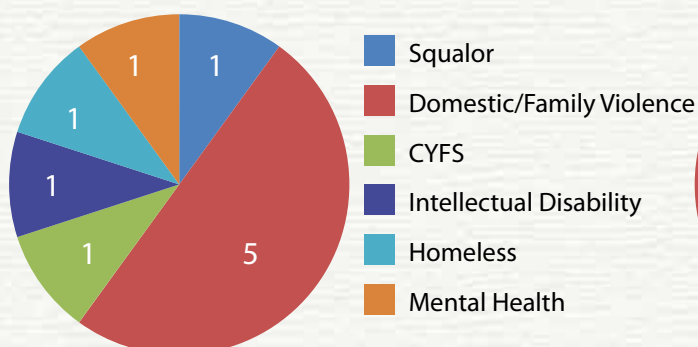


Referrals by Service

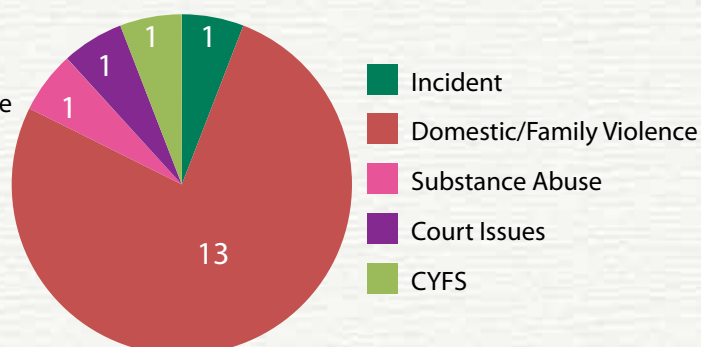


REASONS FOR REFERRALS BY ETHNICITY

New Zealand European



Māori



Family Violence Intervention Programme (FVIP):

Midwives and maternity staff including community midwives are offered FVIP training.

The self audit completed Sept 2015 by the FVIP coordinator showed that:

- 1 April 2015 –30 July 2015: 25 files were examined to provide evidence that women who came through the maternity services at Taranaki DHB were screened in the past 12 months for family violence.
- 15 out of 25 were screened for FV = 60%
- Three of 15 were positive = 20%

This is well placed within the national median but it is hoped to reach 70% in 2016/2017



BREASTFEEDING

Taranaki DHB Lactation Consultant Services May 2016

Baby Friendly Hospital Initiative (BFHI)

In 2015 Taranaki DHB Base and Hawera Maternity Units achieved continued BFHI Accreditation following on site auditing. Annual surveys are completed to ensure standards are maintained.

Lactation Consultant Services

- Inpatient, outpatient and antenatal Lactation Consultant services continue on receipt of a referral.
- A Lactation Consultant clinic is held each fortnight at Hawera Maternity Unit.
- Outpatient services are now supported by regular clinics managed by Tui Ora.

Education Neonatal Unit (NNU)

Maternity/NNU Breastfeeding days supporting BFHI education requirements and Midwifery standards were held twice during the year. Feedback received was very positive. Community health workers were also invited to attend. The study days provide excellent network opportunities.

Whangai U

Regular attendance to the Whangai U network meetings continue. This is a valuable networking opportunity for those attending including La Léche League, Taranaki DHB Health Promotion, Plunket Well Child and Lactation Consultants.

Midlands DHBs achievements for breastfeeding

- Development of the BreastfedNZ app.
- Draft donor milk protocol.
- Mama Aroha Breastfeeding card distribution

2016/2017

Breastfeeding case reviews (commenced April 2016).

These meetings enable discussion and an opportunity to learn and to apply the latest literature and recommended best practices as well as celebrate cases of success. *This is a new initiative. (See Appendix 6)*

Education

Maternity/NNU study day to be held in July. A new Midwifery Breastfeeding template will then be developed to cover educational requirements for Midwives and BFHI for the upcoming period.

Lactation consultant services

Continued liaison with Tui Ora and development of community Lactation support in Taranaki.

Lactation consultant education

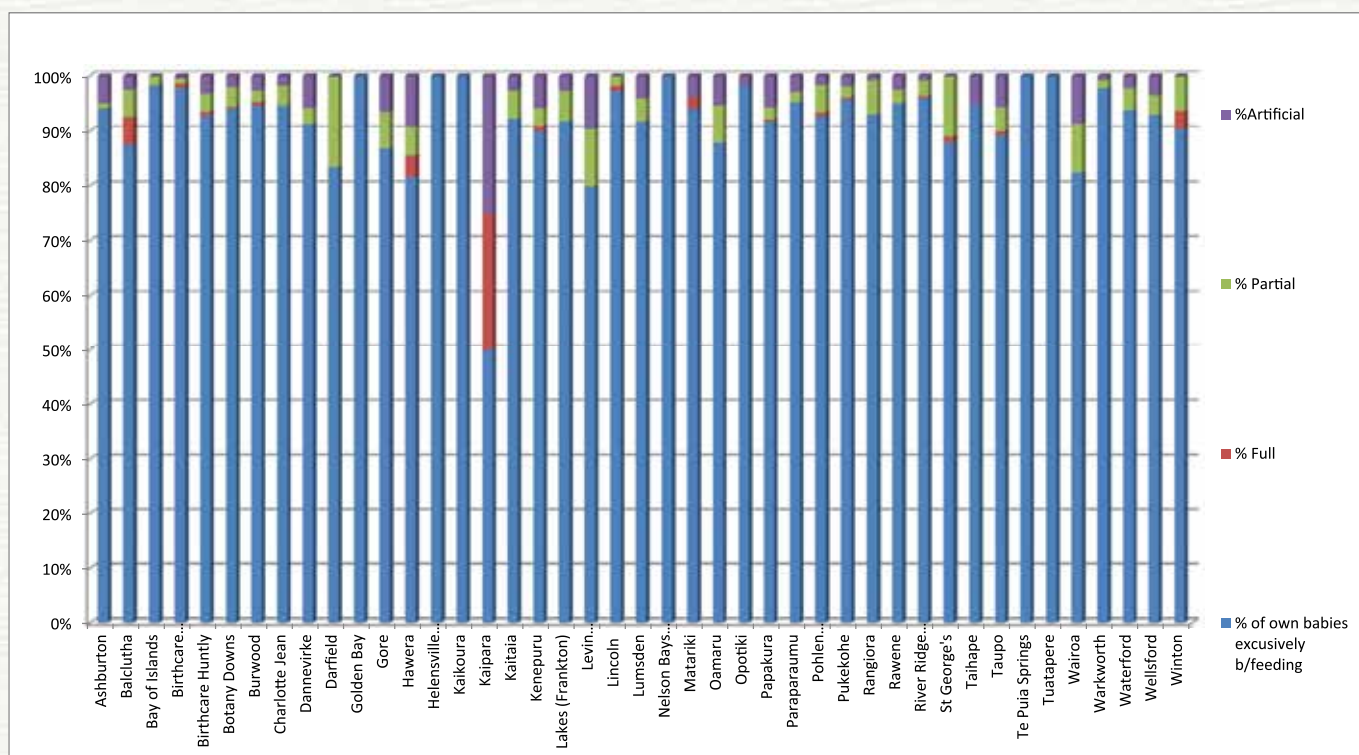
Establish opportunities to discuss clinical situations with other Lactation Consultants.

Resources

Tongue tie services and guidelines.

The resource "Tongue tie... What you need to know" brochure is in its development phase. The brochure and guidelines will be circulated for consultation.

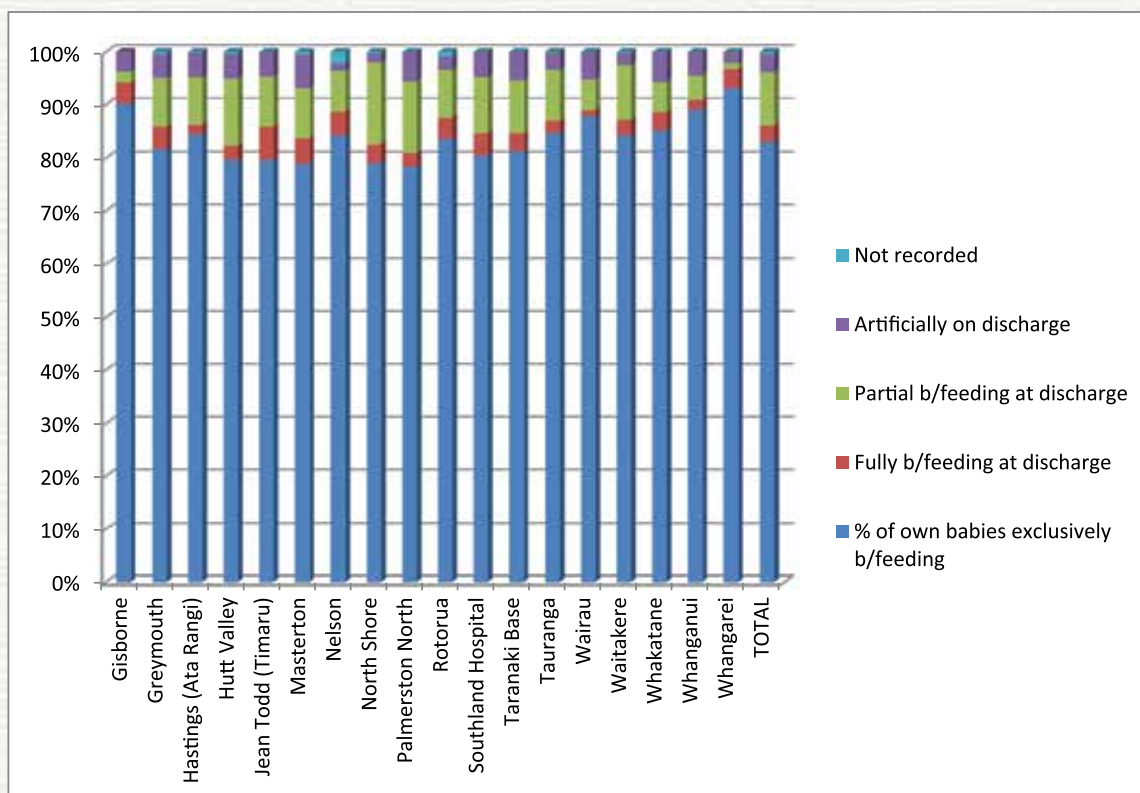
Infant Feeding Rates for Primary Services 2014



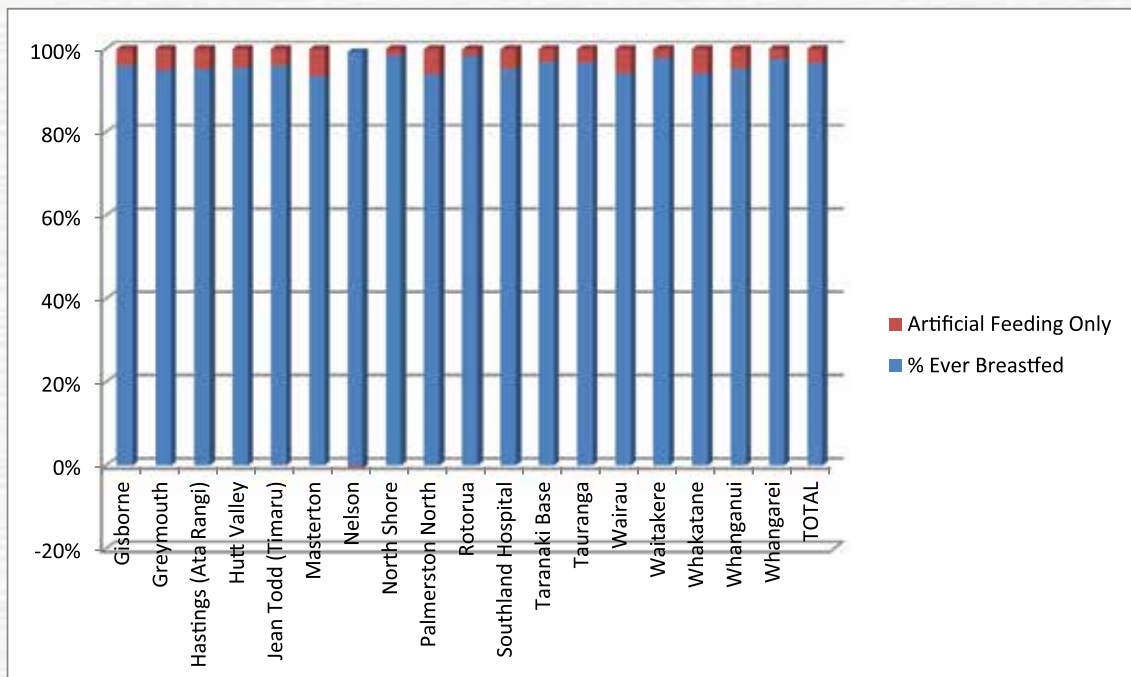
Breastfeeding Rates by Ethnicity (Hawera 2014)

	NZ European	Māori	Pacifica	Asian	India
Percentage Exclusive	68	74	0	50	50
Percentage Fully	12	10	0	0	50
Percentage Partially	7	5	100	50	0
Percentage Artificially	12	11	0	0	0
Percentage Ever Initiated (estimated)	88	89	100	100	100

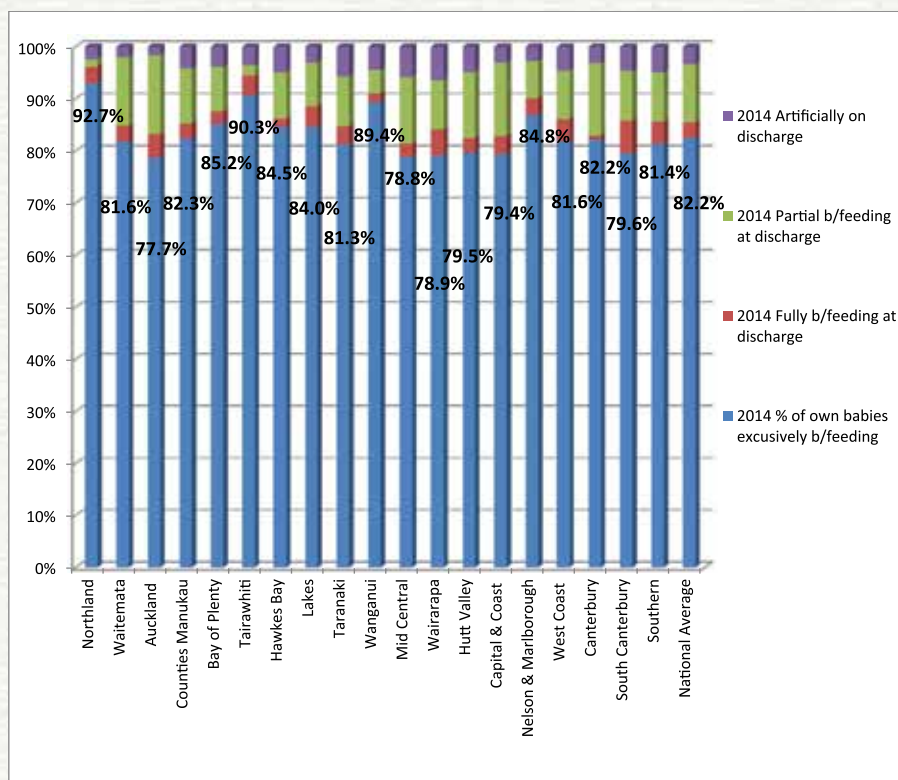
Infant Feeding Rates for Secondary Maternity Services 2014



Infant Feeding Rates: Ever Initiated/Artificially Fed Rates for Secondary Maternity Services 2014



Infant Feeding Rates for DHBs (2014)



Breastfeeding Rates by Ethnicity (Taranaki Base Hospital 2014)

	NZ European	Māori	Pacifica	Asian	Other	Indian
Percentage Exclusive	82	82	63	65	81	88
Percentage Fully	3	3	6	4	8	4
Percentage Partially	10	8	19	26	11	8
Percentage Artificially	5	7	13	4	0	0
Percentage Ever Initiated	97	96	88	96	100	100



BREASTFEEDING DEFINITIONS

EXCLUSIVE BREASTFEEDING: The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breast milk, from the breast or expressed, and prescribed medicines have been given from birth.

FULLY BREASTFEEDING: The infant has taken breast milk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 24 hours.

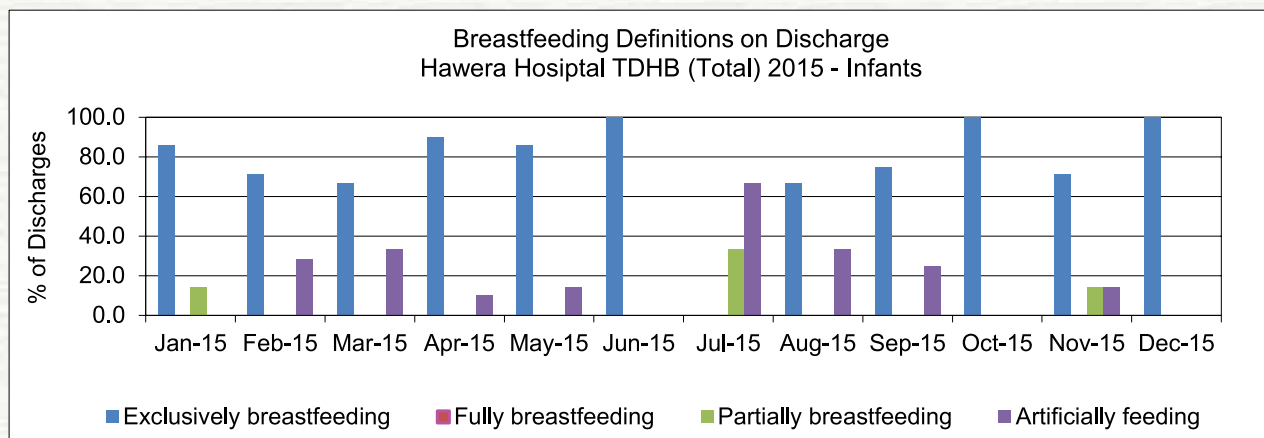
PARTIAL BREASTFEEDING: The infant has taken some breast milk and some formula or other food or other solid food in the past 48 hours.

ARTIFICIAL FEEDING: The infant has had no breast milk but had alternative liquid such as infant formula with or without solid food in the past 48 hours.

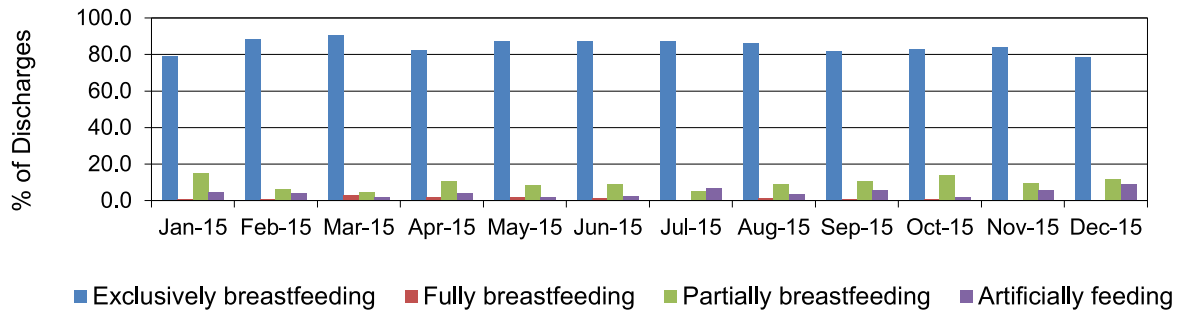
(Coubrough L.MoH 1999)

BABY FRIENDLY HOSPITAL INITIATIVE

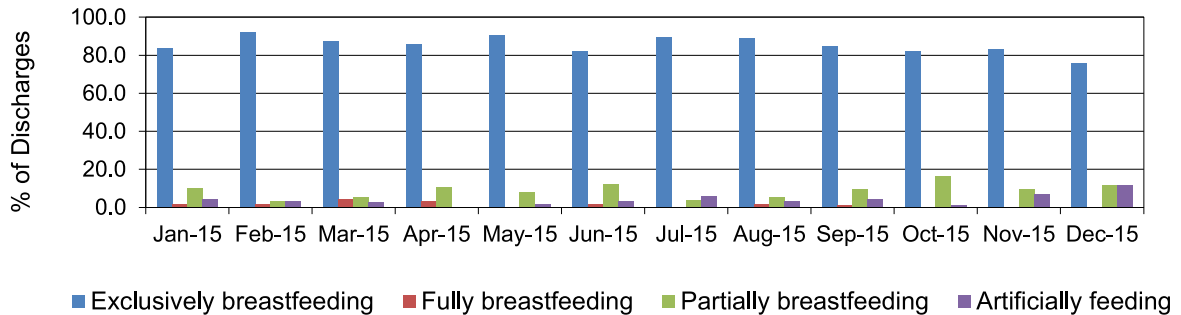
Breastfeeding lays a foundation for good health in infancy, childhood and into adult life. Maternity hospitals have a special role in supporting the establishment of breastfeeding. The Baby Friendly Hospital Initiative (BFHI) assists all maternity hospitals to become centres of breastfeeding support. BFHI is a World Health Organization and United Nations Children's Hospital fund. Base Maternity and Hawera Maternity Units were last audited in 2015 and maintain BFHI.



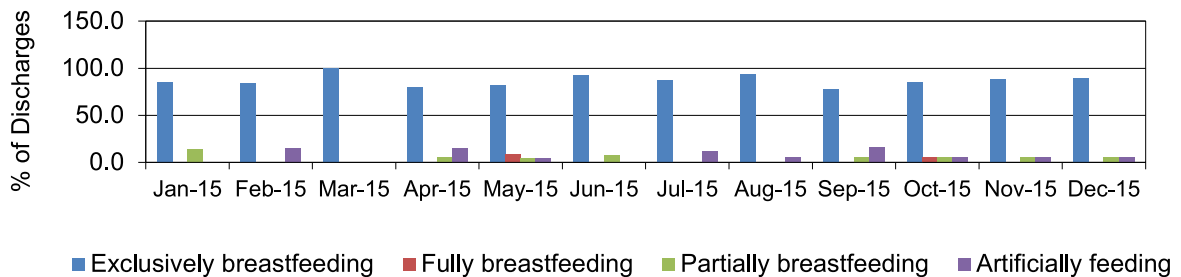
Breastfeeding Definitions of Babies on Discharge
Base Hospital Taranaki DHB (Total) 2015



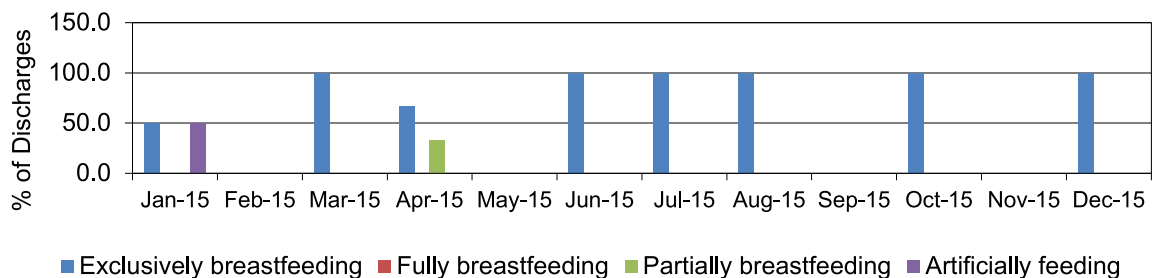
Breastfeeding Definitions of Babies on Discharge
Base Hospital Taranaki DHB (NZ European) 2015



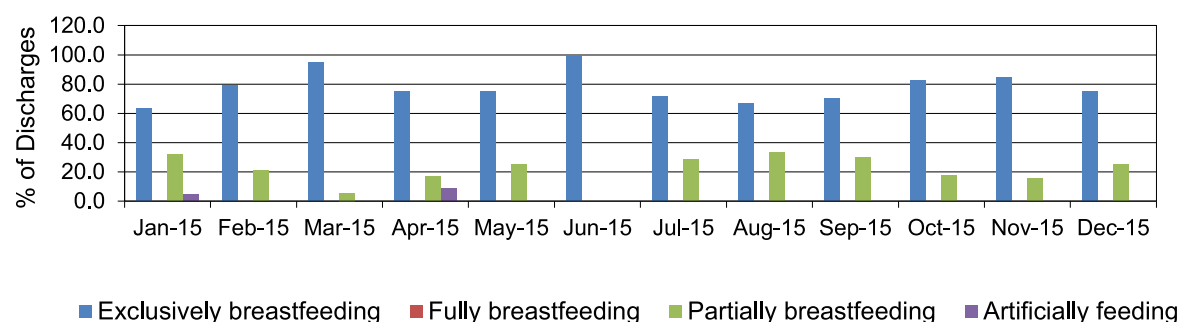
Breastfeeding Definitions of Babies on Discharge
Base Hospital Taranaki DHB (NZ Maori) 2015



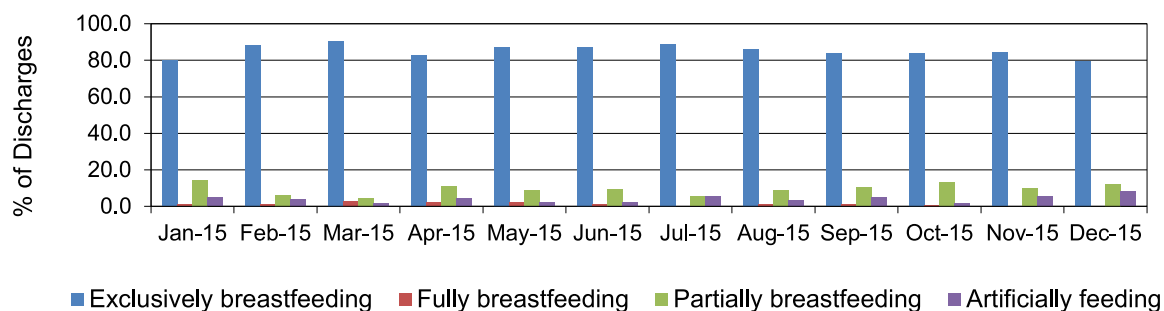
Breastfeeding Definitions of Babies on Discharge
Base Hospital Taranaki DHB (Pacific) 2015



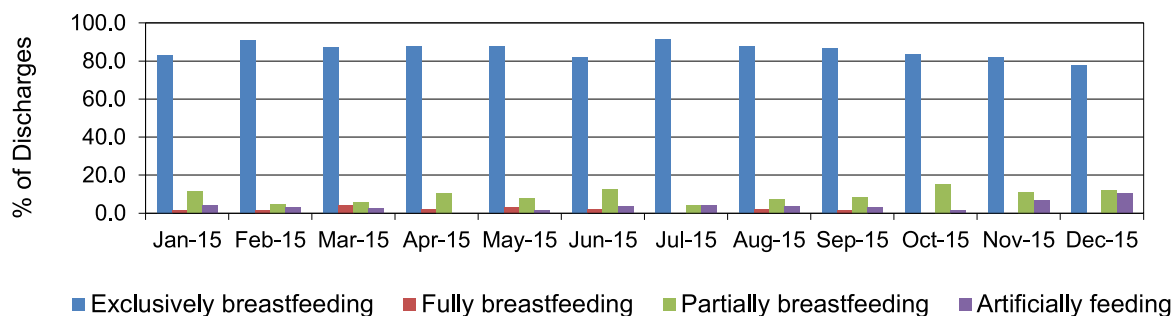
Breastfeeding Definitions of Babies on Discharge
Base Hospital Taranaki DHB (Other) 2015



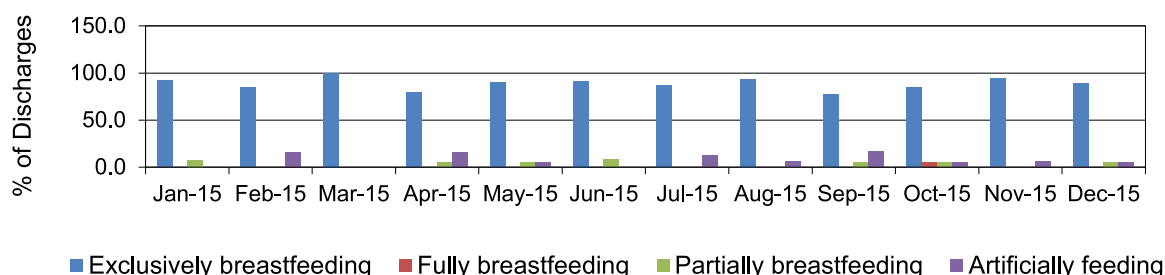
Breastfeeding Definitions on Discharge
Base Hospital Taranaki DHB (Total) 2015 - Mothers



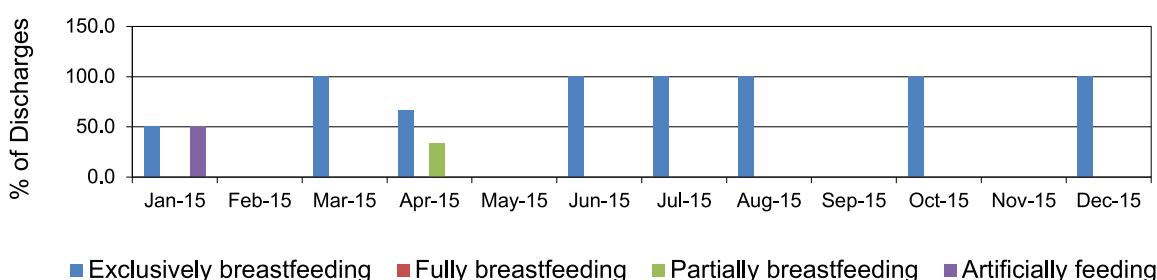
Breastfeeding Definitions on Discharge
Base Hospital Taranaki DHB (NZ European) 2015 - Mothers



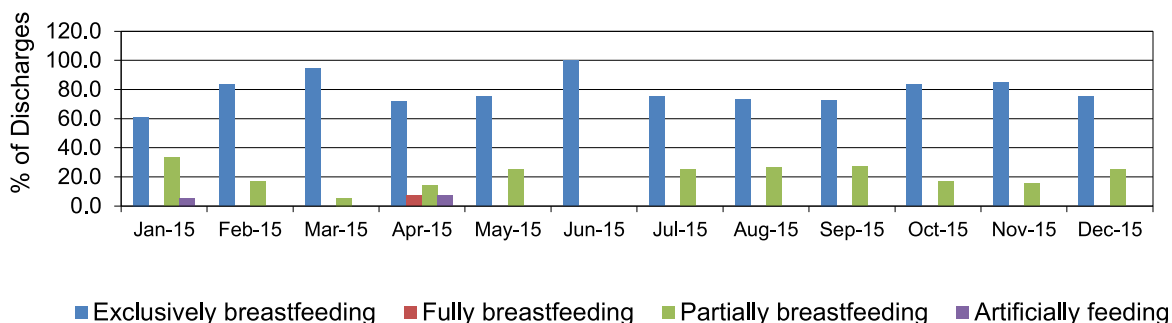
Breastfeeding Definitions on Discharge
Base Hospital Taranaki DHB (NZ Maori) 2015 - Mothers



Breastfeeding Definitions on Discharge
Base Hospital Taranaki DHB (Pacific) 2015 - Mothers



Breastfeeding Definitions on Discharge
Base Hospital Taranaki DHB (Other) 2015 - Mothers



BREASTFEDNZ MOBILE PHONE APPLICATION

Midland Maternity Action Group – Maternity Quality & Safety Programme Regional Initiative

Background

The New Zealand Institute of Rural Health published a study, supported by the Midland Maternity Action Group: 'Midland Region Rural Maternity Services Consumer Engagement Study' (June 2014)

Recommendation - information theme:

'Review/search for apps for mobile phones on pregnancy and birth. These should be provided free of charge to newly pregnant women.'

The idea

A breastfeeding mobile phone application - providing free and timely information and support to breastfeeding mothers throughout Aotearoa New Zealand

Why develop an app?

- perfect tool for native IT users (X and Y generation)
- information sharing has changed:
 - › print resources not well utilised
 - › web based info almost outdated
- DVD uptake poor
- accessible, portable, 'in the moment'
- access to information at the tap of a screen

Project team

Project Manager (HealthShare), Senior Lactation Consultant – Lead Content Developer (Bay of Plenty DHB), Public Health (Toi Te Ora), Web Developer/ Graphic Designer, App Developer

Stakeholder engagement from the beginning

- **Midland wide survey of women** asking about their breastfeeding experiences and what they wish they had known about breastfeeding
- **Midland wide survey of Health Care Professionals** – what they believed women needed to know about breastfeeding
- **Toi Te Ora Public Health Unit** (Bay of Plenty and Lakes DHB areas)
- **Māori health** involvement
- **Extensive review and feedback** from across Midland and beyond on the draft app content during development



BreastFedNZ

 **Midland**
District Health Boards
www.midlanddhbs.health.nz



BreastFedNZ

Six chapters of content – from pregnancy to weaning

- 'in the moment' messages
- kiwi language and use of Te Reo
- conversational style
- realistic, 'sage' advice
- women's stories and photos (peer learning)
- short video clips
- links to: websites, community support, public breastfeeding support

...supporting *BreastFedNZ* app uptake in Midland

Designing te reo app resources

Free app resource design files developed, eg wallet cards, posters and increased visibility of Māori mamas.

Tikina tō Taupānga Whāngai Ū KOREUTU

Tikiake i te taupānga **BreastFedNZ** mō te koreutu hei kimi i ngā āwhina, ngā kōrero, tautoko

Rapua ngā pātaka Google Play, iTunes rānei mō **'BreastFedNZ'**

Download on the App Store | GET IT ON Google play

www.breastfednz.co.nz

FEEDBACK FROM MIDWIVES

“ Just loving the new breastfeeding app. I'm telling people wherever I go. ”

“ As a midwife I thought I'd better have a quick look through the app. I'm impressed! Clear, concise content, good info around latching, which is so helpful! ”

Get Your FREE Breastfeeding App

Chapter Contents

Available now to download

Chapter 1
Pregnancy
Why breastfeed?
Your body, what's happening
Can everyone breastfeed?
How do I prepare?
Who can I talk to?
Dad's page
Good to know

Chapter 2
Learning to breastfeed
Day 1 & 2
Your breastmilk is amazing
How ...
Babies are born clever!
Latching and positioning
Will it hurt?
Days 3 - 5
When the milk comes in
Hand expressing
Full breasts and other things
Breast and nipple care
Weighing babies
Other baby stuff
Red flags
Dad's page

Chapter 3
How ...
Red flags
Cluster feeds & growth spurts
What is a 'let-down'?
Weeks 3 - 6
Looking after yourself
Dad's world
Painful nipples
Nipple shields
Tongue tie
Sore breasts, lumps & bumps, mastitis
Too much milk
Too little milk
Unsettled babies, spilling, reflux, colic
Baby blues and other clues

Chapter 4
Babies change
Ages and stages
Common concerns
Managing other children
Breastfeeding toddlers and children
Breastfeeding while pregnant and tandem feeding

Chapter 5
Late pre term babies (35-37 weeks)
Premature babies (32-37 weeks)
Very premature babies (24-32 weeks)
Twins
Special babies

Chapter 6
Finding support
Going out/travelling
Expressing & storing milk
Going back to work/study
Your health
Medicines whilst breastfeeding
Contraception when breastfeeding
Smoking when breastfeeding
Alcohol and recreation drugs
When breastfeeding doesn't work out
Weaning

Search Google Play or iTunes stores for **'BreastFedNZ'**

Chapter 1 Contents

1 Pregnancy & Birth

Pregnancy
Why breastfeed?
Your body, what's happening
Can everyone breastfeed?
How do I prepare?
Who can I talk to?
Dad's page
Good to know

Birth
The birth and breastfeeding
Skin to skin and the first feed

Download on the App Store | GET IT ON Google play

Consumer engagement

Involved in sharing their breastfeeding 'stories', photos, videos, ideas and feedback along the design journey

Feedback from consumers and midwives

“ The **BreastFedNZ** app has been a hugely beneficial tool and valuable resource whenever I need it, right at my fingertips! ”

BreastFedNZ

Social Media and Website – celebrating a home grown NZ breastfeeding app!

- website developed www.breastfednz.co.nz – a central place for free access to resource design files, eg wallet cards, posters, Well Child book stickers, te reo resources
- BreastFed NZ Facebook Page – 500+ followers – actively managed to increase awareness and link consumers with other breastfeeding resources
- QR code for easy downloading
- available on Apple and android platforms



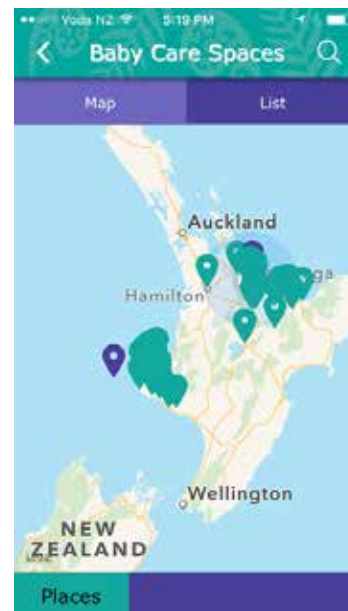
Integration:

- ✓ **supporting breastfeeding in public and private community spaces**
 - › 214 breastfeeding accredited spaces added to GPS activated map
 - › Public Health Units in Midland (Taranaki, Bay of Plenty and Lakes DHBs) have incorporated their breastfeeding accredited spaces into the app under 'baby care spaces' – includes libraries, cafes, Plunket rooms, etc
 - › Waikato DHB Population Health and Hauora Tairāwhiti looking to add their breastfeeding accredited spaces into the app
- ✓ **encouraging women to continue breastfeeding beyond six weeks**
 - › 5,000 Well Child book app stickers provided throughout Midland

- › Ministry of Health approached to consider incorporating the app sticker into the next print run of Well Child books
- › presentations to Well Child providers on the use of the app
- › linking to the WellChild and Raising Children apps

✓ linking women with support services and agencies

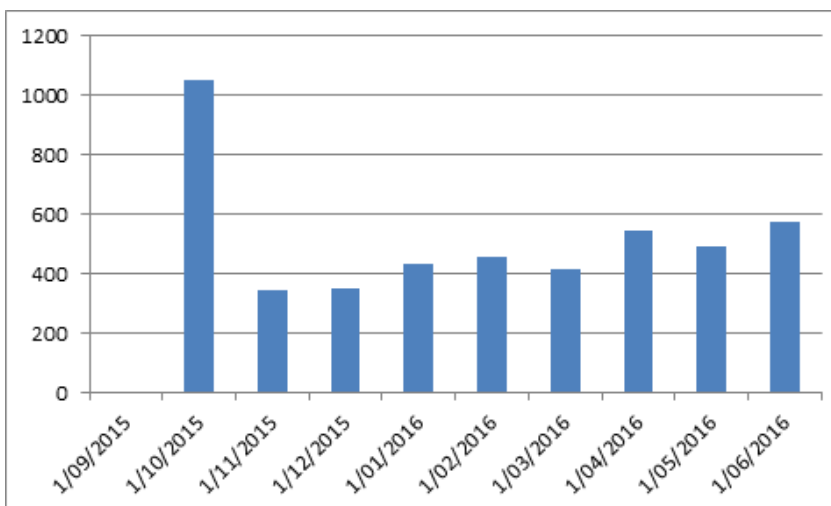
- › 31 support agencies added to 'Get Support' tab on app and BreastFedNZ website, eg Plunket, Healthline, Smokefree – Help Quitting, Alcohol Support, etc



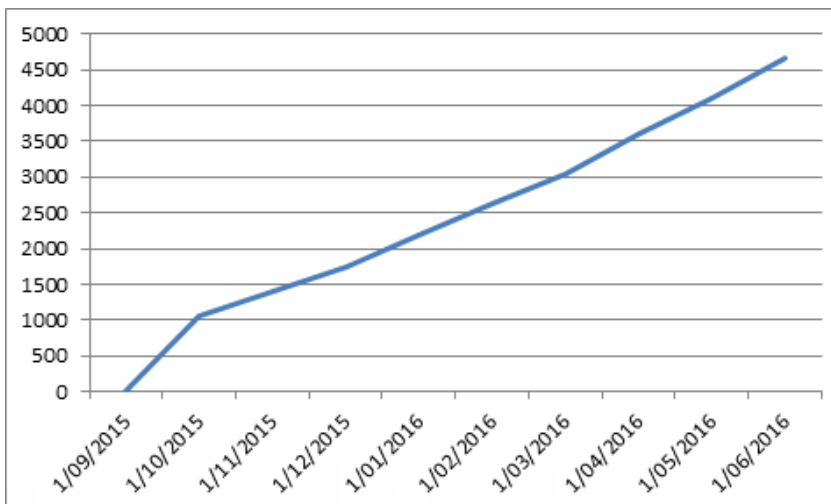
Tracking the app downloads since launch 1 September 2015:

4,665+ app downloads as at 2 June 2016

BreastFedNZ App - Monthly Number of Downloads



BreastFedNZ App - Cumulative Number of Downloads



BreastFedNZ



PROMPT multidisciplinary obstetric emergency team training

BIRTHING ENVIRONMENTS

A working group was initiated to map out changes that could be made to improve the birthing environments at base and Hawera Maternity Units, with the welcoming knowledge that a recent announcement was made for the commencement of a new maternity facility in New Plymouth within a five year timeframe. Our student midwife scholar Angela Worthington worked with the MQC coordinator and maternity unit staff on the project of Improving our maternity environment by initially de cluttering and focusing on important messages to our consumers. Taking the “looking through eyes of a consumer” approach as well as listening to staff ideas.

Many of the key messages we are passionate for the women and whanau with whom we work, to understand were lost due to too much information, too many words. We wanted to aim to capture all literacy levels by displaying powerful images that have the capacity to evoke emotion

and memory than well meaning statistical graphs and lengthy explanatory resources.

What we did:

- Removed lengthily confusing and dated messages
- Displayed posters and messages in dashboards ensuring the walls remain “clean walls” creating colour and creativity
- We have displayed donated photography that have positive messages eg skin to skin, fathers, mothers and babies
- We have purchased bean bags and aids to assist mobility in labour.

Additionally this next year 2016/17 we wish to continue to focus on increasing our normal birth rate and decreasing our assisted and caesarean births. The plan is to provide a display of our current normal birth, assisted and caesarean birth rates on dashboards along with a display of messages and positive actions to promote confidence in normal birth.

IMMUNISATION IN PREGNANCY AND THE NEWBORN

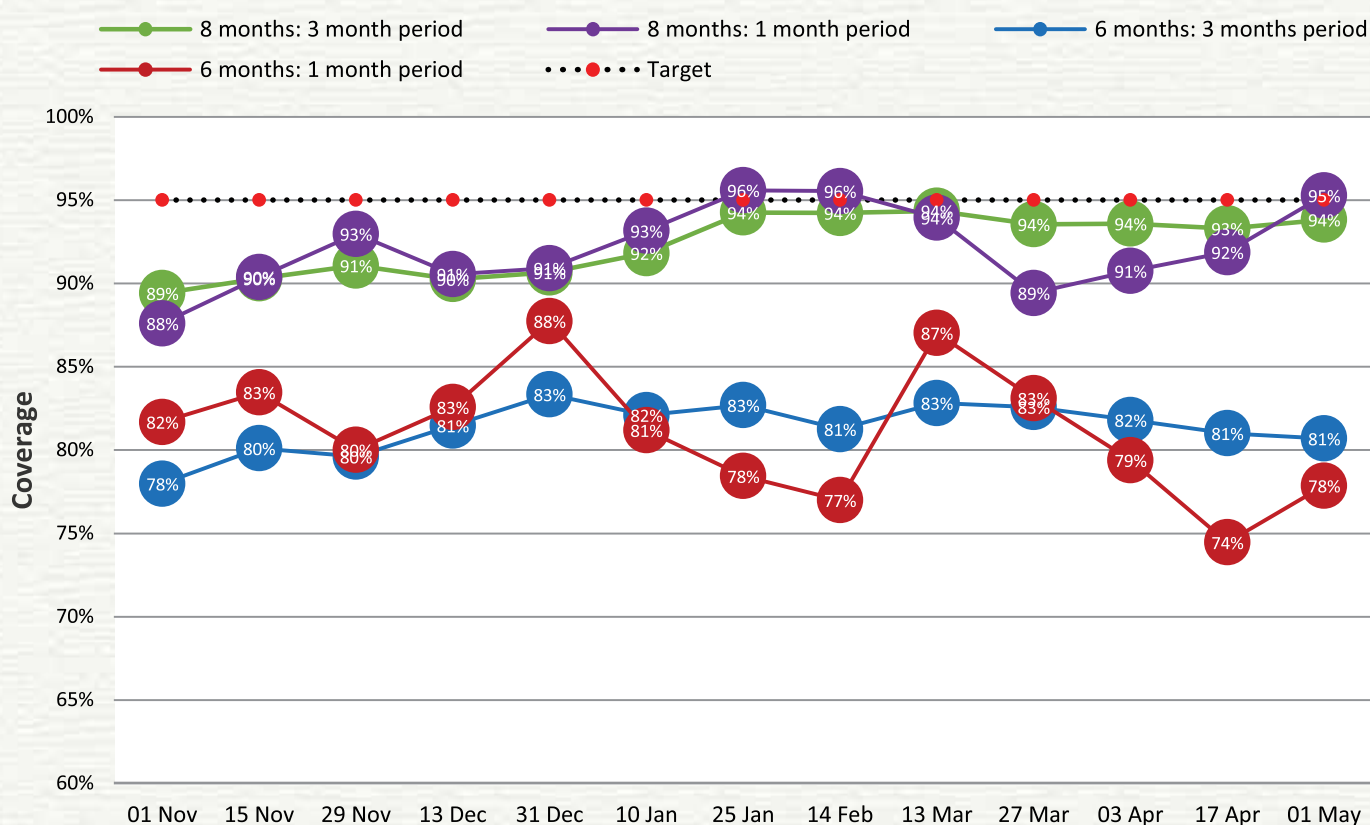
Taranaki DHB secondary antenatal clinic offers a weekly drop in clinic for pregnant women to obtain free immunisation in pregnancy for Flu and Boostrix.

During immunisation week a daily drop in service was implemented with a good response from marketing this initiative on the Taranaki DHB Facebook page and the Taranaki Maternity Quality and safety Facebook page.

A stamp has been initiated to use in the maternity records to recognize which women have been immunised and identify any in patient antenatal admissions who may not have been immunised so that opportunistic immunisation can be offered.

The Taranaki Immunisation strategy group has been working hard to improve the immunisation rates for infants. Community midwives and hospital staff have been working together to improve new-born enrollment by encouraging women to be registered with a GP in pregnancy to ensure new born infants receive timely immunisation from their GP at 6 weeks. There have been challenges for women to access a GP who will accept new patients so a list of GPs is regularly updated and circulated to community or hospital midwives to give to women. If the woman is not registered with a GP the ward clerk offers to assist her to complete an enrollment pack if she wishes before discharge from the postnatal ward. The Implementation of the National Child Health Information Platform (NCHIP) in June 2016 should improve the information sharing and milestone achievements of our newborn, infants and children.

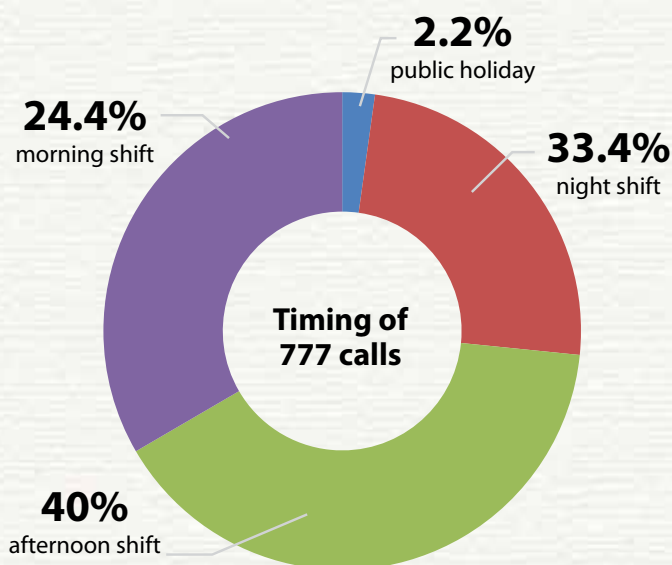
Taranaki DHB Immunisation coverage of children at six months and eight months



CAESAREAN SECTION AND VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

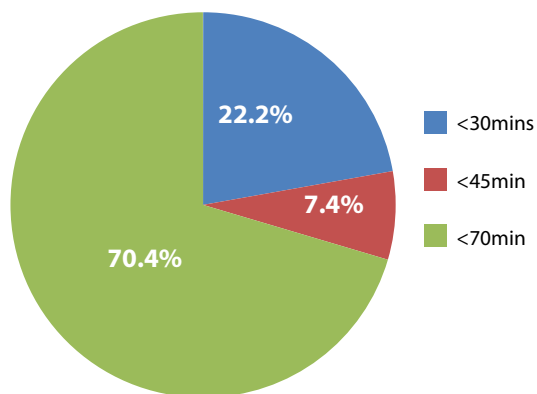
A total of **48** "777" level 1 emergency maternity calls in 2015 were reported by the audit trail by making the 777 call.

75.6% of the 777 calls are out of normal working hours (Mon –Fri 7.00-16.00 non weekend or non public holiday)

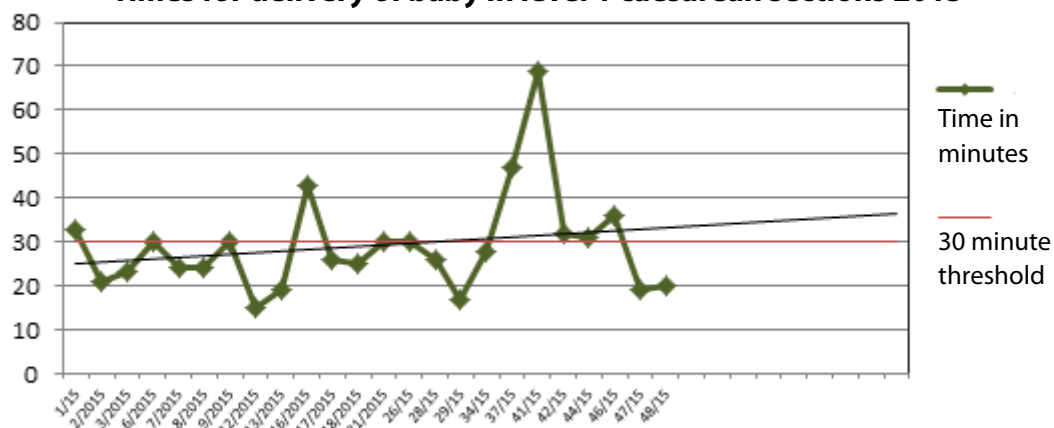


Timing from decision to delivery for level 1 caesarean sections

This graph does not include the number of level 1 caesarean sections that were called off or down graded for CTG abnormality.



Times for delivery of baby in level 1 caesarean sections 2015

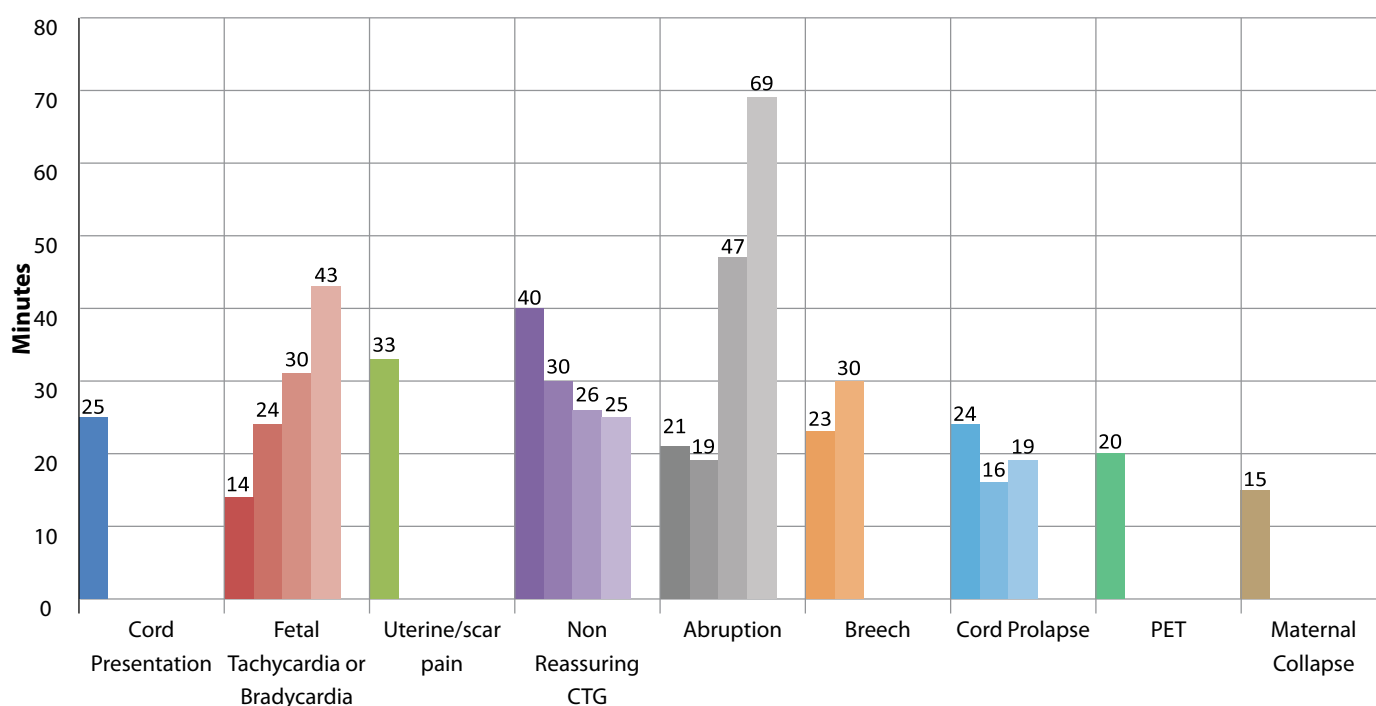


70.4% are within the 30 minute auditable standard, investigations need to be made on the cases exceeding this.

It is recommended that cardiotocography (CTG) training should be provided annually and consideration should be given to having leadership/senior staff out of hours.

Level 1 Emergency Caesarean Sections

1 January - 31 January 2015



Reason for Emergency Caesarean

Discussion and key recommendations:

All calls for:

- Maternal cardiac arrest
- Level 1 caesarean
- Obstetric emergency

Should be made via the 777 operator call stating one of the above and should not be complicated by any other title for example cord prolapse, abruptio, eclamptic fit or Post Partum Haemorrhage (PPH).

Documentation in the operating theatre records on what level the caesarean section proceeds at, whether it was downgraded from a level 1 and the rationale for the decision for General Anaesthetic (GA) versus spinal anaesthesia could assist the audit and provide clarity for the correct identified auditable standard.

A number of improvements have been made and are still in progress:

- Emergency cones have been purchased for each delivery room to be placed in the corridor during a clinical emergency so that help on arrival can identify the location of the emergency
- Further work has been carried out with the switchboard/operator directives.
- New battery back up delivery beds have been purchased with a further three beds on order to allow immediate departure from the ward for level 1 caesarean if appropriate.

- Speaker phones are in all delivery rooms to enable hands free speaking during an emergency
- Ward 14 doors have been enabled to facilitate a slow release movement.
- A cordless digital phone is available to be carried by a member of staff to enable immediate contact for assistance.

A follow up audit on emergency caesarean section calls (level1 and 2) was conducted to examine the time of decision for caesarean to the time of leaving the ward, to the time of arriving in pre op to the time of procedure to try and identify if any further progress could be made in improving timings from decision to delivery time. Initial findings indicate that further investigations from arrival at preop to commencement of surgery should be made to see if timings can be improved. Further to this documentation could be improved to assist the audit trail and the availability and utilisation of stamps to capture the timings.

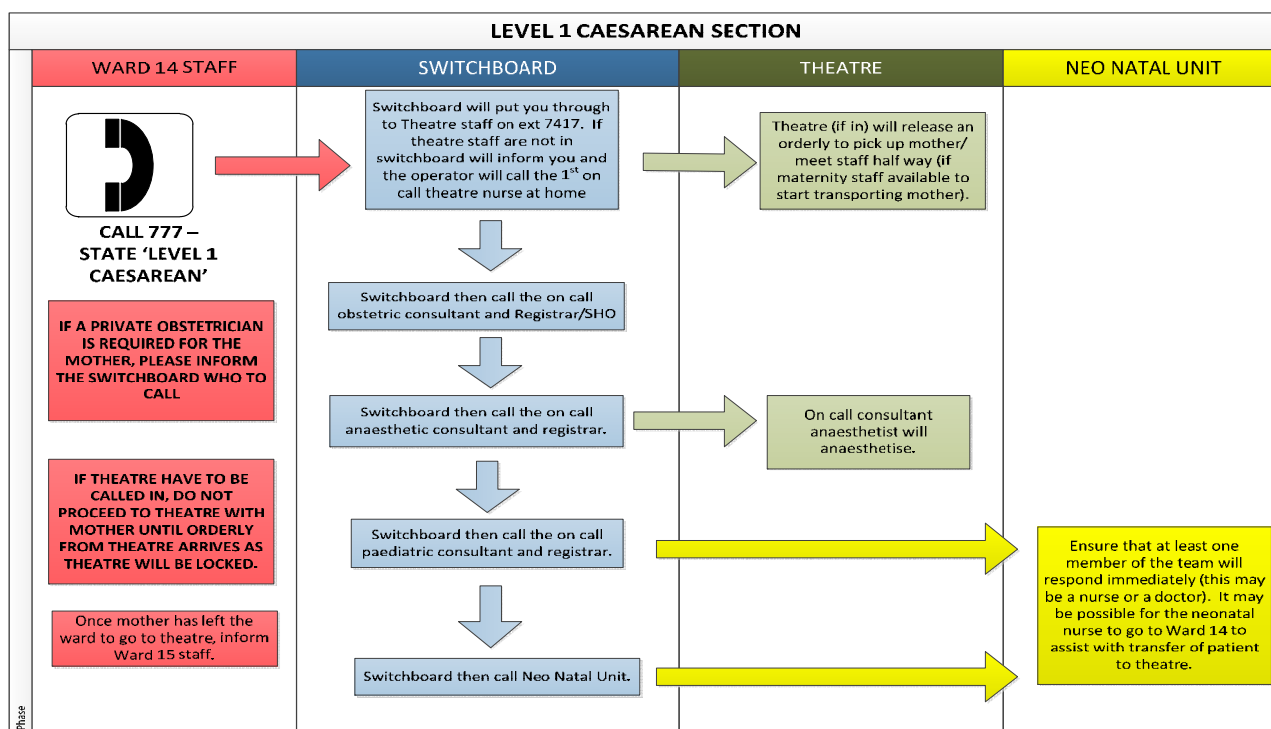
Emergency 777 Call Directive in all birthing rooms next to the phones

EMERGENCIES

777	Obstetric Emergency (State if anaesthetist needed)
777	Maternal Cardiac Arrest (See Peri Mortem Protocol)
777	Level 1 Caesarean Section
0	Duty Obstetrician
7783	Blood Bank
7417	Theatre
7746	NNU
8908	Labour Ward Office
7750	Post Natal

EMERGENCY CAESAREAN DIRECTIVE

LEVEL 1 CAESAREAN; Immediate threat to the life of the mother and fetus, e.g. cord prolapse, massive APH, etc. This is an audited process and the standard is birth within 30 minutes of calling a level 1.



LEVEL 2: Maternal and fetal compromise which is not immediately life threatening, e.g. failure to progress. This is an audited process and the standard is birth within 75 minutes of calling a level 2. **Action taken;** On call Obstetrician will activate Level 2 call out. Ward staff will inform Ward 15 and Neo Natal Unit.



Vaginal Birth After Caesarean Section

What is Taranaki DHB doing about Vaginal Birth After Caesarean Section (VBAC)?

Total VBACs	Total Potential VBACs	VBAC Rate	Financial Year
27	163	17%	2009/10
22	144	15%	2010/11
23	126	18%	2011/12
36	150	24%	2012/13
30	157	19%	2013/14
26	158	16%	2014/15
19	111	17%	2015/16

For women who have had a previous caesarean section, the following services and support are available at Taranaki DHB:

Following emergency caesarean section, the aim is for the obstetrician involved to consult/debrief with the woman the following day, or when appropriate. It is at this early stage that we aim to sow the seed for VBAC in the future, especially if this is in the best interests of the woman. Accordingly, the obstetrician will clearly document in the theatre record and discharge letter whether or not a woman is a suitable candidate for VBAC or if a repeat caesarean section is indicated.

Women who have had a previous caesarean section are referred for consultation with a specialist by their LMC to attend our secondary antenatal clinic held at Base or Hawera Hospital. This is a requirement as per the Section 88 Referral Guidelines. (There are insufficient numbers of women coming to the clinic with VBAC to have a clinic dedicated to VBAC). The secondary services are dependent on the community midwives or LMC to discuss and promote confidence in VBAC if clinically appropriate prior to the consultation. If the referral indicates the woman wishes a VBAC, then the clinic will see her following her 20 week scan for consultation. At this consultation she will be advised on the risks and benefits of VBAC. Her care during labour and birth is discussed, e.g. I.V access and continuous cardiotocograph (CTG) monitoring during active labour. We also discuss methods for Induction of labour if her pregnancy unfolds in this manner. Taranaki DHB are very supportive of women who wish to try for a VBAC.

For women who are unsure or may be requesting a repeat caesarean section, the secondary consultation clinic see them after their 20 week scan and then again later in the third trimester, presenting them the information and promoting VBAC when clinically appropriate so they are able to make an informed decision.

All women considering or wanting VBAC should be given the RANZCOG pamphlet 'Vaginal Birth After Caesarean Section'. Also during the clinic visit a DVD is shown which discusses VBAC. For women who have had two or more previous caesarean sections, a repeat caesarean section is usually offered.

Towards the end of 2015, Taranaki DHB started a small working group to look at ways of improving our VBAC rates. At this stage, the antenatal clinic co-ordinator is looking into starting a VBAC information evening. This will be midwifery-led but will hopefully have the support of one of our obstetricians. Taranaki DHB are planning to run this in the evening so that partners/whanau are able to attend. The aim would be to openly discuss VBAC, to provide evidence-based information and to increase women's confidence in VBAC.

Review of the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatre:

A working group to address concerns raised regarding the care of mothers and their babies during transfer, delivery and return from the operating theatres during and after caesarian sections.

The concern was the high numbers of babies born during caesarean section that were admitted to the Neonatal Unit (NNU), thereby being separated from their mothers. The working group was to try to understand the reasons for these babies' admission to the NNU.

There was a total of 415 Lower Section Caesarian Sections (LSCS) performed at Taranaki DHB between July 2014 and June 2015.

Approximately 49% of these were acute and 51% elective.

Of the babies born from these caesarean sections, 72 were admitted to the NNU. Of the 72, 19 (26%) were admitted for less than two hours, whilst 21% were admitted for less than 24 hours before being transferred to the Post Natal Unit. The costs calculated by the coding office amounted to a total of \$58 658.01 for these admissions.

As part of the new staffing trial (described under maternity staffing trial) it was decided to trial on the night shift where a third staff member is rostered, a midwife or NNU nurse would attend all caesarean sections to care for the mother and provide newborn life support if required and remain with them until they are returned to the ward to improve the quality and safety of mothers and babies in the post operative recovery area. It is hoped it will reduce short term admissions to NNU and separation of the mother and baby. This trial is underway and NNU admissions post caesarean section will be part of the evaluation of this trial.

As part of this trial it was agreed to standardize neonatal resuscitation trolleys throughout Taranaki DHB to assist staff in times of emergency and reduce confusion in finding equipment and drugs used in neonatal resuscitation.



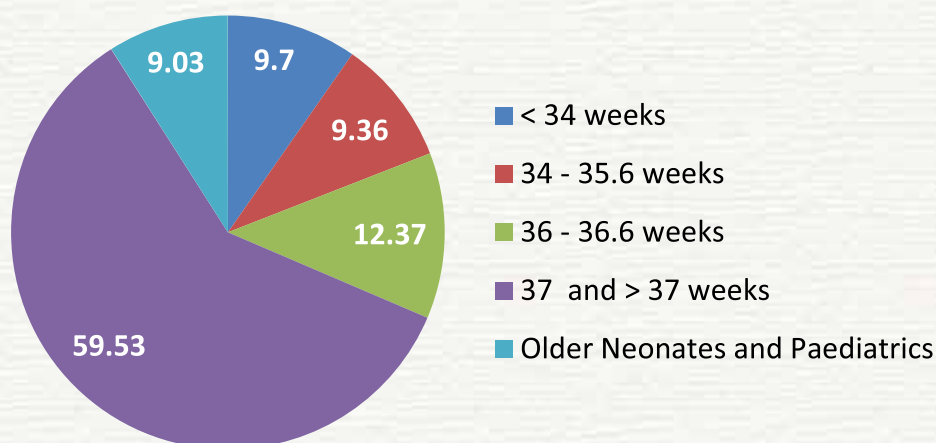
NEONATAL ADMISSIONS INCLUDING PRETERM BIRTHS

Monitoring of neonatal admissions continues – gestation, reasons for admission and length of stay (LOS). The Neonatal Unit (NNU) has been working more closely with maternity to try and keep mothers and babies together, in particular the late preterm infants.

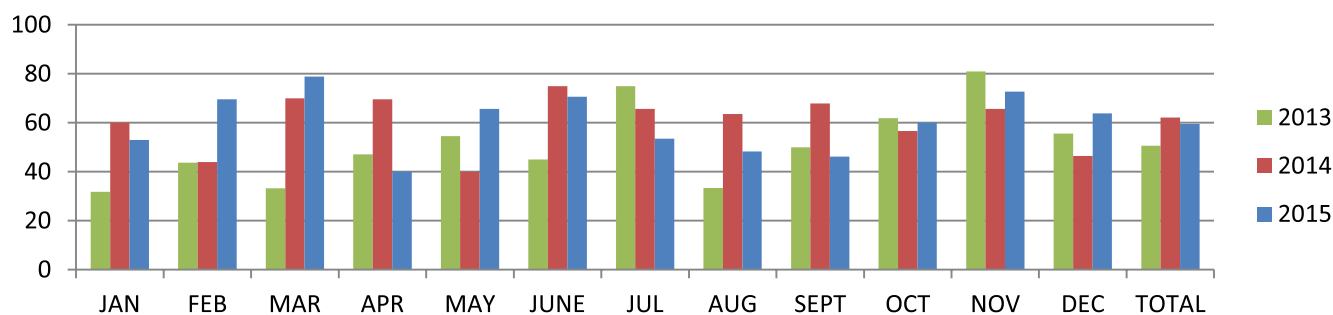
Number of Admissions

Admission numbers to the Neonatal Unit for 2015 (299) are very similar to 2014 (304). Babies of 37 weeks gestation, or greater, made up 59% of all admissions, similar to previous year. Preterm infants were 31% of all admissions and the breakdown by gestation is demonstrated in the graph below. Older neonates and paediatric admissions include babies admitted from home at about two weeks of age (or older); together with admissions of sick babies from the children's ward – with sepsis or respiratory illness requiring intensive care.

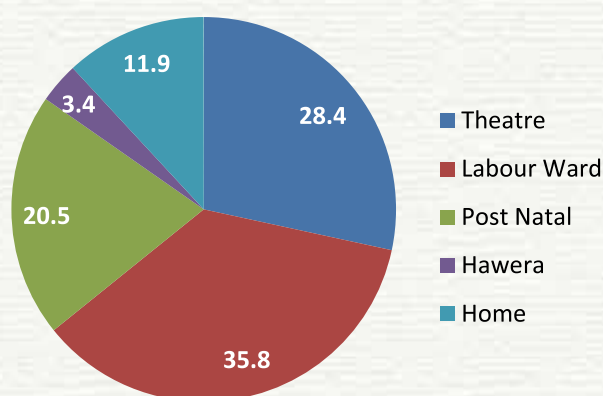
2015 - Admissions by Gestation - (as % of total)



37 and 37+ Weeks Gestation - % Total Admissions



37 and 37+ Weeks Gestation - Admitted From - (as %)

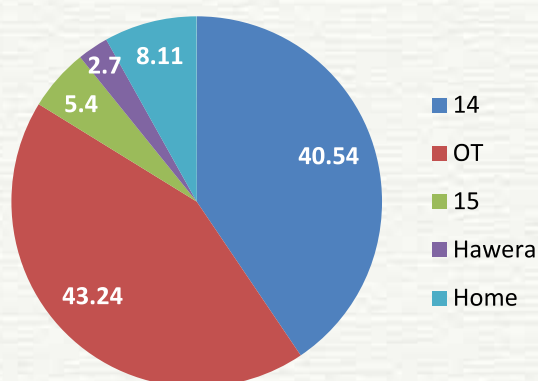


Exploration of how and where babies are observed as they transition to extra-uterine life, whilst maintaining baby with mum, continues to be discussed. The co-location of NNU with maternity (as is proposed in the future) remains an important factor.

Post Anaesthetic Care Unit (PACU) staff requested education on assessment and care of the baby, including skin to skin and initiation of breast feeding, to enable them to safely keep mother and baby together post caesarean delivery. Two, well attended sessions were delivered to PACU staff in the last 12 months including education on transition of a baby from intra-uterine to extra-uterine life – including physiological changes; basic resuscitation at birth and familiarisation with equipment available; basic care of the newborn – observation, and keeping babies ‘warm, sweet and pink’; and who and when to call if the baby needs additional care.

Education on skin to skin and initiation of breast feeding are still to be scheduled.

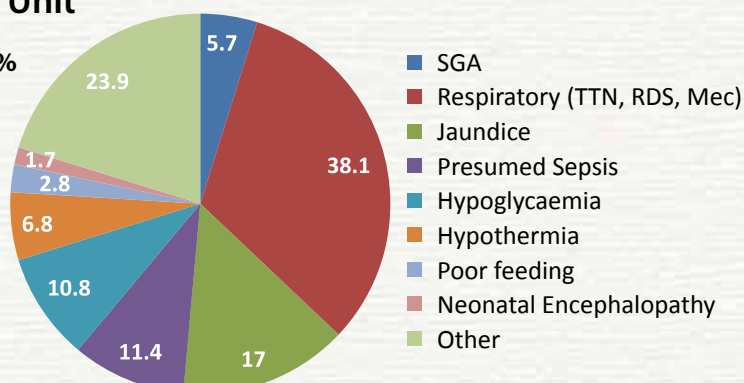
36 - 36.6 Weeks Gestation - Admitted From - (as %)

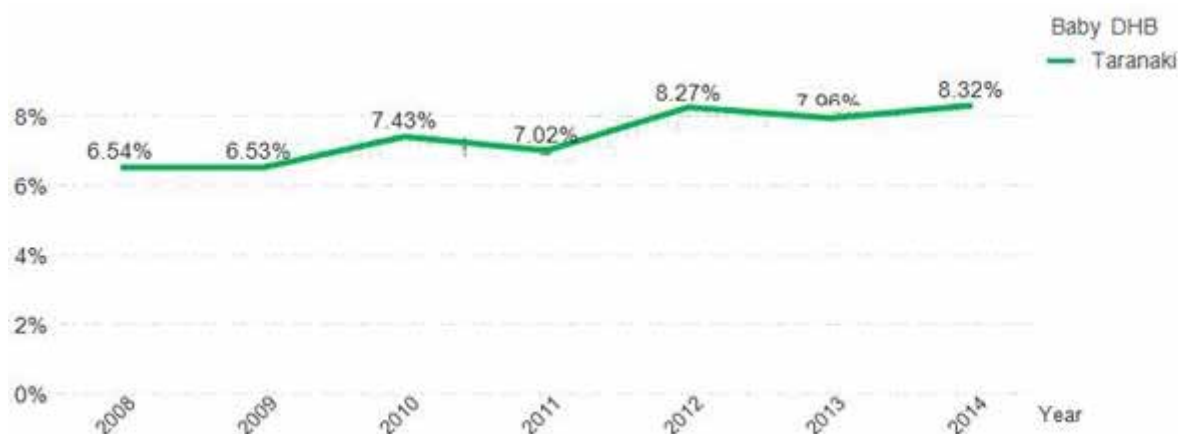
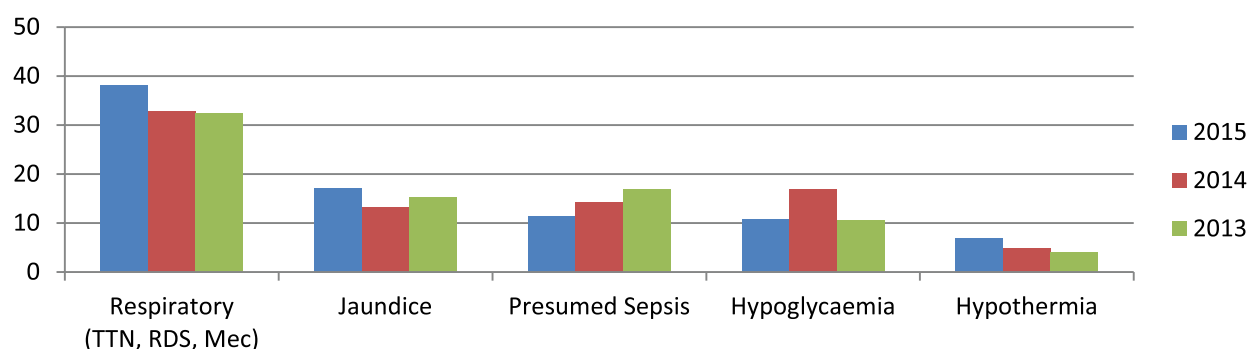


Education in the management and care of the late preterm infant is ongoing. However there have still been times when babies have had to remain in, or return to, the neonatal unit for ongoing care because of staffing shortages, skill mix or high acuity in the postnatal ward. The neonatal unit tries to accommodate the mothers of these babies as soon as possible. During the coming year, factors that impact on mothers and babies staying together, or not, will be audited – for example, assessment at birth, decision making, staffing levels, bed availability, medical intervention.

Reason for Admission to Neonatal Unit

37 and 37+ Weeks - Reason for Admission - as %



Preterm Birth Rate for Taranaki DHB 2008 - 2014**Reason for Admission 37 and 37+ Weeks Gestation**

59 babies were admitted to the Neonatal Unit for a period of less than 24 hours. 32 of these babies were admitted from theatre. The main reason for the short admission was respiratory – transient tachypnoea of the newborn (TTN), or a period of observation. 29 babies were admitted for less than six hours.

‘Other’ category includes babies admitted for observation, boarder babies because of care and protection concerns or mother being in HDU, and babies with Neonatal Abstinence Syndrome (NAS).

During the year we have successfully treated jaundice with using the Bilisoft in the community. If managed well and supported by midwives and the neonatal team, this could become more routine. It would, however, probably need additional equipment.

Length of Stay

The average length of stay in the Neonatal Unit for babies of 37 and 37+ weeks gestation, excluding those babies whose stay was less than 24 hours, is 6.1 days (compared to 4.1 days for the previous year). Factors that have affected the increase are, several babies with severe sepsis requiring a stay of seven to 10 days, two babies with NAS that required a hospital stay of eight weeks, and a number of 37 weeks gestation that as late preterm infants took longer to establish feeding. There has been an increase in the number of babies transferred to postnatal at 48 hours to complete their course of intravenous antibiotics whilst being with their mothers. Neonatal staff have continued to monitor these babies and administer the medications.

The Neonatal Unit will continue to work with all maternity staff in maintaining the mother and baby unit together and providing support to ensure a smooth transition to home.



SUMMARY OF THE TARANAKI DHB UNIVERSAL NEWBORN HEARING SCREENING AND EARLY INTERVENTION PROGRAMME 2015/16

Background

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, whānau 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.

The Taranaki Newborn Hearing screening programme is managed by the UNHSEIP Coordinator and is part of the Allied Health, Scientific and Technical Service.

Staffing

Recruitment to a 0.4 FTE vacancy for a screener occurred in October 2015. Rebecca Davis was employed and successfully completed the newborn hearing screening specific training and is screening independently. The service is fully-staffed.

Quality Improvements

- A new screening protocol was implemented in mid-2015 following a staged national roll-out. There was minimal interruption to services during implementation.
- New equipment (Maico Beraphones MB11 x 2) was commissioned in mid-2015. The equipment used for screening is now specified by the NSU with a national agreement for the supply of equipment. This has resulted in significant savings in capital expenditure and consumables.
- A new monitoring and reporting protocol was implemented in January 2016. The protocol has four components:
 - Narrative report
 - Volume report
 - Screener monitoring
 - Financial report

Local monitoring of DHB newborn hearing screening data is a requirement to inform programme management and quality improvement, to identify areas that are performing well and highlight areas that require improvement.

- The new hearing surveillance protocol was implemented. This replaces the targeted follow up protocol and changes responsibility for identifying babies who require audiology follow-up from screeners to clinical staff. Education sessions were held with midwives and paediatricians.

**Total newborn hearing screens completed for the period 1 January- 31 December 2014
(Latest national report)**

DHB	Completed total ¹	Live births ²	Percentage complete within period
Northland	1,720	2,097	82.0
Waitemata	7,177	7,910	90.7
Auckland	5,920	6,370	92.9
Counties Manukau	7,192	8,279	86.9
Waikato	5,046	5,325	94.8
Lakes	1,389	1,393	99.7
Bay of Plenty	2,486	2,785	89.3
Tairāwhiti	679	722	94.0
Taranaki	1,491	1,529	97.5
Hawke's Bay	1,963	2,098	93.6
Whanganui	722	822	87.8
MidCentral	1,817	2,112	86.0
Hutt Valley	1,856	1,863	99.6
Capital and Coast	3,645	3,572	102.0
Wairarapa	466	443	105.2
Nelson Marlborough	1,417	1,438	98.5
West Coast	292	353	82.7
Canterbury	5,918	6,032	98.1
South Canterbury	635	658	96.5
Southern	3,296	3,296	100.0
Total	55,127	59,097	93.3

1 sourced from UNHSEIP national database

2 sourced from National Maternity Collection

Future Plans for Newborn hearing screening in Taranaki:

- Implementation of NHIMS (Newborn Hearing Information Management System) is planned, following the implementation of MCIS (Maternity Clinical Information System).
- The screening service will link in with NCHIP (National Child Health Information Platform)

SUMMARY OF AUDITS 2015-2016

1. Intrapartum Electronic Fetal Monitoring (IFEM) (Sharon Howe)

Objectives:

Audit Purpose:

- To investigate whether the need for Intrapartum Electronic Fetal Monitoring (IEFM) was identified.
- To repeat the IEFM audit as recommended from 2014.
- To ascertain if appropriate intrapartum IEFM was implemented.
- To ensure satisfactory interpretation of cardiotocograph (CTG) recording.
- Identify if appropriate actions were taken where CTG findings deviated from the normal
- Report and inform Taranaki DHB and maternity practitioners of audit findings and identify if any changes in practices were required.
- Coding system utilized to protect practitioner anonymity.

Audit Sample:

- Discussion between Associate Director of Midwifery (ADOM) and auditor to identify audit sample size of 25 sets of notes from the month of March 2015 to give an adequate sample size (repeat audit was recommended in 2014).
- March was chosen as it was one year from the last audit.
- 122 women laboured at Taranaki DHB in March 2015
- 25 sets of notes were randomly selected.

Findings:

- Private Obstetrician who did not take cord gases when recommended now takes cord gases as per recommendations.
- All women who had intrapartum meconium stained liquor had Neonatal Unit (NNU) called and present for birth.
- Three newborns were admitted to the NNU after birth - one was for prematurity, one was for Small for Gestational Age (SGA) and one was due to the mother being admitted to the High Dependency Unit (no staff there were able to care for the baby while the mum was ventilated).
- No babies were admitted to NNU due to inaccurate CTG interpretation.
- CTG envelopes now in situ in the notes from March 2015 - all notes audited, had the CTGs stored and labelled correctly in the envelopes.
- One woman had a CTG initially at the start of her induction of labour, which was reactive and reassuring. The woman's membranes then ruptured and it was identified in the notes as meconium stained but a CTG was not done for a further two hours as recommended by Royal Australian & New Zealand College of Obstetricians & Gynaecologists (RANZCOG) IEFM guidelines. Short bursts of monitoring are shown

for a period of one to three minutes but not for one hour after the membranes ruptured. Fetal heart was auscultated.

Documentation Recommendations:

- One set of notes did not have the liquor documented – this was an emergency caesarean section (C/S). Additionally the same notes did not have birthweight or APGAR score recorded either.
- Importance of accurate documentation (incidental finding) in relation to APGAR scores, liquor colour and volume relayed to maternity staff and practitioners.

Recommendations:

- ADOM to discuss and implement a supportive performance improvement plan with noted community midwife.
- Identified maternity practitioner, will be recommended to attend the first Taranaki DHB RANZCOG fetal surveillance workshop on 22 April 2016 and complete the assessment.
- Presentation of audit findings to maternity practitioners.
- Audit findings submitted to Service Manager, Health and Disability Commission, Head of Department Obstetrics, Maternity Quality Commission and Quality & Risk.

2. Safe Sleep Audit

See Safe Sleep section page 43.

3. Documentation (Sharon Howe)

Objective:

To summarize 10 sets of clinical notes to evaluate if documentation standards are of an expected level for Taranaki DHB

Summary 10 notes audited by S Howe:

- Audit remains complicated by the difference between documentation expectations between community and core midwives (eg community do not have to fill in partogram).
- All core staff advised they needed to complete on line effective midwifery documentation audit - Clinical Midwife Manager (CMM) investigating into how many core maternity staff have completed their effective documentation.

Positive Points Noted:

- Notes were sequential in all.
- All entries timed and dated except one.
- Allergy status marked clearly in all-improvement from last audit in 2015.
- Parents ethnicity documented on all bar one (obstetrician LMC).

- Changes in woman's diagnosis or condition updated in all applicable.
- All CTG's labelled and stored correctly - great improvement from last year - due mainly to CTG envelope.
- Frequency of documentation suitable in all cases.

Issues:

- No notes achieved all the audit criteria.
- Smokefree form completed in 75% sets of notes.
- Lines drawn through empty spaces absent in two sets of notes.
- ISBARR COMMUNICATION TOOL only used in one set of notes-opportunity for use in eight.
- Pages not numbered in three sets of notes - no improvement from last audit in 2014.
- MEWS CHART not complete in any notes where applicable - same as last year.
- Observations documented for Syntocinon augmentation as per protocol where applicable in only one set notes.
- One set of notes had consent for third stage management.
- One set of notes only had Vitamin K consent.
- Only half the notes had a completed booking sheet.
- Three sets of notes with NHI label missing on page(s).
- Partogram not used by community midwife when commenced by core for abnormal labour.
- Obstetrician LMC not completing booking sheet with Ethnicity, family violence screening status and Body Mass Index (BMI) missing.
- Stamps were only used correctly in three sets of notes
- Red pen noted to be used by two staff members - not recommended.
- Medication charts noted not being completed in special care and supplementary charts section.

Incidental finding (not part of audit):

Only one set of notes had maternal weight documented on admission.

Recommendations:

- Repeat Audit 2016.
- Supportive performance management of core staff who do not meet expected standards after second notice - competency plan sent to CMM early in 2015. Staff not meeting expected standards recommended to undertake documentation workshop and have preceptor until the standard is met. Additionally documentation issues noted during weekly case review compilation are sent to CMM for staff notification.
- All core staff to complete 'effective midwifery online documentation package' as part of the orientation to maternity.
- MEWS training by Lisa Gilbert (in service booked for early 2016).
- Community midwives not following Taranaki DHB guidelines for documentation will have a supportive discussion with the ADOM.

4. ISBARR (Carol Wells)

Objective:

To audit 20 sets of notes to see if the ISBARR tool is being used in situations where they are required.

- Two out of the 20 sets of notes had the ISBARR tool used.
- 11 out of the 20 sets of notes required ISBARR according to the criteria
- Themes noted:
 - One midwife felt it was a waste of time.
 - Some staff knew about it and forgot to use it.
 - Some staff didn't know about it.
 - When ringing from the room there are no forms-this was checked by PN co-ordinator and forms are now in every room.
 - Other staff said it was quicker in the notes.

Recommendations:

- Dr to counter-sign the ISBARR form where appropriate.
- Re-educate about fact forms/pads are in every room - staff meeting.
- Plastic holders containing ISBARR pads have been placed on walls by the phone in each room that has a phone for easier accessibility.

5. Primigravid Caesarean Sections at Taranaki Base Hospital (Dr Lisa Newby)

Objective:

Was to calculate the prevalence of primigravid caesarean sections at Taranaki Base Hospital over a one year period and to characterise their indications.

A retrospective cohort study was undertaken of the 1488 births that occurred at Taranaki Base Hospital between 1 June 2013 and 1 June 2014. There were 385 caesarean sections, of which 144 were primigravid women.

Results:

The primigravid caesarean section rate was 37.4%. The majority of these were emergency caesarean sections (80.6%). The most common indications for elective primigravid caesarean sections were fetal malpresentation (28.6%) and maternal request (25%). The indications for emergency primigravid caesarean sections were more varied, but the most common were failure to progress (39.7%) and cardiotocography (CTG) abnormalities (29.3%). CTG abnormalities while on Syntocinon and fetal malpresentation each accounted for 9.5%.

Primigravida emergency caesarean section rates are unusually high in this region, and one of the leading causes is CTG abnormalities. Issues surrounding intrapartum fetal monitoring may contribute to this, which if rectified may assist in reducing our caesarean section rates.

Further investigations are recommended to examine

clinical decision making in relation to Intrapartum CTG interpretation and maternal request for elective caesarean section in relation to counselling and recommendations.

6. Caesarean section (Dr Katherine Orme)

Aims:

- To assess indication for elective caesarean section (C/S)
- To assess the quality of counselling given to women with previous caesarean section.
- To review the indications of elective C/S by individual obstetrician at Taranaki Base Hospital
- To identify any modifiable trend aimed at reducing the elective C/S rates.

Data source: Patient records, Clinic letters

Audit type: Retrospective

Data collected:

- Previous C/S yes or no, if yes indication?
- Vaginal Birth After Caesarean Section (VBAC) discussed and documented?
- Was counselling (risks/benefits) of mode of delivery given.
- Indication for C/S.
- Documented C/S leaflet given yes or no.
- Gestation/steroids if <39/40.
- Post op maternal complications.
- Post-op fetal complications.

Sample: 40 patients in total:

- 10 patients under each consultant.
- Patients booked for elective C/S, captured at time of booking (by ANC coordinator) and retrospectively via medical records (by auditor).
- September 2014 – September 2015.
- 10 patients were booked for their first C/S.
- 19 patients had had 1 previous C/S
- 11 patients had had >1 previous C/S.

Summary:

- 40 women booked for elective c/s were audited.
- Our local rate of c/s is increasing consistently with national and global trends.
- Unfortunately, as the maternity population grows older and more co-morbid, C/S rates will increase, and VBACs are less likely to be successful in this same population. This is self-perpetuating.

Aim 1: To assess indication for elective caesarean section
Indications for elective C/S were appropriate and 'un-modifiable' in 39/40 cases.

Aim 2: To assess the quality of counselling given to women with previous caesarean section.

- Documentation of VBAC discussion needs to improve.
- Documentation of risks of mode of delivery(MOD) needs to improve.
- There was some consultant variation in counselling on risks of MOD.
- Information leaflet should be given and documented.

Aim 3: To review the indications of elective caesarean by individual obstetrician at Taranaki Base Hospital.

This study was not of significant size or design to pick up a meaningful difference between indications for C/S per consultant.

Aim 4: To identify any modifiable trend aimed at reducing the elective C/S rates

- No modifiable trends were identified.
- Steroid administration is suboptimal in elective C/S occurring under 39 weeks gestation.
- There are risks with caesarean to both mother and neonate.
- There was consultant variation in steroid administration.

Re audit recommendations:

- Do not include women booked for elective C/S who have had 2 or more previous C/S.
- Part of this audit was to provide feedback for each consultant – therefore, to avoid selection bias, selecting patients should be random via medical records, so the auditor is blinded initially to the cohort included.
- Larger numbers will identify trends more accurately, if they exist
- All patients in a given time frame need to be audited to accurately conclude on consultant variation in booking indication

Difficulties:

- There are no clear guidelines/funding limitations for obstetricians to decline LSCS in women requesting this with a 'soft' indication. 'Maternal choice' is a significant player in a consultation.
- We rely on documentation of discussion for this audit.

7. Caesarean Section Audit (Ganesha Rosat RM)

Purpose:

- The aim of this audit was to identify any trends around the use of Syntocinon augmentation and CTG interpretation that may reduce the C/S rate.

Method:

- Review 40 cases from a three month period of 2015. The RANZCOG Intrapartum fetal surveillance clinical guideline (2014), Taranaki DHB hospital protocols and the article safe prevention of the primary caesarean delivery were used as guides when reviewing case notes to reduce auditors' bias.

Limitations:

- Unable to achieve 40 case notes over a three month period for level two caesarean sections so a total number of 36 cases was completed, reducing the validity of the audit. Also documentation gaps left questions unanswered in some of the auditing process.

Results:

Clinical responsibility, hand overs and continuation of care:

- These questions were included due to research around continuation of carer reducing C/S but also about fresh eyes to assess changes in CTG and instigating timely augmentation.
- 75% of women were under the responsibility of a community midwife with a matching number remaining under primary care. 69% remained primary for intrapartum care with 25% having a transfer of care to the secondary services. Only 29% (10 women) did not have continuity of carer during labour and birth.

Risk factors prior to labour:

- These questions relate to possible factors reducing the use of Syntocinon augmentation ie hesitation with previous C/S.
- Surprisingly 64% (23) had risk factors prior to labour, these being previous C/S (34%), hypertensive disorders (30%), Prolonged Rupture of Membranes (PROM) (22%), raised BMI over 40 (18%), Acute Partum Haemorrhage (APH) (9%), Intrauterine Growth Retardation/Small for Gestational Age (IUGR/SGA) (9%), Amniotic Fluid Index (AFI) abnormalities (9%), Gestational Diabetes Mellitus (GDM) (9%).
- In the previous C/S category only one case had Syntocinon augmentation, the majority of these cases did not establish in labour before C/S was called. Two had abnormal CTGs and two had Antepartum haemorrhages hence no Syntocinon trailed.

Induction of labour (IOL) verses spontaneous labour:

- 53% (19) were IOLs, 42% (15) were spontaneous and the remainder were not in established labour. This was an interesting result as the auditor expected a much higher number of IOLs resulting in C/S due to the current understanding of IOL risk factors.

Augmentation:

- 42% (15) did not have acceptable progress verses 36% (13) acceptable progress.
- 51% (21) were 5cm and in established labour when the C/S decision was made but still a large number 39% (14) had not achieved 5cm dilated or established labour.
- Of the 15 who did not have acceptable progress 12 had Syntocinon augmentation.
- The three who did not undergo Syntocinon augmentation; one case was a previous C/S but there was no documentation indicated why augmentation was not offered, however there was a plan made that if not in established labour for C/S. The remaining two were considered failed IOLs.
- Future audit could be of value to explore cases considered to be failed IOL with a view of reviewing the IOL process.
- The cases where Syntocinon augmentation ensued nine (25%) women had delays; these were mainly due to the CTG recording and awaiting pain relief. Just under half the women (42%) had epidurals and two cases had

a PCA where epidural was contraindicated. Not every woman who had Syntocinon running had an epidural (4 (30%).

Consultations and caesarean section timing:

- 34 out of the 36 cases that went to C/S had a face to face consultation at the bedside. The average number of consultations intrapartum was 2.4 with the most being 10.
- Afternoon shift had the highest number of C/S at 18 (50%), followed by morning shift having 11 (31%) and lastly the night shift which only had 5 (14%). Could ask the question is this because we are preventing the call out for a night C/S?
- The average wait for level two C/S from decision to baby out was 77 minutes. The quickest was 30 and the longest was 178 minutes.

CTG:

- 92% of women had a clinical indication for CTG monitoring and the majority of these cases were all clearly recorded. Five cases (13%) did not have adequately recorded CTG, three had Fetal Scalp Electode (FSE) in place prior to C/S.
- Six (17%) case records demonstrated CTG interpretation and documentation as per the RANZCOG clinical guidelines. It would be interesting to see how this changes now that the course has been run locally in April 2016.
- Of the 23 with recorded abnormalities six cases (26%) did not have first line actions documented. Of the first line actions used reducing the Syntocinon augmentation or turning it off was the most used.
- 20 CTGs had another person review the CTG before consultation, which goes in line with recommendation.

Outcomes:

- 27 (75%) of the babies born in this audit were well with good Apgars. Seven (19%) babies went to NNU mainly for prematurity. Interestingly the three babies with abnormal cord gases/lactates did not go to NNU and appeared well. The average weight was 3486 grams with the smallest being born at 31 week weighing 1378 grams and the largest being 4640 grams at 39 weeks. The average gestation was 39 weeks.
- 81% of women had no medical events after the birth and two (6%) required admission to HDU.

Recommendations:

- There are no tangible implications for practice that have resulted from this audit only further areas to focus on. This may have been due to the overloading of questions on the audit it's self. Refining the audit into smaller groups for example audit all the level 2 C/S for abnormal CTGs, the failure to progress and the failed IOLs. This will make it easier to see trends in clinical practice. Other areas to consider to investigate in the future are; the use of Syntocinon in the case of previous C/S cases, failed IOL, delays in implementing Syntocinon augmentation and the timing from decision to delivery.

8. High Dependency Unit Admissions at Taranaki DHB for Pregnant Intrapartum and Postnatal Women (Glenda Martin and Sharon Howe)

Objective:

- To ascertain the reason why women are admitted to ICU/HDU from maternity.
- If and how often mother and baby were separated during the admission to ICU/HDU
- To inform TDHB Maternal and Child Health Service Manager, Associate Director of Midwifery (ADOM), Head Of Department (HOD) Obstetrics & Gynaecology (O&G), Midwife Manager, Intensive Care Unit/High Dependency Unit (ICU/HDU) Nurse Manager, Maternity Quality Safety Committee (MQSC) and Maternity practitioners of findings, identify any gaps in systems or services and identify any changes or improvements in practices that are required.

Summary of HDU admissions

PPH (9)

Cardiac (4)

Post partum sepsis (2)

Pre-eclampsia (PET) (3)

Chest pain (1)

Planned Spinal Morphine following EI LSCS (1)

Seizure like activity (1)

Was mother and baby separated?

Yes 13

Clinical indication: 6 cases (5 preterm babies, 1 twin transferred to Waikato)

No Clinical Indication: 7 (to NNU but not clinically indicated to be admitted to NNU)

No: 7

N/A: 1 (17 week fetal loss)

Summary of findings:

- Length of stay ranged from <5 hours to six days
- 19 out of 21 women's length of stay between 18-36 hours
- Follow up maternity input not consistent and omitted in some cases
- Mum and baby were separated for 13 of the HDU admissions-clinically indicated in six cases (5 x premature baby, one transfer to tertiary), not clinically indicated for the baby for seven cases
- Post Partum Haemorrhage (PPH) was the main reason for HDU admissions in nine out of the 21 cases
- Admissions for maternal cardiac conditions was due to lack of telemetry function in Maternity
- Four women in labour were admitted to HDU (cardiac telemetry) and 17 women were admitted in the postnatal period.
- Documentation incomplete regarding visits to HDU by Core Staff and LMC's

Recommendations:

- Maternal HDU flow chart/policy to be developed-working group to be established to work towards reducing the mother/baby separation.
- Telemetry coverage to be improved for maternity to enable women to be monitored in labour ward - this will reduce the amount of staff on call, anxiety for staff and the mother and whanau of birthing in HDU. (Environmental facility in HDU for labour and birth is not conducive to birthing eg sound proofing, privacy and not en suite bathroom facility).
- Mother on HDU to be visited by RM/RN/LC at least once a shift.
- Documentation essential when woman visited in HDU.

9. Neonatal Unit Admission/Secondary Neonatal Care For Hypoglycaemia Audit 2015 (Moerangi Tamati, Scholarship Medical Student)

Objective:

To evaluate whether Neonatal Unit (NNU) admissions during the period August 2014 - August 2015.

- Complied with the Management of Late Preterm Babies – Large for Gestational Age (LGA)/Small for Gestational Age (SGA) babies on Postnatal Ward protocol implemented in August 2014.
- Identify and explore reasons for admission to NNU.
- Identify areas for improvement in the care of the late preterm, LGA/SGA infant.

Definitions:

- LGA** is defined as a birth weight greater than the 90th percentile for age. This can include, but exclusive to, babies born to diabetic mothers.
- SGA** is defined by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) as an infant born with a birth weight less than the 10th percentile. It should be noted that the Taranaki DHB.
- Late Preterm** - A baby born between 35 weeks gestation and 37 weeks gestation.

Summary of discussion on findings:

This audit revealed that Taranaki DHB sees a range of cases of hypoglycaemia among neonates. This cohort saw a significant proportion of LGA, SGA and Late Preterm (LPT) babies. It appears by the majority, these cases of hypoglycaemia were adequately and safely cared for. Most of the high risk babies were identified antenatally or early following delivery and were assessed and treated accordingly. However, several issues were raised as a result of this audit. This included antenatal identification SGA/LGA babies, percentile calculations, documentation of Blood Glucose Level (BGL) results, Prefeed (AC) and Postfeed (PC) BGL assessment timing, first line treatment method, venous glucose testing, discharge feeding codes and coding issues.

Findings/recommendations:

- Taranaki District Health Board has a thorough protocol for the management of LGA/SGA/LPT babies that is research based and up to date.
 - Education re initial BGL taken 1-2 hours post breast feed.
 - Education on BGL taken ac feed until a further three normal consecutive readings.
 - Education on rechecking BGL in 1 hour pc if develops hypoglycaemia.
 - Education on documentation of BGL.
 - Treat other high risk hypoglycaemia babies the same as this protocol.
 - First line feeding/Expressed Breast Milk (EBM) - emphasise antenatally the importance of early PN expressing/ACE-if no EBM use HMF.
 - Birthweight centiles are valuable easy tool for identification of high risk babies and recommend this is used.
 - Treatment should be based on local guidelines and protocols rather than from other hospital protocols.

10. Referral Guidelines - Section 88 (Isabelle Lewis, Trainee Intern)

Objective:

To audit 40 random clinical notes of women who birthed at Taranaki Base Hospital, to identify whether there were any indications of a requirement for consultation or transfer of care as per the Referral Guidelines during the antenatal, intrapartum or postnatal period.

This audit covers the NZ Maternity Standard 3 (23.1 and 24.1).

50 randomized women who birthed at Taranaki base hospital

No exclusion criteria

Data sources

- Taranaki DHB patient clinical records
- Birth booking forms
- LMC labour records
- IBA
- Taranaki DHB midwife educator Sharon Howe

Indication	Appropriately transferred (n=17)
Pre-existing and/or co-existing medical conditions	2
Previous gynaecological conditions or surgery	-
Previous maternity history	7
Current pregnancy	2
Labour and birth	2
Following birth	4

Table 3: Indications for transfers of care and whether these occurred appropriately

Conditions that were transferred appropriately	n=17
Elective caesarean*	9
Emergency caesarean	1
Complicated labour#	1
Large PPH	2
Retained placenta	1
Baby transferred to NNU	1
BMI > 40	1
Pre-eclampsia (severe)	1

Table 4: showing the conditions that were transferred appropriately according to the referral guidelines

* elective caesarean indications included previous LSCS (7), chronic pubic symphysis and back pain (1), breach presentation (1)
Ventouse delivery/meconium liquor/abnormal CTG

Conditions that met criteria for transfer of care but were not transferred	n=3
Increased BMI>40	1
Pre-eclampsia (severe)	1
Retained placenta	1

Summary of findings:

What are we doing well:

- Antenatal clinics
- Consults
- Transfers of care
- LMC providing midwifery care under clinical responsibility of obstetrician

Areas for improvement:

- Completed booking forms
- Appropriate admission/transfer/discharge stamping
- Electronic discharge summaries
- Three-way (women/whanau+ LMC+ O&G) communication, along with appropriate documentation of this.

11. Post Partum Haemorrhage Audit

Objective:

To evaluate whether the management of Post Partum Haemorrhage (PPH) follows current guidelines.

Audit findings:

- 87% medications given in accordance with National PPH guidelines.
- 75% women had an active third stage documented.
- 13% of PPH were due to retained placenta-placenta checking well documented.
- 76% women had an In Dwelling Catheter (IDC) placed.
- 90% of women with PPH did not require a blood transfusion.
- Over half of the women who had PPH did not have their antenatal risk factors taken into consideration.

- IOL identified as leading risk factor for PPH.
- 777 obstetric emergency call was not made in any of the cases audited.
- Two-thirds of all women who had a PPH did not have a fluid balance chart commenced.
- Bi manual compression was not performed in 93% of PPH cases audited.
- 63% did not have a Maternity Early Warning Score (MEWS) commenced.
- 75% of women with PPH documented as symptomatic of PPH.
- Over half the women did not have a PPH medication chart completed.
- 87% women who had a PPH did not have the PPH Proforma commenced.
- Only one women required HDU admission.

Recommendations:

- PPH Proforma to include a place for medications to be signed as on CPR Proforma sheet
- Further education on the use of the 777 Obstetric emergency call, importance of bimanual compression and IDC, identification of antenatal risk factors and implementation of care planning where risks are identified, documentation; use of MEWS, fluid balance, use of PPH Proforma/and development of online package to be implemented
- Investigate effect of no blood being transfused on breastfeeding.



Taranaki DHB Maternity Unit receives a generous donation of nappies from Countdown.

MIDLAND REGION WORKPLAN AND UPDATE

Midland Maternity Action Group

Chair: Corli Roodt (Associate Director of Midwifery, Waikato DHB)

Project Manager: Suzanne Andrew

Context:

Key objectives:

- **People powered** – designing people-led maternity service delivery in partnership with consumers
- **Closer to home** – living well in healthy communities, with increased support to pregnant and postnatal women experiencing mental health and alcohol and other drug conditions. Promoting healthy nutrition and activity for pregnant women to reduce the prevalence of adult and childhood obesity. Promoting all birthing options in their local facilities.
- **Value and high performance** – building leaders and capability for the future. Also building a high performing system that promotes health and wellbeing, including pae ora (healthy futures), early intervention, and streamlined care across the settings (primary care, secondary and tertiary services). Fostering and spreading innovation and quality improvements to support equity and efficiency (systems focus)
- **One team** – Midland DHB maternity services working within the MoH's Maternity Quality & Safety Programme to support information sharing and learning, and monitoring performance and variance of the Midland DHBs maternity related data
- **Smart system** – best use of technology and information - improving coordination and expanded delivery of information to support consumer self-management in health through the use of digital solutions, including implementation of the National Maternity Information System Platform (MISP) and BreastFedNZ app.

National MoH measures MMAG is working towards:

Breastfeeding

Targets: 75% at six weeks (full or exclusive); 60% at three months (full or exclusive); 65% at six months (receiving breast milk)

Smokefree pregnancies

Target: 90% of pregnant women (who identify as smokers at confirmation of pregnancy in general practice or booking with a Lead Maternity Carer) will be offered advice and support to quit smoking

Sudden Unexpected Death in Infancy (SUDI)

Target: 0.4 SUDI deaths per 1000 Māori live births. This is the five year rate achieved by non-Māori (95%CI 0.34-0.52) (ref Mortality Data Group, Ministry of Health Well Child Tamariki Ora reporting data)

Maternal mental health, including alcohol and drug addictions

Increase support to pregnant and postnatal women experiencing mental health conditions, including alcohol and drug addictions (ref. a-j of '1. Perinatal mortality' in the PMMRC Ninth Report 2015).

Healthy weight gain in pregnancy / management of bariatric pregnant women

Promote healthy weight gain in pregnancy, healthy behaviours and self-management as the MoH shares best practices and identify, publicise and spread examples of innovation that demonstrate improved equity of health outcomes, efficiency, quality and safety, and reduction of harm. Work in partnership with Midland Health Promotion Units to reduce maternal obesity locally.

Primary and rural birthing options for women in their local facilities

Strengthening maternity services for women who reside in rural areas, including more timely access and more equitable access to community based primary care and services.



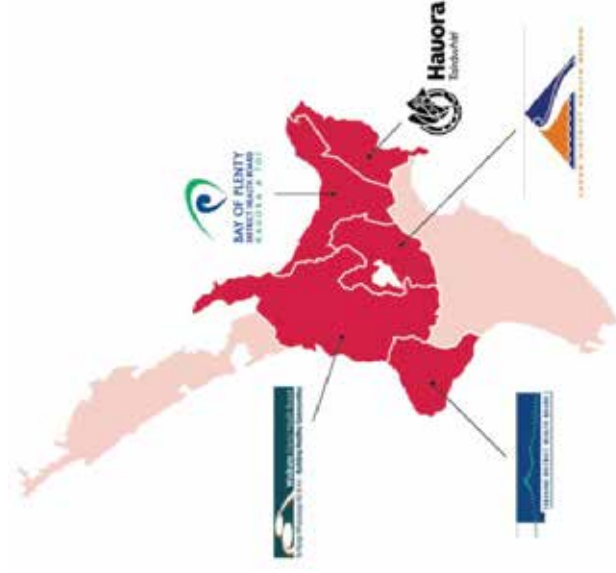
Midland Maternity Transfer & Repatriation Standards Midland Maternity Action Group – Maternity Quality & Safety Programme Regional Initiative

Background

The **Midland Maternity Transfer & Repatriation Standards** have been developed over the past three years, from a draft A3 flow chart into a comprehensive regional document, which was formally approved on 25 May 2016 by the Midland Maternity Action Group.

The Standards:

- focus on enabling smooth patient flow and ensuring best, most appropriate and safest maternity care is delivered as close to the woman's home as possible
- describe the transfer and repatriation processes between the Midland region's secondary to tertiary hospital, and repatriation from tertiary back to secondary hospitals
- provide guidance on discharge of women back to their home domicile, where they no longer require admission to a secondary hospital.



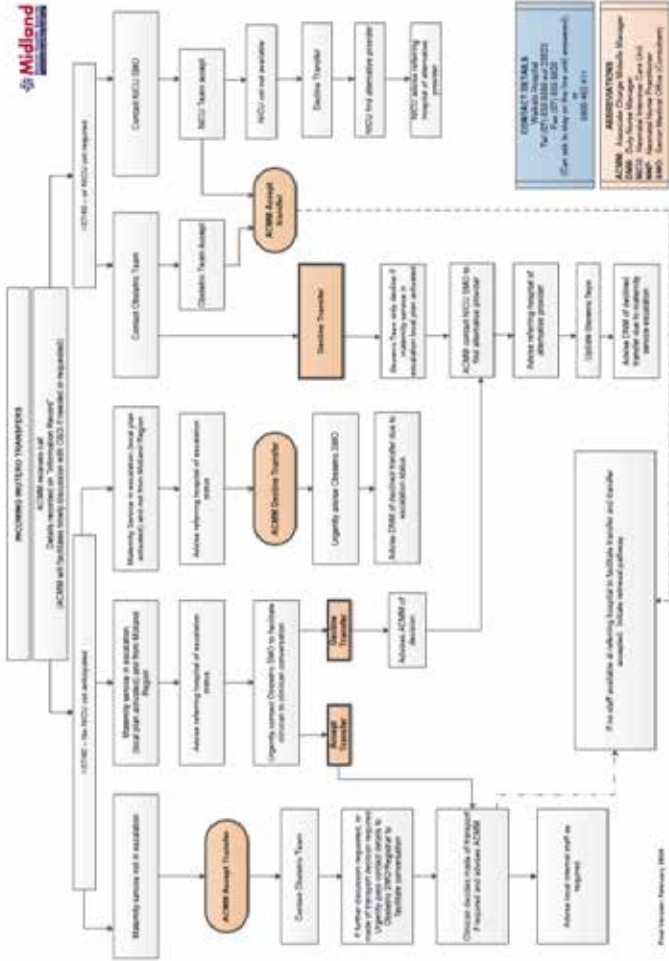
Contents of Standards

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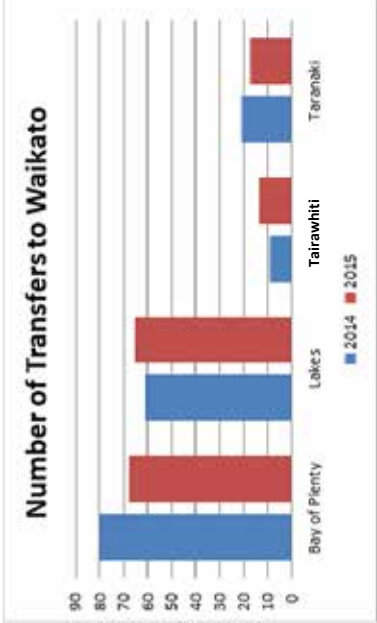
The Regional Transfer Process

The Standards have been developed over the past three years, involving extensive circulation, rounds of iterative consultation and feedback, and trialing of the process over the past few months in the region. During this period Waikato DHB has established the **Associate Charge Midwife Manager (ACMM)** roles, providing 24/7 coordination and facilitation of incoming maternity inter hospital transfer and repatriation processes.

Waikato DHB internal process utilising the ACMM role for incoming in-utero transfers (below)



Midland Maternity Data



Associate Charge Midwife Manager (ACMM) positions established at Waikato Hospital to support local and regional transfers:

"I am fielding telephone calls constantly. I am the single point of contact for calls from outside the hospital. This may be GPs or LMCs wanting to send someone into the assessment unit, or LMCs asking to transfer a woman to hospital. I also take calls from LMCs working in remote parts of the region looking for advice. There will also be conversations about how a woman is to be transported to hospital if her case is urgent."

Mothers and babies may also need to be transferred if the level three newborn unit is full or if other units need to send their sick babies to our level three unit. I then need to liaise with multiple people to ensure this transfer process goes smoothly. Sometimes I need to call midwives with flight training to ask them to come in off duty, so that a retrieval or transfer can take place."

If there is an emergency case coming in I need to ensure that all the appropriate midwifery and medical staff are ready. This might involve bringing theatre nurses and anaesthetists from elsewhere in the hospital, moving midwifery staff around the unit, to free up staff ready to work with the LMC and the woman she is bringing in. You need to make a lot of judgement calls and think ahead."

Excerpt from Midwifery News 'A day in the life of a core midwife' www.midwife.org.nz



Waikato Hospital Maternity Services staff, including ACMMs, providing 24/7 support to the Midland region for incoming in-utero transfers and repatriations

Consumer's experience of transferring from New Plymouth to Waikato

"We arrived at Taranaki Base at 27 weeks with light bleeding. I knew this would mean my hospital stay was likely to be brought forward, which I was happy with. Dr X met with my husband and I, and voiced his concerns about having vasa previa, and the set-up of Taranaki Base Hospital - the distance to theatre and theatre staff being on call at night. He felt the risk to me and our baby was too high, and we were so thankful for his honesty and call on that. We were happy to be transferred."

The transfer happened quickly; within a few hours. And my admission to Waikato was processed fairly quickly - I was on the antenatal ward within three hours of arriving. (I initially thought this wait was long, but other women often waited 6 hours plus to go through Waikato Assessment Unit to the ward!). We were discharged from Waikato Hospital to River Ridge East Birth Centre two days after the caesarean, and returned home ourselves after that."

I honestly can't say enough how well we (including my husband, and our baby after he was born) were cared for. Our midwife, Jan, provided so much support even while I was in Waikato, and came up for our caesarean. We are so grateful for that, I appreciated having someone voice and carry out our wishes for us before and during the surgery."

The midwives were all lovely, caring and kind. We felt listened to, and the few concerns I had were always addressed. They even set up a postnatal room for us on the antenatal ward as I had been there so long and was comfortable with all the staff there. This made the two days post birth feel relaxing and calm - I felt like I was 'home'. All the staff I met on the ward; including the orderlies, cleaning and food staff were always happy, chatty and kind. It wasn't an ideal situation to be in, but everyone involved made it into an honestly pleasant stay."

[Misty, New Plymouth]



Misty and Shaun's lovely baby

Feedback from an Obstetrician SMO based in New Plymouth

"As Waikato Hospital Obstetric Department was already aware of Misty, easy transfer was facilitated. There is an easy method via the Waikato Labour Ward Coordinator [ACMM]; however, due to the exceptional circumstances involving Misty, I have spoken to the duty Obstetrician in Waikato prior to the transfer. A very easy transfer process followed and Misty was accepted and transferred the same afternoon without any obstacles."

[Misty's Obstetrician SMO, New Plymouth]

Feedback from a Community Midwife, New Plymouth

"Misty asked for me to attend the LSCS in Waikato, which I did. I was well taken care of there; welcomed, housed and made to feel part of the team. Misty and Shaun's birth plan was respected and followed, and I felt the whole process was treated as a birth celebration, rather than a task to be effected."

[Misty's community Midwife, New Plymouth]

Next steps:

The Midland Maternity Transfer and Repatriation Standards are now with the Midland DHBs Chief Operating Officers Group for endorsement and implementation across the region.

Suzanne Andrew
Regional Project Manager – Clinical Networks
HealthShare Ltd

1 June 2016

Acknowledgement: *The 'stories' shared by Misty, her Obstetrician SMO, and community Midwife in New Plymouth are gratefully acknowledged.*



2015-16 Midland Regional Services Plan – Midland Maternity Action Group Work Programme (with commentary from Project Manager)

Chair: Corli Roodt (Clinical Midwife Director, Waikato DHB)

Vision: to lead regional maternity activity on behalf of Midland DHBs to grow the right skilled health practitioners to provide maternity care – improving the quality, safety and experience of care; improving equity and accessibility to care, resulting in the best value from Midland's resources.

Key Objectives aligned to Triple Aim:

- **Improved quality, safety and experience of care** - maternity workforce development to reduce vulnerability and to increase sustainability; improve access to information sharing for LMCs, maternity service providers, and consumers;
- **Improved health and equity for all populations** - undertake an agreed regional work programme that supports the implementation and ongoing sustainability of the National Maternity Quality and Safety Programme (MQSP) as core DHB practice;
- **Best value for public health system resources** - 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.

Midland Maternity Action Group (MMAG) initiatives	Issues to be resolved	Expected outcomes for communities from the initiative
1. Workforce development and forecasting	<p>A focus is required to:</p> <ul style="list-style-type: none"> • support a sustainable rural maternity service to improve accessibility and equity of maternity services for Midland women, including breastfeeding support • understand the current workforce and the utilisation of the future workforce, eg regional passport/ePortfolio with transportability of certifications, leadership succession, and development • consider emergent health issues, eg gestational diabetes management, obesity, pre-term births, etc, and align a regional education plan to support the maternity workforce to meet the ongoing educational needs around complex care. 	<p>Intelligence:</p> <ol style="list-style-type: none"> 1. 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. 2. 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. Look at a regional passport with transportability of certifications. Succession planning. <p>Utilisation:</p> <ol style="list-style-type: none"> 1. Identify future maternity workforce requirements and develop plans to ensure ongoing, safe and appropriate maternity care provision in line with Safe Staffing Healthy Workplaces principles. 2. Explore options to develop Midland maternity education packages that can be delivered across the region by Maternity Educators, if required, eg Midland Emergency Practice Day. <p>Education:</p> <ol style="list-style-type: none"> 1. Consider emergent health issues to inform the development of a prioritised regional health education plan and support regional education where possible. 2. Maximise collaboration between Midland regional maternity educators, lactation consultants, clinical midwife managers, BFHI coordinators, MQSP coordinators, safe sleep champions. 3. Investigate the increasing use of Moodle as an electronic platform for e-learning modules to share education across the region. 4. Load Midland DHB education into a regional education calendar on www.healthshare.co.nz

		regional website for all maternity service providers, including LMCs and medical practitioners.
Project Manager's Update: <ul style="list-style-type: none"> MMAG supported water birth and active birth workshops in each of the five Midland districts, delivered by the Tairāwhiti Midwife Educator & Quality Coordinator to LMCs and DHB maternity staff. Workforce issues and challenges for the five Midland DHB maternity services has been collated – this information will be sent to the Midland GMs HR group Maternity workforce data collected and analysed – differences in coding across the region was noted, including the coding of maternity staff to other services, eg nursing, education; making it difficult to use the data for sustainable workforce planning and forecasting. MMAG has decided to focus on other areas where more gains can be made. Midland workforce has mapped the location of LMCs across the region and collated DHB maternity workforce FTE (see previous note). Midland maternity educators (apart from Lakes) have worked together to develop a Midland Region Midwifery Emergency Refresher Day 2014-17, with positive feedback received. MMAG is developing a regional Quality Leadership Programme, with a Midland DHBs certificate designed. MMAG has worked with Midland Workforce to develop a midwifery section on Moodle so that new graduate Midwife ePortfolios and Maternity Educator ePortfolios can be uploaded, as a first phase. Presentation on Toi Te Ora Public Health's work on Childhood Obesity Prevention was received by MMAG. A Public Health Service representative is now on the MMAG membership and will like with Midland DHBs public health/population health units. 'Management of the Bariatric Pregnant Woman' protocol has been developed and approved by MMAG, and is with the Midland Chief Operating Officers group for endorsement and implementation 'Midland Maternity Transfer and Repatriation Standards' developed and approved by MMAG, and is with the Midland Chief Operating Officers group for endorsement and implementation. These Standards have been extensively consulted, and trialed in the region, with positive feedback received (see separate project report). 		
Midland Maternity Action Group (MMAG) initiatives	Issues to be resolved	Expected outcomes for communities from the initiative
2. Maternal mental health services	What are the problems to be resolved? <ul style="list-style-type: none"> A coordinated pathway and accessible information is required to support a seamless referral process between Midland's community practitioners and secondary services to enable the right referral, to the right agency, at the right time, is accessible to women requiring maternal mental health services. 	<ul style="list-style-type: none"> Map of Medicine Perinatal Mental Health (primary) Pathway developed with local content linked into this and accessible by LMCs in the Midland region. Pre and Post Pregnancy Directories developed at each Midland DHB and linked to the Map of Medicine Perinatal Mental Health (primary) pathway under local district tabs. Support better knowledge in the maternity sector of the perinatal mental health services available to women, eg conduct surveys with LMCs and GP practices pre and post intervention and engage consumers. Support the linking of maternal mental health services into local MQSP governance boards. Consider how best to inform women about access and treatment for maternal mental health services.
Project Manager's Update: <ul style="list-style-type: none"> Map of Medicine clinical pathway for Maternal Mental Health (primary) has been developed with Midland Mental Health & Addiction Service. Midland DHBs are localising the pathway and incorporating pre and post pregnancy support services directories (based on Taranaki DHB work). Information on depression and anxiety, alcohol and recreational drugs whilst breastfeeding, and links to mental health support services for women, and also specifically for dads, have been added to <i>BreastFedNZ</i> app and website. 		

MIDLAND REGION WORKPLAN AND UPDATE

Midland Maternity Action Group (MMAG) initiatives	Issues to be resolved	Expected outcomes for communities from the initiative
<p>3. 'Protective parenting': smoking, safe sleep, breastfeeding, immunisation, family violence and never shake a baby</p>	<p>What are the problems to be resolved? MMAG needs to understand Midland DHBs maternal smoking rates, SUDI rates, and the challenges to breastfeeding for women to drive down smoking exposed pregnancies, SUDI rate and early breastfeeding cessation rates. MMAG needs to support an increase in awareness of on time immunisation, the health impacts caused by family violence and harm caused by shaken baby syndrome for babies.. MMAG aims:</p> <ul style="list-style-type: none"> • smokefree pregnancy - continue to reduce the rate of smoking in pregnancy • safe sleep - continue to support safe sleep practices • breastfeeding - continue to improve breastfeeding rates and that support is available for women when facing challenges with breastfeeding • immunisation – continue to increase on time immunisation rates for babies • family violence – continue to support education for family violence screening and universal screening of women receiving maternity care • never shake a baby – continue to support the shaken baby prevention programme in Midland. 	<p>Smokefree pregnancy:</p> <ul style="list-style-type: none"> • 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 incentivises smoking quit support uptake amongst pregnant women in Waikato. Evaluation used to inform regional roll-out/ learnings. • Partner and support the Midland Safe Sleep Programme facilitated by Te Puna Oranga Waikato DHB, Maori Health Service on behalf of Nga Toka Hauora (Midland Maori General Managers Forum), MMAG, and in partnership with Change For Our Children. • Networking and sharing of resources throughout the Midland region. <p>Safe sleep:</p> <ul style="list-style-type: none"> • Continue the implementation and auditing of the Midland Safe Infant Sleeping (Birth to 1 Year) Policy and Midland safe sleep programme to reduce Māori SUDI rates, in alignment with national indicator (<0.5 per 1,000 live Māori births) • Partner and support the Midland Safe Sleep Programme facilitated by Te Puna Oranga Waikato DHB, Maori Health Service on behalf of Nga Toka Hauora (Midland Maori General Managers Forum), and in partnership with Change For Our Children • Networking and sharing of resources throughout the Midland region. <p>Breastfeeding:</p> <ul style="list-style-type: none"> • Complete Mama Aroha breastfeeding training with key health practitioners inclusive of midwives, LMCs / Māori provider staff across Midland region. • Explore the development of IT tools, eg mobile phone applications and the use of the regional website to improve access to information for all parents, particularly Māori and vulnerable mothers re breastfeeding, safe sleep and smokefree pregnancy. • Networking and sharing of resources throughout the Midland region. <p>Immunisation:</p> <ul style="list-style-type: none"> • Networking and sharing of resources throughout the Midland region • Share education resources across the Midland region. <p>Family violence:</p> <ul style="list-style-type: none"> • Networking and sharing of resources throughout the Midland region • Share education resources across the Midland region.

	Never shake a baby: <ul style="list-style-type: none">• Networking and sharing of resources throughout the Midland region• Share education resources across the Midland region.
	Project Manager's Update: Smoke free pregnancy <ul style="list-style-type: none">• CO monitors purchased by MMAG and delivered to the Midland DHBs, based on number of pregnant women who smoke in each district, to support smoke free pregnancies. An educational and training video is being developed by Waikato and shared with Midland to support staff and LMCs to discuss the benefits of smoke free pregnancies with women• Presentation of the Smoke Free Pregnancy Tupeka Kore Framework (a Waikato MQSP initiative) to MMAG by Dr Nina Scott (Te Puna Oranga Public Health Physician) – MMAG has incorporated this framework into its 16-17 work plan• Smoking when breastfeeding information provided in <i>BreastFedNZ</i> app and website, including links to seven smoking cessation and dependency support agencies. These links mirror the Well Child app links. Safe sleep <ul style="list-style-type: none">• Midland safe sleep e-learning module available across Midland and aligns with the Midland Safe Infant Sleeping (Birth to 1 Year) Protocol – approved in 2014 and due for review in 2017.• Education around safe sleep practices has been incorporated into <i>BreastFedNZ</i> app. Breastfeeding Mobile phone app <i>BreastFedNZ</i> developed and launched: <u>Key milestones:</u> <ul style="list-style-type: none">• Phase 1 – app content (ch.1, 2 & 3) launched 31 August 2015 (Apple and android platforms)• Phase 2 – app. content (ch.4, 5 & 6) launched 31 October 2015 (Apple and android platforms)• Phase 3 – implementation and ongoing roll out across Midland maternity services, Well Child/Tamariki Ora providers (Windows platform via app website).• Website and Facebook page launched to support app implementation (www.breastfednz.co.nz and 'Breastfed NZ' Facebook page) – one FB post was shared 14 times – linking better with midwifery practices, support groups, and consumers• Supporting promotional print material developed (wallet cards, DLE flyers, A5, A4, A3 and A2 posters developed, including Te Reo – free design files available on website)• Over 250 breastfeeding accredited spaces uploaded on app's GPS activated map (Bay of Plenty, Lakes, and Taranaki spaces – Waikato and Tairāwhiti still to be loaded)• Five media releases issued, resulting in National Radio interview with Lead Content Developer, Karen Palmer; Tainui Radio interview in te reo with BOPDHB Maori Health Planning & Funding Portfolio Manager; newspaper and magazine articles, presentations given locally and nationally.• 4,600+ app downloads as at 31 May 2016• App content used as a breastfeeding education tool for maternity, LMC and WCTO staff training – content provided on DVD to support breastfeeding education• Print runs of wallet cards, Well Child book stickers, flyers and posters has been funded by MMAG for maternity services and Well Child services• Links to external resources and support incorporated into the app and website, including Find Your Midwife, MoH, LLL, WellChild app, Raising Children app, smoking cessation, mental health, etc

MIDLAND REGION WORKPLAN AND UPDATE

- Formalised linking with the MoH's 'Breastfeedingnz' Facebook page, with monthly promoting of the app as a free resource for women
- The MoH's information on 'feeding your baby in an emergency' added as a separate tab to *BreastFedNZ*
- Opportunities to incorporate pregnancy focused messaging eg Taranaki's resource '5 things to do within the first 10 weeks' of pregnancy; adding Well Child and Tamariki Ora provider information, and antenatal pregnancy education and parenting support provider information
- *BreastFedNZ* is now available for Windows platform phones at www.breastfednz.co.nz/app.

Other breastfeeding activities

- MMAG facilitated three Mama Aroha Breastfeeding Talk Card workshops in the BOP district, with over 100 Well Child Tamariki Ora providers, Plunket staff, Midwives, Lead Maternity Carers, Child Birth Educators, Public Health staff attending. These workshops were held to support the implementation of the MoH's national funding of Mama Aroha resources to health care providers.
- Midland is working on updating a postnatal breastfeeding poster for maternity facilities, incorporating the app and updating photos.
- A Midland Use of Donor Breastmilk Protocol is being drafted by MIMAG

Immunisation

- Immunisation messages for mamas to be developed by the Māori Immunisation Facilitator – Midland, and uploaded to the app – June 2016

Family violence

- Links to Women's Refuge, power to protect, and emergency services added to Useful Links on *BreastFedNZ* website

Infant and child health messages

- A 'Midland healthy pregnancies – healthy families' DVD resource has been collated and circulated to Midland DHBs. The content includes national and regional short film resources, eg never shake a baby, and links to Midland developed resources eg the *BreastFedNZ* app and the Child Health Action Group's skin conditions work.

Midland Maternity Action Group (MMAG) initiatives	Issues to be resolved	Expected outcomes for communities from the initiative
4. Pregnancy and parenting programmes	<p>What are the problems to be resolved?</p> <ul style="list-style-type: none"> • Improved access to pregnancy and parenting education/classes is required, particularly for rural and Māori pregnant women, with the aim to increase the number of vulnerable pregnant women who enrol in pregnancy and parenting/ antenatal classes, especially in rural and high deprivation areas. • Midland DHB planning and funding divisions are engaged with MMAG to support the implementation of the 	<ul style="list-style-type: none"> • Engage with Midland DHB planning and funding divisions to support improved access and uptake of pregnancy and parenting education/classes, particularly for rural Māori pregnant women. • Collect and analyse data, including ethnicity breakdown, from Midland DHB planning and funding divisions on the utilisation of Midland's pregnancy and parenting/antenatal education/classes. • Support and partner with Te Puna Oranga Waikato DHB, Maori Health Service on behalf of Nga Toka Hauora (Midland Māori General Managers Forum) with TPO's proposal to develop and produce a Hapu Wananga Curriculum & Toolkit for the Midland region. The intent of the curriculum and toolkit is to grow the number and breadth of culturally appropriate pregnancy and parenting programmes in the Midland region that can be used in both rural and urban settings. • Support the development of the Hapu Wananga curriculum and toolkit content design.

	<p>pregnancy and parenting service specifications at a local level.</p> <ul style="list-style-type: none"> • regular information and data (including ethnicity breakdown) on the utilisation of Midland's pregnancy and parenting/antenatal education/classes is required by MMAG from the Midland DHB planning and funding divisions • Māori and Pacific fair the poorest in terms of maternal and infant health outcomes, therefore an investment toward developing a curriculum for Māori has yet to be realised. 	
<p>Project Manager's Update:</p> <ul style="list-style-type: none"> • Additional Mama Aroha breastfeeding resources purchased for Lakes DHB and also for inclusion in the Hapu Wananga Curriculum & Toolkit being developed by Te Puna Oranga Waikato DHB Maori Health Service on behalf of Nga Toka Hauora (Midland Maori General Managers Forum) • MMAG supports the development of this curriculum and toolkit and looks forward to receiving a presentation from Te Puna Oranga team after it has been formally presented to the national GMs Maori Health forum • Discussed the opportunity with BOPDHB Planning & Funding and GM Maori Health Planning & Funding to incorporate antenatal pregnancy education and parenting support provider information in <i>BreastFedNZ</i> and also Well Child and Tamariki Ora provider information. Plunket rooms are currently incorporated into the 'baby care spaces' tab of the app (BOP, Lakes and Taranaki). 		

Suzanne Andrew
Regional Project Manager – Clinical Networks
HealthShare Ltd

Line of Sight

- National Maternity Monitoring Group 2015/16 Work Programme
- Māori Health Plan template 2016/17: page 5 – child health (breastfeeding), page 8 – smoking cessation: percentage of pregnant Māori women who are smoke free at two weeks postnatal, and page 12 – Sudden Unexpected Death in Infancy (SUDI) – actions required from the Midland DHBs on Māori SUDI rates
- 'Maternal and Child Health Promotion Service Review Consultation Document', MoH (December 2015)
- DHB Annual Plans: not included in planning guidance as the Maternity Quality & Safety Programme has separate reporting requirements for DHBs
- DHB Public Health Unit Plans: activities will be informed by evaluation and learning from existing initiatives across Midland region.

Initiatives				Milestone/Date	Responsibility
<ul style="list-style-type: none"> • Develop a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the Midland region. The framework will include: <ul style="list-style-type: none"> – an overview of literature – New Zealand and Midland research findings – quantitative breastfeeding data – qualitative feedback from Midland's women and maternity and WCTO health care providers (focus groups, semi-formal interviews, surveys) – learning from existing breastfeeding activity within DHBs of the Midland region The framework will influence the following key overarching themes for breastfeeding in the Midland region that: <ul style="list-style-type: none"> – supports, protects and celebrates breastfeeding in the community – provides quality support services for women to overcome breastfeeding challenges – has maternity and community services that follow best practice breastfeeding standards Key themes will be underpinned by specific priorities and can add value to the current and future work plans, and also support information sharing and learning across DHBs in the Midland region. The framework may be of interest to anyone working directly or have an influence on services provided for young children, women through pregnancy and families. • Midland Breastfeeding App – BreastFedNZ – 10,000 downloads of the App is achieved (currently at 3,500) <ul style="list-style-type: none"> – Interest in the App content is maintained <ul style="list-style-type: none"> <input type="checkbox"/> social media management continues <input type="checkbox"/> Midland breastfeeding friendly accredited spaces added <input type="checkbox"/> WCTO and pregnancy and parenting service providers added <input type="checkbox"/> issues and barriers to breastfeeding identified in focus groups of Midland breastfeeding framework are addressed, where applicable – Post-implementation <ul style="list-style-type: none"> <input type="checkbox"/> evaluation of effectiveness and uptake (12 month mark: September 2016) <input type="checkbox"/> content is reviewed against topics of smoke free pregnancies, safe sleeping, mental health messages, alcohol and drugs, maternal nutrition, immunisation, etc <input type="checkbox"/> increased visibility of Māori breastfeeding women, partner and whanau support in app, website, and resources • Implement the 'Midland Use of Donor Breastmilk Protocol' • 				<p>*key MMAG output</p> <p>Q1-Q4 2016/17</p>	MMAG; Midland Population/ Public Health Units; Midland Māori Health Services; CHAG; Midland DHB
<p>NZ Health Strategy strategic themes alignment: people-powered, closer to home, value and high performance, one team, smart system</p>				Q1-Q4 2016/17	
<p>1: Improve Māori health outcomes</p> <p>2: Systems integration across continuum of care</p> <p>3: Improve quality across all regional services</p> <p>4: To build the workforce</p>				Q2 2016/17	
1	1	2	2	2	1
<p>Smokefree pregnancies</p> <ul style="list-style-type: none"> • Explore training video demonstrating a discussion of benefits of a smokefree pregnancy, how to incorporate the use of a CO monitor into a consultation (note: CO monitors were distributed as part of MMAG's 15/16 work plan) • Smoke Free Pregnancy Tupeka Kore Framework (Waikato MQSP initiative) – look to implement across Midland maternity providers (<i>to be confirmed by Waikato MQSP/ Māori Health Team and Midland DHBs</i>) <p>NZ Health Strategy strategic themes alignment: people-powered, closer to home, value and high performance, one team, smart system</p>				<p>Q1 2016/17</p> <p>Q2 2016/17</p>	MMAG; Midland Māori Health Services; Public Health Units; Midland DHBs

1: Improve Māori health outcomes 1	2: Systems integration across continuum of care 1	3: Improve quality across all regional services 2	4: To build the workforce 2	5: Improve clinical information systems 2	6: Best value for public health systems resources 1
Sudden Unexpected Death in Infancy (SUDI) <ul style="list-style-type: none"> Undertake a three yearly review the Midland Safe Infant Sleeping (Birth – 1 Year) policy, update safe sleep e-learning package on Moodle Audit against the Midland Safe Infant Sleeping (Birth – 1 Year) protocol (note regional protocol due for review 2017). NZ Health Strategy strategic themes alignment: people-powered, closer to home, value and high performance, one team, smart system				Q1 2016/17 Q2 2016/17	MMAG; Midland Māori Health Services; Public Health Units; Midland DHBs
1: Improve Māori health outcomes 1	2: Systems integration across continuum of care 1	3: Improve quality across all regional services 2	4: To build the workforce 2	5: Improve clinical information systems 2	6: Best value for public health systems resources 1
Maternal mental health, including alcohol and drug addictions <ul style="list-style-type: none"> Support training opportunities in Midland for perinatal anxiety and depression workshops across maternity and WCTO providers. Share information, resources, and screening tools to help identify women with modifiable risk factors for perinatal related death, and identify areas where MMAG can work collectively to address these (PMMRC 9th Report 2015, recommendation 1). NZ Health Strategy strategic themes alignment: people-powered, closer to home, value and high performance, one team, smart system				Q2 2016/17 Q2 2016/17	MMAG; Midland Māori Health Services; Public Health Units Midland DHBs
1: Improve Māori health outcomes 1	2: Systems integration across continuum of care 1	3: Improve quality across all regional services 2	4: To build the workforce 2	5: Improve clinical information systems 2	6: Best value for public health systems resources 1
Healthy weight gain in pregnancy /management of the bariatric pregnant woman <ul style="list-style-type: none"> Ongoing implementation of the MoH childhood obesity package, namely initiatives 4, 6 and 7: <ul style="list-style-type: none"> guidance for healthy weight gain in pregnancy, gestational diabetes guidelines, and referral pathways to Green Prescriptions for pregnant women (at risk of gestational diabetes) for LMCs to access via DHB Map of Medicine/Bay Navigator tools Implement the 'Midland Management of the Bariatric Pregnant Woman Protocol' NZ Health Strategy strategic themes alignment: people-powered, closer to home, value and high performance, one team, smart system				Q1-Q4 2016/17 Q1 2016/17	MMAG; CHAG; Midland Māori Health Services; Public Health Units Midland DHBs
1: Improve Māori health outcomes 1	2: Systems integration across continuum of care 1	3: Improve quality across all regional services 1	4: To build the workforce 2	5: Improve clinical information systems 2	6: Best value for public health systems resources 1
Primary and rural birthing for women in the Midland region <ul style="list-style-type: none"> Share resources on how to reduce risks and interventions Review findings of Wintec research project on the experiences of women and LMC using primary facilities in the Waikato to identify learnings across Midland. NZ Health Strategy strategic themes alignment: people-powered, closer to home, value and high performance, one team, smart system				Q1 2016/17 Q3 2016/17	MMAG; Midland Māori Health Services; Public Health Units; Midland DHBs
1: Improve Māori health outcomes 1	2: Systems integration across continuum of care 1	3: Improve quality across all regional services 1	4: To build the workforce 1	5: Improve clinical information systems 2	6: Best value for public health systems resources 1
Coding in Midland maternity services <ul style="list-style-type: none"> Explore coding issues across Midland maternity services and work with DHB coders to find a resolution to support improved quality in the reporting of maternity data. NZ Health Strategy strategic themes alignment: value and high performance, smart system				Q1 2016/17	MMAG; Midland DHBs
1: Improve Māori health outcomes 2	2: Systems integration across continuum of care 2	3: Improve quality across all regional services 1	4: To build the workforce 2	5: Improve clinical information systems 1	6: Best value for public health systems resources 2



Baby Friendly Hospital Initiative. Left to right: Julie Stufkens (CEO - NZ Breastfeeding Authority), Debbie Wright (SCN - Lactation Management), Belinda Chapman (Associate Director Midwifery), Carol Wells (Midwife), Karen Ferracioli (Midwife), Leigh Cleland (Clinical Services Manager - Maternal & Child Health), Alisha Stone (Health Promotor), Lara Bertie (Neonatal Unit Staff Nurse)

WHAT HAVEN'T WE INVESTIGATED THAT WE PLANNED TO DO

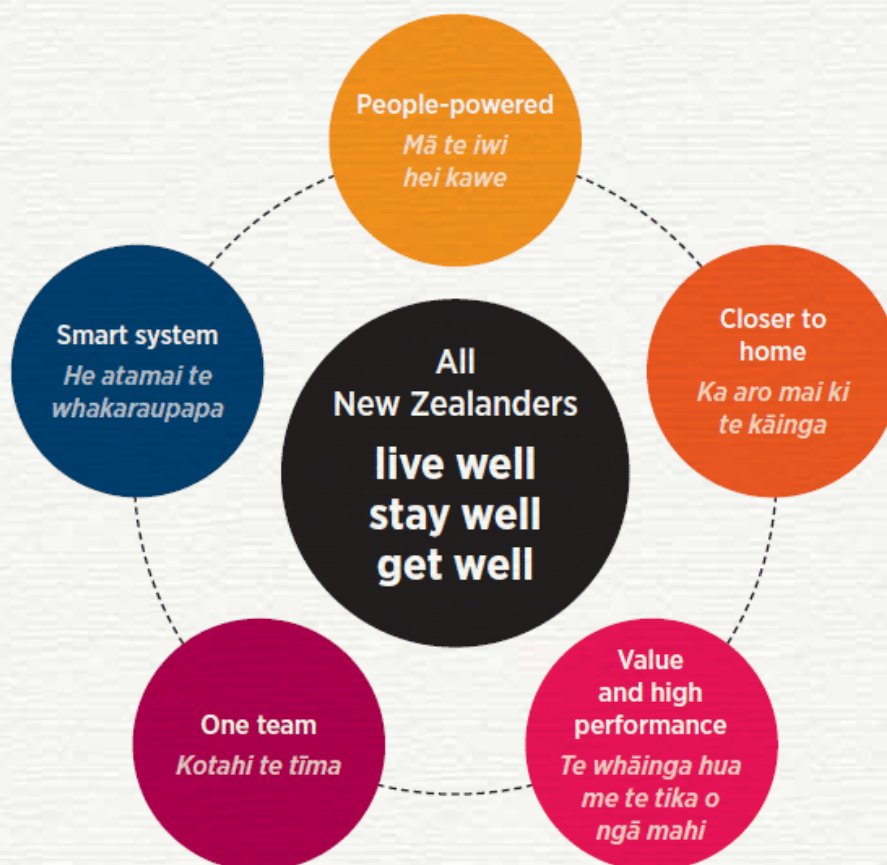
Access to Primary Ultrasounds

It was proposed for the 2015/16 work plan that the Maternity Quality committee would investigate the reasons for the escalating primary ultrasound pregnancy scans rates and that the referrals met the section 88 criteria. Due to changes in the local private and public services this has not been able to be carried out; it will be taken forward to the 2016/17 work plan once the changes to the services are better established.

It is unfortunate that all Nuchal thickening scans have had a \$50 fee applied, since this has happened we have seen an increase in MSS2 testing and a subsequent increase in amniocentesis. Additionally we now have information to give to pregnant women on the Non-Invasive Prenatal Testing (NIPT) and Harmony testing should amniocentesis not be elected. It would be good to see some national directives and funding/support on these latter two tests.

Pregnancy and Parenting Education

The contract for Pregnancy and Parenting Education (PPE) is being devolved from Waikato DHB to Taranaki DHB from 1 July. Taranaki DHB have been waiting for the release of the Hapu Wananga curriculum/programme which is currently being piloted in the Waikato region. Four child birth educator students have commenced training in 2016 to meet the future needs of these services.



GOING FORWARD AND FUTURE PRIORITIES

Please see full work plan in Appendix 10.

- Future planning of maternity services; how where and when services will be delivered eg primary and secondary intrapartum and post natal care
- Ultrasound scanning
- Continue with maternity staffing trial
- Continue to explore GDM services and how a GDM specialist midwife and obstetrician can be implemented
- Small for Gestational Age (SGA) Investigation for improvements in outcomes (clinical indicator 20)
- Standardization of Newborn resuscitation trolleys
- Continue to investigate NNU admissions with a focus of reducing admissions >37 weeks gestation.
- Alliancing project
- Child SLAT and NCHIP implementation
- Continue with the Perinatal and Maternal Mortality recommendations
- Vaginal Birth After Caesarean section
- NMMG recommendations
- Coding



APPENDIX 1: ALIGNMENT WITH THE AIMS AND OBJECTIVES WITH THE NATIONAL PRIORITY AND RECOMMENDATIONS

Multidisciplinary review process/meetings that have been coordinated

- Monthly MQC meetings
- ADOM meetings with community midwives (rural and urban)
- Maternity Obstetric outcomes case review meetings weekly
- Fortnightly Maternity service management meetings
- Monthly direct report meetings
- Fortnightly core maternity staff meetings
- Monthly perinatal mental health liaison meetings
- Monthly multidisciplinary complex care meetings
- Midland Maternity Action Group meetings-quarterly includes sub groups for breastfeeding, educators, midwifery leaders
- Perinatal Mortality meetings two to three times per year
- Taranaki Immunisation strategy group meetings
- Breast feeding case reviews and terms of reference
- Maternity Wellbeing and child protection multi agency meetings, including terms of reference, memorandum of understanding and set templates
- Child Health Service Level Alliance Team (SLAT)
- National Child Health Information Platform (NCHIP)
- Attendance at National MQSP meetings
- Attendance at National Severe Acute Maternal Morbidity (SAMM) and SAMM Kids meetings.

Changes in clinical practice and quality improvements driven by MQSP

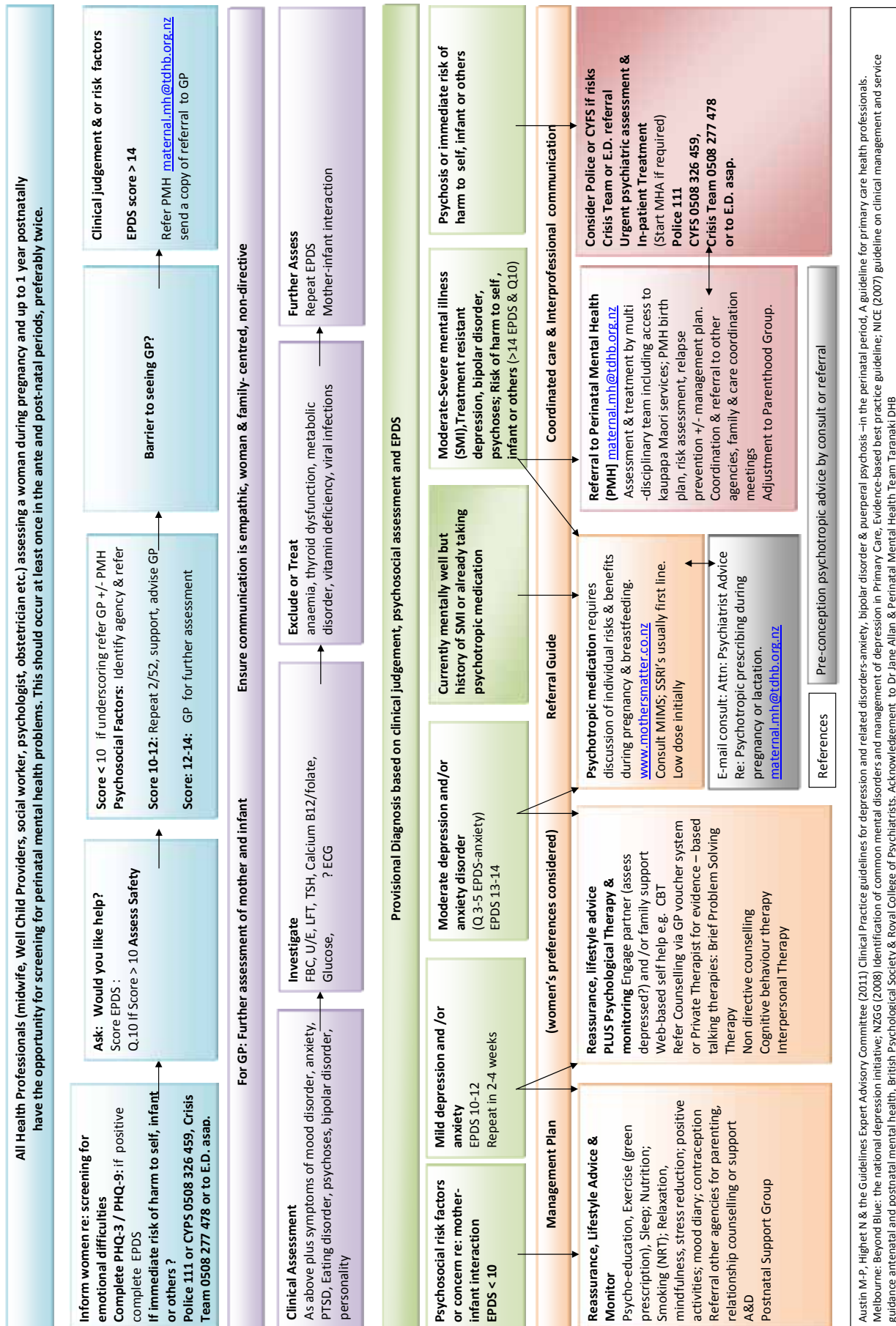
- Breast Feeding Mama Aroha talk cards to maternity and well child practitioners
- Emergency cones to be placed outside rooms to identify emergency
- New phone and auto message for Hawera Maternity Unit
- Donation of a Cuddle Cot for Intrauterine/Neonatal death babies
- Visible guidelines for Health Care Assistants (HCA) and for casual HCAs
- Emergency Proforma Clipboards implemented into each delivery room
- Colour Prints of PPH Proforma and Proforma enlarged
- Shoulder Dystocia Proforma
- Cord Prolapse Proforma
- Photographic blood loss estimation cards available in each delivery room cupboard for reference
- Laminated prints for completing smoking and VTE Form

- Consumer rights flip cards
- IV trolleys-named and labelled contents for antenatal, 14 and 15 to assist in an emergency
- Extra secondary clinics implemented to match workload
- Prolonged Rupture Of Membrane protocols (PPROM and PROM)
- Amnisure testing
- Nuchals translucency scans available at Parklands surgery
- Cadd solis epidural pumps received
- Green prescriptions and education on referral process
- CTG storage envelopes
- PROMPT training implemented to rural unit twice yearly
- PROMPT training held twice yearly in secondary unit
- GP meetings to promote early pregnancy screening, referral and early engagement with LMC
- WOMAD early engagement with and LMC information tent and breastfeeding facility
- Review of role of HCA
- Six month staffing trial to try and better meet the peaks and troughs in maternity
- Quality Leadership Programme regional template, guideline and roll out of new national document
- BreastFedNZ App, posters and business cards
- Opportunistic antenatal immunisation in pregnancy for inpatients
- Weekly drop in pregnancy immunisation clinics for whooping cough and Boostrix
- Upgrade of the maternity pages of the Taranaki DHB website.

New maternity Initiatives

- Carbon Monoxide monitors (Smoklyzer)
- New graduate midwife position and guideline
- Standardization of Neonatal resuscitation trolleys
- DATIX quality risk management reporting system
- RANZCOG annual fetal surveillance training (annual)
- Amniocentesis procedure is performed at Fulford Radiology where there are superior scanning facilities
- Midland Maternity and repatriation standards
- Fetal Day assessment Unit guideline
- Perinatal Mental Health (PNMH) pathway. Inpatient Mental Health referral procedure.

APPENDIX 2: PERINATAL MENTAL HEALTH PATHWAY. INPATIENT MENTAL HEALTH REFERRAL PROCEDURE



APPENDIX 3: QUALITY AUDIT AND REPORTING GRIDS

Taranaki DHB Maternity Quality Audit Grid 2015/16

	2016						2017					
	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
MEWS <i>Core Representative</i>	☺						☺					
Customer Satisfaction Survey <i>Consumer</i>		☺										
Documentation Audit <i>ME</i>					☺						☺	
ISBARR <i>Postnatal Coordinator</i>			☺						☺			
Electronic Fetal Monitoring Audit <i>ME</i>						☺						
Midland Referral Guidelines Audit <i>ME</i>												☺
Safe Sleep Audit <i>Safe Sleep Champion</i>		☺										
Caesarean Sections <i>O&G</i>				☺							☺	
High Dependency Unit Admissions Audit <i>ME</i>						☺						☺

APPENDIX

Taranaki DHB Maternity Quality Committee Reporting Grid 2016/17

	2016						2017					
	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
PMMR and Case Review/trends/ great saves <i>ME/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/CMM</i>		☺								☺		
Wound infections/ General Anaesthesia and Blood Transfusions (caesarean section) <i>CNS – Infection Control</i>				☺								
Consumer Report <i>Consumer Representative</i>			☺									
Breastfeeding and Lactation services <i>Lactation Consultant</i>	☺				☺				☺			
Better Help For Pregnant Women To Quit Smoking <i>Tobacco Control Coordinator</i>	☺						☺					
Newborn Hearing Screening <i>Allied Health Manager</i>								☺				
Review of Governance group and Terms of Reference <i>MQSP Coordinator</i>					☺							
Work Plan <i>MQSP Coordinator</i>			☺			☺			☺			☺
Maternity Case Review Outcomes											☺	

APPENDIX 4: MIDWIFERY PROFESSIONAL DEVELOPMENT 2016

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
Epidural (1/2 day)	RM only		4 May, 12 September (Education Centre)	Sharon Howe/Tom Lupton/ Emma Patrick	1230-1700
Vaccinator training 2 day course	Midwives, RN		26 and 27 July Taranaki DHB	IMAC/Mel Hurliman	0830-1630
Update for Vaccinators	Midwives, RN, health professional who vaccinate		10 may	IMAC/Mel Hurliman	1730-2130
Breastfeeding study day	All	Yes	5 July, (lecture Theatre)	Sharon Howe/Deb Wright	0815-1300
Newborn life support – full day	RN RM O&G Dr's & Paed Dr's ONLY		13 May, 18 Nov (Clinical Skills Lab)	Abi Webber/Sharon Howe	0900-1600
Pain Management	Core Midwives, RN's		See Stargarden	Eileen Davey	0830-1200
Perineal Suturing (1/2 day)	RM only		15 Feb, 16 August, 30 November, (Education Centre)	Sharon Howe/Eddie Williams	1230-1630
Perinatal Mortality Meeting	O&G, NNU, Paeds, LMC's, Maternity		23 Feb(Rm 4 &5 Education Centre), 20 September (Lecture Theatre)	Sharon Howe/Belinda Chapman	7-9pm
PROMPT Course	RM, Obst, Anaesthetists		19 February , 8 July, 18 Nov	Sharon Howe, Belinda Chapman, Tom Lupton, Bill Viner	0800-1630
Midwives Practice day	RM only		22 March (Lecture Theatre)	Sharon Howe	0830-1630
Midwives Emergency Refresher workshop	RM only		20 May, 12 August and 4 November	Sharon Howe	0800-1630
Hawera PROMPT	RM ED staff Ambulance staff		15th July	Sharon Howe/Rosemary Darby/Belinda Chapman	0800-1630
Safe sleep/ Smokefree Te Hapu Ora	RM/RN	Yes	2 May Lecture theatre	Alys Brown	1000-1400
Taranaki DHB FVIP WORKSHOP	RM RN		19 Feb, 18 Mar, 15 Apr, 27 May, 24 Jun, 29 Jul, 26 Aug, 23 Sept, 28 Oct, 25 Nov (Education Centre)	Marianne Pike	0830-1630
Holding on and Letting Go Workshop	Midwives, O&G		March 3rd Clinical skills lab Taranaki DHB	Vicki Culling	0900-1630
RANZCOG one day workshop	RM, O&G		22 April Lecture theatre	RANZCOG	0800-1700

Midwifery Council of New Zealand (MCNZ) compulsory education requirements:

APPENDIX

- Annual Midwives emergency day training which includes maternal resus to the standard of level 4, Neonatal resuscitation and emergency drill training. PROMPT and ALSO (not provided at Taranaki DHB) training days will cover an annual midwives emergency refresher workshop (once in every three years only, remaining two years must be Midwives emergency refresher workshop). Taranaki DHB PROMPT includes newborn life support.
- Midwives practice day every three years
- Attendance at a Breastfeeding approved workshop (minimum four hours) every three years, in addition must attend another education session with no hours specified which can be a conference, on line learning or other activities (it can be the second half of a different full day breastfeeding related workshop)
- Midwifery standards review every two to three years
- Professional and elective education as stipulated by midwifery council

DHB requirements for Core Midwives

- Epidural study day every three years
- Pain management every three years
- Suturing workshop every three years
- Newborn life support full day (recommended to be attended every three years but not compulsory)
- Family violence
- Clinical compulsory study day every three years
- BFHI compulsory core staff education/NNU and one hour clinical component

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

APPENDIX

APPENDIX 5: MATERNAL OBSTETRIC OUTCOMES INDICATORS

Maternity Obstetric Outcome Data Collection Form

Patient Bradma

Database Record: ☐ ☐ ☐ ☐

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

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

Category	Fetal and Maternal Outcome	Circle	Y	Comments/Indication/Gestation
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 ≥ 1000mls (caesarean birth)	OT/W		
	Caesarean section elective	DS		
	Caesarean section emergency	DS		
	General anaesthetic caesarean section	DS		
	Epidural in labour	DS		
	Uterine death /TOP > 20weeks	DS		
	3 rd or 4 th degree tears/anal sphincter trauma	DS		
	Induction of labour	DS		
	Wound infections post caesarean	W		
	Postnatal readmission	W		
	Number of days post natal inpatient stay ≥ 5 days	W		
	VBAC	DS/OT		
	GDM	W/DS		
	Assisted Birth Forceps Ventouse	DS/OT		
	IOL or Elective C/S before 38 +6/40	DS		
Case Review	Unexpected maternal transfers to ICU	DS/OT W		
	SGA	DS/W		
	PPH>1000mls	DS/W		
	Eclamptic Seizure	DS/W		
	Visceral Trauma; Uterine scar rupture/dehiscence, urinary system or bowel trauma. 3 rd and 4 th tear/anal trauma	DS		
	Caesarean Hysterectomy	DS		
	Level 1 caesarean section	DS		
	NND/Intrauterine death /TOP >20weeks	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 & PN when ≥37weeks gestation and excluding fetal abnormality	DS/W/ OT		
	Apgar score <5 at 5 min and/or <7 at 10 min, and/or cord pH <7.0	DS/OT		

TDHB: Core Midwifery	Responsibility: Midwife Educator	Version 4
Date Issued May 2016	Review By Date: May 2019	Authorised by: Associate Director of Midwifery

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	Post natal readmission	DS/W		
Mandatory Reporting	Intrapartum fetal demise	DS		Datix Report must be completed Line manager must be informed.
	Maternal Death	DS/W		Datix Report must be completed Line manager must be informed.
Other concerning outcome - requesting review:				Detail and comment:

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

If a 'Yes' has been indicated on this form, then the SHO/HS must do a discharge summary to GP Form to be forwarded to Midwife educator and ADOM on discharge.

TDHB: Core Midwifery	Responsibility: Midwife Educator	Version 4
Date Issued May 2016	Review By Date: May 2019	Authorised by: Associate Director of Midwifery

APPENDIX 6: TARANAKI DISTRICT HEALTH BOARD BREASTFEEDING CASE REVIEW

Service:	Women and Children's Health Service
Date Issued:	March 2016
Review By Date:	March 2019
Responsibility:	Taranaki DHB Lactation Consultant/PN Coordinator
Authorised By:	ADOM
Version:	1
Page	1 of 2

Purpose

- To discuss breastfeeding outcomes and provide an opportunity to learn and to apply care to the latest literature and recommended best practice.
- Identify areas of care that have been managed well/could be improved upon.
- Learn about system failure, and inform practice to improve outcome.

Definition:

- Any case may be referred to the 2 weekly breastfeeding case review meeting by any maternity practitioner by completing the case review template and / or notification form
- Cases included, but are not limited to, breast feeding cases to celebrate, breast feeding problems that have required extended length of stay, cases that required NNU admission due to perceived dehydration, neonatal hypoglycaemia, severe mastitis, breast abscess, use of nipple shield, milk formula top ups or supplementation. Other cases where any member of staff wishes to refer for discussion/review

Terms of Reference

- The Taranaki Breastfeeding Case review meeting is an informal review process of all cases of Interest for learning purposes, benchmarking and identifying areas for improvement in care and does not replace Taranaki DHB Reportable events Policy
- The meeting will identify care that meets the standard and make recommendations for further teaching and/or improvements to clinical practice/care where appropriate.
- The meeting will be held 2 weekly (except public holidays) Wednesdays at 12:00 in PN ward Lounge. If reviews need to be cancelled an email will be sent out by 10:00 on the morning of the intended review by either LC or PN Coordinator.
- Reviews will be held at Hawera Maternity Unit Monthly.
- The identified LMC will be notified of any cases that are to be discussed

Chairperson:

The Taranaki DHB Lactation Consultant or PN coordinator (or delegated person in their absence) will act as Chairperson and under the direction of the ADOM.

- Cases will be discussed confidentially in a constructive and non-punitive manner
- The case review template is completed with recommended action points (see Appendix 1)
- A summary of data of all cases discussed will be reported to the Maternity Quality Committee including trends/themes identified.

Membership:

- Taranaki DHB Maternity, Lactation consultants, Perinatal staff, NNU staff, student Midwives, Paediatricians , any other relevant Taranaki DHB employed stakeholders
- Self employed Midwife, General Practitioner and Private Obstetric LMC's

Co-opting Power:

The committee/meeting shall have the power to co-opt members of staff as required.

Quorum

A quorum shall consist of not less than four members.

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Meeting Time Frame:

- 2 weekly meetings. Meetings will be held on Wednesdays from 12-1300 hours.
- Monthly meetings at Hawera Maternity Unit.
- All cases that have been requested and/or as per rotational agreement below.

Procedure:

Any person wishing to review a case is encouraged to complete the template and forward to the PN Co-ordinator or LC. When submitting a case review and workload allows, please attend to present the case with support from the LC or PN Co-ordinator.

Following the review discussion recommendations/comments will be added to the template by LC or PN Co-ordinator and the completed document finalised.

Any recommendations will be fed back to appropriate personnel.

The reviews may be use for educational purposes with confidentiality maintained.

On completion the template will be saved in the U drive.

BFHI education hours and attendance will be recorded.

Conflict of Interest

To be declared when a potential conflict exists with an agenda item.

Confidentiality of cases is maintained.

Reporting Relationship

Information is filed electronically on the U drive under 'breast feeding case reviews', date, year and themes/ trends reported to the Maternity Quality Committee.

Minute Circulation

Issues identified and an action plan will be the only written record and reviewed at each meeting. A progress report will be reported via the Maternity Quality Committee.

Example below:

Appendix 1

Breastfeeding Case Review Template

Please take no longer than 5 minutes to present the following information:

Identity

Patient age, location, delivery date, gestation, gravida, delivery details, relevant medical/social history

Background:

Details of first feed, how feeds progressed and when feeding problem identified.

Assessment/ Issues

'The story'.

Interactions and issues experienced.

Communication, clinical, workload, support, referral.

Outcome / Suggestions / Solutions

1

2

3

Attendance:

Date:

APPENDIX 7: MATERNITY QUALITY COMMITTEE NEWSLETTER

Maternity Quality Committee



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

July 2015 Issue 4



Kia Ora – Hello and welcome to our 4th issue of the Maternity Quality Committee (MQC) Newsletter. Before we continue I would like to acknowledge the sad departure of Frances McNulty to greener pastures. Frances was an integral founding member of the MQC group and had an amazing passion for quality. We wish her well in her new venture and miss her advice and input into our group. We would like to welcome Des Paulsen who has taken over from Frances, and also to new Committee members Ngamata Skipper and Jenny James ☺

Updates!

The Ministry of Health (MOH) have recently announced that the national Maternity Quality and Safety Programme (MQSP) will be funded for a further three years. A draft service specification and self assessment of Taranaki DHB's preferred excelling tier has been submitted to the MOH; feedback is expected to be received in late August 2015.

Maternity outcomes, trend setting, case review and reportable events guidelines

GDM (Gestational Diabetes Mellitus) and SGA (Small for Gestational Age) have been added to the form along with assisted births. It was also decided to review elective and emergency caesarean sections to identify trends that could be contributing to the increasing caesarean section rate at Taranaki DHB.

The last updated pre and post pregnancy referral directory for pregnant women and their families was circulated in April 2015; if you wish to receive a copy of this please email for a copy.

Pepi Pod distribution progress

To date approximately 180 have been distributed. Our dedicated safe sleep champion/Pepi Pod Co-ordinator Merry Sorensen has decided to hand the reigns over to Kirsty Loveday as Merry starts to wind down toward retirement. The MQC would like to thank Merry for all her tremendous hard work with co-ordinating and securing a \$10,000 donation to make sure we have replacement Pepi Pods in Taranaki. We look forward to working with Kirsty.

Taranaki MQC Facebook Page

The page now has 80 followers. This is used to consult with our consumers and as a general notice board. Please find us and join us on Facebook by searching for Taranaki Maternity Quality and Safety.



The MOH Gestational Diabetes Guideline

can be viewed on <http://www.health.govt.nz/publication/screening-diagnosis-and-management-gestational-diabetes-new-zealand-clinical-practice-guideline>. A reminder that all pregnant women should be offered an HBA1C at booking if <20weeks gestation as per the guideline and follow the flow chart for further referral, screening and testing. Additionally, Standard 20 of the quality standards diabetes care toolkit applies to diabetes in pregnancy:

<https://www.health.govt.nz/system/files/documents/publications/standard-20>.

Guidance for healthy weight gain in pregnancy

It is recommended that all pregnant women are weighed/monitored in pregnancy, please see: <http://www.health.govt.nz/publication/guidance-healthy-weight-gain-pregnancy> guidelines, quick reference guide and tools that can be used to guide women on healthy weight gain, eating and exercise in pregnancy.

Vitamin D and sun exposure in pregnancy information can be found on the MOH site:

<https://www.health.govt.nz/publications/Vitamin%20D>

Maternity Clinical Indicators (2012) can also be found at

<http://www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2012>

Report on Maternity:

<http://www.health.govt.nz/publication/report-maternity-2012>

MSS1 combined maternal serum screening services, nuchal thickness scanning can now be accessed free of charge from Dr Hardus Schwartz in Parklands Medical Centre, Bell Block. Additionally, these services can be accessed in Wanganui if South Taranaki residents prefer, at Riverside Ultrasound.

Taranaki DHB Maternity Annual Report

The 2015/16 report has been completed and has gone to the MOH. It will be available to view on the Taranaki DHB maternity internet page once feedback has been received from the MOH and the National Maternity Monitoring Group.

All enquiries to: maternityqualityinfo@tdhb.org.nz

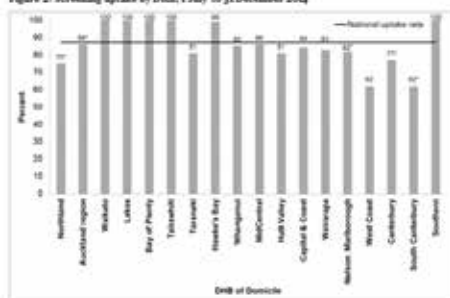
Maternity Quality
Committee

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



HIV screening – please ensure Taranaki pregnant women are given informed choice and offered this at booking; the current rate of screening is identified in the graph below. We are hoping to increase this rate.

Figure 21. Screenings results by year, 1 July to 31 December 2014



Stratford Maternity Unit closed its doors in November 2014. This was a response to significant challenges and experiences the independent provider had in recruiting and retaining midwifery and nursing staff. An options appraisal was undertaken which involved consumer, stakeholder and practitioner consultation and feedback. As a result of this it was agreed by the Taranaki DHB Board that exploration of a women's and child health hub for Stratford and an upgrade of Hawera primary maternity unit would be undertaken along with other recommendations.

The Ninth Annual Report of the Perinatal and Maternal Mortality Review Committee (PMMRC) can be viewed on:

<http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/2123/>.

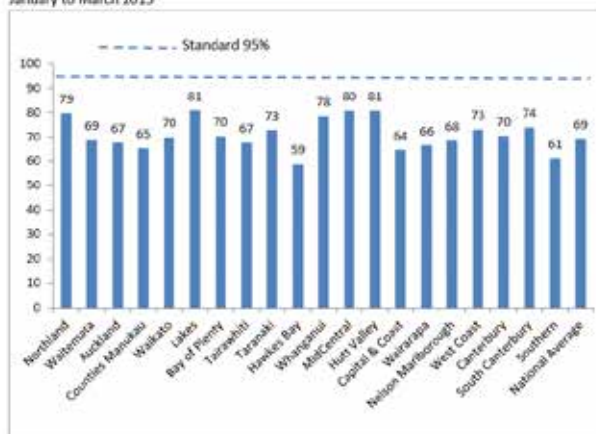
The perinatal related mortality rate is the lowest since the PMMRC began collecting data from 2007.

Antenatal Vaccination Clinics

51 women attended the vaccination clinic in 2013 for flu and/or Whooping Cough and 102 women attended the vaccination clinic in 2014, a 100% increase – great news and well done to the Antenatal Clinic. We are well on the way for even more in 2015 😊

To improve the timing of Guthrie cards reaching the national screening unit, improvements have been made. On a Monday-Friday daily basis, the card and envelopes are collected from Maternity and the Neonatal Unit and dropped directly into a fast post box by the Taranaki DHB van driver on his rounds. We are hoping to see further improvements in Taranaki rates as displayed in the dashboard below, which should enable quicker investigation and treatments for our babies that return an abnormal screen.

Figure 1 Percentage of samples meeting the NMSP transit time standard of four days or less, by DHB, January to March 2015



NMSP = Newborn Metabolic Screening Programme (Guthrie testing)

Updating of the external Taranaki DHB maternity internet page is underway. Not only will you be able to access the most current list of LMCs and the www.findyourmidwife.co.nz site but you will also be able to access other information on Taranaki DHB's maternity services including antenatal class information and resources. You can access the current list of LMCs on: http://www.tdhub.org.nz/services/maternity/lmc_contacts.shtml. We are hoping to increase the number of women engaging with an LMC in the first trimester.

Multi Agency Group (MAG) meetings (maternity care, wellbeing and child protection multi agency group). These will commence in August 2015. This will allow LMCs, GPs and other healthcare providers to refer women and babies who are identified as having vulnerabilities during the maternity care period so that wraparound services can be implemented to strengthen families. This will involve multi agency collaboration to engage support agencies to work with the mother and her whanau in a culturally safe manner. Information will soon be circulated to LMCs and GPs on how and when to refer.

All enquiries to: maternityqualityinfo@tdhb.org.nz

Maternity Quality Committee

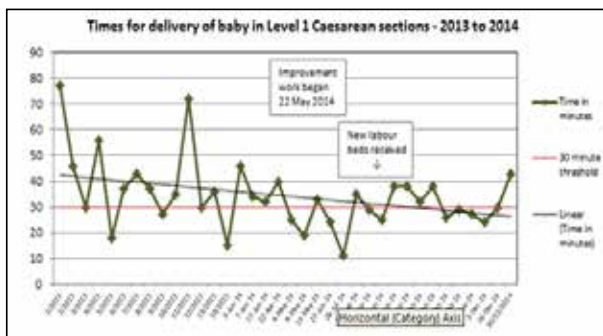


The Maternity Quality Committee is a clinical governance group that monitors and manages standards of clinical care, and is committed to ensuring a quality maternity service exists for the women and families of Taranaki.

Newborn (NB) Enrolment: Initiatives have been introduced to improve early NB enrolment and timeliness of the first infant immunisations. LMCs who book cases for birth at hospital who are identified as "unknown GP" are now contacted by the ward clerk to ensure the LMC has the latest list of GPs accepting new patients. Additionally Monday-Friday the ward clerk ensures any maternity inpatients with "unknown GP" are given the latest list of GPs to encourage registering with a GP. The NB hearing screeners also encourage women and babies to register with a GP. We are seeing a decline in women coming through the maternity unit identified as "unknown GP", thanks to everyone.

Decision to delivery of Level 1 caesarean section

The below graph shows the improvements we have been making in achieving the 30 minute auditable standard following a multi disciplinary Failure Mode Effect Analysis which led to the purchase of two new labour beds, emergency cones and telephones. Additionally, the directive and telephone operator audit sheet has been implemented to improve the process.



Midland Shared Protocols/Guidelines

- Midland have adapted Taranaki DHB's Maternity Bariatric Protocol and e-Learning tool for use throughout the region.
- Midland's Transfer and Repatriation Guidelines have been through a six month trial and final adaptations are in progress.
- Midland e-portfolio is in the process of development.
- Midland new graduate midwife guidelines are in draft and awaiting endorsement.

Better help to support smokers to quit: Midland Maternity Action Group have worked collaboratively to produce sets of six posters for display around Taranaki to encourage pregnant mothers to quit smoking. Additionally it is planned to have two Carbon Monoxide (CO) Monitors to assist LMCs to support women to quit.



Monitoring your carbon monoxide



All enquiries to: maternityqualityinfo@tdhb.org.nz

APPENDIX 8: MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB AND THE MIDLAND REGION

LIST OF PRIORITIES, DELIVERABLES AND PLANNED ACTIONS FOR 2015-2018

Maternity Quality Committee (MQC) Work Plan

Chair: Belinda Chapman (ADOM, Taranaki DHB)

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	Planned activities	Measure	Work Completed
1	Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance at Taranaki DHB to enable consumer informed decision-making Consumer engagement survey Consumer representative for the Māori, Indian and Pacific ethnicities identified and utilised to assist MOC.	Consumer voices (via survey, individuals, focus group, complaints and compliments, road show) is collected and informs the future direction of service delivery for Taranaki DHB.	Sept/Oct 2015: Pilot survey, conduct 100 surveys per year and collate information and publish findings annually. Consumer conducting face to face surveys, a target of 100 surveys from across Taranaki and across the demography is aimed. The consumer uses this time to increase consumer awareness of the BreastFedNZ app, Pepi Pods and other consumer focussed initiatives Sept/Oct 2015: An advert for a second consumer has been advertised on Taleo and on Facebook for a period of five weeks, interview dates to be set with panel member being a consumer, Māori representative, MQS member	100 consumer surveys completed annually. Two maternity consumer representatives sit on the MQC governance group.	Progress the survey, 80 have been completed so far for 2015/2016. Second consumer appointed May 2016 - identifies as Māori.

APPENDIX

	Project	Expected outcome	Planned activities	Measure	Work Completed
2	<p>Promotion of primary birth campaign (use of primary facility and homebirth)</p> <p>Strengthen the model of care at Hawera Maternity Unit - aligning with past Stratford unit.</p> <p>Upgrade of Hawera primary maternity unit</p>	<p>Increase in consumer knowledge of primary birthing.</p> <p>Safe, low tech homely environment that is whanau/family friendly and meets the needs of the local population for low risk birthing.</p> <p>Timely emergency response and skills from St John and base hospital for neonatal retrieval.</p> <p>Increase in bookings for primary birthing.</p> <p>Upgrade of Hawera Maternity facility is completed</p>	<p>An information leaflet on Hawera Primary maternity unit is to be developed and published.</p> <p>Visit other primary maternity units to view facilities with core midwives and present to local LMC, consumer and LMC's to promote engagement in facilitating the upgrade of Hawera Maternity Unit.</p> <p>Develop a proposal of changes to be made and facility upgrade.</p> <p>Upgrade facility and market the changes and facility</p> <p>Upgrade the Taranaki DHB Internet site on maternity services and local information on primary and homebirth.</p> <p>Neonatal Emergency Response Team (NERT) process to be implemented in consultation with rural midwives, St John and Taranaki base hospital.</p> <p>PROMPT training to be held twice yearly in Hawera primary maternity unit to promote relationships within rural emergency response services.</p> <p>Rural midwives and St John encouraged to share orientation of layout of emergency resuscitation equipment and communication.</p>	<p>Information leaflet developed by September 2016</p> <p>Proposal development</p> <p>Upgrade of facility commenced by June 2016.</p> <p>Taranaki DHB Maternity Internet site has up to date information on availability of maternity services in Taranaki and information on homebirth.</p> <p>Increase in bookings at Hawera Maternity Unit to 120 by June 2018.</p> <p>NERT response is implemented.</p> <p>PROMPT training is implemented and held twice yearly.</p>	<p>Staff member identified to lead this project</p> <p>Visit to other primary units has been completed and proposal drawn up in Oct 2015. Awaiting facilities management</p> <p>Work commenced in Maternity Internet information update in Oct 2015</p> <p>NERT response flow chart implemented in July 2015.</p> <p>PROMPT training planned for 27th Nov 2015</p>

APPENDIX

	Project	Expected outcome	Planned activities	Measure	Work Completed
3	Exploration of a maternal and child health hub for Stratford and surrounding districts following the closure of Stratford primary maternity unit	A completed investigation and report on the feasibility of having a maternal and child health hub for Stratford and surrounding district.	<p>Key stakeholders and community groups identified Draft project plan by June 2015.</p> <p>Agreed governance structure and participation by beginning of July 2015.</p> <p>Establish a governance group structure and participation.</p> <p>Assess feasibility for hub by: Engaging the Bishops action foundation trust to run the scoping project for a hub Develop Project Scope Including:</p> <ul style="list-style-type: none"> • Project timeframes and milestone • Linkage with the wider Stratford health services integration project • Liaison with other services, PHO and Healthcentre • Intersectoral Focus – Role of Other Agencies • Improving access to services • Consider visiting other sites with similar models of care • Future proofing • Appropriate process for engagements with mothers and families about services for the area <p>Complete a report on findings.</p>	<p>Scoping project for hub completed by June 2016.</p> <p>Report completed by Sept 2016.</p>	<p>Draft project plan and governance structure completed in June 2015.</p> <p>Concept of maternal and child health hub fully explored. Results indicate this concept is not wanted in the Stratford district. Report has been completed.</p>
4	Review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres	All Caesarean Section (C/S) cases have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre. Reduction in number of babies admitted to NNU for <24hrs.	<p>Project group to be formed with representation from quality and risk, operating theatre, NNU, maternity, service manager and consumer.</p> <p>Investigate feasibility of implementing a midwife or RN to follow through women and babies undergoing caesarean section birth. Include benefits and risks of current service and future services, what will be required to implement change including staffing, education and training.</p>	<p>All women undergoing caesarean section have a core RN/RM present to care for mother and baby before, during and following caesarean section by 2017.</p> <p>Reduction in babies admitted to NNU <24hours by 20%.</p>	<p>Sept 2015 project group initiated</p> <p>October 2015 admission to NNU < 24hrs old examined and costed.</p> <p>Staffing options explored Oct 2015.</p> <p>Staffing trial commenced April 2015.</p>

APPENDIX

	Project	Expected outcome	Planned activities	Measure	Work Completed
5	Stop smoking support and NRT therapy for pregnant women, partners and whanau is available and executed in a timely manner.	<p>All pregnant women are screened for smoking in pregnancy and are given brief advice and offered referral to smoking cessation support and NRT therapy.</p> <p>Posters initiated, distributed and displayed around Taranaki promoting pregnant women and families to quit smoking.</p> <p>Purchase of three CO monitors to use in primary community to support LMC's in smoking cessation promotion.</p> <p>Increase in number of pregnant women who have received NRT, referral and or quit smoking who are hospitalised.</p> <p>Maintain 95% of hospitalised pregnant women who are screened for smoking status, and those identified as smokers are offered effective advice, support and referral to cessation support.</p> <p>Reduction in number of small for gestational age babies (SGA) born in Taranaki at term.</p> <p>Reduction in rates of SUDI in Taranaki</p>	<p>Monitor all pregnant women who smoke. Ask about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support for hospital based admissions.</p> <p>Monitor the number of pregnant smokers to specialist stop smoking services.</p> <p>Develop and establish a referral process and pathway for hospitalised pregnant smokers to specialist stop smoking cessation services by April 2016.</p> <p>Enable training around best practice to support attainment of quit smoking support indicator for all pregnant women within Taranaki.</p> <p>Provide training to maternity practitioners in use of CO monitors to use as a tool to encourage pregnant women to stop smoking.</p>	<p>95% or > pregnant women who identify as smokers are screened for smoking, given brief advice.</p> <p>100% of women who consent to referral to smoking cessation support services are referred.</p> <p>100% of women who are referred are contacted and seen within seven days of referral.</p> <p>Two training sessions per year are presented in Taranaki to engage all maternity related practitioners in smoking cessation training including use of CO monitors.</p>	<p>CO monitors received end Oct 2015.</p> <p>Training on use of CO monitors in March 2016.</p>

APPENDIX 9: MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB AND THE MIDLAND REGION

LIST OF PRIORITIES, DELIVERABLES AND PLANNED ACTIONS FOR 2015/2016

Maternity Quality Committee (MQC) Work Plan

Chair: Belinda Chapman (ADOM, Taranaki DHB)

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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	Outcomes
1	Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance at Taranaki DHB to enable consumer informed decision-making <ul style="list-style-type: none"> • Consumer engagement survey • Meet your maternity services road show • Consumer engagement survey • Wahakura weaving • Stratford Maternal and child health hub, consumer representative • Consumer representative for the Māori, Indian and Pacific ethnicities identified and utilised to assist MQC • Promotion of primary birth campaign (use of primary facility and homebirth) • Upgrade of Hawera primary maternity unit. 	<p>Consumer voices (via survey, individuals, focus group, complaints and compliments, road show) is collected and informs the future direction of service delivery for Taranaki DHB.</p> <p>Local MQSP consumer representatives have a Taranaki DHB forum space to share ideas and connect with each other to strengthen consumer input into maternity services.</p> <p>Consumers have knowledge and understanding of maternity and primary ultrasound services</p>	<p>80 Surveys completed and inserted into Maternity annual report 2015/16.</p> <p>Consumer included in review of Stratford community.</p> <p>Consumer road show commences July 2016.</p> <p>Carried Forward (C/F) Wahakura weaving.</p> <p>2nd Māori consumer recruited May 2016</p> <p>Hawera leaflet in draft to get Comms to assist in design (C/F).</p> <p>Proposal for upgrade of Hawera Maternity; clean wall and poster boards in place, painting commenced, furnishings completed awaiting purchases of products (C/F).</p> <p>C/F toy box.</p>

APPENDIX

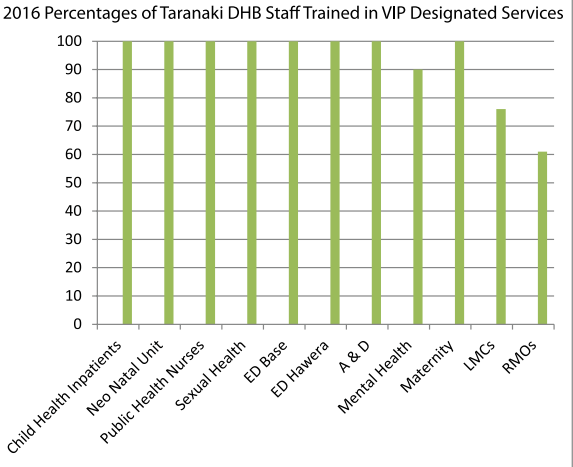
	Project	Expected outcome	Outcomes
2	<p>Improve LMC registration so that access to care is increased – increase the number of women registering with an LMC in their first trimester</p> <ul style="list-style-type: none"> • Create a pathway for GP's & practice nurses for referral to LMC, primary ultrasound and secondary antenatal clinic • Meet with GPs and practice nurses in South, central and North Taranaki to update on LMC and maternity services, assessments, screening and referrals • Continue 5 top things to do in the first 10 weeks of pregnancy. 	<p>Improved first trimester LMC registration across Taranaki DHB.</p> <p>Improved access to LMC maternity care across all ethnic groups.</p>	<p>Oct 2015: Business cards developed and ordered and distributed 1500, plus a further 1500 rack cards distributed.</p> <p>The maternity pages of the Taranaki DHB website have been updated and improved with better access to information on finding an LMC, information and resources.</p> <p>2nd draft April 2016: Electronic two minute advert being devised by Supa Suga to target young Māori women to engage in pregnancy services early to include top 5 things to do, breastfeeding, immunisation and parenting. C/F.</p> <p>2nd DRAFT of electronic two minute advert completed in April 2016.</p> <p>WOMAD tent completed in March 2016. Pregnancy information and breastfeeding tent manned by maternity staff at WOMAD included top 5 things to do in early pregnancy, breastfeeding and working packs etc.</p> <p>A banner has been purchased to use at events and on a daily basis within the DHB to encourage and support breastfeeding.</p> <p>Midland shared initiative for pathway, this has not been progressed yet. To be C/F.</p> <p>Two two meetings completed by May 2016. GP/Practice nurse meeting in South Taranaki was held on 4th November 2015 and a meeting with Care First GP's on 2/5/16. A power point presentation and information packs were presented/ given out as well as the resources on top 5 things in the first 10 weeks of pregnancy. Was well attended and information well received.</p> <p>Increasing rates as per KPI's annual report.</p>
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>Education on assessment, investigation and treatment for preterm labour, PPROM, tocolysis and fetal fibronectin testing.</p>	<p>Data captured to benchmark regionally and nationally. 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>	<p>Data being captured and reported to MQC. Working with PHO on early enrolment, early consultation with a specialist if risk of PTL.</p> <p>Cervical length measurement.</p> <p>Amnisure Process has been reviewed –staff now request from the laboratory so that they can be monitored.</p> <p>PPROM protocol completed 19th April Terbutaline protocol not completed O and G responsible C/F.</p>

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	Project	Expected outcome	Outcomes
3A	<p>Neonatal Admissions.</p> <p>Continue to monitor numbers of term, late preterm and preterm admissions to NNU, include the total number of babies born in Taranaki from 36-36+6 weeks' gestation</p> <p>Identify and explore reasons for admission.</p> <p>Monitor length of stay.</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>Reduction in Neonatal unit admissions.</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>Post natal ward staffing available for transitional care.</p> <p>Closer liaison and integration of postnatal and NNU staff</p>	<p>Maternity staff have been orientated to NNU and OT orientation sessions have been held. 6 month staffing trial commenced 6th April 2016 for 3rd midwife on night shift to circulate, no longer an on call midwife on these shifts, staff member to follow through mother and baby at c/section to try and reduce short admissions to NNU for TTN on staffing trial shifts. Maternity staff orientated to NNU and orientation to theatre sessions held. Weekly evaluation of trial meetings are in progress. C/F.</p> <p>Medical student audited Hypoglycaemia admissions to NNU (increase in admissions for hypoglycaemia in 2014) Audit completed by Moerangi Tamati and presented at PMMR meeting Feb 2016.</p>
		<p>Training and education of all Maternity and Neonatal staff in the care of the late preterm infant. Training of maternity, NNU and PACU staff on care of the "at risk newborn" including monitoring of blood glucose and early breastfeeding.</p>	<p>Completed training of all maternity and neonatal unit staff Sept 2015.</p> <p>OT have cancelled training for PACU twice. PN coordinator to set a date with PACU staff To be C/F.</p>
4	<p>Maternity services</p> <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 Taranaki DHB (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>	<p>Security to the existing areas improved with video surveillance and remote access at Base Hospital Completed in 2015.</p> <p>The possibility and feasibility of a maternal and child health centre that will include the current paediatric ward, Maternity services (and potentially a primary birthing unit), NNU is currently being considered by the facilities committee. To be carried forward.</p> <p>Risk register to be set up by Quality and Risk for each department. Corrective Action for Recertification (CAR) risks will be documented in register. Risk register to be C/F.</p>
	<p>Strengthen the model of care at Hawera Maternity Unit - aligning with past Stratford unit.</p>	<p>Safe, low tech homely environment that is whanau/ family friendly and meets the needs of the local population for low risk birthing</p> <p>Promotion/campaign for low risk births/increase in birth rate at Hawera Maternity Unit</p> <p>Timely emergency response and skills from St John and base hospital for neonatal retrieval</p>	<p>CMM, ADOM and primary unit midwife visited 3 Waikato primary maternity units in August 2015. Information and photos gathered and presented to primary unit staff. Proposal developed and currently with service and facilities managers C/F</p> <p>Completed Neonatal Emergency Response Team (NERT) process has been implemented in July 2015.</p> <p>Hawera PROMPT course held 27th Nov 2015 with excellent feedback, to continue twice yearly. Completed.</p> <p>Rural midwives and St John encouraged to share orientation of layout of emergency resuscitation equipment and communication.</p>
	<p>Exploration of a maternal and child health hub for Stratford and surrounding districts.</p>	<p>Key stakeholders and community groups identified.</p> <p>Governance group established.</p> <p>Feasibility for hub assessed</p> <p>Report on findings completed</p>	<p>Bishops Action Foundation were contracted to survey the providers and Stratford community on the interest in a child/ maternal hub. As a result of limited feedback, the DHB is no longer progressing a hub.</p>

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	Project	Expected outcome	Outcomes
6	<p>Improve screening and services for vulnerable perinatal women, babies and families.</p> <p>Provide information on maternal mental health services to stakeholders and clients</p> <p>Collect data to inform services on the delivery of PMMH services.</p>	<p>A) Update pre and post natal referral directory implemented and sent to all stakeholders of maternity.</p> <p>Acute Perinatal Mental Health (PNMH) nurse position is established and prioritises PNMH referrals.</p> <p>Maternity providers, clients and stakeholders have knowledge of the Perinatal mental health services by the provision of an information leaflet for the maternal-infant health practitioners and one for clients.</p> <p>Data is collected on access to PNMH services, timing of referral to first meeting, how many referrals and how many are accepted, reasons for referral, gestation/baby age at referral, age, ethnicity, parity/gravidity, who referred.</p> <p>Improved integration of PNMH, maternity, drug and alcohol and well child provider services.</p>	<p>Directory updated and circulated Jan 2016. Next due August 2016.</p> <p>PNMH nurse in position and triaging referrals. The expected outcomes re increased volume increased assessment rates feedback to referrers and uptake by PNMH team for therapy have eventuated, application to increase PNMH FTE (temp) to help cope with the influx.</p> <p>In-services to both Midwives and Plunket nurses on their respective study day has occurred. The use of the Edinburgh Postnatal Depression Scale (EPDS), the approved PNMH referral Pathway was included. Also the key diagnostic indicators for PND and the language needed to identify the condition when writing a written referral. Feedback to referrers regarding the need to include obstetric history with the referral is ongoing.</p> <p>Information leaflet in draft May 2016.</p> <p>All clients have access to a Sector Psychiatrist if required.</p> <p>Improved relationships by regular meetings, sharing of information and care planning within the perinatal mental health liaison meeting and the Maternal Wellbeing and Child Protection Multi-Agency Group (MWCPMAG) meeting.</p> <p>The introduction of the 'electronic white board' into Maternity and NNU will enable at a glance alerts for vulnerable women. Electronic whiteboard to be C/F.</p>

	Project	Expected outcome	Outcomes
		<p>B) FVIP screening and training on how to screen and refer is available to all maternity practitioners. 100% maternity patients screened for FVIP.</p>	<p>Sept 2015:</p>  <p>MoH Self Audit 2015 with 25 files from 1 April – 30 June 2015 Ward 15 (Post Natal Maternity) has a 60% Intimate Partner Abuse screening rate (15/25), with a 20% disclosure rate (3/15).</p> <p>New FVIP national guidelines will be launched in June 2016, these will be implemented across the DHB.</p>
7	<p>Investigate rising primary maternity ultrasound scans Explore consumer, primary practitioner and providers of primary ultrasound scans expectations of primary ultrasound scans.</p>	<p>Reasons for escalating primary ultrasound scanning identified and addressed Referrals for ultrasound scans meet section 88 criteria</p>	<p>Implemented in September 2015 with MAG representation and care planning in place.</p> <p>Already showing an increase in referrals, better sharing of information and action planning to support maternal and child protection.</p> <p>FTE to take to service managers for Child Protection Coordinator (CPC) and Clinical Midwife Manager (CMM) C/F.</p> <p>Meeting with CYFS re the changes to be introduced from 1st July in relation to family members who have been under CYFs care. He will provide a bullet point information leaflet to distribute at the PMMR meeting in Feb 2016 and provide an in service education session with midwife educator C/F.</p> <p>Leaflet provided and distributed.</p> <p>Email sent but Fulford Radiology undergoing changes. Will readdress in early 2016.</p> <p>Fulford moving back under Taranaki DHB management in early 2016 has supported discussion relating to scanning and ultrasound guided amniocentesis. C/F to 2016/17.</p>

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	Project	Expected outcome	Outcomes
8	<p>Caesarean Section (C/S).</p> <p>Monitor timing of decision to delivery of Level 1 C/S.</p> <p>Monitor GA C/S rate.</p> <p>Audit elective C/S for gestation, reason and individual obstetrician practice to identify any trends.</p> <p>Retrospective audit on emergency (C/S) for failure to progress and non reassuring cardiotocography CTG to identify any education needs required on intrapartum care and CTG interpretation.</p>	<p>Timings of Level 1 C/S is within the recommended 30 minutes for Level 1 C/S.</p> <p>C/S rates among primiparae and multiparae compare to similar populations e.g. Lakes DHB.</p> <p>C/S performed only if clinically indicated prior to 39 weeks' gestation.</p> <p>Reduction in C/S rate</p> <p>Any education requirements are identified and addressed</p>	<p>Information collected, tabled and reported to MQC, meeting the decision to delivery time within 30 minutes. Completed and presented.</p> <p>C/S audit completed and presented at Perinatal Mortality Meeting 2016.</p> <p>Every emergency C/S is examined at weekly case review in attempt to reduce rate.</p> <p>Completed EL C/S < 39 weeks gestation.</p>

	Project	Expected outcome	Outcomes
9	<p>A) Antenatal Clinic Services Establish a virtual consultation clinic for cases e.g. may require aspirin in early pregnancy, early advice required from specialist.</p> <p>Improve uptake in Vaginal Birth After Caesarean (VBAC) and decrease elective C/S rate.</p> <p>Investigate if a clinical midwife specialist in gestational diabetes would improve the services & outcomes for Gestational Diabetes Mellitus (GDM) clients.</p>	<p>Virtual consultation clinic is established to free up timely antenatal specialist appointments.</p> <p>Increase in VBAC rates. VBAC counselling and education is consistent and as per RANZCOG guidelines.</p> <p>Decrease in elective C/S rates.</p> <p>GDM women have timely services for healthy eating, healthy weight gain, exercise monitoring and treatment in pregnancy, labour and birth.</p> <p>Number of green prescription referrals in pregnancy.</p> <p>Continuity of midwifery and medical care.</p>	<p>Oct 2015: Virtual consultation clinic email address has been shared with O and G for non urgent advisory consults, e.g antenatal aspirin, raised PAPP-A etc. Issue identified in that all O and G cannot view the response. ANC coordinator communicating with IT to try and improve process. Medical records have agreed the document storage process. IT unable to change the sent box. Unless the obstetrician copies the virtual consult into the reply there is no record on there. One O and G does not like the system and sees it as another clinic. He would prefer a phone call (paper trail?) C/F.</p> <p>VBAC practitioner meetings commenced Oct 2015 to explore how we can encourage pregnant women to be empowered and confident to make the informed choice for VBAC where appropriate. Discussion around setting up a series of antenatal education classes to discuss this. Since then covering ANC coordinator has suggested starting with an information evening to see what the response is to get the ball rolling. Aiming for April 2016. C/F.</p> <p>Auditing women with GDM who are recruited onto Target Study.</p> <ol style="list-style-type: none"> 1) Time between getting diagnosis and appt with Diabetic CNS. 2) Advice given in the interim regarding diet/exercise. 3) Green prescription being offered and if taken up. C/F. <p>Data sent to service manager re number of newly diagnosed GDM's and pre existing IDDM's to provide evidence of the need for CMS in diabetes. Previous attempts at running a joint service with the diabetic service was not well attended by CNS diabetes because of other work loads. ANC proposes an extra clinic could be run on Fridays by specialist and CMS diabetes.</p> <p>In service completed on the Green Prescription for LMC's; Discussed at WCTO and LMC workshop in Jan 2016</p> <p>Surveyed Midwifery leaders around NZ to investigate what services are available around the country. Most report a CMS diabetes or working towards/on wish list. M&CHS manager investigating if FTE from CNS diabetes can be transferred to a CMS Midwife/Diabetes.</p>
	<p>B. Timely access to Maternal Fetal Medicine (MFM) services by establishing relationships and developing telemedicine/ communication.</p>	<p>MFM services are accessed within seven working days of referral with a focus on consultation being provided by telemedicine where appropriate.</p>	<p>Oct 2015: Wellington MFM specialist offered services to come to Taranaki DHB on a private contract opposed to the role in the tertiary hospital. M&CHS manager investigating if telemedicine and video conferencing an option for complex care MFM meetings and consults. Taranaki DHB has not proceeded with the private contract</p>

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	Project	Expected outcome	Outcomes
10	Review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres.	<p>All C/S cases have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre.</p> <p>Reduction in number of babies admitted to NNU for <24hrs.</p>	<p>Project commenced Sept 2015: Oct 2015: A number of meetings of the project group have been held. Areas considered and information gathered to date:</p> <ul style="list-style-type: none"> • Flow of staff to and from OT • Number of babies admitted to NNU for ≤ 24 hours • Reasons for these admissions • Costs of these admissions • What other DHBs are doing • Staffing requirements • Training requirements <p>A business case including the above findings now needs to be drawn up. New staffing trial commenced 6 April where mothers and babies will be followed through during the trial period on the night shift.</p>
11	<p>Stop smoking support for pregnant women, partners and whanau.</p> <p>Better support for pregnant women to stop.</p> <p>Ensure all pregnant women who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support for hospital admissions.</p> <p>To monitor the number of pregnant smokers to specialist stop smoking services.</p> <p>To develop and establish a referral process and pathway for hospitalised pregnant smokers to specialist stop smoking cessation services by December 2015.</p>	<p>Posters distributed and displayed around Taranaki promoting pregnant women and families to quit smoking.</p> <p>Purchase of three CO monitors to use in primary community to support LMC's in smoking cessation promotion.</p> <p>Increase in number of pregnant women who have received NRT, referral and or quit smoking who are hospitalised.</p> <p>Maintain 95% of hospitalised pregnant women who are screened for smoking status, and those identified as smokers are offered effective advice, support and referral to cessation support.</p>	<p>Posters received in June 2015.</p> <p>CO monitors received in Oct 2015. An in service on their use has been presented by PHO. The CO monitors are based in the Antenatal Clinic, Hawera Maternity and wards 14/15 (combined use). MQC Coordinator has been attending the Taranaki smoking coalition group meetings and under discussion re the formation of a smoking cessation pathway for pregnant women, KPIs and triaging of referrals. Awaiting training video and plan on how these will be utilised in Taranaki DHB pregnant communities and hospitals.</p> <p>Pinnacle have developed a pathway in discussion with ADOM.</p> <p>CO monitor training completed March 2016</p> <p>Te Hapu Ora training presented twice in 2015/2016.</p> <p>Working with tobacco control coordinator and PHO smokefree coordinators to plan a way forward to work together to reduce the number of pregnant women who smoke.</p>
12	<p>Pregnancy and parenting services meet the requirement of consumers:</p> <ul style="list-style-type: none"> • Investigate along with MMAG how we can better meet the needs of consumers. • Investigate if Child Birth Educator (CBE) demand meets the services, explore options to train more CBEs. • Work with LMC's and the Te Kawanu Maro Mama, Matua, Pepi, Tamariki (MMPT) services to increase uptake to pregnancy and parenting education. 	<p>See Midland Maternity Action Group (MMAG).</p> <p>Number of child birth educators meet the needs of the services.</p> <p>30% Māori, Pacific and teen first time parents/pregnant women complete DHB funded pregnancy and parenting education.</p>	<p>CBE students have commenced training Plunket pregnancy and parenting education contract is being devolved from 1 July 2016 from Waikato. This means all services are funded locally. Awaiting release of the Hapu Wananga programme – services will then be reviewed to look for ways to introduced the new programme as an option for Taranaki mothers/whanau.</p> <p>The Te Kawanu Maro MMPT project is into second phase. This phase includes prototyping and testing the new model of care with several families and whanau.</p>

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	Project	Expected outcome	Outcomes
13	Audits: Guidelines for referral.	All women are referred to a specialist in a timely manner and meet the recommendations of the guidelines of referral.	Educator and medical student completed audit to be presented at the PMMR meeting in February 2016. Issues raised: <ul style="list-style-type: none"> • Three different types of booking forms. • Improvements in Electronic Discharge Summary (EDS) completion recommended as women not always transferred to secondary correctly • Stamps for documentation and transfer of care need improvements in correct usage.
	AUDITS continued	Ensure care of the pregnant bariatric woman aligns with local guidelines.	Presented 23/11/15.
	Care of the pregnant bariatric woman		
	Post partum haemorrhage	PPH care aligns with national and local guidelines.	Completed Nov 2015.
	Elective C/S	All elective C/S have a valid indication and fully informed choice. Are >39 weeks' gestation unless clinically indicated.	Completed Feb 2016.
	Emergency C/S: CTG interpretation, failure to progress cases	All emergency C/S for CTG abnormality and failure to progress are indicated	Completed May 2016.
	HDU/ICU admissions:- Assess number of admissions, reason for admission, emergency or routine admission?	All women are admitted for appropriate reasons and care examined to identify improvements for practice	Completed 2016.
14	Continue to explore how staffing levels can better meet the requirements of ward acuity and variance of wards Trendcare implementation to allow accurate reporting. Health Care Assistant (HCA) role review.	Staffing levels meet the ward acuity, reduction in staff deficit forms. IRR testing completed 100% compliance of staff in engagement with Trendcare. HCA role has increased job satisfaction. HCA role integrated into team work	Proposal for 3rd midwife to work night shift Wed-Sunday as a result of investigations. Position being advertised to trial for a 6 month period. Interviews conducted in Oct 2015 and staff now orientating. Commences 6th April 2016 . C/F Trendcare compliance being monitored and improving. IRR testing still to take place Set date for IRR testing. C/F HCA role completed and evaluated by survey and followup meetings September 2015.
15	Full implementation of the guidelines: Gestational Diabetes (GDM) guideline. MOH quality standards for diabetes care toolkit, 2014, standard 20. MOH guidance for Healthy weight gain in pregnancy (2014).	Baseline data established on number of women who have had HbA1c <20weeks. 100% pregnant women referred to the secondary antenatal clinic and specialist diabetes services who are diagnosed with GDM. Pregnant women who are identified as obese and suitable are offered the green prescription.	Working with Planning and funding & PHO to implement improvements to educate GP's, LMC's and maternity staff to do HbA1C at booking. GDM guideline distributed. Request to add HbA1C to lab initial pregnancy blood assessment box (Planning and Funding coordinating this). This will be updated in next print of forms. Completed early 2016.

APPENDIX 10: MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB AND THE MIDLAND REGION

LIST OF PRIORITIES, DELIVERABLES AND PLANNED ACTIONS FOR 2016/2017

Maternity Quality Committee (MQC) Work Plan

Chair: Belinda Chapman (ADOM, Taranaki DHB)

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	Responsibility
1	<p>Carried forward (C/F) from 2015/16</p> <p>Continue to Investigate co location of the maternity and neonatal units to be nearer to the operating theatre and child health services.</p> <p>Explore what the future maternity services will look like in Taranaki and whether a further primary maternity unit is required.</p>	<p>Taranaki DHB have sufficient primary, secondary maternity and neonatal facilities that are conducive to safe birthing and a satisfying experience for women and their Whanau.</p> <p>Focus on providing continuity of care, integration, efficiency and effective use of staff and equipment.</p>	Planning and Funding, M&CHS manager, Quality and Risk, ADOM, CMM.
2	<p>C/F from 2015/16</p> <p>Continue to progress the strengthening of the model of care at Hawera primary maternity unit.</p>	<p>Provides a safe, low technical homely environment that is whanau/family friendly and meets the needs of the local population for low risk birthing.</p> <p>Continue to promote the use of Hawera Maternity unit for low risk birthing.</p> <p>To audit, review and reduce the length of stay in base maternity Unit, reaching comparability with other similar size and demographic units.</p>	CMM.
3	<p>Continue from 2015/16</p> <p>Inclusion of consumers in the Maternity Quality and Safety programme (MQSP) governance at Taranaki DHB to enable consumer informed decision making</p> <ul style="list-style-type: none"> • Commence meet your maternity services road show • Investigate Wahakura weaving parenting sessions • Annual consumer feedback survey and follow up of recommendations from 2015/16 survey • Inclusion of Māori consumer 	<p>Consumers have knowledge and understanding of the maternity services in Taranaki DHB.</p> <p>Consumer voice is collected via surveys and feedback and informs the future direction of service delivery for Taranaki DHB.</p> <p>Consumers in Taranaki DHB have a forum/space to share ideas and connect with other maternity consumers to ensure all ethnicities and needs are met.</p>	ADOM/consumer

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	Project	Expected outcome	Responsibility
4	Continue from 2015/16 Improve Lead Maternity Carer (LMC) registration so that access to care is increased-increase the number of women accessing an LMC in the first trimester. Early engagement with an LMC promotion. GP practices are refreshed in assisting women to find an LMC, and early pregnancy assessment and care	Consumers engage in the first trimester with an LMC with an aim of increasing to 78%. Progress the video advert on early engagement with an LMC to improve access across all ethnic groups. 5 Top things to do in the first 10 weeks of pregnancy messages are received. Continue the GP road show to communicate with and update GPs on assisting women to find an LMC, and early pregnancy assessment and care.	O and G, ADOM and ANC coordinator
5	C/F from 2015/16 Training of theatre staff on the importance of early skin to skin, breastfeeding and care of the at risk newborn.	Theatre staff have the knowledge of the importance of skin to skin and promotion of early breastfeeding post caesarean section (C/S) where medically appropriate.	PN coordinator
6	Continue from 2015/16 Investigate how to reduce Neonatal admissions by continuing to monitor and explore reasons for admission, and action plan any identified improvements for care and practices Initiate MDT case review meetings to review all cases admitted to NNU from 35 week gestation onwards with a focus on reasons and decision making for admission.	Neonatal Unit admission rate reflects 10-15% of Taranaki DHB birth rate. Reduction in separation of mother and babies due to NNU admission.	NNU manager/ CMM/MQSP coordinator
7	Timing of planned early birth at Taranaki DHB (including elective C/S and inductions of labour). See audit section.	Planned Early births <39weeks gestation will be done in consultation with all appropriate parties and within the recommended RANZCOG guidelines, due to the increased risk of respiratory morbidity, surfactant deficiency and pulmonary hypertension for neonates when delivered before 39 weeks gestation.	O and G
8	The maternity unit has a risk register.	Corrective actions and identified risks are documented in the register.	QR
9	Improve screening and services for vulnerable perinatal women, babies and families. Investigate FTE to coordinate MWCPMAG (MAG).	Updated pregnancy and parenting directory (in August and February) that is distributed to maternity stakeholders and practitioners. There is set FTE to meet the required hours needed to coordinate MAG. Maternity staff are educated on the CYFS changes that come into place on 1st July 2016. Information leaflet on the Perinatal Mental Health (PNMH) services is available for maternal-infant health practitioners and one for clients. PNMH services are monitored to ensure the service meets the needs of local clients and that practitioners are aware of the services available. Improved integration of PNMH, maternity, drug and alcohol and well child provider services.	MQSP coordinator CMM/MCHSM ME PNMH PNMH/MQSP coordinator
10	Vaginal Birth After a Caesarean (VBAC) section: Continue to investigate what range of services and support Taranaki DHB can offer to women in support of VBAC. Including retrospective audit of potential VBACs. C/F.	Women that are considered suitable for VBAC have a consultation with a specialist and are counselled and presented with full information on the risks and benefits of VBAC, with a focus on promoting confidence to labour where appropriate.	ANC coordinator/ OG

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	Project	Expected outcome	Responsibility
11	C/F from 2015/16. Pregnancy Ultrasound: investigate the rising primary and secondary ultrasound scans in relation to equity, access and timeliness and audit of repeat anatomy scan reasons.	Reasons for escalating ultrasound scans is identified and addressed. Referrals for primary ultrasound scans meet the section 88 criteria.	Fulford/OG
12	C/F from 2015/16. Continue to train maternity staff and community midwives on FVIP screening and assessment. Monitor maternity patients screened for FVIP. Implement new guidelines.	100% maternity staff trained for FVIP screening, assessment. 70% of women who come through the maternity services at Taranaki DHB are FVIP screened. Guidelines are implemented.	FVIP coordinator
13	C/F 2015/16. Continue to monitor the level 1 C/S and general anaesthetic (GA) rate in relation to timing and % of level 1 C/S.	Timing of level 1 C/S meets the auditable standard of 30 minutes from decision to delivery time. GA C/S rate compare to similar geographical units eg Lakes DHB. Presentation of data to inform practitioners Educational requirements are met.	MQSP coordinator
14	Antenatal clinic services: Further develop the virtual consultation clinic for cases eg that may require aspirin in early pregnancy or early advice from a specialist C/F from 2015/16: Explore how gestational diabetes services can be improved by the implementation of a midwife specialist in GDM to work with O and G specialist	Virtual consult clinic is established and utilised. GDM women have timely coordinated services for healthy eating, healthy weight gain, exercise, monitoring and treatment in pregnancy with a focus on continuity of care Green Prescription is prescribed and utilised.	ANC coordinator/ CMM
15	C/F from 2105/16 Continue to review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres	All cases 24/7 have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre and until transferred to the postnatal ward. Neonatal unit admission rate is reduced and within 10-15% of birthing population.	ADOM/MCHSM/ CMM/NNU CNM/ Paeds
16	Standardisation of neonatal resuscitation trolleys throughout Taranaki DHB.	All departments which require to resuscitate newborn babies have standardized resuscitation trolleys to reduce risk and confusion.	

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	Project	Expected outcome	Responsibility
17	<p>C/F from 2015/16</p> <p>Better help for pregnant women to quit smoking:</p> <p>Updating of the screening and referral form.</p> <p>Review the ABC pathway, resources and training.</p> <p>Investigate incentivizing packages and/or peer group support for pregnant women who wish to stop smoking.</p> <p>Increase access to Nicotine Replacement Therapy (NRT) and smoking cessation medicines within hospital based maternity services.</p>	<p>Ensure 95% of all women hospitalised who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support even if they don't want to quit within the hospital based maternity services.</p> <p>Quality improvements made to the ABC pathway-screening and referral form.</p> <p>Resources, internal and external are available including communication of services available eg Quitline and smoking cessation support/providers.</p> <p>Induction compulsory training for all new employees to include specific section for maternal and child health Maternity training on screening and supporting women to quit smoking is provided free to all maternity practioners.</p> <p>Taranaki DHB maternity stop smoking champion.</p> <p>Raise the profile and improve the referral process and pathway for hospitalised pregnant smokers to specialist stop smoking services.</p> <p>KPI-quarterly monitoring and reporting:</p> <ul style="list-style-type: none"> Tobacco Health Target Increase pharmacy NRT use <p>Taranaki data shows a reduction in pregnant women who have quit in pregnancy</p>	Tobacco control coordinator/ MQSP
18	<p>C/F from 2015/16</p> <p>Pregnancy and Parenting Education (PPE)services meet the requirements of consumers</p> <p>Devolvment of the PPE contract locally from 1 July 2016.</p> <p>Work with LMC's and the Te Kawau Maro Mama, Matua, Pepi, Tamariki (MMPT) services to increase the uptake of PPE.</p>	<p>PPE contract is implemented locally.</p> <p>30% of Māori/Pacific and teen first time parents complete funded pregnancy and parenting education.</p> <p>Hapu Wananga programme is released and utilised in Taranaki DHB.</p>	PI and Funding/ MQSP
19	<p>Small for Gestational Age (SGA) babies born 40-42 weeks (Clinical Indicator 20):</p> <p>See audit section below.</p>	<p>Number of babies born SGA between 40-42 weeks gestation are reduced to 35%.</p> <p>Education on recognition of risk of SGA and use of diagnostic tools is implemented</p>	OG/ MQSP
20	Clinical coding: Identify and review clinical coding processes to ensure the quality of local data is reliable and accurate.	Errors in coding are identified and actions are implemented to ensure coding errors are minimised	Coder manager/ MQSP
21	NZ Maternity Clinical Indicators are reviewed and presented to practitioners locally. Acknowledge where local data is excelling and identify actions to improve outcomes where data indicates.	<p>All maternity practitioners are aware of local outcomes by presentation of data on local dashboards, newsletters and education sessions.</p> <p>All practitioners are engaged in actions for improvements.</p>	MQSP/OG
22	Children's service level alliance team (SLAT): Maternity representation and alliancing to progress SLAT work plan including implementation of National Child information Platform (NCHIP)	<p>SLAT work plan is progressed.</p> <p>NCHIP is implemented and established by September 2016.</p>	ADOM/SLAT

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	Project	Expected outcome	Responsibility
23	Alliancing project between NZCOM, community midwives, DHB and PHO's.	<p>Primary maternity leadership is developed in the community midwifery workforce in Taranaki DHB.</p> <p>Capacity for community midwifery equals demand.</p> <p>Partnerships among community midwives, DHBs/PHOs/ GP are evident.</p> <p>IT infrastructure is conducive to information sharing between community midwives, DHB and PHO/other primary care providers.</p>	NZCOM chair/ ADOM
24	National Perinatal and Maternal Mortality Review (PMMR) committee and National Maternity Monitoring Group recommendations.	That all recommendations from both annual reports are noted and communicated to Taranaki DHB maternity practitioners and implemented where appropriate.	
	AUDITS:	Purpose	
1	Clinical Indicator 20 SGA 40-42 weeks	<p>To retrospectively investigate the antenatal management of cases of SGA born between 39-42 weeks gestation to see if there are improvements/education and practices that can be identified and implemented to reduce risk and number of cases undiagnosed.</p> <p>Identify if SGA risk was identified in pregnancy and if consultation with a specialist and preventative treatments were implemented eg aspirin.</p> <p>Smoking prevalence in SGA cases.</p> <p>MSS1 / Low PAPP: were recommended pathways and consultation with a specialist followed.</p> <p>Was SGA diagnosed and was appropriate care planning and management instigated.</p>	
2	Preterm Birth	<p>To examine local practices in relation to the national PMMR recommendations on preterm birth: Focussing on practices where there is a history of preterm birth: Early consultation, consideration of progesterone treatment, cervical length measurement.</p> <p>Focussing on recommended practices: Fetal fibronectin testing, use of antenatal steroids, tocolysis, magnesium sulphate for neuroprotection and inutero transfer.</p>	
3	Syntocinon Augmentation in labour	<p>To investigate how and when the use of Syntocinon augmentation is implemented.</p> <p>Ensure Syntocinon augmentation is utilised appropriately To explore if further education is required for the use of Syntocinon augmentation in labour.</p>	
4	Induction of labour/cervical ripening	To evaluate the implementation of the cervical ripening procedure introduced in 2015.	
5	Variation in gestation at birth	<p>Evaluate Induction of labour processes in Taranaki DHB with a focus on variation in gestation of birth.</p> <p>Evaluate elective C/S performed before 39 weeks gestation with a focus on variation in gestation of birth.</p>	
6	Intrapartum Fetal surveillance audit	To audit practitioners pre and post RANZCOG fetal surveillance training as per RANZCOG.	
7	Implementation of GDM guidelines	Ensure the pregnancy pathway for women who have GDM is followed. Recommended testing in pregnancy is followed eg of HbA1C at booking,	

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	Project	Expected outcome	Responsibility
8	Ultrasound scanning (Please see item 11 on work plan)		
9	Length of Stay at Base Maternity Unit.	To audit, review and reduce the length of stay in Base Maternity Unit, reaching comparability with other similar size and demographic units.	
	<p>EDUCATION REQUIREMENTS:</p> <p>Educational sessions to be planned as per feedback from case review and audit:</p> <p>Use of fetal scalp clip;</p> <p>PPH- identifying risk factors-early recognition and treatment;</p> <p>SGA recognition of risk factors-diagnosis and treatment</p>		

APPENDIX 11: GESTATIONAL DIABETES - STARTED DIETARY INFORMATION



Gestational Diabetes – Starter Dietary information

You have been diagnosed with gestational diabetes which is a temporary form of Diabetes that can occur in pregnant women.

This means your body is not effective at processing sugar that you eat resulting in high blood sugar levels. You will be referred to a Clinical Nurse Specialist/Diabetes educator who will explain your condition in more detail, and a Dietitian who will help you plan your food intake while you have gestational diabetes.

We recommend you make the dietary changes listed below.

Reduce added sugars.

Try not to eat:

- Any type of simple sugar e.g. white, brown, raw or coconut sugars; golden syrup
- Fizzy drinks or fruit juices
- Sweet spreads e.g. honey, jam, marmalade
- Lollies, chocolate, cakes, biscuits and sweet pastries
- Muesli bars

So what can you eat?

We recommend you eat regular meals - breakfast, lunch and dinner

For example:

Breakfast : cereal i.e. weet-bix or porridge, yoghurt and fruit or poached egg on toast

Lunch: sandwich with protein and salad plus fruit or yoghurt, or leftovers from the previous night's dinner heated well

Dinner: meat or other protein source, vegetables and potato/rice/pasta/bread

Snacks: cheese and crackers, fruit, nuts

Aim for 3 pieces of fruit per day and spread evenly over the day.


If you are feeling hungry eat more protein eg egg, cheese, meat, chicken, yoghurt, nuts.

If you haven't heard from the Dietitian within two weeks please phone: (06) 75 37751

Please note this is very basic information intended to get you started. You will need to speak with a Dietitian so your diet can be fully assessed to ensure you are doing what is right for you and your baby.

August 2015

APPENDIX 12: HAWERA MATERNITY BROCHURE



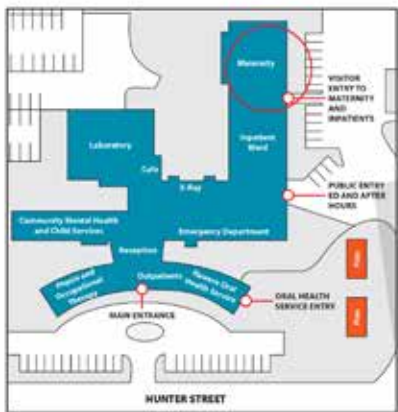
TARANAKI DISTRICT HEALTH BOARD

Car Seat

To take your baby home you must have a safety approved car seat.

Site Map

Tours of Hawera Maternity Unit are held each Saturday at 1pm.



Contact

As you will already have your own Lead Maternity Carer (LMC), it is expected you will contact her for advice before contacting Hawera Maternity Unit.

LMC

Phone


Hawera Maternity Unit: 06 278 9911
Taranaki Base Hospital Maternity Unit: 06 753 7712
(If you are booked to give birth at Taranaki Base Hospital)

Phone for advice at any time.

VISITING

2pm to 8pm daily for general visitors.
 Partners and children may visit freely.
 Our mothers and babies need rest, and we ask that all visitors be considerate


Welcome to Hawera Hospital Maternity Unit



Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki

www.tdhb.org.nz

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Taranaki Together, a Healthy Community
 Taranaki Whanui He Rohe Oranga

