TARANAKI DISTRICT HEALTH BOARD

Taranaki District Health Board

MATERNITY ANNUAL REPORT

1 July 2012 - 30 June 2013

TARANAKI TOGETHER, A HEALTHY COMMUNITY
TARANAKI WHANUI HE ROHE ORANGA

Taranaki District Health Board
27 David Street, Private Bag 2016,
New Plymouth 4310
Taranaki, NEW ZEALAND

Contents

Acknowledgements

The following people are acknowledged for their contribution to this report:

Steve Perry, Data Analyst (Taranaki DHB)

Suzanne Andrew Healthshare Midland Maternity Action Group Project Manager

Belinda Chapman, Associate Director of Midwifery (Taranaki DHB)

Jane Bocock, Neonatal Unit Manager (Taranaki DHB)

Leigh Cleland, Child and Maternal Health Services Manager (Taranaki DHB)

Phillipa Edwards, Midland Regional Data Analyst

Taranaki DHB MQC members

Dr Keith Blayney, GP

Lisa Gilbert CNS Infection Control

Finola Mooney, Core Midwife (Taranaki DHB)

Frances McNulty, Quality Improvement & Effectiveness Coordinator (Taranaki DHB)

Dr Jeremy Smith, Obstetrician

Message from Dr Jeremy Smith - Clinical Leader, Belinda Chapman - Associate Director of Midwifery and Leigh Cleland - Clinical Service Manager.

The Maternity leadership team consisting of the above staff endorse the below annual plan, we believe it reflects the services we provide the women and families of Taranaki and highlights areas that we are planning to improve on and enhance.

The year to 30 June 2013 has seen a period of changes and challenges coupled with a greater understanding of what we are achieving and what remains to be done.

Senior medical staff positions are now all filled following the retirement of a long service obstetrician Dr Arthur Brooks. His position has been filled by Dr Eddie Williams who comes to us from Wellington and brings a wealth of experience.

Junior staffing continues to present challenges, because we have six month gaps from time to time where there is no registrar. Having a registrar enables optimal use of consultant's skills and some respite from the 24/7 nature of the job of a consultant in a smaller hospital. A recent Royal Australian and New Zealand College of Obstetric and Gynaecology credentialing of our registrar training at Taranaki Base resulted in a glowing report.

Our greater understanding of what we are achieving has come about through the greatly enhanced reporting of maternity outcomes. It is gratifying to see Taranaki produce some good figures, but we are reminded that there is still much that can be done. It is also recognised that the data must be as accurate as possible, not only to guide our practise, but also to make comparisons between units valid if changes are contemplated. To this end we are all making great efforts to be accurate and candid in our assessments. We are always looking for better and more user friendly ways to collect and analyse data.

With safety and enhanced services in mind, we have introduced weekly meetings where midwifery and medical staff discuss events of the previous week, thus highlighting what we do well and what must be improved. PROMPT training simulations have been implemented and we anticipate that these will become more frequent in the next year.

The building of the new hospital wing is wonderful, but for the Maternity service it highlights how much we would like things to be upgraded for our women and partners, so hopefully our turn will come soon.

Challenging issues for our department include the updating of ultrasound and fetal monitoring capability which will involve capital expenditure. Another area that causes a degree of anxiety is the need to transfer mothers in or at risk of premature labour. This issue is not unique to Taranaki, and arises from the need to put the unborn baby's health foremost. It is very stressful to the mother and whanau and involves considerable social cost, often with loss of income when it is most needed. We work very closely with our neonatal care staff, and thank them for their empathetic approach. Transfer of patients is a fact of life, as a region we are working towards streamlining the process for everyone, and regard this as one of our priorities for the next year. Equally important is our commitment to maintain the

maternity service in Hawera to be efficient and sustainable within the best possible standard, whilst at the same time continuing to improve the care that Base Hospital offers to all Taranaki women.

Message from the Chair, Midland Maternity Action Group

The Midland Maternity Action Group was established in 2011, the group includes stakeholders from across the five Midland DHBs. The current membership is:

- Bay Of Plenty DHB: Marg Norris (Midwifery Leader), Bill McCauley (O&G HOD), Sachit Gagneja (MQ&SP)
- Lakes DHB: Dale Oliff (COO), Simon Ewen (O&G HOD), Sue Finch (Clinical Midwife Manager/ MQ&SP)
- Waikato DHB: Ruth Galvin (MQ&SP), Sue Hayward (DON&M), Corli Roodt (Clinical Midwife Director / MMAG Chair), Pip Wright (Midwife Educator), Claire Hutchinson (Hamilton LMC, River Ridge East Birth Centre)
- Taranaki DHB: Belinda Chapman (Assoc. Director of Midwifery/ MQ&SP)
- Tairawhiti DHB: Virginia Brind (Planning and Funding), Nicki Dever (Clinical Care Manager, Women Child & Youth Clinical Care Group), Tiziana Manea (MQ&SP)
- GMs Maori Health: Jade Chase (Waikato DHB)
- Communications: Mary Anne Gill (Waikato DHB)
- HealthShare: Suzanne Andrew (Project Manager), Philippa Edwards (Data Analyst)

The primary purpose of the group is to lead regional activity, including implementation of maternity actions on behalf of the Midland DHBs, and to provide expert technical advice to the DHB CEOs 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 across the Midland region provided to those women and their families requiring maternity services.

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

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

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

Our Vision

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

HE URUNGA WHENUA

HE URUNGA TANGATA

HE URUNGA OHI

HE URUNGA TARANAKITANGA

KI TE TAIAO

MAU TONU

Purpose

This Annual Report covers the implementation and outcomes of Taranaki DHB's Maternity Quality & Safety Programme (MQSP) in 2012/2013, as required under section 2.2c of the Maternity Quality & Safety Programme Crown Funding Agreement (CFA) Variation (Schedule B42):

This Annual Report:

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

Background

Alignment with New Zealand Maternity Standards

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

Expectations of the New Zealand Maternity Standards:	
Standard One: Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.	
8.2	Report on implementation of findings and recommendations from multidisciplinary meetings
8.4	Produce an annual maternity report
8.5	Demonstrate that consumer representatives are involved in the audit of maternity services at Taranaki DHB
9.1	Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Taranaki region
9.2	Identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs
Standard Two: Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage.	
17.2	Demonstrate in the annual maternity report how Taranaki DHB have responded to consumer feedback on whether services are culturally safe and appropriate
19.2	Report on the proportion of women accessing continuity of care from a Lead Maternity Carer (LMC) for primary maternity care
Standard Three: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.	
24.1	Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility

MATERNITY OUTCOMES

SECTION ONE:

AIMS / OBJECTIVES OF THE TARANAKI MATERNITY SERVICE AND MQSP

Summary of aims/objectives of Taranaki MQSP
The Taranaki Maternity services and MQSP aims to provide, monitor and action improvements in services to optimise safety for women, babies, families/whanau, service users and service providers of Taranaki. Taranaki DHB also participates and collaborates with the 4 other Midland regional DHB's through the Midland Maternity Action Group (MMAG), Midland Midwifery Leaders group (MML) and the Midland Regional Educators sub-group and are working towards sharing education sessions and templates, protocols and other strategies to reduce duplication, workloads and increase efficiency and networking.
Alignment of aims/objectives with national priority and recommendations
Objectives of Taranaki DHB's MQSP for First Year
1. Establish the Taranaki Maternity Quality Governance (MQC) Group 2. Implement the new referral guidelines and maternity specifications 3. Establish a framework for multidisciplinary quality audit and reporting framework for maternity (see appendix 2 and 3) 4. Set up communication for the wider community to inform them about access and obtain feedback on Maternity services 5. Communicate with the Maternity Providers to identify any concerns and collaborate to action improvements 6. Engage consumers in the programme 7. Review data for the first annual report
Maternity Quality and Safety Programme Objectives and actions to date

Objective One: Establish the Taranaki MQC Governance Group		Status
Expressions of Interest sent out to clinicians, managers, stakeholders and consumers	√	Completed
MQC established with representation from community and DHB clinicians, managers, stakeholders and consumers with contracts and fees for LMC and consumer attendance	√	Completed
Terms of Reference and Monthly meetings implemented	√	Completed
Objective Two: Implement the new referral guidelines and maternity specifications		
Local protocol developed and implemented for transfer of care to include the new referral guidelines	√	Completed
Discussion sessions and agenda item for meeting with community and hospital practitioners on new referral guidelines, protocol and service specifications. Written information circulated to reach all practitioners	√	Completed
Objective Three: Establish a framework for multidisciplinary quality audit and reporting framework for maternity (see appendix 2 and 3)		
Audit and reporting Grids defined for Maternity		In draft (see appendix 2 and 3)
Results presented to MQC as per framework	√	Commenced
Development of Case Review TOR and implementation of weekly case review sessions (see appendix 4)	√	Completed
Objective Four: Set up communication for the wider community to inform around access to and feedback on Maternity services		
TDHB website covers access to information and feedback on TDHB Maternity services including how to access an LMC	√	Completed
Consumer Feedback survey conducted, evaluated and recommendations made for suggested changes		Survey complete. Recommendations

		in progress
Reporting system devised to present a summary of consumer feedback/complaints/compliments/ common themes/trends		In progress
Objective Five: Communicate and collaborate with the Maternity Providers to support, identify concerns and agree action for improvements		
Assistant Director Of Midwifery (ADOM) meetings initiated with rural maternity units and rural LMC's to listen, inform and identify any actions required	√	Initiated
Continue clinical service, management, stakeholder and self employed meetings to support, communicate and collaborate with all maternity practitioners to identify and improve safety and quality of maternity services for women	√	In place
Objective Six: Engage consumers for the programme		
Establish a liaison role to engage with consumers, consumer groups and community based maternity practitioners		Planning
Consumer feedback obtained to inform services on what is done well and what could be done better	√	Completed
Objective 7 Review data for the first annual report		
Data utilised to inform practice and identify areas for improvement	√	In progress
Data utilised to benchmark against other DHBs nationally and regionally	√	In progress
Priorities for data collection identified	√	In Progress
Circulate and discuss 12 Maternity Clinical Indicators to all Maternity practitioners/clinicians	√	In progress

Summary of Maternity Service Delivery Including steps taken/plans to address issues

Maternity Facilities

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

Taranaki District Health Board maternity facilities:

- Taranaki Base Hospital primary and secondary births
- Elizabeth R primary birthing unit, Stratford (Central Taranaki)
- Hawera Hospital (DHB) primary birthing facility
- Home birth, offered by midwife LMCs
- Total approximate 1507 births in 2012

Taranaki Base Hospital (2012)

- 1286 total births 2012r
- 939 Primary Midwife/LMC
- 136 Primary Obstetrician/LMC births
- 211 Secondary Births (including transfer of care in labour)
- Level 2A Neonatal Unit

Taranaki Base Hospital Staff

- 3 employed Taranaki District Health Board Obstetricians (two have full-time contracts and 1 has a part time contract). Additionally 1 private Obstetrician (not contracted to DHB) and 1 private Obstetrician intending to retire in August 2013.
- 2 MOSS (1.5FTE)
- 1FTE Obstetric Registrar
- 2FTE House Surgeon
- Associate Director of Midwifery 0.6FTE
- Maternity Quality project co-ordinator (0.2FTE)
- Clinical Service Manager, Child & Maternal Health
- Midwifery, Nursing and Admin staff 31.65 FTE

Taranaki Base Antenatal Clinic

- Co-ordinated by antenatal clinic midwife co-ordinator
- Maternal Fetal Medicine Specialist Clinic one day per month from visiting specialist
- Outpatient Specialist Consultation Clinics
- Secondary antenatal team clinics
- Amniocentesis clinics

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

The antenatal co-ordinator has noticed an increase in antenatal clinics and antenatal consultations. An action is planned to examine antenatal clinic data to assess the reasons for this increase which may support further assistance in running the antenatal clinics.

Antenatal and Labour Ward

- 6 Delivery Rooms (For Primary and Secondary births)
- 1 Birthing Pool
- 7 Antenatal Rooms
- Operating Theatres (which are located in the main hospital block)

Post Natal Ward

- Located on a separate floor above the labour ward
- Total of 19 beds - 9 single rooms, plus 2 single rooms with en-suite, two 4 bedded rooms.
- Accommodates boarder mothers when no facilities available in the NNU

Taranaki Base Hospital Neonatal Unit

- Approx 240 admissions per year
- 6 Cots
- 2 Intensive care cots
- Accepts >1000gms and >28week gestation
- 8 Paediatricians, 6.7FTE
- 4 House Surgeons
- 2 Registrars
- Nursing Staff 13.5FTE
- 0.8 FTE Homecare and Lactation Consultant

Hawera Hospital Primary Maternity Facility (DHB)

Hawera Hospital is a primary maternity facility with a rural health focus that is one hour by road from base Hospital.

- 95 births in 2012
- 1 GP/LMC and 5 Midwife/LMC access this facility
- 1 Delivery Room
- 4 post natal beds
- Visiting Specialist Consultation and secondary clinic
- 5.05FTE Midwifery and nursing staff (Includes a lactation consultant)
- GP support for emergencies

Proposed changes for staffing Hawera Hospital Maternity Unit (HMU)
Hawera Hospital Primary Maternity Unit is currently undergoing a consultation period to plan a way to staff it more efficiently and sustainably. This follows a review of data that indicates that in recent years, up to 50% of the time there have not been any inpatients. The service that is received by women of South Taranaki will not be reduced. Staff, LMCs and managers are exploring different options to staff the unit more efficiently when it has low or zero occupancy. The group are also looking at ways of encouraging south Taranaki women to increase utilisation of the maternity unit.

LMCs previously reported difficulty in transferring women into the secondary services due to the rural locality and the unavailability of a nominated midwife and obstetrician to provide continuity of secondary outpatient obstetric and midwifery care. Further Obstetric secondary antenatal clinics have been implemented and a nominated secondary antenatal clinic midwife has been introduced to allow women who meet the criteria for secondary antenatal care to be transferred into these services. Some women with complex care needs are choosing to transfer clinical responsibility to the secondary obstetrician but have their LMC midwife continue the midwifery component of their care, but we have recognised the need to educate staff on providing clear documentation of who is clinically responsible for the care with clear plans in place.

Elizabeth R Maternity, Stratford (Non DHB facility)

- 35 minutes by road to transfer to Base Hospital
- 89 births in 2012
- 1 Delivery Room
- 1 Birthing Pool
- 4 Postnatal Beds
- All midwife LMC cases

Elizabeth R has a midwife who co-ordinates and manages the maternity, who is also a self employed midwife. Staff are employed by Elizabeth R to provide postnatal services, the FTE is as required. When they are not required for maternity, they are allocated to work in the rest home/hospital wing.

Home Births

- Approx 40 in 2012 by self employed midwife LMCs however there is difficulty in accessing accurate data

Workforce

The medical maternity workforce is fully staffed with no current FTE vacancies. There has been an improvement in Obstetric Registrar rotation to Taranaki, (we have recently found out that we will not be getting a registrar for the next six month period). Additionally a MOSS (1 FTE) has been appointed to support the Obstetric consultants.

There are two private obstetricians in LMC practice, of which one is retiring in August 2013. A private Obstetrician provides the Nuchal Translucency ultrasound scanning service for first trimester screening, but when she is on annual leave, the DHB has no service. This results in women travelling out of the district or choosing not to have the test because of financial barriers or impractical reasons (the nearest services are 3 hours distance by road).

A temporary clinical midwife educator (CME) has been recruited, but Taranaki DHB are having difficulty in recruiting a CME on a permanent basis and are continuing to advertise this position. Fortunately there has been less difficulty in recruiting core midwives. Taranaki DHB are continuing to promote midwives to engage with the Quality Leadership Programme (QLP) and participate in post graduate education.

There has been a change in Clinical Midwife Manager (CMM) as the previous CMM has retired, a new CMM has been recruited who commenced employment at the beginning of May 2013.

The new position of Associate Director of Midwifery (ADOM) was successfully appointed in July 2012 and gives TDHB a recognised professional midwifery leader and advisor. Additionally the new position of post-natal co-ordinator was appointed in November 2012. This position has provided recognised leadership, continuity of co-ordination, improved communication of the postnatal services, as well as improved neonatal unit liaison. It has also increased staff morale, fostered more efficient use of staffing and greater engagement in progressing the ward and patient care. Both these new positions give a local option for career pathways in midwifery in Taranaki which may assist in retaining staff in the long term.

The first “home grown” (trained locally via the AUT satellite programme) new graduate midwife has been recruited with a “new graduate” programme in place for her. A further two new graduate midwives are expected to qualify this year which should assist midwifery recruitment. There has been a reduction in Registered Nurses employed on the postnatal ward due to an increase in the availability of registered midwives, which gives a greater flexibility in covering staff rosters. The only current FTE vacancy is 0.6FTE (educator position).

Access Agreement Holders

There are 43 active access agreement holders throughout Taranaki DHB, who claim through Section 88. These include Midwives, GPs and private Obstetricians. Taranaki DHB has not received any reports of women who are unable to access an LMC, however replacement self employed midwives have been difficult to attract to replace retiring or leaving midwives, despite extensive advertising through the Midwives Maternity Provider Organisation (MMPO) and the DHB website. Taranaki DHB could accommodate more self employed LMC midwives and the increase in numbers of midwives training locally and nationally may improve this situation in the future. Rural midwives have utilised the rural midwife locum service for leave.

The secondary antenatal clinic does not have any cases that cannot access an LMC at this current time.

Hospital New Building

2013 will see the opening of the new hospital building at Taranaki DHB (Project Maunga). The paediatric and adolescent services will be accommodated in the new facility, along with the operating theatres. Unfortunately there is still quite a distance between the theatre suite and maternity services. Ideally in the future, maternity, NNU and paediatric services will be closer to each other. Plans for this have been put on hold due to financial constraints.

It would be more efficient and promote greater continuity of care if Base Maternity was run as one unit on one floor as opposed to two floors/wards. It is hoped once the new hospital building is commissioned, an area for maternity will be found nearer to the operating theatres and can be run as one floor, to include the NNU. The NNU being located a distance from the theatres creates problems for the neonatal unit requiring maternity and neonatal staff to leave their working areas for a considerable time to transport clients to theatre.

Core Midwifery Services for Private Obstetricians

There are still unpredictable work loads for core midwives as they provide labour and birth services to primary obstetricians' clients as well as postnatal care. It is out of the DHB's control as to how many women are booked by the private obstetricians per month. This may decline with the retirement of one private obstetrician. It is planned to review the provision of midwifery care to private obstetrician cases by September 2013.

Obstetric Anaesthesia

There has been an improvement in communication and collaboration with the Anaesthesia team with the appointment of two Anaesthetists who have Obstetric portfolios, giving closer working relationships. Education sessions have been developed and implemented to improve training and maintain skills in epidural care and PROMPT training. It is hoped that epidural training will decrease the amount of LMC Midwives handing over care to the secondary services when women request an epidural.

Perinatal Mortality

Taranaki DHB has seen a decline in the number of cases classified for Perinatal Mortality in 2012. This could be a reflection of the work carried out by the national PMMRC, implementation of GROW charts and care plans for secondary clients, plus a greater number of women having first trimester screening and a greater number of high risk women being transferred to secondary antenatal care.

Staff Appraisals

Timely staff appraisals are a challenge to be completed. An increase in senior midwife roles and QLP leadership midwives means there will be more midwives available to provide staff appraisals in a timely manner.

Information Technology

Information Technology (IT) is outdated and has proved a challenge in sourcing information and data. The accuracy is dependent on clerical staff manual data collection with no specific maternity IT package being available in TDHB. This should improve in the future with the implementation of the national Clevermed IT system in 2014.

Discharge Summaries

The timely completion of maternity discharge summaries has been a challenge because some Midwife LMC's do not have Healthlink addresses for automated sending of these summaries. Midwife LMC's all have access to Concerto from their practice addresses so they can now access electronic discharge summaries once their clients are transferred back to their care.

SECTION TWO:

DATA ANALYSIS

Summary of maternity services provided in Taranaki

Taranaki Base Primary care plus Secondary care	Hawera Primary care	Elizabeth R Primary care
• Normal Delivery • IP postnatal care • Out patient specialist consultation and secondary antenatal clinics • Monthly visiting Maternal Fetal Medicine specialist consultations • Orthopaedic hip checks • Ultrasound • Caesarean section • Complex delivery • Lactation consultant services • Inpatient antenatal care • Management of miscarriage • Support for Obstetrician LMC • Newborn Hearing screening • Level 2A Neonatal services	• Normal Delivery • IP Postnatal care • Out patient specialist consultation • Orthopaedic hip checks • Lactation Consultant services • Newborn Hearing screening	• Normal Delivery • IP Postnatal care • Newborn hearing screening

Home birth services by Midwife LMC's are available in all three demographic areas.

Please see Appendix 5 for data tables that are analysed below.

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 will be identified. The information will be circulated to all maternity practitioners and stakeholders and priorities will be set in an attempt to improve outcomes in maternity care as well as celebrate areas we excel in.

Clinical Indicators:

Indicator 1 Spontaneous Vaginal Birth

STRENGTH: Taranaki has a stable rate of 73.5% in 2011, 79.1% in 2010, 76.6% in 2009, still above the national average of 70.%.

Indicator 2 Instrumental Vaginal Birth
STRENGTH: Taranaki has a of 9.1% in 2011, 5.6% in 2010, 8.8% in 2009 and well below the national average of 13.9%.

Indicator 3 Caesarean Section among Primiparae
INVESTIGATE: Taranaki has an increasing rate of 17.4% in 2011, 15.3% in 2010 up from 14.6% in 2009 and above the national average of 15.4%. Benchmarked against the other Midland DHBs Taranaki has the highest rate and is an area for investigation.

Indicator 4 Induction of labour among Primiparae
STRENGTH: Taranaki has rates of 3.1% in 2011, 3.4% in 2010,2.9% in 2009 but under the national average of 4.3%

Indicator 5 Intact Lower Genital Tract: - Vaginal Birth
STRENGTH: Taranaki has consistent rates of 50.2% in 2011, 46.7% and 46.6% in 2009, 2010 against the average 33.1%.

Indicator 6 Episiotomy and no 3rd or 4th degree tear
STRENGTH: Taranaki has rates of 8.4% in 2011 which is well below the national average of 19.%.

Indicator 7 3rd or 4th degree tear sustained with no episiotomy
STRENGTH: Taranaki has a consistent rate of 1.3%, national average is 3.2%.

Indicator 8 Episiotomy and 3rd or 4th degree tear sustained
STRENGTH: Taranaki has rates of 0.6% in 2011, 0 in 2010, 0.9% in 2009, well below the national average of 11%

Indicator 9 General Anaesthesia for all caesarean sections
INVESTIGATE: Taranaki has rates of 11.6% in 2011, 11.9% in 2010 up from 10.7% in 2009 which is above the national average of 8.4% The general Operating Theatres are used for caesarean sections which is a considerable distance from the maternity unit and until a location is found to house the maternity unit nearer to the Operating Theatres this rate is unlikely to change, following discussion at the MQC and anaesthesia team meeting. However the anaesthesia team have agreed to audit all 2012 General anaesthetic caesarean section cases to try and identify any trends in practices or process.

Indicator 10 Postpartum Haemorrhage (PPH) blood transfusion after caesarean section birth
STRENGTH: Taranaki has rates of 2.1% in 2011, 2.8% in 2010, 2.3% in 2009 whereas the national rate fell from 3.8% to 3.3%. This is currently being audited but due to very small numbers no trends have been identified.

Indicator 11 PPH and blood transfusion after vaginal birth
STRENGTH: Taranaki has a rate of 1% in 2011, 1.7% in 2010, up from 1% in 2009, below the 1.6% national average.

Indicator 12 Premature Births (delivery from 32-36 weeks)
STRENGTH: Taranaki has a stable rate of 5.9% in 2011, 6.1% in 2010 up from 5.7% in 2009, the national average has risen to 6.1%.

Other Comments:

Timing of registration with an LMC:
Analysis of the data provided by the Ministry of Health indicates that Taranaki has 98% of women registered under an LMC. 70% of these register with an LMC in the first trimester which is above the national average of 63% and by the end of the second trimester 97% are registered. When comparing age and geography further investigation is required to explore how pregnant women in the 16-19yr age group and South Taranaki pregnant women can access an LMC at an earlier gestation. Additionally it is intended to look at ways of encouraging GP's to initiate first trimester screening and facilitate women to expedite booking with an LMC early.

Age and demographics:
The commonest age group delivering their first child (Primaparae) in Taranaki is the 25-29 yrs old group, for European (rural or urban) and 20-24 for Maori (rural or urban) and for all ethnicities 25-29 is the most common, closely followed by the 5 years above or below this, so most women are having their first baby between 24-34. This is consistent with our falling teenage pregnancy rate, possibly due to better education and access to contraception.

Taranaki has the lowest teenage pregnancy rates in Midlands (largely due to fewer Maori teenage births - from the highest in 2009 to 2nd lowest in 2011).

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

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

SECTION THREE:

MQSP GOVERNANCE AND OPERATIONS

Taranaki DHB MQSP Governance Structure and Purpose

The MQSP governance group is known as the Maternity Quality Committee (MQC) and is chaired by the ADOM (0.6FTE) / Maternity Quality project co-ordinator (0.2FTE) and meets monthly to support the Taranaki Maternity Services, the Taranaki Clinical Board and maternity related multidisciplinary clinical teams to monitor and manage standards of clinical care to ensure they are of a high quality.

Taranaki DHB MQC supports and facilitates formal clinical governance and clinical practice improvement processes in Taranaki DHB Maternity Services by monitoring and reviewing systems, standards, indicators and outcomes which reflect the quality of clinical care provided within the Taranaki DHB Maternity services.

Its main functions are to:

- Monitor and oversee regional and local activities associated with:
  - The national Maternity Quality and Safety Programme
  - The national Maternity Standards
  - Maternity service specifications
- To provide a forum in which decision making and responsibilities for the quality of maternity care are shared between clinicians and managers in consultation with consumers and stakeholders
- To report these activities to the Taranaki DHB Clinical Board through the Chief Operating Officer/Chief Nursing Advisor (COO/CNA)
- To manage Obstetric clinical risk

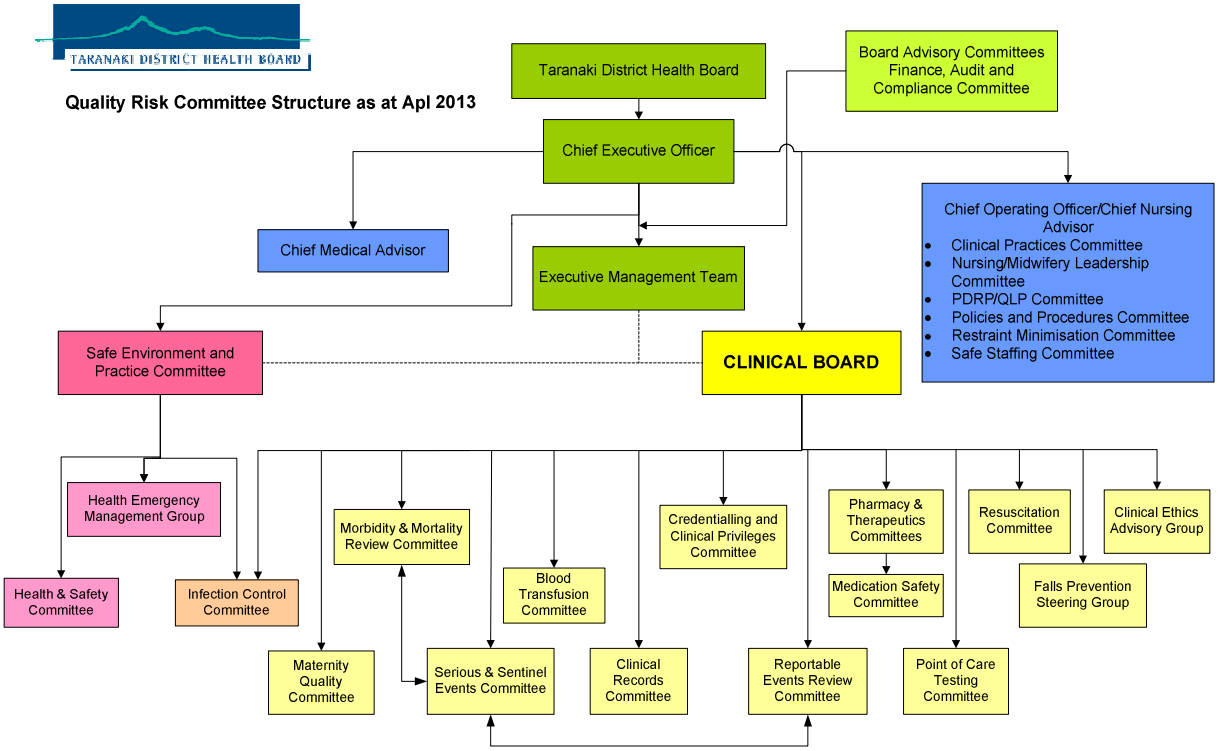
Membership consists of:

- Clinical Directors: Obstetric and Gynaecology and Paediatrics
- Associate Director of Midwifery (ADOM)
- Clinical Midwife Manager
- Stakeholders x 4
  - Neonatal Unit Manager
  - Maternity Social Worker
  - Maternal Mental Health Social Worker
  - Clinical Nurse Specialist (CNS)-Infection Control
- Child and Maternal Health Service Manager
- Quality Improvement and Effectiveness Co-ordinator
- Clinical Midwife Educator
- LMC Representatives x 2

- Rural
- Urban

- Maori Health representative
- Consumer representative
- Maternity Quality Risk Delegate / core midwife

Taranaki DHB MQSP Governance Accountability within the Wider TDHB Governance



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

- Priorities for the Maternity Quality Committee are to review, monitor and recommend improvements for:

  - Actions and themes arising from adverse events submitted to the Serious and sentinel events and reportable events committees and the Perinatal Mortality and Morbidity reviews
  - Clinical Indicator Reviews
  - Actions and themes arising from complaints submitted to Customer services and the reportable events committee
  - The national Maternity Quality and Safety Programme
  - The national Maternity Standards
  - Maternity service specifications

The MQC evaluates service improvements as a result of the committees recommendations

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

Recommendations and actions from the Maternity Quality Committee are forwarded to the Maternal and Child Health Services Manager and Clinical Midwife Manager or other relevant units.

- The activities/minutes are submitted monthly to the COO/CNA and Quality and Risk Manager
- Information and direction is communicated to multidisciplinary clinical teams, including Lead Maternity Carers (LMCs) and stakeholders through relevant members of the Maternity Quality Committee

Consumer Representation on Taranaki DHB MQC

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

The representative is an active advocate for empowered birthing and informed consent and brings an open minded and honest view / approach of maternity services in Taranaki. She is a recent service user as well as an active member of community maternity consumer groups: Active Birth Taranaki and La Leche League.

Community Practitioner Representation on Taranaki MQC MQSP

Please see membership above for stakeholder and LMC representation.

There are no General Practitioner (GP) representatives despite approaching the GP liaison group for nominations for membership; however the GP liaison representatives are notified of any pertinent information relevant to them and Maternity Quality and Safety within Taranaki DHB so the information can be shared within their group meetings.

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

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

Consumer Feedback on TDHB's MQSP

All consumers of the maternity service are invited and encouraged to provide feedback around the care they receive during their stay. Taranaki DHB uses this information to both celebrate success and to improve the service that we provide to women and their families. Feedback is logged with our customer services team and if a reply is required it is sent to the Service Manager to undertake an investigation and co-ordinate a reply to the patient. A letter of acknowledgement is sent to the patient and a reply is expected to be sent to the patients within 20 working days of receiving the feedback. If there is a delay in being able to respond, the patient is informed of this.

A maternity consumer satisfaction survey is carried out and evaluated annually. The 2012 survey summary is as follows:

- 64 maternity surveys were viewed
- 59 women had care at Base Hospital and 10 women had care at Hawera Hospital (5 of these had also spent time at Base Hospital)

The results from this survey had similarities to the consumer satisfaction survey that was targeted at Base Maternity:

- The Neonatal Unit were praised for their work
- Maternity were praised for their speed at responding to clients needs and for being helpful, professional and caring
- Meals were found to be lacking in taste and size
- Postnatal rooms were found to be too small and the bedding wasn't changed often enough.
- Breast feeding support was varied.
- Customer service training is required for some staff although other comments complimented the care that was received.

The results of this survey will be presented to staff and actions where appropriate will be taken to improve the services.

Roles Established in Support of Taranaki DHB's MQSP

The Associate Director of Midwifery (ADOM), who holds a 0.6FTE with an additional 0.2FTE Maternity Projects co-ordinator drives and communicates this programme.

There is no designated administrative support or maternity consumer liaison position and this is seen as an area to address in the future. The Midland and Taranaki DHB existing data analysts are utilised for information and data.

SECTION FOUR:

QUALITY IMPROVEMENT

Quality Improvement Actions Undertaken in 2012/2013 by Taranaki DHB and MQSP, in relation to:
It is noted that the MoH is aware that much of 2012/13 has been focused on setting up the MQSP and that quality improvements will continue to be developed and implemented.
- **New or revised multi-disciplinary review processes/meetings that have been coordinated**
• Monthly MQC meetings • ADOM meetings with remote rural and rural midwives • Weekly case review TOR, template and sessions with targeted procedures/outcomes • Induction of labour documentation and template
- **Changes in clinical practice that have been driven by MQSP initiatives**
• Elective caesarean sections are planned no less than 39 weeks gestation unless medically indicated, in this case antenatal steroids are now administered • Antenatal clinic midwife and two core midwives trained to capture and provide opportunistic immunisation of the flu vaccine and Boostrix • Monthly reporting templates from the educator, postnatal coordinator, Lactation consultant have been implemented • Dashboards for KPIs and information are displayed in wards 14 and 15 • Hand held records have been implemented for secondary antenatal clients • Maternity Internet site has been initiated with a description of the maternity services including information on stakeholders and how to access a midwife • Quality reporting Grids (draft see appendix 2) • Maternity Audit Grid (draft see appendix 3) • IV antibiotics given one hour prior to elective caesarean section to reduce the risk of wound infection • Maternal Mental Health draft pathways developed • Update of staff on Neonatal Resuscitation guidelines and installation of air and blenders • Epidural recertification package and training devised (first session April 2013) • Yearly Maternity Education Calendar developed/updated • Staff Appraisal template and system to address timeliness • Security swipe card installation at rear entrances to maternity. • New born enrolment system for women with unknown GP to encourage early enrolment of the baby for timely immunisation • Smoking cessation KPI data collected

- Diabetic Nurse Specialist attending secondary antenatal clinic appointments for women with known diabetes to promote integration of services and combine appointments means women only attend one appointment and are less likely to default.
- Implementation of MEWS protocol and training
- Escalation protocol for times of high acuity and staff absence developed
- Safe Sleep policy and in service education sessions
- Breast Feeding
    - Following an audit in 2012 the following recommendations were requested:
      A formula register has been put in place to audit how often formula is used and the reasons for its administration. It will also enable us to acknowledge the recent trend of late preterm, twins etc remaining in Post Natal ward and the associated clinical requirements.
    - All Maternity units are re-examining "rooming in" practices
      A survey to examine how information on rooming in is being shared and received between antenatal clients and LMCs and how core and LMCs can work more collaboratively to impart this information
    - Antenatal Colostrum Expressing (ACE) has commenced with a booklet, kit and guidelines being available to women who meet the criteria for this.
- Review of of jaundiced babies requiring bilisoft treatment being:
    - Admitted to ward 15 under the Neonatal team (mother a boarder mother) instead of Neonatal Unit.
    - Developing services for home phototherapy (bilisoft bed) under neonatal homecare.
    - Write and re launch a new protocol for care of the jaundiced baby.
    - Purchase an additional bilisoft to help reduce neonatal admissions, (offset by the cost of admission)

- **Communication forums, or networks, that have been established or strengthened and the quality improvements have resulted from these**

Monthly ADOM meetings with rural primary maternity units and LMCs

- Improvement in communication on transfers of care
- Identification labelling of Mothers and Babies in rural unit
- Planning for upgrade of Neonatal resuscitation equipment (ER Stratford)
- Data collection and reporting of rural maternity units midwifery activities
- Induction of labour template

Two monthly combined LMC and Taranaki DHB maternity service meetings

- Opportunity to keep LMCs up to date with new projects, initiatives and services and receive feedback from LMC's on TDHB services

Weekly case review meetings

- Noted that a number of women are not being referred to pre-admission clinic. Some related to time constraints, others related to private Obstetricians. All

parties have been contacted re importance of this referral pathway.

- IV antibiotics have been included as part of pre-operative preparation for elective caesarean sections. This is in line with best practice guidelines with the aim of reducing post-operative infections. Good discussion with anaesthetic department prior to implementation.
- Discussion and liaison around the importance of obtaining cord gases on all emergency caesarean section babies to give baseline recordings.
- Generally, inpatient documentation has been excellent. A few exceptions with booking form documentation noted. LMCs notified of the importance of completing.
- LMCs and women will be returned to LMC primary care following caesarean section deliveries or when deemed to be fit to return to primary care.
- Feedback from NNU and review outcomes which is increasing collaboration and understanding between departments.

Quality Improvement Activities Undertaken at a Midland Regional Level

Refer to the Midland Regional Services Plan – Midland Maternity Work Programme 2012/2013 (includes Midland regional progress report as at June 2013).

SECTION FIVE:

MQSP STRATEGIC PLAN DELIVERABLES FOR TDHB AND MIDLAND REGION

List of priorities, deliverables and planned actions for 2013/14

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

Governance

Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Planned start/finish dates
Ensure cultural responsiveness of all MMAG related activities - delivery on the RSP Māori accountability framework	Ethnicity data in each initiative/ programme of work will be captured All regional planning documents are reviewed against the HEAT tool	Improved responsiveness to vulnerable population	MMAG has a Maori representative responsible to communicate and input into MMAG related activities.	August 2013 – June 2014
Inclusion of consumers in maternity decision making groups – ensure consumer input is established at all levels of maternity services	An agreed regional framework exists relating to consumer involvement, (inclusive of payment, job descriptions, contracts) Implement the Consumer Framework in all DHBs in the Midland region, at the local governance level	Decisions made inclusive of consumer view	Consumers involved in each DHB's MQ&SP activities and MMAG is developing a regional consumer and LMC framework for the Midland Region	July 2013 – June 2014
Administration and community consumer liaison support	Implement set administration and community consumer liaison position in TDHB	Admin support in place and improved responsiveness to consumers	Evidence of consumer liaison meetings and admin support	Sept 2013-June 2014

Quality & Safety				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Improve LMC registration - increase number of women registering with an LMC in their first trimester	DHB data regarding number of women who register by end of first trimester with an LMC is available and monitored regionally. Enhance GP proficiency in first trimester screening and expedite booking with an LMC	Improved access to care. Early uptake of first trimester screening Increased number of women booking with an LMC by end of the first trimester	MMAG developing regional strategies to encourage consumers to register with an LMC early in the first trimester. Increase number of women in Taranaki registering before the end of the first trimester to 77% by 2014; 83% by 2015 and 90% by 2016	August 2013 – June 2014
Improve patient care quality and safety through establishing a robust transfer system - implement consistent system for maternity transfers across Midland and beyond	Regional maternity patient flow policy with sign off by COOs. Capability of each hospital is agreed so safe repatriations can occur, maternity transfer guidelines in place Quality indicators for maternity transfers developed, standards for midwifery coordination developed and implemented to underpin transfers	Expedient transfers to place of definitive care Reduced number of women experiencing compromised care Improved communication between midwifery coordinators	Evidence of MMAG revised inter facility referral, transfer and repatriation processes, guidelines and standards All cases transferred are reviewed against the guidelines and outcomes. Number of transfers that were appropriate re criteria as a proportion of all transfers . Aim = 100%	December 2013-June 2014
Implement Perinatal Mental Health Pathways to improve processes for identification referral and treatment of perinatal mental health illness	Consultation with all practioners involved with maternity cases up to 1 year post delivery.Llaunch of the pathway, referral process and education on diagnostic tools and processes	All practitioners are educated and provided with the information to confidently screen and refer cases early if concern for perinatal mental health	No of cases of Perinatal mental health screened, and referred correctly over the total number of cases	August-June 2014

Quality & Safety *cont.*				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Strengthen consistency of practices through shared educational activities - maximise collaboration between Midland regional midwifery educators	E-learning modules are developed in collaboration with GMs HR and e-learning facilitator Regional education plan is developed and activities are prioritised annually	Consistent and supported maternity education delivered across region Midland Maternity Educators group are sharing resources, training calendars, and assisting with training regionally Regional support for identified items of maternity education and training equipment	Number of staff completing Midland shared education modules over the number of practitioners in TDHB. Aim 30% by June 2014	August 2013 – June 2014
Reduce the smoking and SUDI rates - support the reduction of SUDI rates and numbers of women who smoke in pregnancy across Midland	All maternity providers have access to education around smokefree pregnancy Progress towards 90% of all pregnant women entering into LMC/obstetric care are assessed using the MoH ABC programme All providers of maternity services are trained in promoting safe sleeping messages	Increased focus on smoking cessation and SUDI prevention with decreased morbidity of infants Increased numbers of pregnant women accessing quit smoking programmes	Aim 100% smoke screening questions and referral process completed on admission to TDHB. All maternity providers have access to education around smokefree pregnancies. All Midland DHB's have a safe sleep policy in place. A regional safe sleep policy is developed and in place . Midland regional support through the purchase of pepi pod safe sleep devices	July 2013 - June 2014

			Number of Pepi Pods distributed over the number of births	
Information and Communication systems				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Strengthen Communication linkages across the DHB	Further investigate and implement audio visual tools to support rural practitioners attendance at meetings and forums	Increase in attendance of rural practitioners at meetings, forums, case reviews and education sessions	Number of meetings where Video Conference/teleconference is available over number of meetings.	Sept-June 2014
Antenatal Clinic (ANC) Data collection	Collection of data to ascertain reasons for consultation and transfer of clinical responsibility align with the referral guidelines	ANC midwifery FTE hours reflect antenatal clinic appointment preparation and care schedules	Number of antenatal clinic appointments over hours of midwifery hours available	Oct-June 2014

Service Delivery				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Improve attendance at pregnancy and parenting classes especially for rural and Māori pregnant women - increase number of pregnant women who enrol in pregnancy and parenting (P+P) / antenatal classes, especially in rural areas	Identify existing classes available, costs, attendance and location Information from the Hapu Wananga Evaluation is utilised as basis for action plan to increase attendance rates for Māori women Implement recommendations from consumer group surveys in rural areas of identified low attendance to determine barriers to attendance and develop plan to improve this	Information to direct recommendations about how many/what sort and where P+P classes need to be held	Evidence of initiatives being undertaken to meet identified needs in pregnancy and parenting/antenatal classes of vulnerable pregnant women	September 2013 – June 2014
Support framework for young vulnerable women who are pregnant - develop a regional programme to address identified issues and provide relevant support	Work collaboratively with primary providers, including Maori health providers, and PHOs to identify the issues and support systems Commence the development with relevant stakeholders and primary providers to develop a regional programme that will wrap support around young vulnerable women who are pregnant, including smoking cessation, substance abuse	Young vulnerable women who are pregnant have improved access to information, support and quit smoking programmes	Collaborative work with primary providers and PHO's towards developing a regional programme for young vulnerable women who are pregnant	June 2013 - June 2014
Service Delivery *cont.*				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Improve access to local Nuchal Translucency (NT) services when the private Obstetrician is on leave	Investigate possibility of locum services to cover TDHB to offer this service when the private obstetrician is on leave	NT Services are available locally to all women that choose this screening	Number of days Nuchal Translucency scanning was not available in Taranaki	August-June 2014

Caesarean Section: Improve timing from phone call of decision to birth of baby for level 1 caesarean section Decrease General Anaesthesia (GA)in Emergency caesarean sections Improve elective caesarean section rate in primiparae	Investigate an area that Maternity and Neonatal Unit can be accommodated near to the new Hospital Building and Operating Theatres Investigate elective caesarean section rate in primiparae to ensure reasons are in line with RANZCOG guidelines	Area is secured for Maternity and Neonatal services nearer to the hospital operating theatres, plans in place for commissioning and moving to new location Decrease in GA for level 1 caesarean section Improved timing for decision to birth of level 1 caesarean section Improved rates for elective caesarean section in primiparae in line with national rate of 15%	GA c/section rates performed under GA over all level 1 caesarean sections Number of level 1 cases not reaching the recommended time from phone call (decision) to birth of baby over all level 1 caesarean sections Number of elective caesarean sections performed in line with RANZCOG guidelines over the number that did not align with the guidelines	Sept 2013-June 2014 2015-2016 Sept-June 2014
Research and Evaluation				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Regional and local data availability - comprehensive data collection systems to enable regional benchmarking and reporting	Regional dashboard for maternity clinical indicators is developed and updated Accurate regional information is available which identifies issues, trends and enables focus for regional initiatives Local data examined on antenatal clinic consultations and transfers to secondary antenatal care	Current regional data is available to shape direction of care and action Sufficient fte and support services to support Taranaki outpatient antenatal services. Appropriate management of Consultation and Transfer of care to and from primary LMC services	The availability of comprehensive regional data Audit results to ensure appropriate consultation and transfer of care antenatally and postnatally	July 2013 – June 2014 Jan-June 2014

Research and Evaluation *cont.*				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Improving breastfeeding rates through use of agreed regional tools - regional agreement to the networking and sharing of resources throughout Midland re breastfeeding	Identify breastfeeding rates in Midland using regional BFHI data Explore the development of the use of IT applications to improve access to information for Māori and disadvantaged mothers	Improved access to consistent breastfeeding information Enhanced availability of breastfeeding resources in the Midland region and the sharing of initiatives and resources through the regional breast feeding/BFHI support group. Evidence of regional support for the purchase of Mama Aroha breastfeeding resources for each Midland DHB	Aim minimum 75% exclusive breastfeeding rates on discharge from TDHB facilities	August 2013 – June 2014
Progressing new Initiatives: Congenital Cardiac Heart Disease (CCHD) screening Care of the jaundice neonate in the community and postnatal ward Maternity Bariatric Guidelines Opportunistic Immunisation for Flu Vaccine and Boostrix	Purchase of equipment and implementation of staff training and TDHB protocols are in place Maternity Bariatric guidelines developed Marketing and advertising the immunisation services	Improved detection and treatment of CCHD Improved services for care of the jaundice neonate including keeping the mother and baby as one unit in the post natal ward and /or home if appropriate Clear guidelines in place to inform clients and practitioners on bariatric cases Increased uptake of flu and Boostrix immunisations for staff and clients, decrease in sick leave and hospital admission in relation to whooping cough and Flu	Number of cases detected prior to discharge from hospital over the total of cases detected in the first year of life Number of babies managed at mothers bed side over the number of babies treated E learning package completed by staff aim for 80% pass within 1 year of guidelines being implemented Number of admissions in relation to flu and whooping cough over total admissions	October 13-June 2014 July 2013 May 2013-June 2014

Enablers / Support				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Workforce intelligence - plan for a sustainable maternity workforce (especially in rural areas)	Head count to service current population vs workforce needed for future birthing trends is identified Areas of shortage are identified Identify rural midwives' issues and work towards regional solutions Trends in LMC and secondary / tertiary midwifery workforce numbers, distribution and forecasting are analysed by regional workforce group	Understanding of current state and future state needs to achieve sustainability	Total FTE vacancies over total FTE	December 2013 – June 2014
Workforce utilisation - identify future maternity workforce requirements and develop plans to ensure appropriate maternity care provision continues	Utility of existing workforce model critiqued against workforce forecasting Options for innovative models explored to support sustainable midwifery care in rural units and geographical areas. Also VBAC clinics and allied health support and collaborative models of care Options for midwifery labour and birth and postnatal services investigated for private obstetricians Staff appraisals completed on an annual basis	Accurate baseline data and engagement of service providers in developing innovation solutions Core midwifery predictable efficient workloads	Total staff appraisals completed over total number of staff	December 2013 – June 2014

Enablers / Support *cont.*				
Priority area	**Planned local actions to deliver quality improvement**	**Expected outcomes**	**Measured by**	**Planned start/finish dates**
Workforce planning and forecasting for medical staff - work with RANZCOG to plan for O&G placements in identified areas	Quantification of percentage of consultant time spent in obstetrics to ascertain level of obstetric workforce need Quantification benchmarked across other three regions by RDOTs Strategic plan for sustainable obstetric physician service provision inclusive of obstetric anaesthetists, SMOs, RMO training, and placements is developed	Robust understanding of workforce issues and identification of workforce needs for the future	Total number of Obstetric registrars over positions available	December 2013 – June 2014
Use IS technology to improve information sharing - improve access to information between LMCs and with consumers	Web portal for LMCs and consumers in place Application development for LMC and consumer smartphone use explored	Increased access to information for consumers and LMCs	Shared electronic space open to LMC's and consumers to access information.	August 2013 – June 2014
Progress connected health concepts to improve access to clinical maternity information - implement national maternity client information system	Work with regional IS to develop implementation plan Participate in MCIS system development at the national level, working with the clinical reference group and CleverMed Implementation plan commenced in early adopter site (Tairawhiti)	Regional implementation plan and timeframe available Users of the system provide feedback to influence system development	MMAG representation on national Maternity Client Information system (working group to assist in developing NZ IS platform)	July 2013 – June 2014

Appendices

Appendix 1

Taranaki and Midland Regional Services Plan – Maternity Work Programme 2012/2013(including detail on local and regional progress as at May 2013)

Notes:

- MMAG= Midland Maternity Action Group;
- Activities highlighted in blue are Taranaki DHB locally led and funded. The remaining activities are to be led, funded and completed regionally.

Taranaki DHB and Midland Regional Services Plan – Maternity Work Programme 2012/2013 (including detail on regional progress as at March 2013)

- Key themes - Project Team - Timeline	Actions to deliver improved performance	Measured by	Outcomes	Midland Regional Progress Report as at March 2013
Governance				
Appoint Associate Director of Midwifery (ADOM)	ADOM Job description formulated and advertisement formulated	• Job description and position advertised	• ADOM appointed	ADOM commenced position in July 2012

Maternity quality committee in place in each DHB MMAG December 2012	Maternity Quality Committees established	• Quality committee in place in each DHB • Standardised TOR agreed • Communication structure between national, regional and local governance groups in place	• Reporting requirements met • Communication processes effective • Committee oversees and ensures coherence of all maternity quality and safety activities	Taranaki DHB has appointed members, TOR agreed and meetings commenced in Dec 2012 Terms of Reference developed and re-visited by MMAG in Feb 2013. Regional outcomes and communication will be improved through the reconfiguration into sub groups, such as, Maternity Educators & Maternity Leaders sub group, LMC sub group, SMO sub group, MQSP coordinator sub group, and BFHI sub group, etc. MMAG and the Maternity Educators & Maternity Leaders Groups meet quarterly; MMAG members are responsible to disseminate information to their local DHB multi- disciplinary teams and feedback into the MMAG regional consultative process. Other meetings are called, as required. TORs for the sub groups will be developed and submitted to the May 2013 meeting of MMAG for consultation. Nexus – an online, secure communication web 'space' is used to work collaboratively on projects across the Midland region, meeting agendas, minutes and documentation are regularly uploaded to Nexus. MQSP coordinators have been included in MMAG membership. National communication is received and actioned both locally and regionally. Progressing.

- Key themes - Project Team - Timeline	Actions to deliver improved performance	Measured by	Outcomes	Midland Regional Progress Report as at March 2013
Governance				
Maternity Strategic Plan MMAG May 2012	Maternity Strategic Plan developed	• Plan approved	• Plan guides future decision making regarding regional maternity services • Consider and, where appropriate, support implementation of recommendations from national bodies such as the Perinatal and Maternal Mortality Review Committee (PMMRC) and the National Maternity Monitoring Group (NMMG)	TDHB Maternity Strategic Plan developed and submitted to MOH June 2012 The Midland Regional Services Plan 2013-2016 (under development) includes the Midland Regional Maternity Work Programme for the period July 2013-June 2016. Submitted to the Ministry on 9 March 2013. Awaiting feedback and direction from the Ministry following its review. The Midland Maternity Work Programme has been developed by MMAG, in consultation with Maori Health, Health Workforce, IS and at a DHB executive level. The work programme is guided by the recommendations from national bodies, such as the PMMRC and the NMMG. Progressing.
Recruit and retain Midwives to fill vacant FTE and sustain the local hospital and LMC maternity workforce	Identify key places for advertising and recruitment campaign	• FTE vacancy • Advertisements posted • NZCOM Conference Midland Recruitment stall	• Appointment of midwives to fill FTE with appropriate skills • Sufficient LMC midwives to provide primary midwifery care. • Appointment of permanent midwife Educator	This is an on going process for core and LMC midwives. The medical workforce has no vacant fte

Maternity Annual Report MMAG June 2013 Taranaki Maternity Annual Report **June 2013**	Maternity Annual Report complete Annual report completed	• Template developed • Final report accepted/approved Template completed Final report accepted/approved	Report guides future developments/RSPs/APs Report guides and informs current and future developments	HealthShare developed a template prior to receipt of the MoH guidance on Annual Report development. A revised Annual Report template has been developed and circulated for use by the Midland regional DHBs. Progressing Progressing
Quality and Safety				
Implement the National Maternity Quality and Safety Programme MMAG June 2013	Maternity Quality and Safety Programme implementation plan developed and agreed	Standardised templates developed to ensure: • Standardised formal review processes for serious and sentinel events are in place • Standardised evidence-based clinical case review processes are in place • Representation of community-based clinicians and consumers in the formal and informal review processes to ensure their perspective is considered. • Defined processes in place to: • implement changes in clinical practices	• Maternity Quality and Safety Programme in place in all 5 DHBs • Mechanisms in place to evaluate systems and processes	• Maternity Quality and Safety Programme in place in Taranaki DHB has a Standardised Case review TOR and weekly sessions have been implemented which are attended by multidisciplinary maternity practitioners including self employed practitioners. Changes have been implemented where indicated and constructive learning has influenced practices, protocols and service delivery. Further development of specific case review templates are to be progressed. Standardised templates have been developed as follows: • Midland regional policy: 'Adverse Obstetric Outcomes: Monitoring, Case Review, Serious and Sentinel Event Requirements and Processes' (draft) The Midland Maternity Educators & Maternity Leaders group has been tasked with progressing the draft templates for submission to MMAG for consultation and approval. Members of MMAG are submitting the draft template to their local DHB Quality & Risk and Serious & Sentinel Events Review Committees for consultation and feedback to MMAG.

- Key themes - Project Team - Timeline	Actions to deliver improved performance	Measured by	Outcomes	Midland Regional Progress Report as at March 2013
		• reduce unnecessary variation in clinical practice • define and strengthen clinical pathways • influence local service delivery planning and policy		HealthShare is to look at the possibility of developing a Midland regional policies, procedures, guidelines and templates repository for documents developed through the Midland clinical networks. A document control process will also be developed. Secure access may be via local DHB users 'linking' to the regional policies through their own DHB's controlled policies library Progressing.
Quality and Safety				
Implement the National Maternity Standards MMAG June 2013	Standards implementation plan developed and agreed	Standardised templates developed to ensure: • MDT meetings in place • Annual report complete • LMCs, consumers and other community / hospital-based maternity practitioners/ stakeholders are involved in appropriate forums	• All Standards are met • Mechanisms in place to evaluate achievement against the standards	Progressing MMAG has developed a 'Midland Region Consumer Representative and LMC Liaison Representative Framework (draft)' and is in a consultative phase. Progressing
RSP Māori Accountability Framework	Deliver upon the standards of the RSP Māori Accountability Framework	Evidence of performance against standards and associated measures as indicated in the RSP Māori Accountability Framework	• All standards are met • Cultural responsiveness KPIs established	MMAG membership includes a representative from Te Puna Oranga (Waikato) and represents Midland Maori Health Services. Te Puna Oranga may be in a position to undertake a service responsiveness audit in 2014.

- **Key themes** - **Project Team** - **Timeline**	**Actions to deliver improved performance**	**Measured by**	**Outcomes**	**Midland Regional Progress Report as at March 2013**
MMAG and associated workgroups June 2013		• Regional resource in place • Meaningful Māori participation on all workgroups associated with this plan • Mechanisms in place to evaluate achievement against standards	•	Cultural workshops are incorporated into the professional requirements of staff in each of the Midland DHBs. Progressing
Quality and Safety				
Policies and protocols in Taranaki **Dec 2012**	Review and update policies and procedures as review date expires Explore further protocols that can be developed and shared regionally Implement safe sleep policy	Current best practice used to drive development LMC's, consumers, Maori and other community/hospital based maternity practitioners/stakeholders Safe sleep and transfer from community protocol implementation	• Audit evaluation tool in place to monitor protocols • Protocols accessible and followed by maternity practitioners	Working regionally on shared protocol s (see below). Educator coordinating the review and update of protocols which are now accessible to self employed and employed practitioners on the maternity intranet (can be accessed off site). Safe sleep policy implemented April 2012, now working with Midland Region on a shared Regional policy.

- **Key themes** - **Project Team** - **Timeline**	**Actions to deliver improved performance**	**Measured by**	**Outcomes**	**Midland Regional Progress Report as at March 2013**
	Transfer from Community protocol New Neonatal resuscitation guidelines and equipment Midwifery Early Warning Systems in place	Education and training sessions in place Pilot observation charts, education and training implementation	Evidence based protocol and equipment in place Protocol and training implemented	Implemented July 2012. New Neonatal resuscitation equipment and training implemented in Base and Hawera units in Oct 2012, ER Stratford still to implement air and blenders, awaiting update of guideline. MEWS charts and protocol implemented August 2012, audit tool being developed.
Explore opportunities for shared educational activities/ initiatives MMAG Education sub-group Regional Training Network	Education sub-group formally established and action plan developed and implemented	Facilitation of the education sub-group to support increased number of educational initiatives available across the region including: • Fetal surveillance training • Epidural recertification • Return to practice pathway • Regional training supervisor network • Initiation of PROMPT in TDHB	Access to maternity education increases on 11/12 • Regional template developed to meet Midwifery Council requirements	Taranaki local education calendar implemented in Dec 2012 MMAG's Maternity Educators & Maternity Leaders sub group is leading the regional work on: Fetal surveillance training compliance. K2 training license renewed in Dec 2012 for online fetal surveillance training which meets the needs of rural , urban, self employed and employed practitioners • Epidural recertification. Epidural workbook and ½ day training devised and to be implemented in April 2013 in TDHB • Return to practice pathway (incorporated into the 'Midland DHBs Regional Midwifery Passport' (draft) – to be reviewed by Midland H&S and HR managers)

- Key themes - Project Team - Timeline	Actions to deliver improved performance	Measured by	Outcomes	Midland Regional Progress Report as at March 2013
June 2013		• Implement ISBARR communication tool in TDHB • Implement the shaken baby programme • Review of regional educational resources and development of resource library • Identified E-learning modules	•	• PROMPT training implemented twice yearly in Taranaki DHB • ISBARR protocol and tool implemented June 2012 • Shaken baby programme initiated in May 2012 • MFYP (a robust framework/pathway for new midwifery graduates) A stocktake of regional education resources has been undertaken and a list of essential equipment/resources developed. Approval sought from MMAG at its May 2013 meeting to purchase items of educational resources required. A learning package has been identified using e-learning modules. These have been added to the e-learning platform. Progressing.

- **Key themes** - **Project Team** - **Timeline**	**Actions to deliver improved performance**	**Measured by**	**Outcomes**	**Midland Regional Progress Report as at March 2013**
Quality and Safety				
Identify the "top ten" policies/guidelines and standardise regionally MMAG Guideline sub-group June 2013	Lippincott Manual reviewed – guidelines for review agreed and action plan developed by Guideline subgroup	Facilitation of the guideline sub-group to ensure: Guidelines/policies are evidence based Guidelines/policies are communicated and implemented	Ten policies/guidelines complete and implemented across the region	MMAG has identified 12 policies/guidelines for the Midland region. These are in a consultative phase and will be further developed by the Midwife Educators & Midwife Leaders sub group of MMAG: • Management of Ante Partum Haemorrhage (includes placenta praevia and abruption placenta) • Anti-D Immunoglobulin Administration • Electronic Fetal Monitoring • Fetal Fibronectin as a Screening Test for Pre-Term Birth • Management of Hyperemesis Gravidarum • SBARR/ISOBAR/ISBARR Communication Tool • Management of Meconium Stained Liquor • Management of Shoulder Dystocia • Vaginal Birth After Caesarean • Water Immersion During Labour and Birth • Maternity Retrieval Team Standards and Competencies • Policy: Safe Infant Sleep A 'Regional Maternity Procedure Development Process' has been implemented to assist with the pathway for regional policies and guidelines to progress from draft to final status It is likely that these regional policies/ guidelines will be placed on a Midland regional web based document repository Progressing

- Key themes - Project Team - Timeline	Actions to deliver improved performance	Measured by	Outcomes	Midland Regional Progress Report as at March 2013
Service Delivery				
Develop a regional neonatal and maternity emergency response plan MMAG June 2013	Regional neonatal and maternity emergency response plan developed and implemented	• All stakeholders involved in plan development • Escalation plan for resource shortages included • Plan links to regional transport project • Plan communicated to all maternity providers	• Emergency response plan in place • Mechanism in place to audit/evaluate communication between providers in cases of clinical emergency	A 'Regional Neonatal and Maternity Emergency Response Plan (Guidance and Templates) DRAFT' has been developed by MMAG. However, consultation has highlighted the need for a Maternity Escalation Plan for the Midland region when shortages in resources are experienced, such as staffing or NICU beds. Local escalation plan formulated and implemented at TDHB Maternity services for times of high acuity, sickness and absence in Sept 2012 A Midland Regional Escalation Plan was identified as a need in the February 2013 MMAG meeting and is in development A 'Midland Regional Maternity Services: Inter Facility Referral, Transfer and Repatriation Processes, Guidelines and Standards' (draft) has been developed and is in a consultation phase. Midland DHBs are providing detail on their capability for repatriations Progressing
Service Delivery				
Integrated pathway developed for two maternity/ obstetric conditions MMAG Guideline sub-group June 2013	Guideline sub-group identify and develop pathways	Facilitation of the guideline sub-group to support: • Current best practice used to drive development • LMCs, consumers and other community/hospital - based maternity practitioners/ stakeholders involved in pathway development	• Two Pathways developed and implemented • Mechanism in place to evaluate compliance/success	MMAG has developed two pathways (in draft): • Midland Regional Threatened / Actual Pre-Term Labour Pathway – Map of Medicine are currently working on transferring the information to a MoM Pathway • Midland Regional Maternity Services : Inter Facility Referral, Transfer and Repatriation Processes, Guidelines and Standards It is likely that these regional policies/ guidelines will be placed on a Midland regional web based document repository Progressing

- Key themes - Project Team - Timeline	Actions to deliver improved performance	Measured by	Outcomes	Midland Regional Progress Report as at March 2013
Service Delivery				
Stakeholders are involved/engaged in all service development activities MMAG Guideline sub-group June 2013	Process in place to ensure stakeholder involvement/ engagement	LMCs, consumers and other community/hospital - based maternity practitioners/ stakeholders are involved in service development activities and improvement Feedback is obtained on local consumer experiences of maternity services	Process implemented Consumer survey developed /implemented as per national agreement	Taranaki DHB conducted an annual Maternity consumer satisfaction survey and reviewed customer feedback/how are we doing and random selection of DHB satisfaction surveys sent to maternity clients. Information obtained has been collated, recommendations for improvements where appropriate are to be made and will be presented to staff and MQC committee MMAG provides support to the New Zealand Institute of Rural Health in the Midland region rural maternity services consumer consultation. It is anticipated that the report will be published in September 2013. Findings from this research will inform MMAG's service development initiatives within maternity and LMC services for consumers. The views of rural consumers will be sought from initial enrolment with an LMC / obstetric provider, through antenatal education (if any), labour, delivery and the first six weeks following delivery MMAG as a clinical network has a presence on the HealthShare website, hosted via Waikato DHB. This enables transparency of the MMAG members representing the regional maternity work Progressing

- **Key themes** - **Project Team** - **Timeline**	**Actions to deliver improved performance**	**Measured by**	**Outcomes**	**Midland Regional Progress Report as at March 2013**
Research and Evaluation				
Develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting against the national maternity clinical indicators MMAG June 2013	• Review clinical indicators and establish what is already collected/where • Ensure regionally consistent approach to data collection and reporting • Data presented locally and regionally to allow for local and regional approach to service improvement where appropriate	• An overview of local maternity demographics and outcomes is available • Information in the New Zealand Maternity Clinical Indicators report is disseminated to maternity clinicians and other relevant stakeholders • Collection of consistent and comprehensive primary maternity data occurs, regardless of the provider of primary maternity care • Data/information used to prioritise quality improvement activities • Processes to audit and improve the quality of maternity data collection, storage and reporting are in place	• Maternity Quality and Safety Programme in place in all five Midland DHBs • Mechanisms in place to evaluate information/ reporting	The HealthShare Data Analyst will provide quarterly maternity data reports and work with MMAG to provide the information the group is interested in analysing. Service improvements will be achieved through this evaluative and informative reporting. The HealthShare Data Analyst is in discussions with the MoH's Data Analysts to seek the release of unofficial annual data to assist regional service improvement initiatives Progressing.

- **Key themes** - **Project Team** - **Timeline**	**Actions to deliver improved performance**	**Measured by**	**Outcomes**	**Midland Regional Progress Report as at March 2013**
Research and Evaluation				
Consistent approaches to audit and evaluation are developed MMAG with DHB Audit teams June 2013	Current audit/ evaluation activity reviewed and regional schedule agreed	Audit/evaluation templates developed for agreed areas	Template and schedule agreed and implemented	Template development and scheduling of audit/evaluation activity to be completed prior to June 2013. To be commenced April 2013
Enablers / Support				
Explore opportunities for a shared regional patient activity repository MMAG June 2013	Regional patient activity repository in place	Ability to consolidate and compare patient activity/information across the five DHBs	• Regional understanding of current patient activity and associated costs • Regional approach to developing future demand scenarios based on regional growth/ demo-graphics, etc Impact analysis of different models of care from a regional perspective	HealthShare's Data Analyst will provide Maternity Reports to MMAG meetings so that areas of opportunity can be identified through the use of data. Discussions are currently being held with the MoH's Data Analysts to seek the timely release of data to assist regional analysis and improvement initiatives. The shared regional patient activity repository requires Midland IS input and therefore is reliant on IS resourcing and planning. MMAG (via HealthShare) is supporting the New Zealand Institute of Rural Health's maternity consumer consultation. The aim of the consultation is to establish whether maternity services in the Midland region fulfil the perceived or actual needs of rural women. Focus groups and individual interviews, supported by a brief demographic questionnaire, will be the method used. Ethics approval is currently being obtained and it is anticipated that the report will be published at the end of September 2013. MMAG will use this report to identify service improvement initiatives to improve models of care for women in the Midland region. Progressing

- **Key themes** - **Project Team** - **Timeline**	**Actions to deliver improved performance**	**Measured by**	**Outcomes**	**Midland Regional Progress Report as at March 2013**
Explore opportunities for a web-based shared communication/ information sharing tool MMAG with Regional IT Manager - June 2013	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to LMCs, consumers and other community-based maternity practitioners/stakeholders	Maternity Quality and Safety Programme in place in all 5 DHBs	Consideration has been given to the use of mobile phone apps . to assist in the transfer of information and communication between LMCs and consumers. Note: any web based shared communication information / sharing tool will need to be in line with the Midland regional IS developments Nexus provides a shared web-based communication / information sharing tool and this is utilised by MMAG to progress collaborative work across the region Progressing
Identify KPI's to assist benchmarking locally, regionally and nationally	Dashboard in place and KPIs identified	LMC's consumers and other community/hospital based maternity practitioners/stakeholders are involved in selection of KPI's	Dashboard display of identified KPI's and progress/action plans	Dashboard in place in antenatal/labour and postnatal ward, staff involvement in display, planning and actions of KPI's. To progress benchmarking locally, regionally and nationally

Appendix 2

DRAFT Maternity QUALITY AUDIT GRID 2013/14

	2013										2014	
	March	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
MEWS *CME-I*	✓	✓	✓	✓	✓	✓			✓			
Customer Satisfaction Survey *ADOM*				✓								
Documentation and Fluid Balance *QR rep Maternity*		✓	✓	✓	✓	✓	✓			✓		
ISBARR *PN co-ordinator*		✓				✓				✓		
Trendcare IRR N/Mw *Audit*		✓						✓				
Appraisals *CMM*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fetal Fibronectin O&G			✓						✓			
Antenatal steroids Audit O&G					✓							✓
Safe Sleep Audit *Safe sleep champ*					✓							
Level 1 c/sections decision to delivery times O & G							✓				✓	

Appendix 3

DRAFT Maternity AUDIT QUALITY PLAN Reporting GRID 2013/14

	2013										2014	
	March	**April**	**May**	**June**	**July**	**August**	**Sept**	**October**	**Nov**	**Dec**	**Jan**	**Feb**
PMMR and case review / Trends/great saves *CME/ADOM*	✓			✓			✓			✓		
Maternal Mental Health *Numbers/Trends – MMH stakeholder*		✓						✓				
Neo Natal Unit *Admissions/trends /issues-CNM Neo Natal*			✓			✓			✓			✓
Complaints/consumer feedback, Trends *Mat Child Health Manager/CMM*		✓				✓				✓		
Wound Infections/ GA & Blood Transfusions (c/sec) *CNS – Infection Control*				✓					✓			
Maternal Social Work cases: Trends/Numbers *Maternal social workerl*	✓							✓				
Breast feeding data *LC TDHB*			✓				✓				✓	
Policies, guidelines and education *CME*					✓							✓
Reportable events/Serious and sentinel events trends/issues			✓				✓				✓	

Appendix 4

Case Review Terms of Reference

TARANAKI DISTRICT HEALTH BOARD (Taranaki DHB) Maternity Case Review

Service:	Women and Children's Health Service
Date Issued:	October 2012
Review By Date:	October 2015
Responsibility:	Obstetric Medical Team
Authorised By:	Head of Department, Obstetrics & Gynaecology,
Version:	2
Page	1 of 2

Purpose

- To analyse obstetric outcomes and provide an opportunity to learn and to apply care to the latest literature and recommended best practice.
- Identify areas of care that are good, could be improved, learn about system failure, and inform practice to prevent further recurrence.

Definition:

- Any case may be referred to the weekly Maternity Unit case review meeting by any maternity practitioner by completing the case review template (see appendix 1)
- Cases included but are not limited to; Postpartum haemorrhage, neonatal unit admissions, Induction of Labour, third and fourth degree tears, elective caesarean section, emergency caesarean section, unplanned Intensive Care Unit admissions, eclampsia, maternal blood transfusion, neonatal fractured clavicle, third degree tear, major anaesthetic difficulties

Terms of Reference

- The Taranaki 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 weekly (except public holidays) and all members will be informed of any cancellations by the Clinical Midwife Educator

Chairperson:

The Obstetric Specialist (or delegated person) will act as Chairperson and under the direction of the O&G Head of Department.

The Obstetric specialist chairperson rotates/changes on a weekly rotational basis to correspond to the consultant on call roster of weeks 1, 2 , 3 and 4:

- The specialist communicates with HOD O&G and Clinical Midwife Educator regarding relevant cases so that the relevant literature and protocols can be prepared for the meeting.

- Cases will be discussed confidentially in a constructive and non-punitive manner
- The case review template is completed with recommended action points (see appendix1)
- A summary of data of all cases discussed will be reported to the monthly Maternity Quality Committee.

Membership:

- Taranaki DHB Maternity, Perinatal staff, student Midwives,
- Self employed Midwife, General Practitioner and Private Obstetric LMCs

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.

Meeting Time Frame:

- Weekly meetings . Meetings will be held on an arranged date from 12-1300 hours
- All cases that have been requested and/or as per rotational agreement below

Procedure:

Week 1 (Obstetrician chair roster week 1): all cases of Post Partum Haemorrhage (Including all cases of blood transfusion) and neo natal admission for week preceding the meeting

Week 2 (Obstetrician chair roster week 2): All cases of Induction/cervical ripening and third or fourth degree tears

Week 3 (Obstetrician chair roster week 3): All cases of Elective caesarean section

Week 4 (Obstetrician chair roster week 4): All cases of Emergency caesarean section

Conflict of Interest

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

Confidentiality of cases is maintained

- No minutes or personal records will be taken of the meeting, however see below re issues identified and action plan maybe formulated to implement improvements in practices.

Reporting Relationship

Information is filed electronically on the U drive under "case reviews", date, year and reported to the Maternity Quality Committee

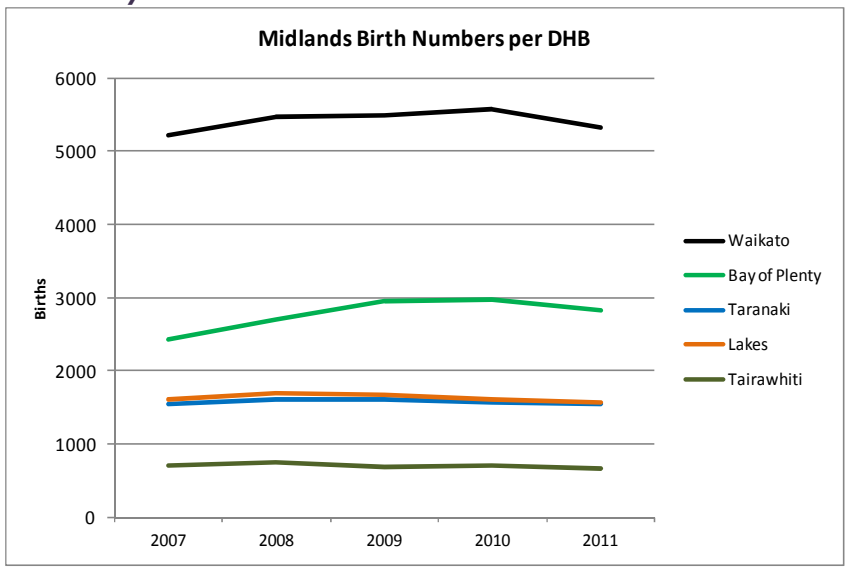
Minute Circulation

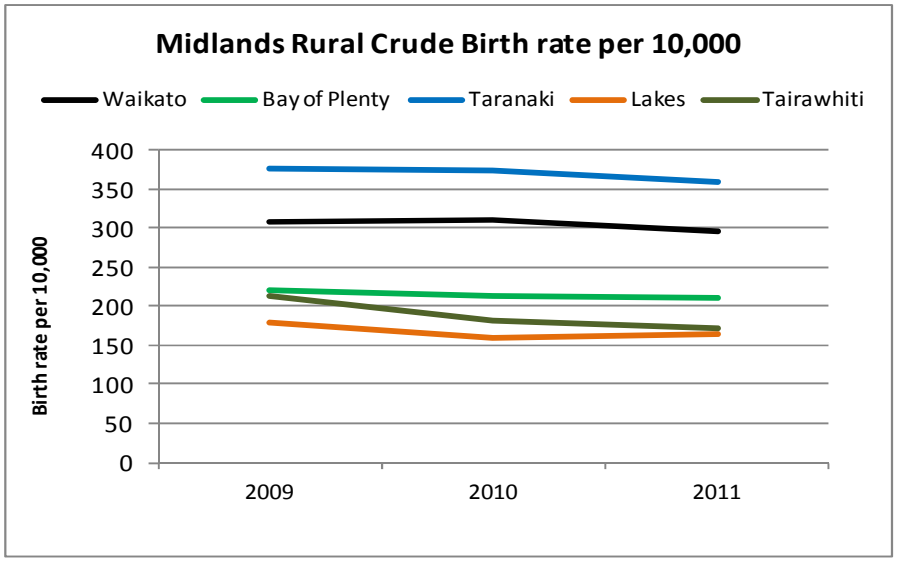
Issues identified and an action plan will be the only written record. A progress report will be reported via the Maternity Quality Committee.

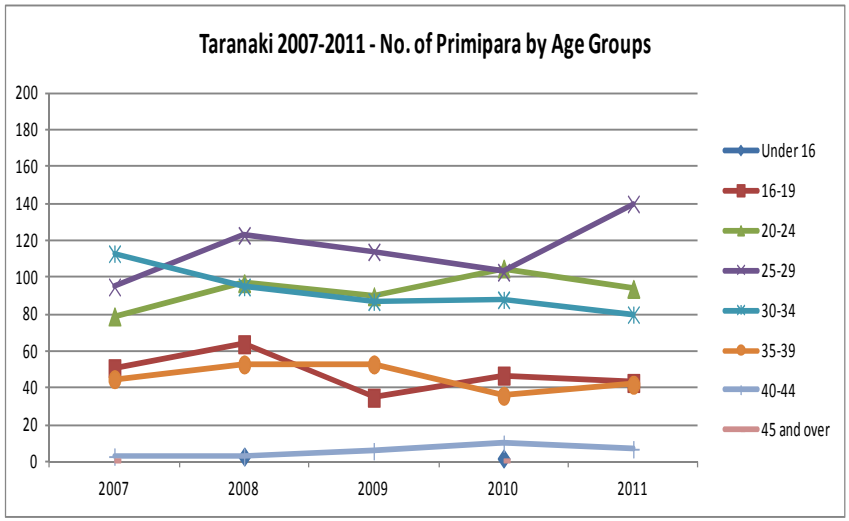
Example below:

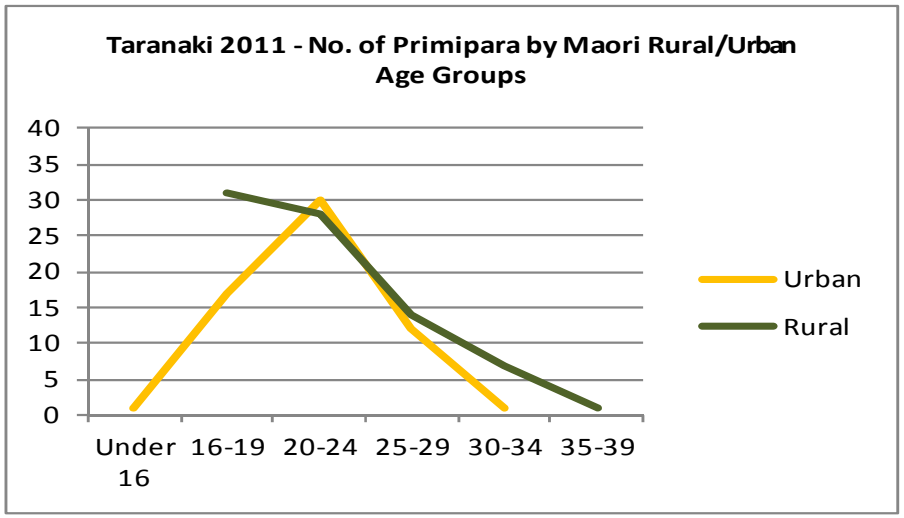
Learning points	Smoking in Pregnancy. Smoking is a well documented risk factor for IUGR. Stopping doubles the likelihood of a good outcome. It is important to give this information as part of antenatal care but also to give the information again if IUGR develops, and monitor during pregnancy. Group B Strep. When swabbing for group B Strep do a low vaginal swab, sweeping to the rectum. If swabbing for Chlamydia, a high vaginal swab is done.
	Placental Swabs Importance of placental swabs at delivery to assist in the diagnosis of the IUD.
	Threatened pre-term labour: Importance of early swabs and MSU, if threatened pre-term labour. Cardiac defect on anatomy scan: In the case discussed, no prevention was available, but for the next pregnancy refer early to obstetric team. Morbid obesity/ High BMI: Cervical suture: In the case discussed: 3 mid trimester losses. Further pregnancy – cervical suture at 13/40. Screen and treat for infection early in pregnancy. Treat Bacterial Vaginosis. Evidence supports treatment prior to 20/40. Fetal Movements: In the case discussed, No FM's for 4/7. Importance of monitoring/ reporting reduced FM's. Ensuring women are aware to report this to her LMC/ birthing suite.

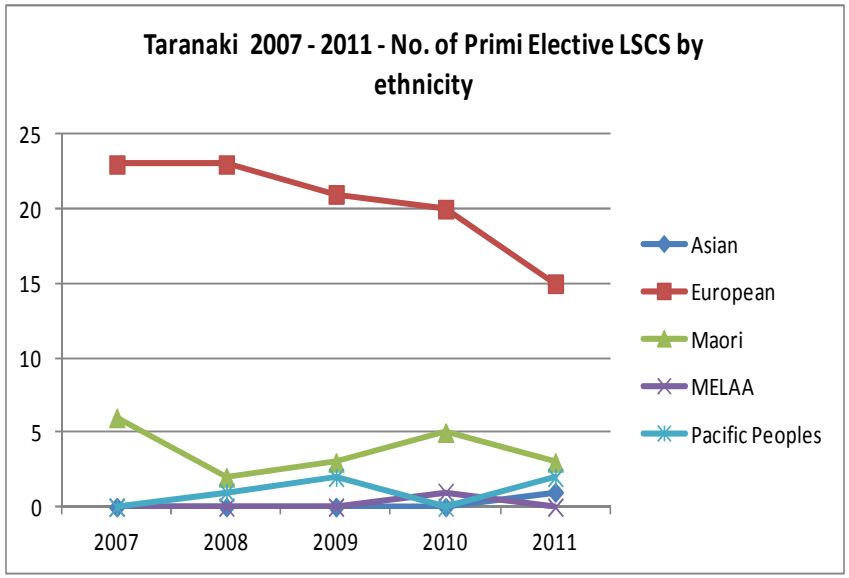
Appendix 5 ***Taranaki DHB and Midland Region Maternity Data***

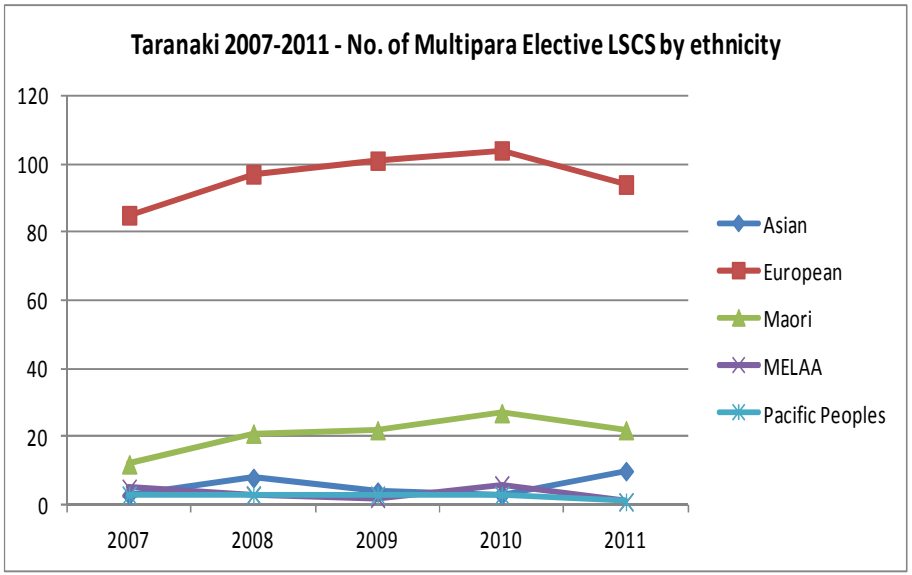


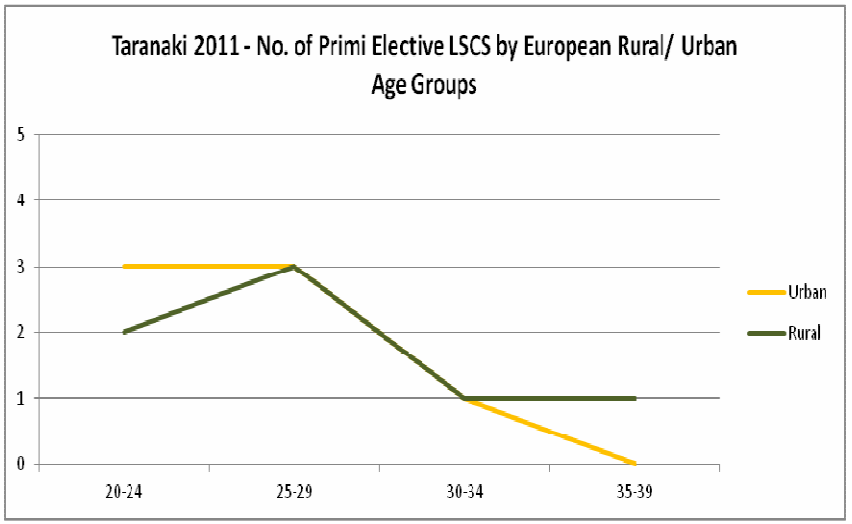


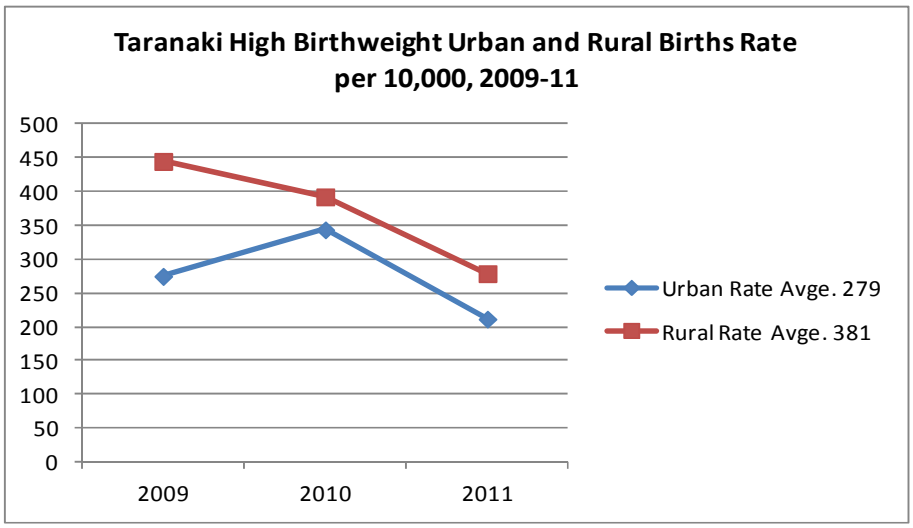


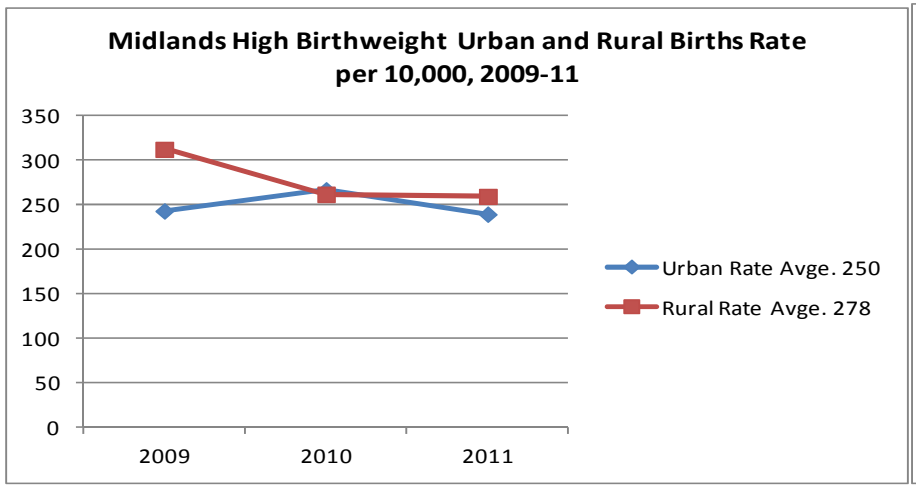


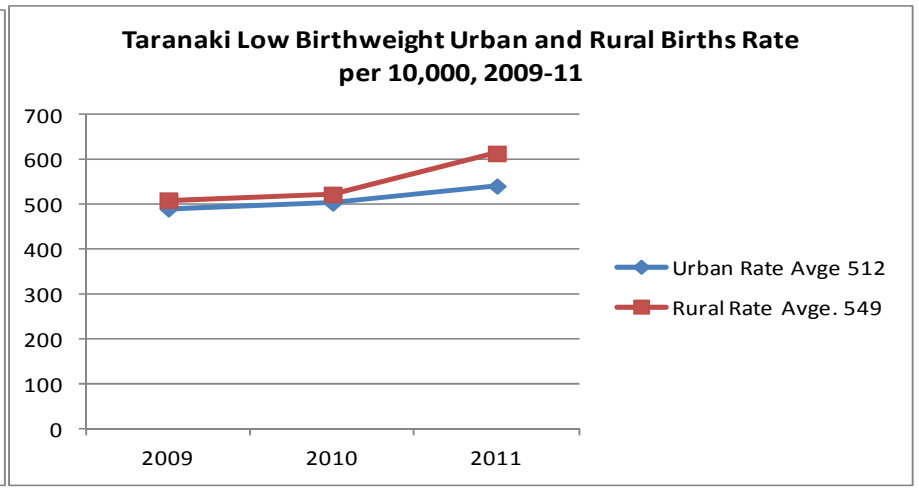

Taranaki 2007 - 2011 - No. of Primi Elective LSCS by ethnicity
25
20
15
10
5
0
2007
2008
2009
2010
2011
Asian
European
Maori
MELAA
Pacific Peoples

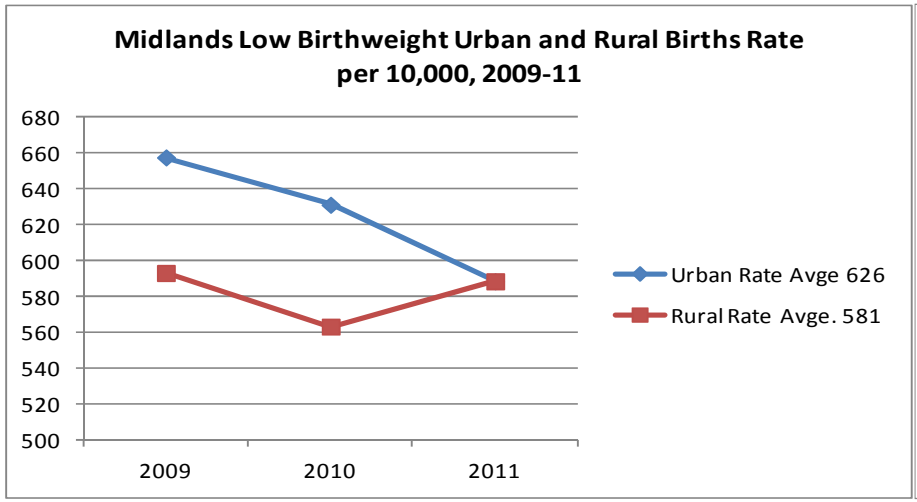

Taranaki 2007-2011 - No. of Multipara Elective LSCS by ethnicity
120
100
80
60
40
20
0
2007
2008
2009
2010
2011
Asian
European
Maori
MELAA
Pacific Peoples

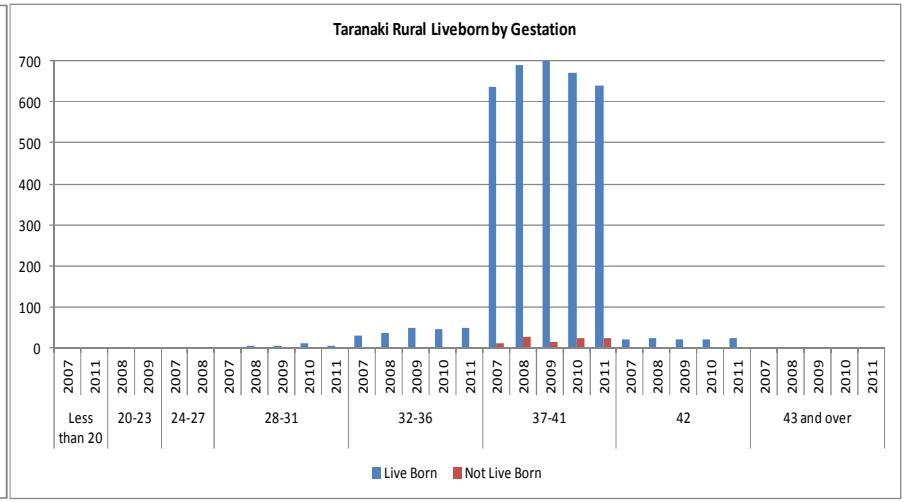

Taranaki 2011 - No. of Primi Elective LSCS by European Rural/ Urban Age Groups
5
4
3
2
1
0
20-24
25-29
30-34
35-39
Urban
Rural

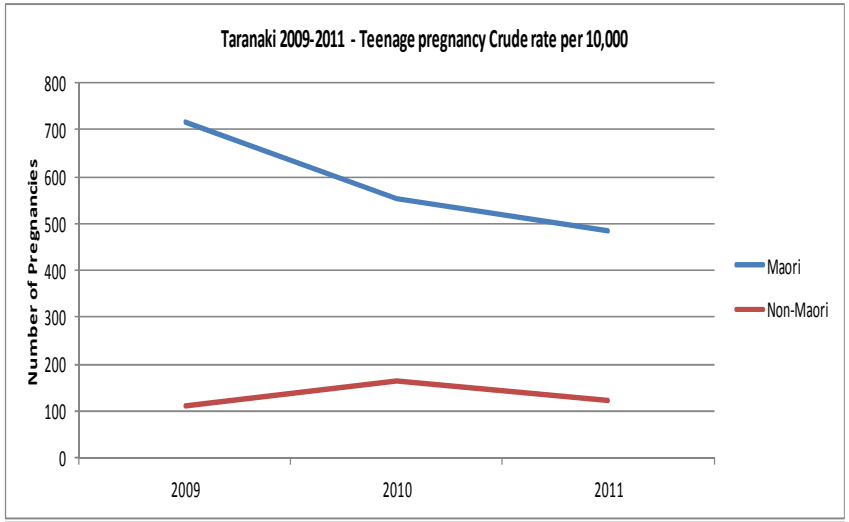

Taranaki High Birthweight Urban and Rural Births Rate per 10,000, 2009-11
500
450
400
350
300
250
200
150
100
50
0
2009
2010
2011
Urban Rate Avge. 279
Rural Rate Avge. 381

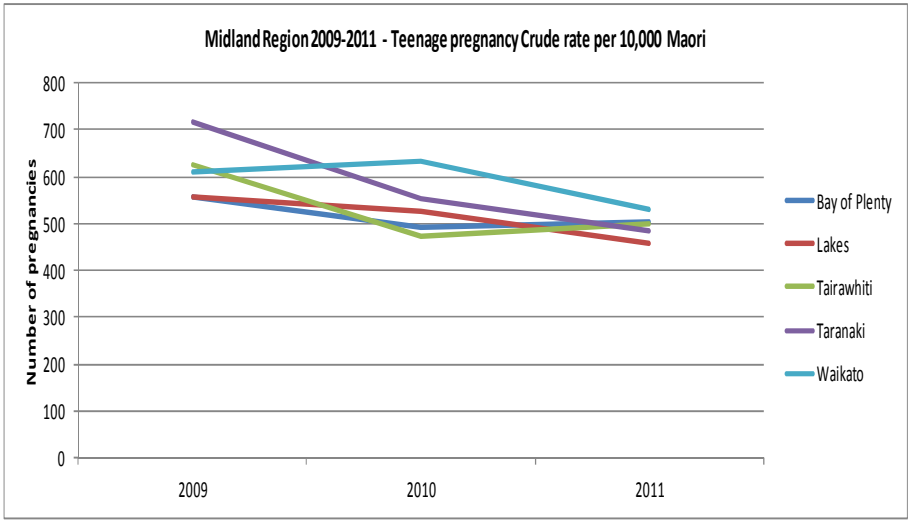

Midlands High Birthweight Urban and Rural Births Rate per 10,000, 2009-11
350
300
250
200
150
100
50
0
2009
2010
2011
Urban Rate Avge. 250
Rural Rate Avge. 278

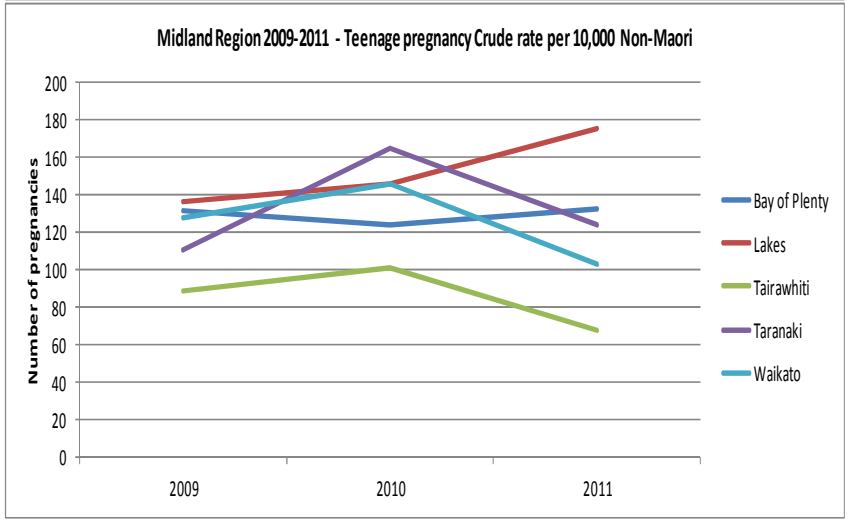

Taranaki Low Birthweight Urban and Rural Births Rate per 10,000, 2009-11
700
600
500
400
300
200
100
0
2009
2010
2011
Urban Rate Avge 512
Rural Rate Avge. 549


Midlands Low Birthweight Urban and Rural Births Rate per 10,000, 2009-11
680
660
640
620
600
580
560
540
520
500
2009
2010
2011
Urban Rate Avge 626
Rural Rate Avge. 581


Taranaki Rural Liveborn by Gestation
700
600
500
400
300
200
100
0
2007 2011 2008 2009 2007 2008 2007 2008 2009 2010 2011 2007 2008 2009 2010 2011 2007 2008 2009 2010 2011 2007 2008 2009 2010 2011 2007 2008 2009 2010 2011
Less than 20
20-23
24-27
28-31
32-36
37-41
42
43 and over
Live Born
Not Live Born


Taranaki 2009-2011 - Teenage pregnancy Crude rate per 10,000
Number of Pregnancies
800
700
600
500
400
300
200
100
0
2009
2010
2011
Maori
Non-Maori


Midland Region 2009-2011 - Teenage pregnancy Crude rate per 10,000 Maori
Number of pregnancies
800
700
600
500
400
300
200
100
0
2009
2010
2011
Bay of Plenty
Lakes
Tairawhiti
Taranaki
Waikato


Midland Region 2009-2011 - Teenage pregnancy Crude rate per 10,000 Non-Maori
Number of pregnancies
200
180
160
140
120
100
80
60
40
20
0
2009
2010
2011
Bay of Plenty
Lakes
Tairawhiti
Taranaki
Waikato

Data

- **proportion of women who register with an LMC**
- **proportion of women who register within each trimester** *(data to be made available by the Ministry of Health in early 2013)*

Number and percent of women registered with an LMC (under Section 88), where year of delivery is 2011, by DHB of domicile

	S88 LMC		No S88 LMC	
	Number	**Percentage**	**Number**	**Percentage**
Taranaki	1536	98%	33	2%
Total NZ	**53839**	**86%**	**8492**	**14%**

This data shows all women with a known birth in 2011, including women who registered with an LMC (funded under Section 88).

Number of Registrations with an LMC

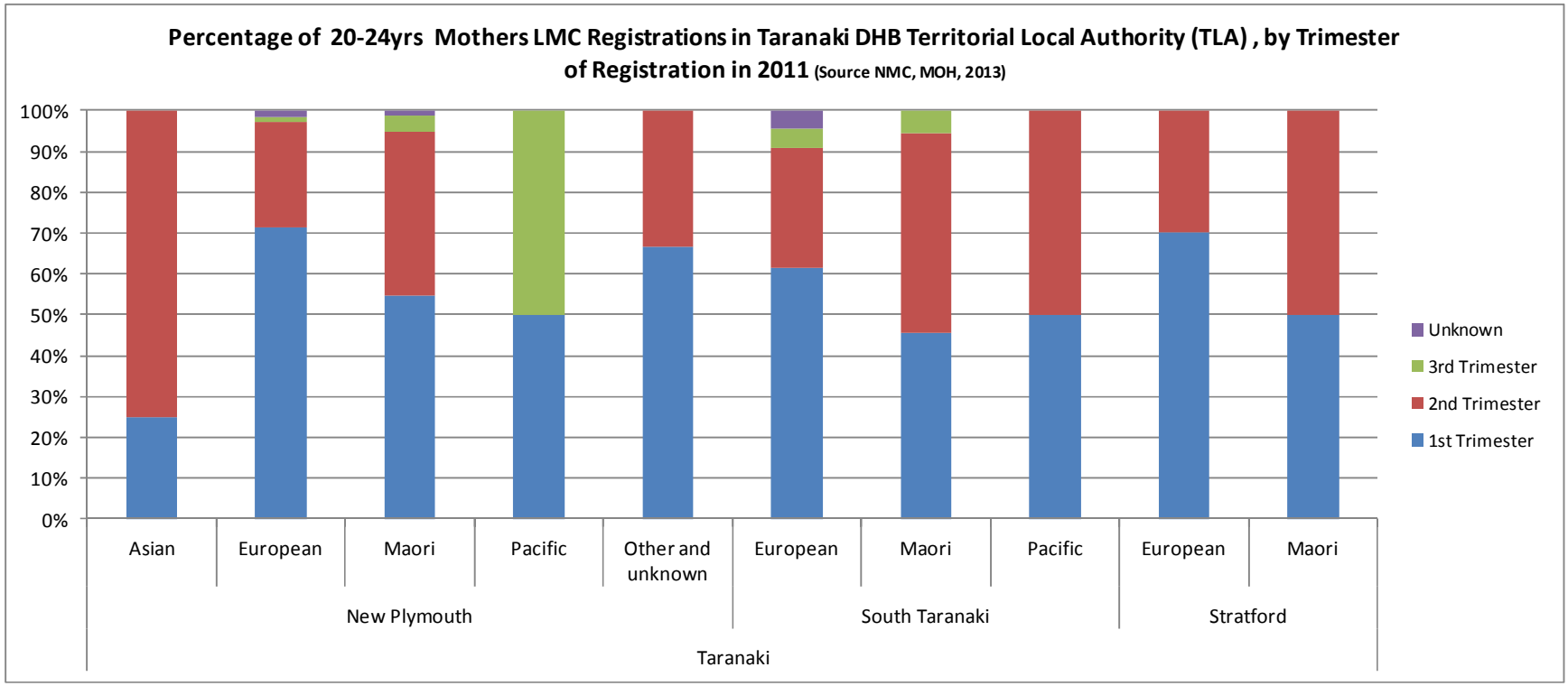
Number and percent of women registered with an LMC (under Section 88) by trimester of registration, where year of delivery is 2011, by DHB of domicile

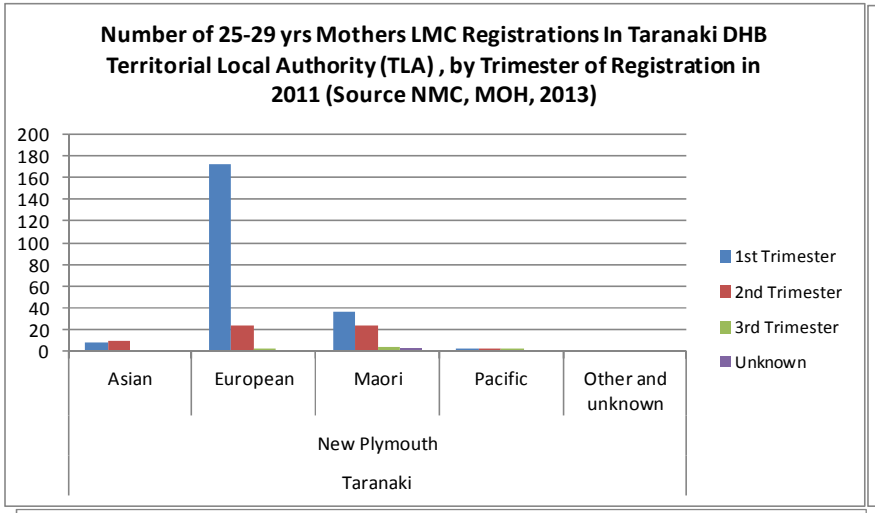
	First Trimester		Second Trimester		Third Trimester		Postnatal first LMC registration	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Taranaki	1076	70%	418	27%	41	3%	1	0%
Total NZ	33679	63%	17520	33%	2553	5%	77	0%

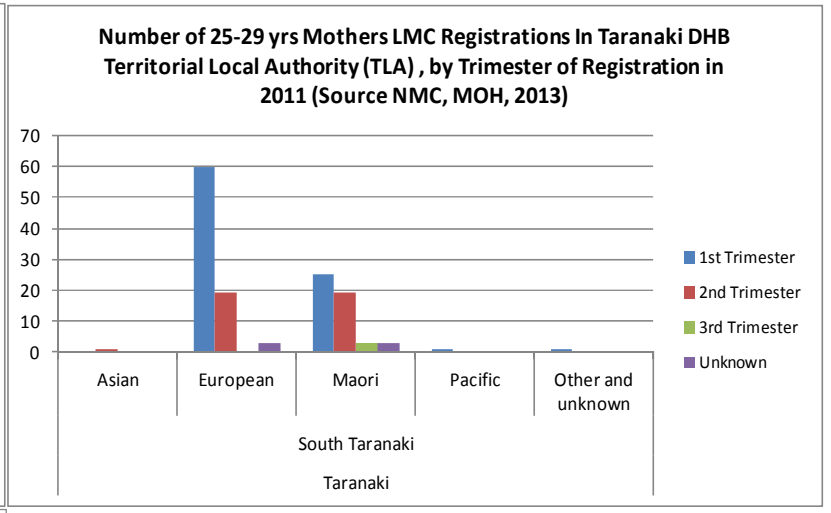
This data only presents women who have an LMC registration reported. Women who do not have an LMC funded under S88 are not included. Women who receive their primary maternity care from DHB funded maternity teams are not included, as DHB primary maternity care data is not currently collected by the Ministry

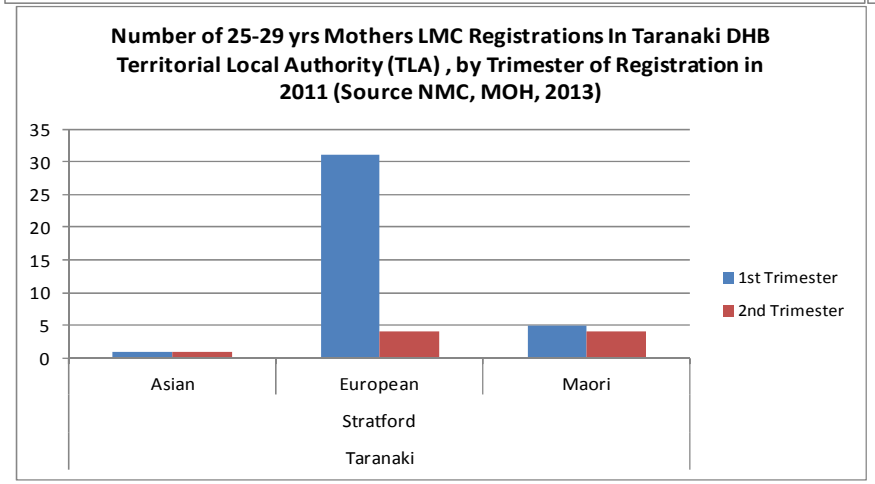
The Ministry is undertaking a project to collect and integrate DHB-funded primary maternity care information into the National Maternity Collection.
Data is expected to become available from mid 2013

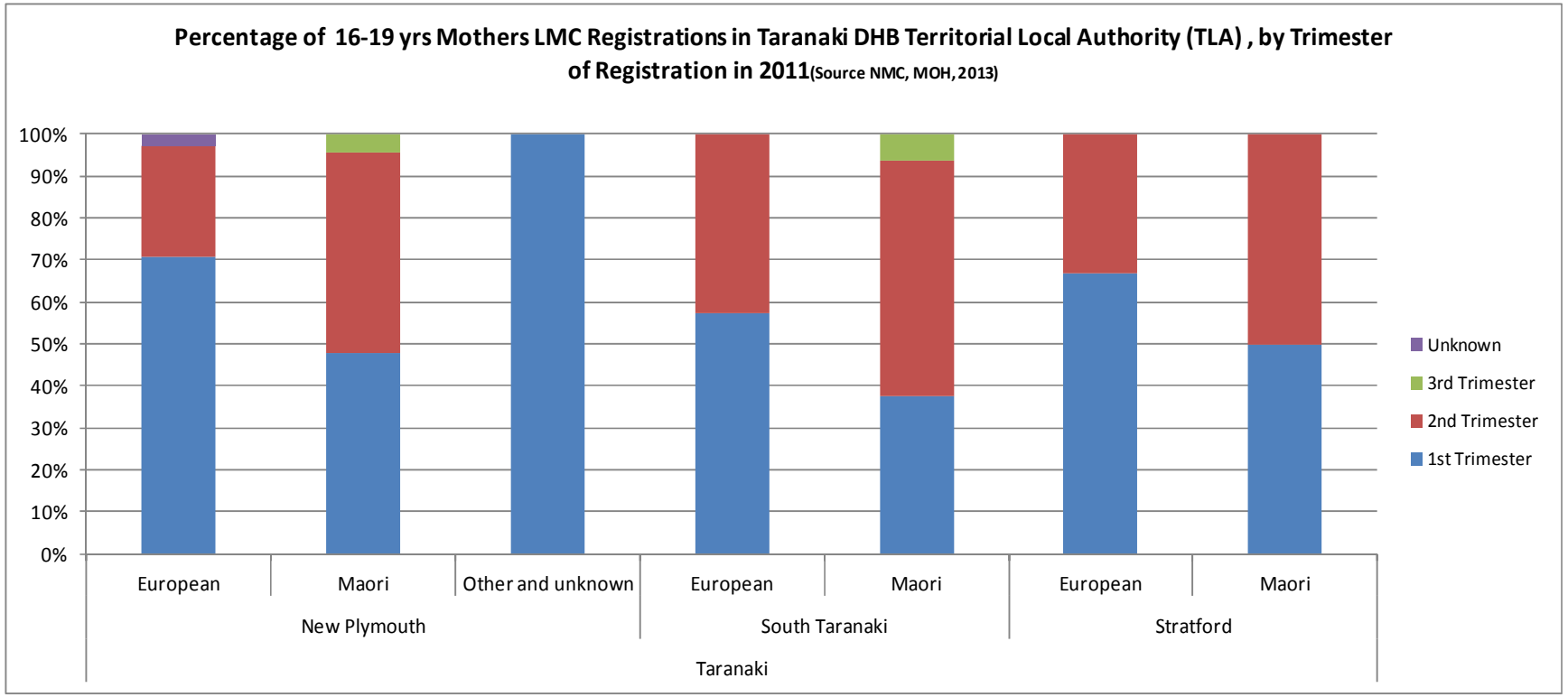
Source: National Maternity Collection, 2012

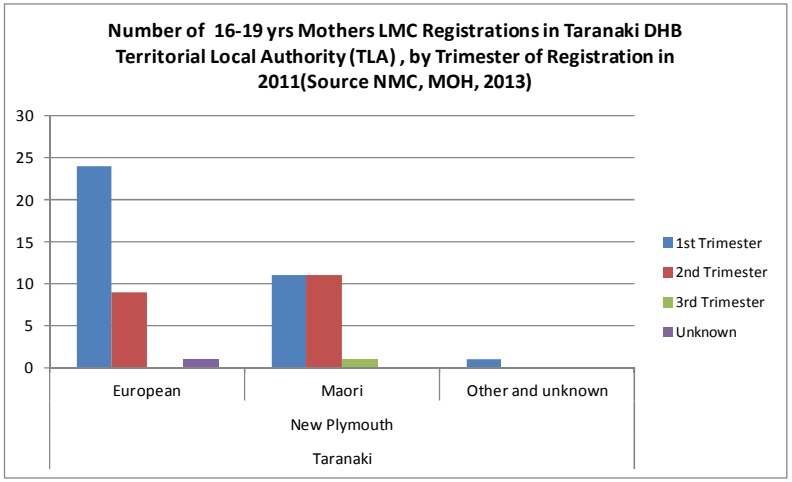

Percentage of 20-24yrs Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011 (Source NMC, MOH, 2013)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Asian
European
Maori
Pacific
Other and unknown
European
Maori
Pacific
European
Maori
New Plymouth
South Taranaki
Stratford
Taranaki
Unknown
3rd Trimester
2nd Trimester
1st Trimester


Number of 25-29 yrs Mothers LMC Registrations In Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011 (Source NMC, MOH, 2013)
200
180
160
140
120
100
80
60
40
20
0
Asian
European
Maori
Pacific
Other and unknown
New Plymouth
Taranaki
1st Trimester
2nd Trimester
3rd Trimester
Unknown


Number of 25-29 yrs Mothers LMC Registrations In Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011 (Source NMC, MOH, 2013)
70
60
50
40
30
20
10
0
Asian
European
Maori
Pacific
Other and unknown
South Taranaki
Taranaki
1st Trimester
2nd Trimester
3rd Trimester
Unknown


Number of 25-29 yrs Mothers LMC Registrations In Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011 (Source NMC, MOH, 2013)
35
30
25
20
15
10
5
0
Asian
European
Maori
Stratford
Taranaki
1st Trimester
2nd Trimester


Percentage of 16-19 yrs Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011(Source NMC, MOH, 2013)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
European
Maori
Other and unknown
European
Maori
European
Maori
New Plymouth
South Taranaki
Stratford
Taranaki
Unknown
3rd Trimester
2nd Trimester
1st Trimester


Number of 16-19 yrs Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011(Source NMC, MOH, 2013)
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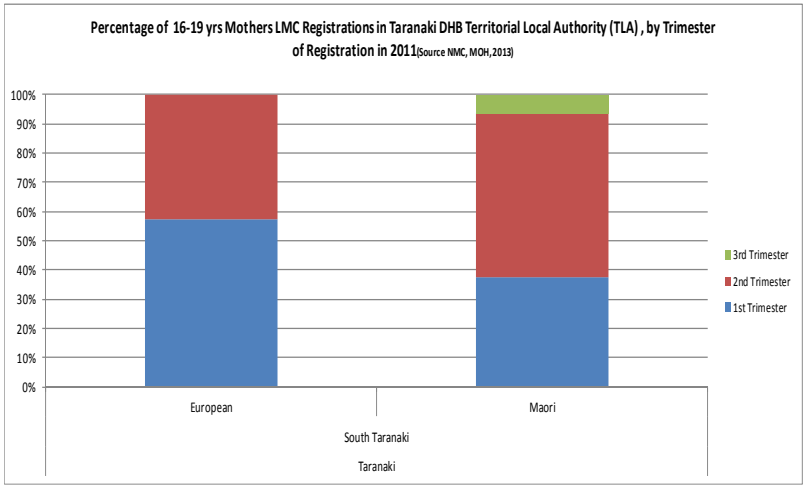
20
15
10
5
0
European
Maori
Other and unknown
New Plymouth
Taranaki
1st Trimester
2nd Trimester
3rd Trimester
Unknown


Percentage of 16-19 yrs Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011(Source NMC, MOH, 2013)
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10%
0%
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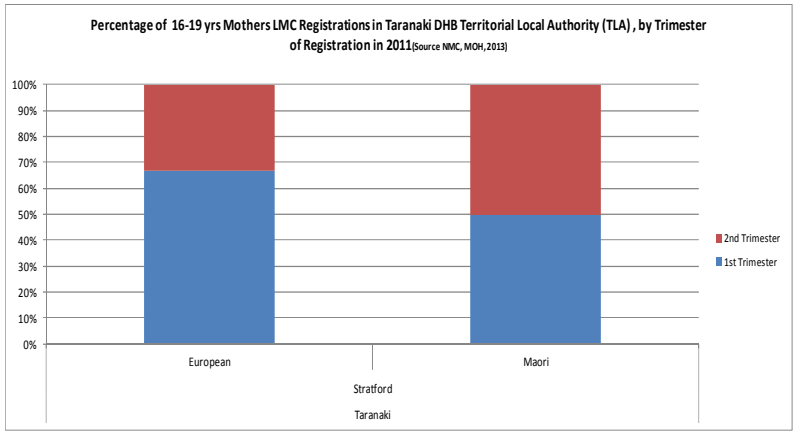
Maori
South Taranaki
Taranaki
3rd Trimester
2nd Trimester
1st Trimester


Percentage of 16-19 yrs Mothers LMC Registrations in Taranaki DHB Territorial Local Authority (TLA) , by Trimester of Registration in 2011(Source NMC, MOH, 2013)
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80%
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40%
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20%
10%
0%
European
Maori
Stratford
Taranaki
2nd Trimester
1st Trimester

Appendix 6: ***DRAFT Perinatal Mental Health TDHB: Local Referral Pathway October 2011***

All Health Professionals (midwife, Well Child Providers, social worker, psychologist, obstetrician etc) assessing a **woman during pregnancy and up to 1 year postnatally** have the **opportunity for screening for perinatal mental health problems.** This should occur at least once in the ante and post-natal periods, preferably twice.

Inform women re: screening for emotional difficulties
Ask them to complete the attached Questionnaire
- **Edinburgh Postnatal Depression Scale**
- **BeyondBlue Psychosocial Assessment**

→ Score EPDS
Further enquiry re:
Psychosocial factors.
Would you like help?

→ Score 1-3 on Q10- **Assess Safety** (see form)
10-12: Repeat in 2 weeks, support, advise GP
>12: **Refer GP for further assessment**
Psychosocial Factors: **Identify agency & refer**

→ Barrier to seeing GP?

→ Clinical judgement & score > 14 or risk factors **Refer PMH & send a copy of referral to GP**

Further assessment of mother and infant by GP **Ensure communication is empathic, woman & family- centred, non-directive**

Clinical Assessment-
As above plus symptoms of mood disorder, anxiety, PTSD, Eating disorder, psychoses, bipolar disorder, personality

→ **Investigate**
FBC, U/E, LFT, TSH, Calcium B12/folate, Glucose, ? ECG

→ **Exclude or Treat**
Anaemia, thyroid dysfunction,, metabolic disorder, Vitamin deficiency, Viral infections

→ **Further Assess**
Repeat EPDS
Mother-infant interaction

Provisional Diagnosis based on clinical judgement, psychosocial assessment and EPDS

Psychosocial risk factors or concern re: mother-infant interaction EPDS < 10	**Mild depression and /or anxiety** EPDS 10-12 Repeat in 2-4 weeks	**Moderate depression /and or anxiety disorder** (Q 3-5 EPDS-anxiety)	**Currently mentally well but history of SMI or already taking psychotropic medication**	**Moderate-Severe mental illness (SMI),Treatment resistant depression, bipolar disorder, psychoses; Risk of harm to self , infant or others** (>14 EPDS & Q10)	**Psychoses or immediate risk of harm to self infant or others**
Management Plan	**(women's preferences considered)**		**Referral Guide**	**Coordinated care & Interprofessional communication**	
Reassurance, Lifestyle Advice & Monitor Psycho-education, Exercise (green prescription), Sleep; Nutrition; Smoking (NRT); Relaxation, mindfulness, stress reduction; positive activities; mood diary; contraception Referral other agencies for parenting, relationship counselling or support (See resource list); A&D Postnatal Support Group	**Reassurance, lifestyle advice PLUS Psychological Therapy & monitoring** Engage partner (assess depressed?) and /or family support Web-based CBT- (resource list) Refer Taranaki Primary Connections or Private Therapist (See list) for Evidence –based talking therapies: Brief Problem Solving Therapy Non directive counselling Cognitive behaviour therapy Interpersonal Therapy		**Psychotropic medication** requires discussion of individual risks & benefits during pregnancy & breastfeeding. www.mothersmatter.co.nz See attached prescribing guide. SSRI's usually first line.	**Referral to Perinatal Mental Health (PMH)** See pamphlet mentalhealth.referrals@tdhb.org.nz Assessment & treatment by multi-disciplinary team including access to kaupapa maori services; Birthing, risk & relapse management plans. Coordination & referral to other agencies, family & case meetings Adjustment to Parenting Group.	(Consider Police or CYFS if risks) **Crisis Team or E.D. referral** Tel: 753 6139 **Urgent psychiatric assessment & In-patient Treatment** (Start Mental Health Act if required)

E-mail consult :Attn: Psychiatrist Advice
mentalhealth.referrals@tdhb.org.nz
Re: Psychotropic prescribing during pregnancy or lactation.

Pre-conception psychotropic advice by consult or referral

References

Austin M-P, Highet N & the Guidelines Expert Advisory Committee (2011) Clinical Practice guidelines for depression and related disorders-anxiety, bipolar disorder & puerperal psychosis –in the perinatal period, A guideline for primary care health professionals. Melbourne: Beyond Blue: the national depression initiative; NZGG (2008) Identification of common mental disorders and management of depression in Primary Care, Evidence-based best practice guideline; NICE (2007) guideline on clinical management and service guidance antenatal and postnatal mental health, British Psychological Society & Royal College of Psychiatrists