HUTTmaternity

Hutt Valley Maternity Care

Maternity Services Annual Clinical Report 2015

www.huttmaternity.org.nz

HUTT VALLEY DHB

We would like to acknowledge the contribution of:

- Chris Mallon, Director of Midwifery
- Debra Betts, Acupuncturist
- Elle Ratcliffe, Admin Support, MQSP
- HVDHB Primary & Community Midwives Team
- HVDHB Lactation Consultant Services
- Jamie Lowe, CYF Liaison
- Jo McMullan, Clinical Midwifery Manager
- Julia Small, National Immunisation Register
- Kerry List, Midwife, Smoke Free Working Group
- Kylie Bolland, Audiologist
- Marlene Beasley, Social Worker
- Maternity Clinical Governance Group
- Meera Sood, Clinical Head of Department, Obstetrics and Gynaecology
- Nicky Jackson, BirthEd
- Nicola Giblett, MQSP Co-ordinator
- Rachel Monerasinghe, Midwife
- Sandra Hoggarth, Newborn Hearing Screening
- Sharon Morse, Business Information Analyst, HVDHB
- Stephen Vega, Smoke free DHB Coordinator
- Violence Intervention Programme Team

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Message from Maternity

The DHB is delighted with the on-going support from the Ministry of Health for the Maternity Quality and Safety Programme. It ensures dedicated focus on quality improvement in the service. It is with this focus that we have been able to embed some of our QSP initiatives as business as usual, including the Shaken Baby Prevention Programme, our annual 3DHB sub-regional Campaign (now in its 3rd year), the Huttmaternity Website and Facebook pages, our automated Birth Deaths Marriages Notification process, integration of the National Guidelines for diabetes and our Trigger event reporting.

It has been a great year with lots of positive movement on our MQSP plans especially with the improvement in early registration with an LMC. Integration with our primary interface has been augmented with the Huttmaternity Expo but we continue on engagement with primary practices.

We are pleased to see the increase in normal vaginal birth rate, with Huttmaternity the 4th highest in the country.

The unit was visited by RANZCOG earlier this year and the department was given a further 4 years of approval for training of Second Year Intern Training Post (ITP). The emphasis on teaching in the unit and the relationship between medical, midwifery and nursing staff was commended.

The momentum from the successes in our programme for 2015 gives us incentive to continue to improve.

Chris Mallon, Director Of Midwifery

Jo McMullan, Clinical Midwifery Manager

Dr Meera Sood, Clinical Head of Department, Obstetrics and Gynaecology

Sarah Boyes, Director of Operations, Surgical, Women's and Children's Directorate (Absent)

Hutt Valley DHB Vision, Mission and Values

Our Vision

Whānau Ora ki Te Awakairangi

Healthy people, healthy families and healthy communities.

Our Mission

Working together for health and well-being

We commit to work cooperatively, as an active part of the health sector and the Hutt Valley community.

Our Values

'Can do' - leading, innovating and acting courageously

Hutt Valley DHB leads the New Zealand health sector. We are committed to quality and innovating to improve the health of our people.

Working together with passion, energy and commitment

We are passionate about our work. We direct our energy to doing the best for our clients and the community.

Trust through openness, honesty, respect and integrity

We regard trust as essential to success. The people we serve must have confidence in us. We are open, honest, and respectful. We act with integrity.

Striving for excellence

We aim for excellence, individually and as an organisation. This commitment defines us, the services we provide, the way we work with each other and how we shape our systems.

Huttmaternity Vision

Everyday we come to work and
remind ourselves what is really important in life:

healthy babies
healthy mothers
healthy families
healthy communities

We help to create new families and the best
start for the next generation of New Zealanders.

HUTTmaternity
Hutt Valley Maternity Care

Ia rangi haere ai tātou ki te mahi me te whakamahara ki
a tātou anō he aha te mea hira rawa o tēnei ao

He kōhungahunga hauora

He kōkā hauora

He whānau hauora

He hāpori hauora

Ko ta mātou mahi, he āwhina kia waihanga whānau
hou me te whakarite tīmatanga tino pai rawa atu mā te
reanga kei Aotearoa e haere ake nei.

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Contents

Executive Summary

It is a privilege to present our fourth Maternity Services annual Clinical report which outlines how we have risen to the challenge of maternity quality and safety, and the work streams undertaken in the 2015 year within the suggested seven elements. Each year we redefine and expand the information we report on to demonstrate an ever improving service. A culture is depicted that supports health improvement through strong clinical leadership, a women centered focus and regional collaboration.

2014-2015 have seen great changes and developments in Hutt DHB. Ashley Bloomfield was appointed our new CEO in August 2015. There was also the appointment of a Director of Midwifery, Chris Mallon, whose role covers both the Hutt and Wairarapa DHBs. There is an understanding that both these positions will both fully support the work streams and understand the value of our strong MQSP in the Hutt Valley.

In 2015 we moved forward with several work streams reflecting localized needs and with consideration to the priorities and recommendation from both the National Maternity Monitoring Group (NMMG) and the Perinatal and Maternal Mortality review committee (PMMRC).

MQSP is well embedded into the Hutt DHB and is working towards being 'business as usual' but there is still work to do to keep this momentum going.

The MQSP requires involvement from all maternity stakeholders for effective communication, teamwork and robust data gathering.

The maternity unit has been steadily growing in business over the 2015 year and the implementation of a workload measurement tool - Trendcare has provided a source of information to all staff about the performance of the service during the year. While it has been difficult at times to add the data when the unit is very busy the staff have really worked hard and we are now seeing the benefits in the acuity being measured accurately, reflecting supply and demand of resources.

We look forward to continuing our positive, collaborative relationship with all our maternity providers and our consumers. As we all continue to work towards the betterment of maternity care for mothers, babies and families in our region.

Section One: About Hutt Valley District Health Board

Our Population

It is essential that we understand our population so that we can design and deliver the most appropriate services. Our DHB provides services for 138,370 people ('usually resident population') and covers two local authorities: Lower Hutt City (98,200), Upper Hutt City (40,180).

We have a diverse community; ethnicity is a strong indicator of need and demand for our health services, so we consider the unique health needs of different population groups in our planning for the future.

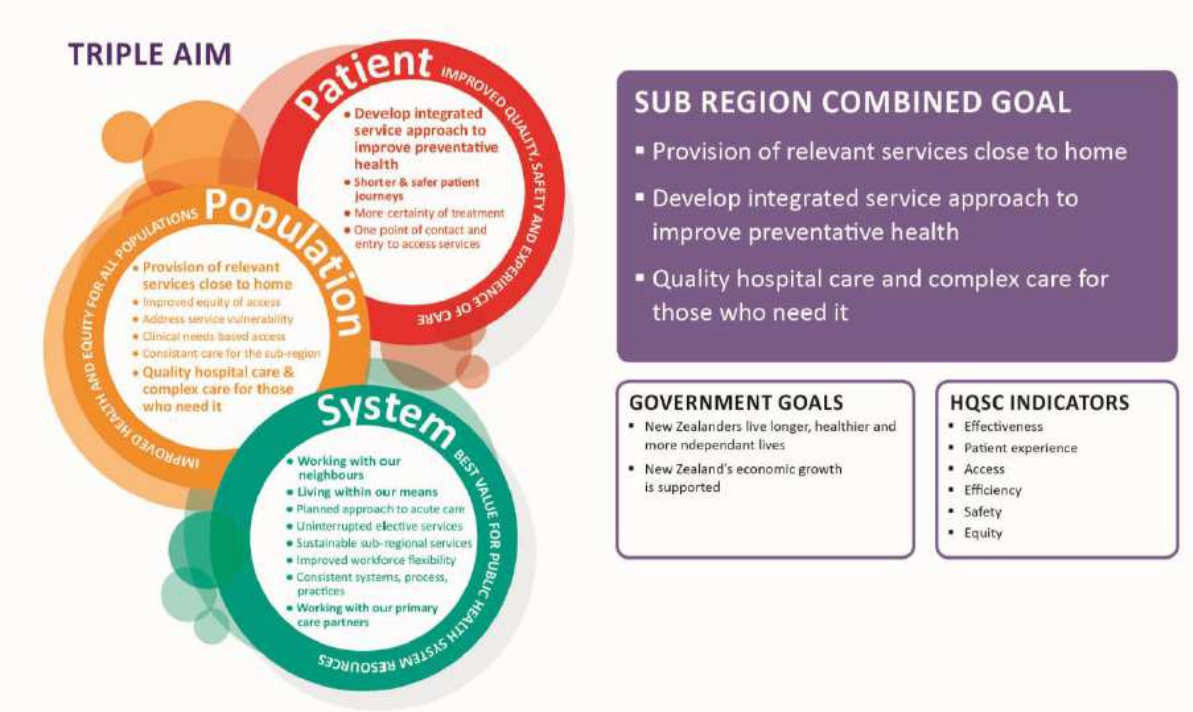
Reducing disparity based on ethnicity is essential for creating a fair health system. Seventeen percent of our population identify as Māori (24,060), and 7% identify as Pacific. Our Māori and Pacific populations are younger and have higher fertility rates.

Our local population is projected to increase by 3% (3,740 people) over the next ten years, which is largely driven by an increase in middle-aged and older people. By 2033 we anticipate that at least one in five people in the sub-region will be older than 65 years and the population over 85 will have doubled; at the same time, the number of children and young people will decline.

Quality - at the heart of what we do

We continue to strive for the highest quality health and wellbeing services for our local population. We develop, review, and update our plans under the lens of the 'Triple Aim' - an international healthcare improvement strategy that outlines a plan for better healthcare systems by pursuing three aims: improving patients' experience of care, improving the overall health of a population, and reducing the per-capita cost of health care. Integration enables delivery of each of these aims. In New Zealand this policy has been adapted by the Health Quality & Safety Commission, who works alongside District Health Boards to support us in maintaining a strong quality improvement focus.

We have a strong, positive culture of continuously improving the quality and safety of the services we provide. Our quality goals are underpinned by working together at all levels of our DHB to achieve patient centred care, openness and transparency, learning from error or harm and ensuring that the contributions of staff for quality improvement and innovation are truly valued. Our clinical and corporate governance framework ensures that systems are in place to guarantee the Board, clinicians, and managers share responsibility, and are held accountable, for patient care and minimising risks whilst continuously monitoring and improving the quality of clinical care. Working together with our neighbouring DHBs is important to protect and develop the quality and safety of our services.



We would like to acknowledge the above information has been sourced from the Hutt Valley DHB Annual Plan 2015-16

Full copies of the Hutt Valley DHB Annual Plan 2015-16, can be found at http://www.huttvalleydhb.org.nz/content/286a32c2-bcfb-4cb8-bdd3-0b0c2e268040.html

Section Two: Maternity Service Configuration and Facilities

Maternity Services

The Hutt Valley DHB is the only birthing facility in the Hutt Valley and provides both primary and secondary care facilities for a largely urban population of 138,370. Hutt Valley DHB supports approximately 1850 births per year. Our birthing population consists of NZ European 55%, Maori 20%, Asian 8%, Pacific Island 10% and Indian 5%.

Whilst there has been a general downward trend in birth numbers over the last four years, HVDHB has had a slight increase in the 2015 year. There has also been a slight increase in the number of non-delivery assessments the Birthing Suite.

Our Services include our Birthing Suite, Antenatal & Postnatal Ward, and a Maternity Assessment Unit.

Table 1: Births in New Zealand and Hutt Valley DHB Facility

	2011	2012	2013	2014	2015
Births in NZ (NZ Statistics)	61,923	61,178	58,717	57,242	Not avail
Births at Hutt Valley DHB	1,969	1,982	1,850	1791	1856
% of all NZ births in Hutt	3.1%	3.2%	3.1%	3.1%	Not avail

LMC providers

In the DHB Region primary maternity care is provided by LMC midwives and private obstetricians who have an access agreement to use the facilities. For women unable to access the services of an LMC midwife, the DHB Hutt maternity midwifery team provide this service. (There are no GPs practicing obstetrics in the Hutt Valley).

LMC midwives: The DHB fluctuate between 40-50 LMC midwives, currently there are 46 community-based case loading midwives with primary access agreements providing lead maternity care.

LMC private obstetricians: There are three LMC obstetricians (two of whom are also employed by the DHB). For women who choose a private obstetrician as their lead maternity carer, midwifery care is subcontracted either by the hospital and / or community based midwives, or by private arrangement with LMC midwives.

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

Workforce

An increasing number of midwives working within the DHB have previously worked in LMC practice and vice versa. This creates an appreciation with each others roles and assists with integrating community based LMCs into hospital based clinical reviews and other quality processes.

The maternity service includes the following clinical staff:

- Director of Operations, Surgical Women's and Children's
- Clinical Head of Department, O&G
- Director of Midwifery (DOM)
- Clinical Midwifery Manager (CMM)
- Associate Clinical Midwifery Manager (ACMM)
- Midwifery Educator
- Lactation Specialists (Two)
- Obstetric and Gynaecology consultants (Six), Registrars (Six with one being an ITP training post), House Surgeon (one), Senior House Surgeon (One), trainee interns on rotation and medical students
- A core DHB employed team of approximately 40 midwives, registered nurse, enrolled nurses and healthcare assistants
- Midwifery students on rotation

The DHB Operations Centre was established in 2013 and introduced Trendcare into the organization. Maternity was incorporated into Trend Care at the end of 2014. These tools will provide better utilization of workforce and bed management across the DHB.

Trendcare: Trendcare is slowly becoming part of business as usual and staff have worked hard to capture all the work they do, especially when flat tack. Once we have 6 months of clean data we will be able to look at how the staffing meets demand with the view to roster re-engineering.

Birthing Suite

Birthing Suite consists of eight birthing rooms and an acute assessment room. Each birthing room is fully equipped for labour and birth, including a neonatal resuscitation station and private bathroom facilities. The rooms have a large deep corner bath for water births.

Birthing suite is staffed by core midwives providing midwifery care for DHB primary and secondary care women, as well as those women under a private LMC obstetrician. The midwives provide emergency care 24 hours a day, 7 days a week and support LMC midwives as required. Medical staff, consisting of a consultant obstetrician, senior registrar or senior house officer are rostered to cover an on call system 24 hours a day.

Table 2: Births at Hutt Valley DHB Facility

	2011	2012	2013	2014	2015
Single Liveborn	1923	1943	1813	1752	1823
Single Stillborn	16	11	12	12	13
Twin Liveborn	29	28	25	27	20
Total births at facility	1968	1982	1850	1791	1856

Figure 1: Maternity Ward and Birthing Suite Obstetric Assessments and Birth Events

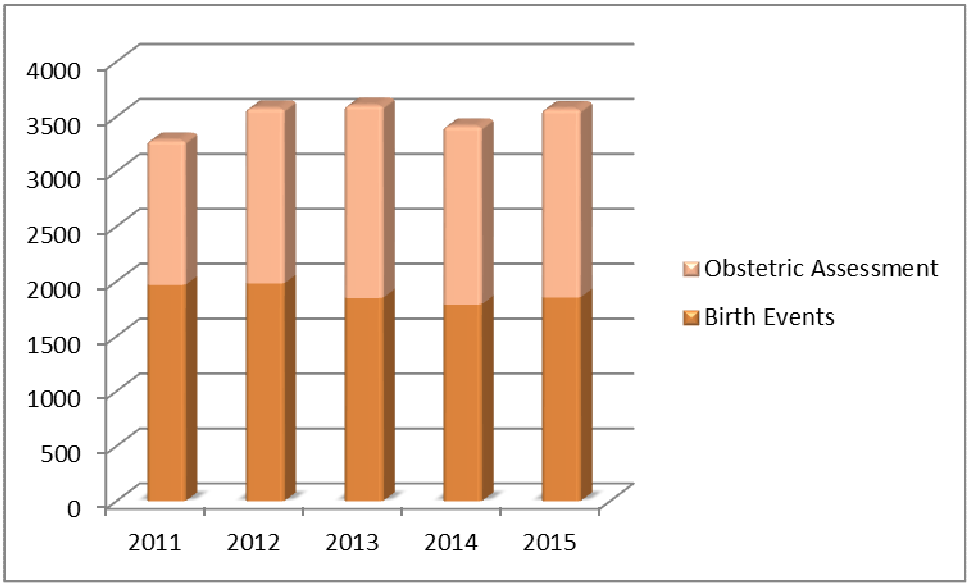


Table 3: Birthing Suite Events by Type

	2011	2012	2013	2014	2015
Birth Events	1969	1982	1850	1791	1856
Obstetric Assessment	1316	1596	1754	1624	1717

Obstetric Assessments are acute, non-delivery assessments in pregnancy, undertaken within the birthing unit environment. (These figures exclude obstetric assessments undertaken in the Maternity Assessment Unit on the ground floor).

The follow tables / figures demonstrate Births Events in Hutt Valley Facilities by: Parity, Age, and Ethnicity

Our analysis of the following data by Parity, Age and Ethnicity show little change in the demographic of birthing population at HVDHB. There has been a small decrease in the birth rate of women between 20-24 years of age.

Figure 2: Births in Hutt Valley DHB Facility by Parity

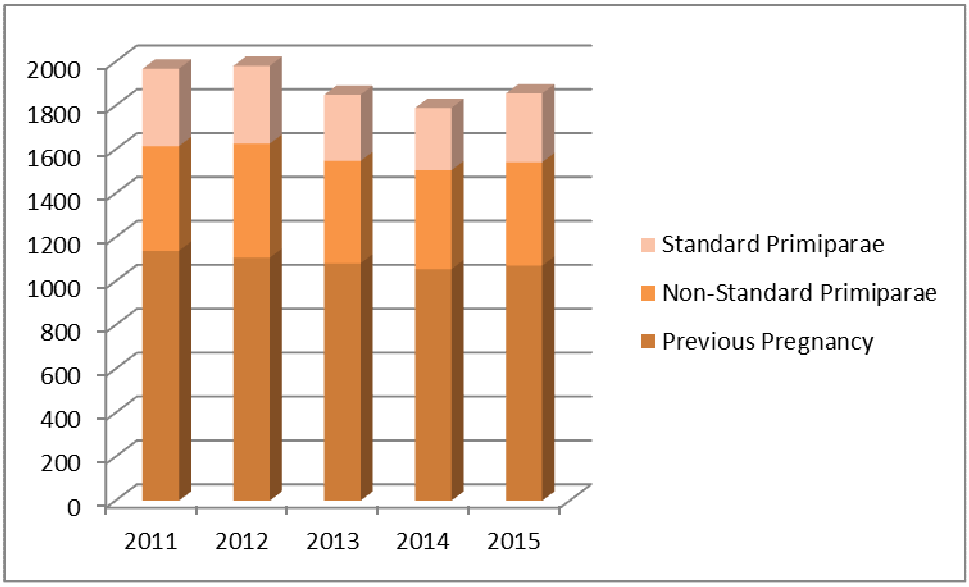


Table 4: Births by Parity type at Hutt Valley DHB Facility

	2011	2012	2013	2014	2015
Previous Pregnancy	1139	1107	1082	1055	1071
Non-Standard Primiparae	477	520	466	451	472
Standard Primiparae	353	355	302	284	313
Total	**1969**	**1982**	**1850**	**1790**	**1856**

"From the time I made it into the Delivery Suite just to get checked out if I was in labour until going home four days later, we had a great experience from all the team involved. From N, our midwife throughout the birth, to B our Anaesthetist who did a great job talking me through what was a strange and sometimes discomforting experience, everyone was very supportive and left me confident we were in good hands"

Figure 3: Birth Events by Maternal Age

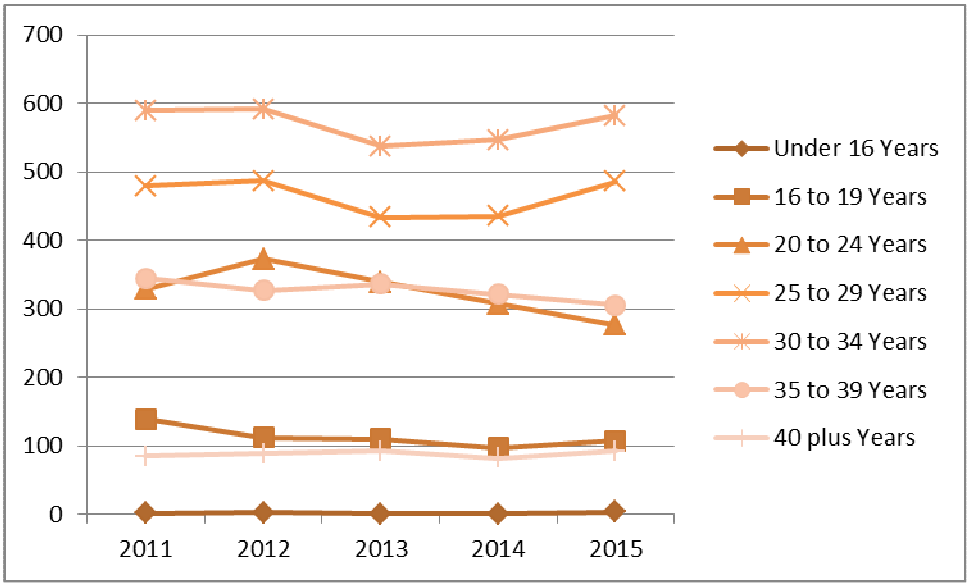
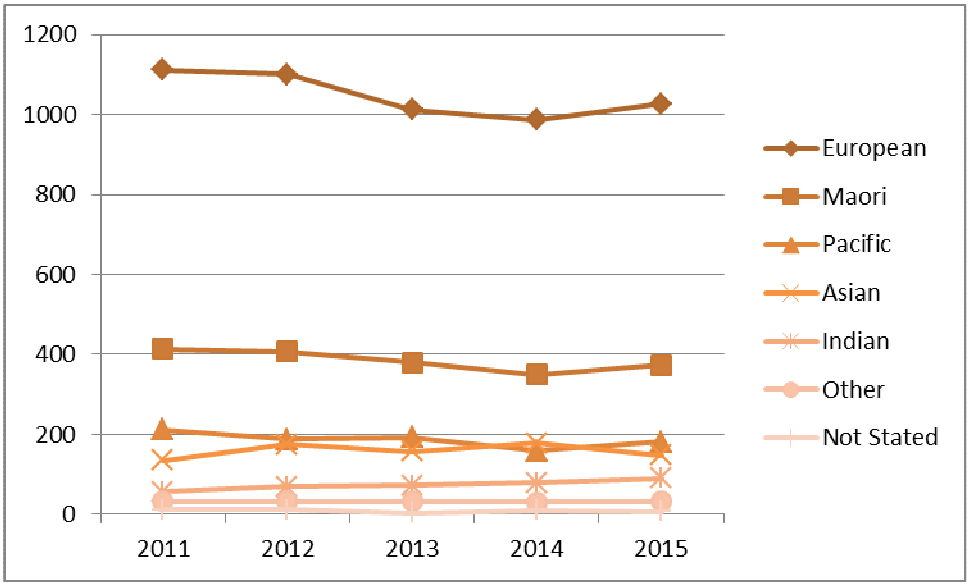


Figure 4: Birth Events by Ethnicity



Maternity Ward

The maternity ward is made up of 13 single rooms and, two double rooms with shared ensuite facilities (an additional four bed spaces can be utilized when the need arises).

Our ward caters for both antenatal and postnatal inpatients as well as provides rooms (if available) for women 'rooming in' with babies in the Special Care Baby Unit (SCBU). The ward is staffed by midwives with assistance from nurses and Health Care Assistants.

Maternity Assessment Unit (MAU)

MAU is an acute assessment area, open Monday to Friday, and works as an outpatient facility. The unit is easily accessible to women and their families and is located on the Ground Floor in the main foyer of the Hospital. It is close to both the Radiology and Laboratory departments. The facility is utilised by community based LMCs and women under DHB maternity care (Primary and Secondary). Women requiring inpatient care are transferred to birthing suite or the ward. The unit incorporates the Secondary Care Obstetric Clinics, Obstetric Assessments and an Early Pregnancy Assessment Clinic (EPAC).

Figure 5: Maternity Assessment Unit (MAU) Total Events

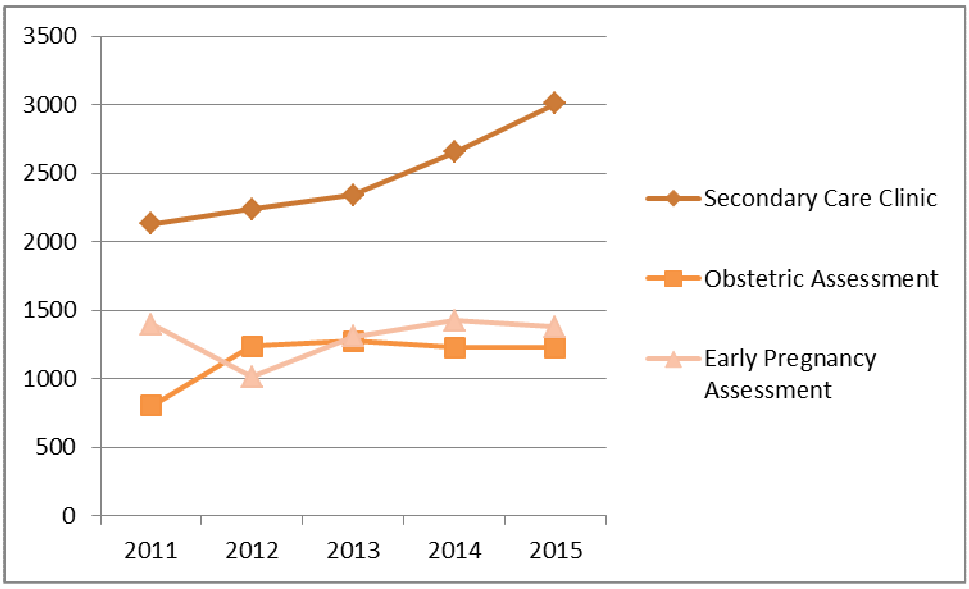


Table 5: Maternity Assessment Unit (MAU) Events

	2011	2012	2013	2014	2015
Secondary Care Clinic	2130	2240	2342	2652	3010
Obstetric Assessment	805	1236	1277	1229	1228
Early Pregnancy Assessment	1399	1014	1309	1424	1377

There are three main work streams in MAU covering the following streams, but assessment of women with post natal complications such as wound infections and endometritis also occurs in MAU. They are included in the assessment numbers above.

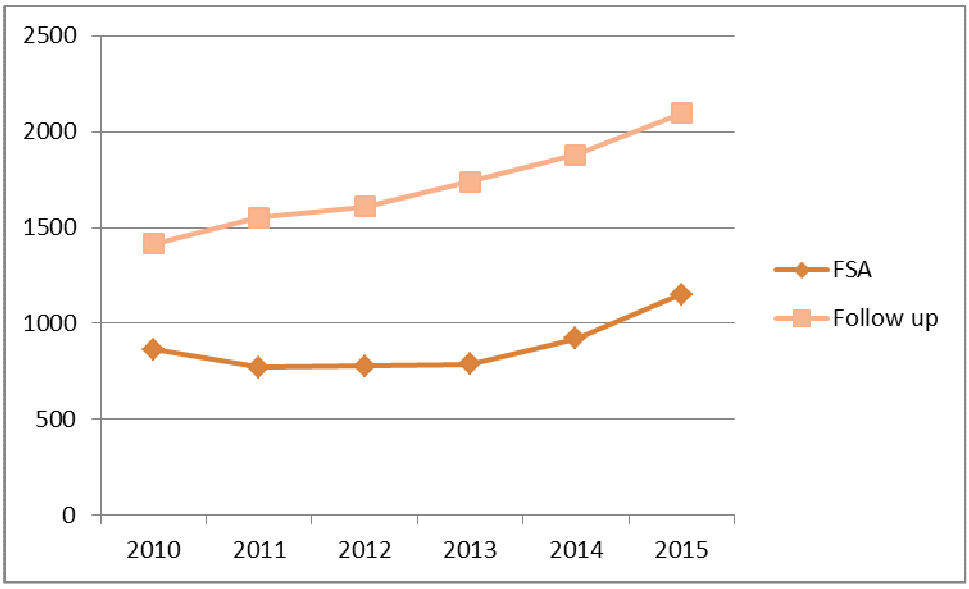
Obstetric Assessments in the MAU include acute assessments of women who are stable enough to be seen in an outpatient setting. Those that required assessment outside of MAU hours or need a higher level of care are assessed in the Maternity Unit on level 2 and are included in the Figure 1 statistics. Examples of this include women with pre eclampsia for day case assessment, women with reduced fetal movements, or those requiring Anti D administration etc.

Early Pregnancy Assessments include women experiencing pain and/or bleeding in early pregnancy who are seen for assessment and management, less than 20 weeks gestation.

Secondary Care Clinic episodes refer to women seen by an Obstetrician at the Obstetric Clinic in MAU. These women have been referred under the Guidelines for Referral and Consultation (2012) for an obstetric opinion.

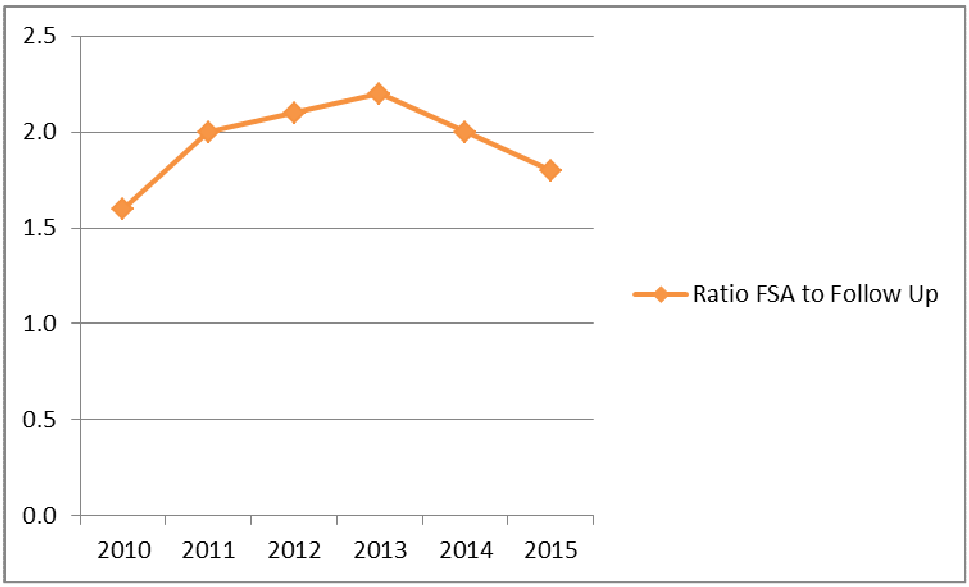
There is over the last 5 years been a significant increase in referrals to the Secondary Care Clinic. In response to this we have had in increase in Obstetric SMO adhoc clinics and locum cover for Annual leave. We have plans to localise the Waitemata RefPLUS document to assist with timely and appropriate referrals. This is outlined in further detail in section 4.

Figure 6: Secondary Care Obstetric Clinic FSA and Follow Up Events



Note: FSA = First Specialist Assessment (new referral)

Figure 7: Ratio of FSA to Follow up Assessments for Secondary Care Obstetric Clinic



Both the number of First Specialist Assessment (FSA) and Follow Up assessments has been increasing. But the ratio of FSA to Follow Up has decreased. This means we are seeing more woman, but for less number of visits, and is a reflection of the increased morbidity in our population and appropriate management of secondary care referrals.

"I would like to thank all the wonderful staff who has been so supportive and helpful with us during our staying at the Maternity Unit. We have had a lot of help since our baby girl D was born, from everyone at the surgery Admission Unit to each person who works here in the Maternity floor during the three turns; morning, afternoon and evening. I only want to say THANKS A LOT for your valuable time and help"

Overall Service Workload

The following tables demonstrate the overall workload across the Maternity Ward, Birthing Unit and the Maternity Assessment Unit. Since 2011 the birth number had fallen to last year's nadir of 1791. However there seems to be an increase in the birth numbers which is predicted to return to 2000 in the next few years. The demand in the secondary care clinics suggests an increasing rate of complexity.

Figure 8: Total Maternity Services Events

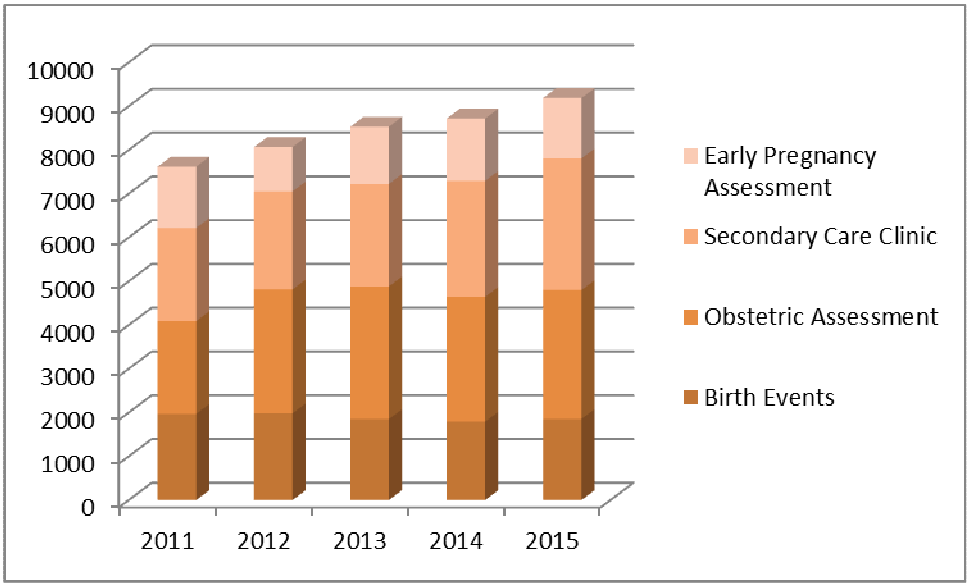
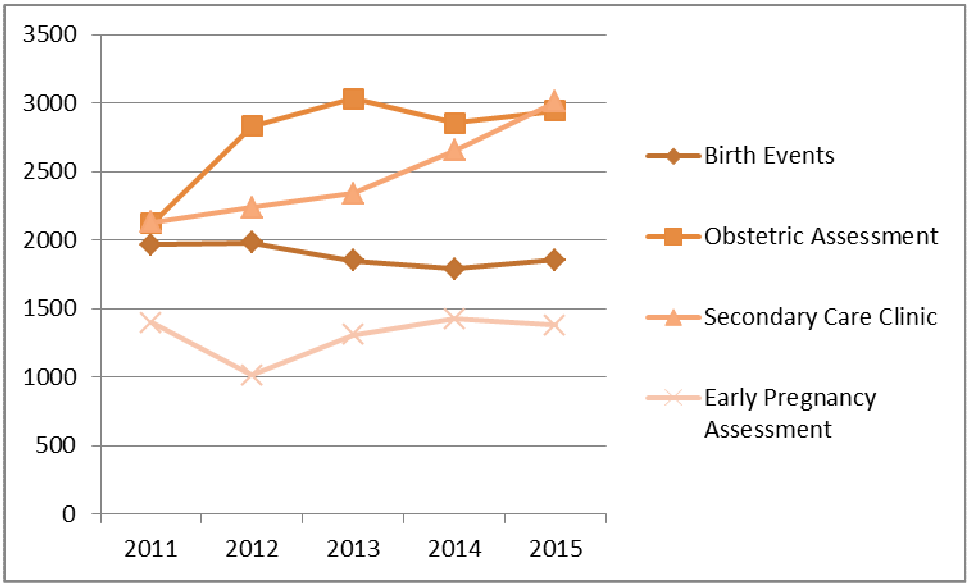


Table 6: Maternity Services Events by type



HuttMaternity Midwifery Team (HVDHB)

Historically we have had a small team of community based midwives providing postnatal care for women with our Secondary Care Obstetric team as LMC or those women who have a private obstetrician LMC.

However in early 2002, in response to a fluctuating population and workforce needs in the community, our midwives team has evolved to include full primary maternity care. This is now a well established service, with many women choosing to return to our team for subsequent pregnancies. Initially this team worked in community based clinics in several locations across the valley, but are now home visit based. Labour care is coordinated by our birthing unit midwives. The team is referred to as our Community Midwives or our Primary Midwives Team (PMT).

Our client demographic:

Anecdotally the team feel their client base reflects a high proportion of the following groups, than is seen overall in the local population.

- There are no LMCs available
- Women choose HVDHB Midwives as LMC
- The family are not NZ residents
- English is a second language
- The woman is late booking
- There are complex social issues
- Teenagers
- Engaging with health care is an issue
- High needs women

Women who are under the clinical responsibility of the Secondary Care Obstetric Clinic are also referred to our PMT for primary midwifery input in their care if they do not have an LMC Midwife.

It is felt by the PMT that the numbers don't reflect the acuity of workload due to the high complexity and social needs of the women under the team. Without having supporting data the team feel they very rarely do less than 12 visits postnatally and spend an hour, or longer with women and their families at each visit.

This demographic also leads to an over utilisation of our resources assisting women and families to navigate their health needs. There is a large component of care coordination, linking with primary care, health promotion and sorting long term health needs.

Workload:

It is difficult to anticipate the work of the PMT, and the subsequent data gives an indication of the potential work loads across the year. This is partially due to the transient nature of the client base, and scenarios of partial care at some point in the women's journey.

The figures below give an indication of the number of women that are booked each month, that do not have an LMC Midwife. This includes women under the PMT, Secondary Care Team and Private Obstetricians. Our PMT will 'book' women under their care and that of the Secondary care team. The 3 Private Obstetricians have midwives subcontracted to undertake their 'bookings', but our PMT will back up these midwives when required. These are included in the "other" figure.

In saying we may or may not undertake the 'booking' appointment for women with a private obstetrician, we will uptake Post Natal care by our Primary Midwives Team for a significant portion of these women.

The pre-admissions (Booking) are based on the due date of the women, so there may be some cross over in the end / beginning of each year, again demonstrating the potential numbers of women that the community/primary team may be involved with for care.

There is also a fluidity of the population base between the 2 regional DHBs, HVDHB and CCDBH, and women who reside outside our DHB domicile. This means there is a fluctuating number of women who may commence care here, but end with another provider for part of care, or transfer into our services part way through their journey.

Table 7: Total Number of Hospital Bookings and Pre-Admissions by LMC type

	2011	2012	2013	2014	2015
Bookings Primary Midwives Team	134	70	51	51	51
Bookings Other (Private Obs, Secondary Care)	329	311	297	240	259
Number of Bookings TOTAL	463	381	348	291	310

Primary Midwives Team Preadmissions	98	66	54	40	40
Private Obs Patients Preadmissions	221	232	192	205	184
Secondary Care Preadmissions	55	68	80	60	47
Number of Preadmissions TOTAL	374	366	326	305	271

The following table demonstrates the actual visits by our Community / Primary Midwives Team. Antenatal Visits include full Primary Midwives Team LMC cases and Bookings. Prior to the private obstetricians subcontracting their bookings out, we also undertook and additional antenatal visit at 34 weeks for Private Obstetric women for on going birth planning. This will have been counted in the figures below and will account for the reduction in number of visits.

A point to note is that not all women continue care postnatally with the PMT. Some women move out of area, or are not within our catchment for postnatal care. This is anecdotally high with Private Obstetric LMC women. They may have gone to a private LMC Midwife especially if they live outside of the Community / Primary Midwives team catchment area, or been linked with Primary midwives teams in those areas.

Table 8: Total number of Primary Midwives Team Visits

	2011	2012	2013	2014	2015
Total number of Antenatal Visits	906	539	659	821	670
Post Natal Visits HVDHB	4632	2551	1770	1369	1313
Post Natal Visits Private Obs Pts		1269	1539	1446	1411
Total Community Midwives Events	5538	4359	3968	3636	3394

Figure 9: Total number of Primary Midwives Team Visits

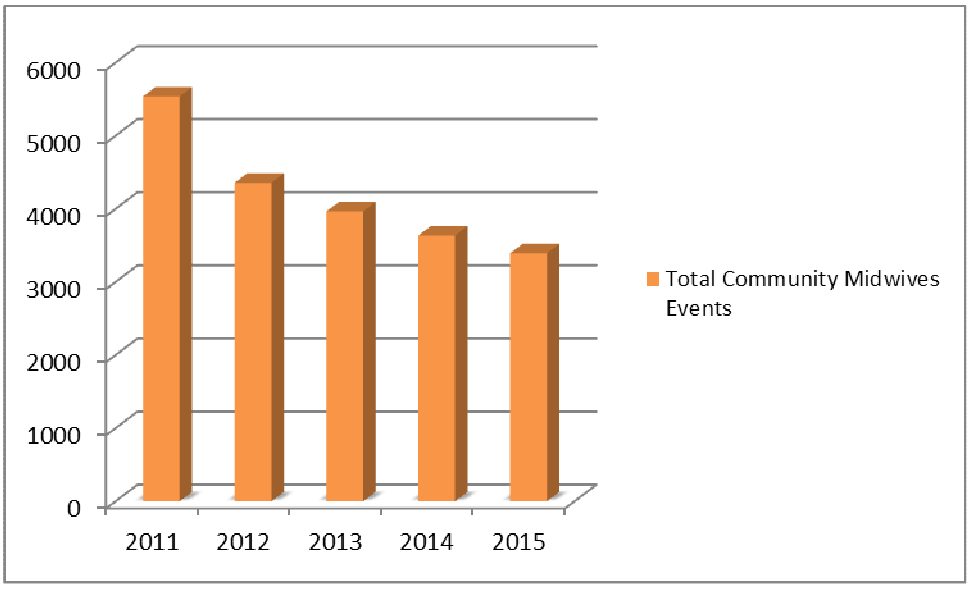
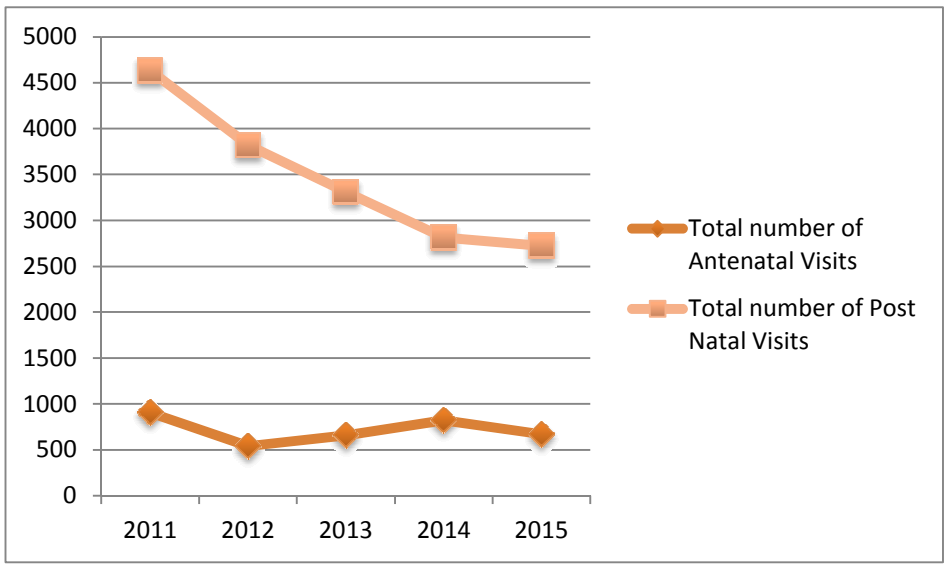


Figure 10: Total Number of Antenatal and Postnatal visits by the Primary Midwives Team



Overall there has been a decrease in the work of the Community Midwives team including women where they undertake full Primary Care. This may be for several reasons including an increase in the number of community based LMCs, and a decreasing birth rate within the DHB. The work load of our Primary Midwives team is very fluid with women moving in and out of the area, and shared care between Primary and Secondary Care.

There has been an increase in the number of midwives working with private LMC obstetricians to being involved with antenatal bookings and post natal care.

"The Midwives on the ward after, particularly C, R and J, were amazing and left us filled with confidence that we were doing okay and would be fine managing at home on our own afterwards"

Lactation Consultants/BFHI Coordinators

HVDHB has achieved Baby Friendly Hospital Initiative (BFHI) accreditation through until 2016. Helping to maintain our BHFI accreditation is a comprehensive Lactation service.

Currently an FTE of 1.1 is shared between two certified Lactation Consultants. The service offers breast feeding and lactation support to mothers and babies on the post natal floor, special care baby unit, and throughout the main hospital campus as requested. Outpatient appointments are offered for Mum and baby up to six weeks old, following referral from the Lead Maternity Carer or Plunket. Our service also accepts referrals for women antenatally with complex breastfeeding needs.

Along side breast feeding support, a reasonable part of our role is the on-going education of DHB staff and external stakeholders to maintain BFHI accreditation.

Our team works continuously to develop our services, and implement quality improvements e.g. audits and policies to maintain our standard of care.

In addition to these services we support and assist with a Breast Feeding Support Clinic run weekly. At this time we also offer assessment and possible frenotomy with regard to Ankyloglossia if impacting on optimum Breast feeding. Follow up is available up to six weeks as required.

Lactation Services Workload:

It has in the past been difficult to ascertain the workload and understanding of our resources with the LC team, due to data capture. We have been unable to prioritise access to services and have a clear understanding of our capacity and demand. In 2015 we developed a different data collection system, where we could collate data on LCS assessments undertaken in the Maternity Ward, Outpatient, Special Care Baby Unit, and within the rest of the DHB campus. This is starting to give us an understanding of the demand on the service and where the FTE allocation is required. This sits along side the work done to produce a Guideline to Services for Lactation Specialist and Breast Feeding Support Clinic, and will help us with further development of the service. We can already see that for outpatients clinics under the BFCONS code from 2011-14 compared to the LSOPD code in 2015 has shown an increased demand in OPD Assessments.

Table 9: Lactation Consultant workload by Clinic Type

	2011	2012	2013	2014	2015
BFCONS – Breastfeeding Consultation (outpatients)	57	239	287	218	n/a
LSINPT –Inpatient Assessment	n/a	n/a	n/a	n/a	557
LSOPD –Outpatients Assessment	n/a	n/a	n/a	n/a	354
LSOTH – Assessment other DHB Department	n/a	n/a	n/a	n/a	23
LSSCBU –Special Care Baby Unit Assessment	n/a	n/a	n/a	n/a	164

Comment: the BFCONS is now a defunct clinic, having been replaced by the LS clinics.

In conjunction with the above service review the Breast Feeding Working Group has worked on several quality initiatives.

A Guideline to Services for Lactation Specialist and Breast Feeding Support Clinic:

Late 2015 we initiated work on the development of a guideline to our Lactation Consultant Services and breast feeding support clinic. Lactation Consultant/Specialist Services, at HVDHB, have been established for some time now, and the aim has been to assist women with complex breast feeding / lactation issues. The volumes of referrals for issues that may only require midwifery support are increasing. The guideline outlines tools available to assist with breastfeeding education and issues, clear pathways on how to refer to the service, scope of what referrals they would accept, and some common scenarios with suggestions. This is to provide robust care to women most in need of specialist breastfeeding support. And will be launched early 2016.

The guideline also includes the pathway for referral to our Breast Feeding Support Clinic, for babies with suspected Ankyloglossia. This clinic has been in operation now for approximately 2 years following the training undertaken by the midwife/lactation consultants. Referrals are accepted from all health care providers who suspect that the mother and baby dyad are experiencing feeding difficulties as a result of a tongue tie.

Breast Feeding Support Clinic

This clinic commenced in 2014 as a breast feeding support service, and also provided the opportunity for an oral assessment and confirmation of Ankyloglossia. At this time the option of Frenotomy is available where there is less than optimum Mum and Baby breastfeeding. The clinic was initiated due to demand for assessments of babies and mums with breast feeding difficulties that were likely to be associated with Ankyloglossia. It enabled a more comprehensive assessment and often breast feeding skills improvement, and management plans and intervention if required.

Table 10: Number of events, Breast Feeding Support Clinic by Type

	2014	2015
Breast Feeding Support Clinic – Referrals New	142	196
Breast Feeding Support Clinic – Follow Ups	84	52
Total	226	248

Ankyloglossia Data:

With the establishment of our Breast Feeding Support Clinic we have worked with our IT department to create a report via our clinical system Concerto. The first stages were to create an online assessment template which was achieved between Jan-March. Using this assessment template we then created a report which includes clinical details of the assessments and outcomes. This report is to be sign off in January 2016. With the development of these we now have an almost paperless system for this clinic.

Breast Feeding Information:

Via the MOH we received 70 sets of Mama Aroha Cards. These were circulated to a variety of stakeholders such as LMCs, IBC Lactation Consultants, BFHI Coordinators, the Huttmaternity Unit, SCBU, Children's ward, Maori Health Services, Pacific Health Services, PPE and La Leche League/Peer Counsellors. They were gratefully received. Huttmaternity ran two educations sessions for users, and two sessions were held by a private Lactation Consultant for the users in the community who were not familiar with the cards.

Based on patient information "Breastfeeding your baby – Commonly asked questions" in use at Hawkes Bay DHB, with their permission we localised a series of flip cards. These are now in every room within our unit, SBCU and the Children's Ward. They are based on questions like "Why breastfeed?", "When to breastfeed?", "Is baby getting enough?" and use a range of easy to view images/diagrams and pictures.

Infant Feeding

Infant feeding status is recorded at time of discharge from our facility. For some this is following Planned Early Discharge from the Birthing Suite, for some following an inpatient stay on our Post Natal Ward. Babies admitted and discharged from the Special Care Baby Unit are excluded from the data presented here. In order to create more robust data we have in the 2014 and 2015 year worker hard to eliminate data with an 'unknown' breast feeding status.

Table 11: Breast Feeding Percentage by Feeding Type

	2011	2012	2013	2014	2015
Exclusive	76.43%	75.47%	76.24%	79.62%	78.80%
Fully	3.10%	2.88%	2.89%	2.69%	3.42%
Partial	13.23%	15.19%	14.56%	12.67%	12.95%
Artificial	6.64%	5.75%	5.78%	5.02%	4.83%
Unknown	0.61%	0.71%	0.53%	0.00%	0.00%

Figure 11: Breast Feeding Percentage by Feeding Type

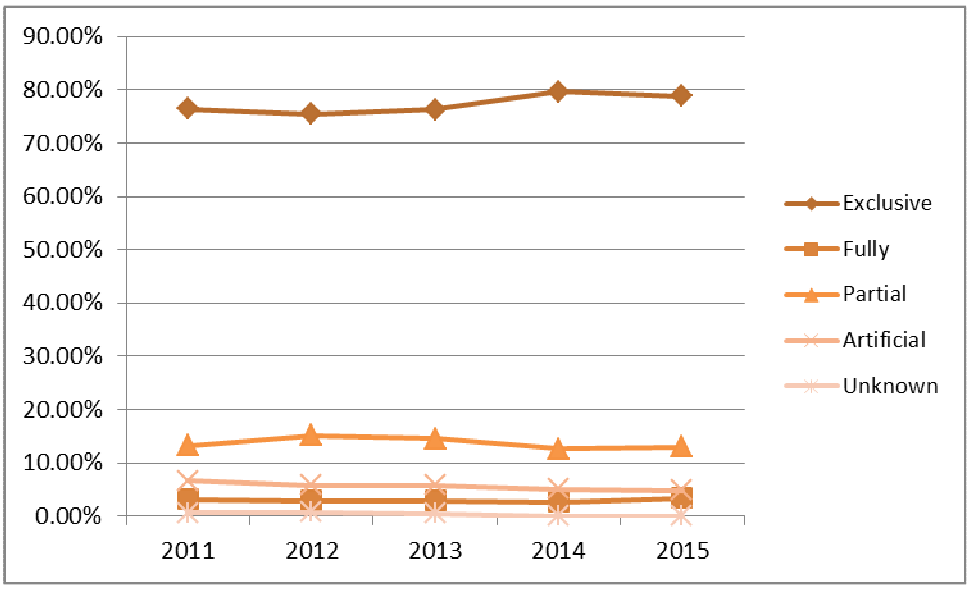
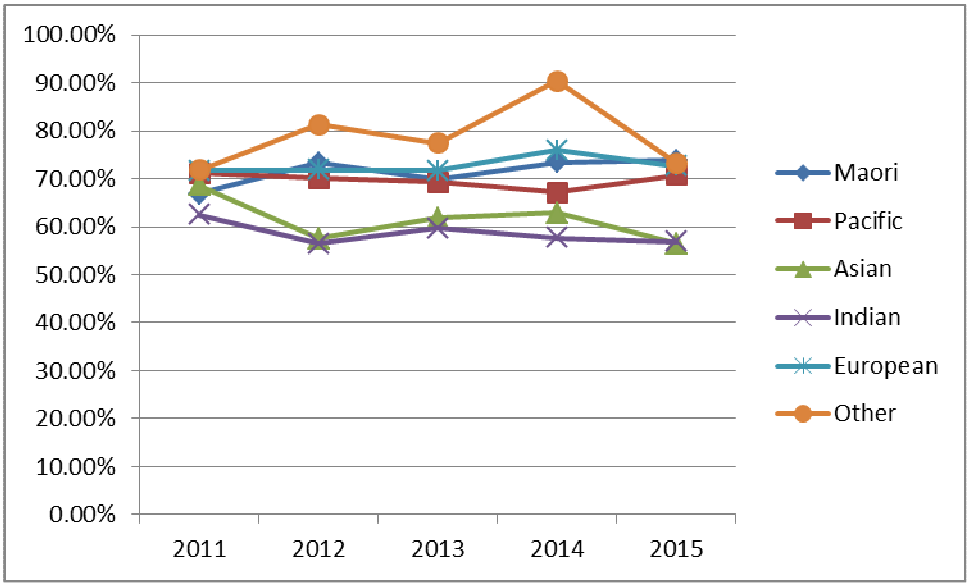


Figure 12: Exclusive Breastfeeding Rates by Ethnicity



Note: Other = Women who have identified their ethnicity as Middle Eastern, Latin American/Hispanic, and African

There is a reduced breast feeding rate among women who identify as Indian or of Asian ethnicity, which may be confounded by cultural beliefs, and increased morbidities such as and increase in rates of intrauterine growth restriction, small for gestation age babies and induction of labour rates.

Table 12: Breast feeding type by Age of mother

	Artificial	Exclusive	Fully	Partial	Other *	Total
Under 16 Years		4				4
16 to 19 Years	6	84	3	9	6	108
20 to 24 Years	17	194	9	28	29	277
25 to 29 Years	22	359	11	39	55	486
30 to 34 Years	20	394	19	76	73	582
35 to 39 Years	11	214	11	43	27	306
40 plus Years	4	50	3	17	19	93
Total	**80**	**1299**	**56**	**212**	**209**	**1856**

** Note: For table 12, 13 and 14 - Other = Includes babies discharged from SCBU where BF status is not recorded in Maternity documentation, or status has not been documented.*

We note that the percentage of women above the age of 40 exclusively or fully breast feeding is significantly less than those less than 35 years. This could be contributed to a number of factors including IVF, higher rates of induction and caesarean section. These mothers are known to have inherent lactation issues that are difficult to alter outcomes.

Table 13: Breast feeding type by Mode of Delivery:

	Artificial	Exclusive	Fully	Partial	Other *	Total
Breech Delivery					3	3
Caesarean Acute	14	193	22	57	69	355
Caesarean Elective	13	138	7	38	19	215
Instrumental Delivery	5	107	6	20	21	159
Vaginal Delivery	48	861	21	97	97	1124
Total	**80**	**1299**	**56**	**212**	**209**	**1856**

Table 14: Breast feeding type by Gestation at birth:

	Artificial	Exclusive	Fully	Partial	Other *	Total
20 to 23 Weeks					1	1
28 to 31 Weeks		2			3	5
32 to 36 Weeks	3	38	7	8	62	118
37 to 41 Weeks	76	1239	49	202	124	1690
42 Plus Weeks		11		2		13
Not Stated	1	9			19	29
Total	**80**	**1299**	**56**	**212**	**185**	**1856**

It is obvious that both mode of delivery and gestation at birth impact breastfeeding status.

Home Births in Hutt

Hutt Valley DHB does not collect data on Homebirths. The Ministry of Health has provided the data for the 2011 – 2013 years which are sourced from the National Maternity Collection.

Table 15: Home Births in Hutt Valley DHB catchment

	2011	2012	2013	2014*	2015*
Number of Homebirths	61	49	63	38	48
Percentage of total birth number	3.1 %	2.5 %	3.3%	2.1%	2.6%

*Provisional Data from Maternity Unit, HVDHB.

Comment:

We had made an assumption that most LMCs submit a hospital 'booking' for homebirth women, and when the woman homebirths the LMC notified Maternity Enquiries and this pre-admission is then cancelled. To try and ascertain some data around homebirths in 2014 we introduced an informal system to capture the number of homebirths that were "booked / pre-admitted" and the Pre-admission cancelled due to homebirth. Administration staff documented 48 cancelled pre-admissions for 2015. This does not account for homebirths where the LMC did not arrange a facility booking / pre-admission, which they are not obligated to do. Of note the National Immunisation Register was notified of 24 home births in the 2014 year, and 41 in the 2015 year. We assume this is due to the new Newborn Enrolment process.

Section Three: Links with Other Services

Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP)

Newborn Hearing Screening is offered nationally through all the District Health Boards. The aim of the programme is the early identification of permanent congenital hearing loss with specific goals of completing screening by 1 month, diagnosis by 3 months, and early intervention offered by 6 months. Early intervention before 6 months has been demonstrated to significantly improve long-term outcomes for children with hearing loss and their whanau.

Screening is offered to all newborns in the Hutt Valley DHB area through inpatient and outpatient services. The service operates 6 days per a week in the Maternity and Special Care units and 3 weekly outpatient clinics are run in the Audiology Department. We have a staff resource of 2 Screeners and 1 Screener / Coordinator (2.0 FTE).

The programme is managed through the Audiology Department under the Surgical, Women's & Children's directorate and is included in the Maternity Clinical Governance Group. Data is collected daily, analysed monthly, and reported quarterly to the NSU. The service maintains a high quality screening programme through continuing to meet or exceed all NSU performance indicators.

This year has seen significant change to the programme with the roll out of the new national screening regime at Hutt Valley DHB in April 2015. This included the introduction of a nationally consistent single screening device, and an aABR only screening protocol.

Following the implementation of the new screening protocol and standardised equipment we noted an increase in referrals for diagnostic audiology. Our Audiology team met this challenge by prioritising screening referrals and increasing diagnostic appointment slots. We experienced a subsequent trending down of demand toward the end of the year.

Table 16: Hutt Valley DHB UNHSEIP Volumes 2015

Newborns Offered Screening	1980
Completed Screening	1971 (99.5%)
Declined Screening	7
Screening Not Completed	2

Table 17: Location of First Screen

First screen as Inpatient	1589 (81%)
First screen as Outpatient	380 (19%)

Table 18: Referral for Audiology Assessment

Ref for Audiology Assessment	72

Table 19: Referral Outcome

Audiology	Confirmed Permanent Hearing Loss	Unilateral	Bilateral
		6	6
Early Intervention	Referred to ENT Specialist	5	
Referred to AODC	5		

It is pleasing at the same time, and a credit to both the Screening and Audiology teams that for the period 1 April to 30 June 2015 figures from the National Screening Unit showed our DHB achieved the highest percentage of screening completed by one month of age in the country at 98.6%. For babies referred to audiology we had the highest percentage of assessments completed by three months of age at 87.5%. In addition over all other volumes there is no marked change and improvements in rates achieved in 2014 have been maintained at the same high level this year.

Next year's work plan includes continuing planning for the implementation of a national newborn hearing information management system and continued focus on diagnostic audiology referral rate.

Pregnancy and Parenting Education (PPE)

There are two primary providers of PPE within the DHB region, Parents Centre which is privately run, and HVDHB contracted services from BirthEd. We are unable to source data from Parents Centre, but BirthEd provide data to the DHB.

BirthEd is contracted by Hutt Valley Board (and Capital and Coast District Health) to provide a range of free courses for adult and youth in the Hutt Valley and in the greater Wellington area. BirthEd provides high quality childbirth and early parenting education and support to women and their whānau or support people, so they can make safe, well informed choices about the birth of their baby and their parenting. They are based both in the hospital and in the community with courses running from Upper Hutt to Wainuiomata, including youth classes at Vibe and the Upper Hutt teen school Titiro Whakamua. Breastfeeding is an important component of BirthEd's nine week course outline and is taught by breastfeeding specialists. A one off three hour breastfeeding course building on the basic information is well subscribed to, and open to antenatal and postnatal women and their breastfeeding support persons.

BirthEd works collaboratively with many agencies including services from Kokiri Marae.

Two additional courses have commenced in this reporting timeframe - Preparing for Homebirth, and a Marae based antenatal course known as Kaupapa M.A.K.E (Māori Antenatal and Kaiāwhina Education) where women and their whānau stay overnight on the Marae. Alongside other antenatal education safe sleep, smoking cessation and tāne only sessions are incorporated in this programme.

BirthEd continuously evaluate their courses and changes currently in progress are: updating of the website www.birthed.co.nz to improve on user friendliness and a proposed daytime youth course in conjunction with Greenstone Doors striving to keep reaching the hard to reach women in our community.

In 2015, 587 women enrolled in BirthEd classes, with 528 actually commencing, and a completion rate of 93%. 93% of attendees were primips and 49% of attendees were under 24 years of age.

Table 20: Number of Courses Offered

	2014	2015
Mainstream	19	20
Youth	6	5
Mainstream Postnatal	19	20
Youth Postnatal	6	5
Baby Cares	12	11
Breastfeeding	12	11
Baby Safety	11	11
TOTAL	85	83

Table 21: Number of Entrants Enrolled, Commenced and Completed

	2014	2015
Number Enrolled	634	587
Number Commenced	534	528
Number Completed	512	489

Table 22: Primip and Youth Rate booked

	2014	2015
Primips	602	549
Under 20	66	52
Between 20-24	135	206

Table 23: Attendance by Ethnicity

	2014	2015
African	3	13
Chinese	36	27
Cook Island Maori	5	0
Fijian	8	3
Indian	33	34
Maori	64	57
Middle Eastern	4	2
Niuean	0	0
NZ European	338	311
NZE / NZM	40	40
NZE/Pacific Island	1	3
NZM/Pacific Island	0	5
Other European	33	48
Samoan	26	16
South East Asian	41	27
Tokelauan	2	1
Tongan	0	0

Violence Intervention Programme

Background

Hutt Valley DHB and all DHBs have been contracted by the Ministry of Health to deliver VIP since 2007. VIP aims to reduce and prevent the negative health and social impacts of family violence and child abuse and neglect through early identification, assessment and referral of victims presenting to health services in hospital and community settings by improving DHB responsiveness

Rationale

Victims of abuse use health services at a significantly higher rate than those not abused. As health harm from abuse is cumulative, early intervention is instrumental for improving long term physical and mental health outcomes. The significant health, social and economic costs of family violence has been well documented internationally and in New Zealand. Health service settings provide opportunities to identify victims of violence and provide support and referral to appropriate services which, can reduce and prevent its reoccurrence.

Evidence

Routine enquiry (for adults) and thorough health and risk assessment (for children) increases identification that can lead to appropriate interventions, and decrease subsequent exposure to violence and related problems.

Family violence assessment and intervention in health services as part of a coordinated systematic approach that includes: policy development, evidence-based best practice guidelines, leadership, documentation, staff training, monitoring and evaluation can be effective.

Adequate staff knowledge and skills, privacy in settings and ownership and acceptance of programmes and practices by staff and organisation leaders support effective interventions. Evidence-based best practice screening tools are most beneficial when complemented by protocols incorporating victim identification and support in routine practice. Training and support are required to implement partner abuse and child abuse and neglect protocols.

Compliance against protocols through, monitoring (including self-audits) and other forms of evaluation are required to support sustainable programme implementation and development

Hutt Valley DHB Violence Intervention Programme

- Two Clinical Nurse Specialists: Annie Vekony and Lynn O'Toole share the 1.0fte to implement the Ministry's VIP at HVDHB.
- VIP Sponsorship and management are led by Sarah Boyes, the Director of Operations, Surgical, Women and Children's Health Directorate.
- The VIP Advisory Group manages and supports programme implementation. This Advisory group meets quarterly.

Policies

The Hutt Valley DHB Partner and Child Abuse and Neglect Policies are currently being reviewed.

Violence Intervention Programme Training

At Hutt Valley DHB, the VIP core 8 hour training was approved by the National training provider and there is on-going external evaluation of the VIP training to align to the national training package.

Services trained and on-going:

- Children's Health Service including:
- Children's Ward, SCBU, Children's Outpatients, Children's community nursing, Child Development Service, ICAFS and School Health Nurses at Regional Public Health.
- Emergency Department and Medical Assessment Planning Unit (MAPU)
- Community Mental Health Services including Alcohol and drug services.
- Cultural units: Pacific Health Service and Maori Health Unit
- Maternity service (in progress)

The future annual VIP Training Plan will focus will focus on refresher training for staff in the designated areas and advanced training for the clinical champions. The core 8 hour VIP training is on-going. For training dates please book on one staff or via your service educator. The core VIP training is approved for five professional development points.

VIP Highlights since implementation at Hutt Valley DHB

- Implementation of the National Child Protection Alert System at HVDHB and the development of a working MDT team to review all CYF reports of Concern.
- Development of the electronic process for DHB staff referring to CYF with an increase of the number of children referred to CYF.
- The recruitment of an administrative support person a combined 0.5FTE to HVDHB VIP and Gateway Assessment Programmes.
- Improving the HVDHB Partner Abuse Programme score from 87 to 92 and the Child Abuse and Neglect Programme score increased from 88 to 90 in the self-audit to AUT in October 2015. This reflects the maturation of our VIP programme at Hutt Valley DHB.
- Approval and implementation of the Shaken Baby Prevention Programme project in June 2016 commencing with identified project lead, Abby Hewitt. It was launched on 26 May 2016 with a 2 hour Train the Trainer session held on the same day. . Auditing is planned as part of the VIP Clinical Audit data.
- The establishment of the CYF DHB Liaison Social Worker position. Jamie Lowe started this role in April 2015 and works closely with the VIP and maternity services related to the Vulnerable Women and Unborn Baby Group.
- Gaining appropriate cultural representation at various VIP forums/groups has been achieved and is on-going.
- An established 24/7/DSAC Nurses roster for the assessment and management of child sexual abuse at Hutt Valley DHB.

National Child Protection Alert System

In December 2014, Hutt Valley DHB was the ninth DHB approved to lodge alerts using the National Medical Warning System. Child protection alerts can be placed on the mother's file antenatal. The alert appears as *CHILD PROTECTION CONCERNS* CONTACT HVDHB. The alert can transfer to the child's file when the baby is born and their NHI number is generated. MDT review occurs prior to discharge from maternity services (6 weeks).

Evaluation and monitoring

As part of the ongoing evaluation and monitoring, VIP completes quarterly clinical audits in the designated services where routine screening for partner abuse is expected. In maternity service there has only been a snapshot audit done and regular quarterly audits will commence now that 26 midwives have attended the core 8 hour training. The annual snapshot audit result in 2015 showed a 48 screening rate and an 8 percent disclosure rate.

Vulnerable Women and Unborn Baby Group

In 2012, Hutt Valley DHB implemented a Vulnerable Women and Unborn Baby (VWUB) Group to identify vulnerable pregnant women and to strengthen collaborative support for these women and their families. In 2012, the group membership included Senior DHB Midwifery clinicians, DHB Social Worker, Special Care Baby Unit Senior Clinical Nurse Manager, DHB Violence Intervention Programme Clinical Nurse Specialist, CYF Practice Manager and later a CYF DHB Liaison Social Worker.

Since then, the VWUB Group membership now includes: Senior DHB Midwifery clinicians, DHB Violence Intervention Programme Clinical Nurse Specialist, Maori and Pacific Health Unit Family Support Facilitators and a Regional Maternal Mental Health senior nurse clinician.

External DHB members include: Police Family Safety Team members, the CYF DHB Liaison Social Worker, Naku Enei Tamariki Early Intervention Service Manager, Kokiri Marae Whanau Ora Social Services Manager, Well Child Providers (Tamariki Ora and Plunket Team Leaders) and a Vibe Youth Health Service senior nurse clinician.

Over the past 12 months the group membership has extended to Well Child Tamariki Ora (WCTO) Providers (Tamariki Ora and Plunket) and the Vibe Youth Health Service. Since WCTO providers have joined the forum, the completion of the involvement of the VWUB Group is now when the baby receives the first core WCTO visit. The group has developed strong working relationships since the establishment of this forum and the group membership highlights a commitment to work together to support these vulnerable pregnant women and their families who reside in the Hutt Valley area.

A Terms of Reference was developed by the VWUB group in 2013. The purpose is to better identify and support pregnant vulnerable women and their families during her maternal care period (Antenatal and to six weeks post-partum) for better outcomes for the woman and her baby. The VWUB group plan to adopt processes and documents, aligned to the national Maternity Care, Wellbeing and Child Protection resource toolkit. This will mean that each woman who is reviewed at the VWUB Group forum will have a Multi-Agency Support Plan to be incorporated in the woman's health records.

Referrals to the VWUB Group

Minutes are recorded at each forum with updates and actions related to each woman who are discussed by the group. A virtual event is created on WebPAS for data purposes. From this clinic 2014 data, 85 women were referred to the VWUB Group and in 2015, 88 women were referred to the group.

There has been no formal data collection of the interventions or evaluation of our interventions and outcomes for the woman and children referred to the VWUB Group. This data can be collected retrospectively for future evaluation.

CYF Liaison

The Hospital Liaison Social Worker provide a link between the DHB and Child, Youth and Family and work collaboratively with health professionals and Police to ensure that we deliver a quality service to children and young people admitted with child protection concerns. They ensure that a multi-agency safety plan is put in place for all of these children and young people prior to leaving the hospital. Hospital Liaison Social Workers also work with others for the early identification and appropriate response for children at risk of abuse and or neglect.

The two key objectives of the Hospital Liaison Social Worker are:

- Ensuring that CYF and DHB work together for all children when there are care and protection concerns
- The early identification and appropriate response for children at risk of abuse and or neglect. This includes risk to Unborn Babies.

The Hospital Liaison Social Workers role is to:

- Build strong functional working relationships across the DHB and promote collaborative practice
- Be the Child, Youth and Family liaison point within the DHB
- Be available to share information and child protection expertise with DHB staff
- Provide support and liaison for DHB staff to ensure that children and young people admitted with child protection concerns receive a quality service from Child, Youth and Family
- Be a first point of contact for advice on working with the DHB. They will support and guide staff when they need assistance. For example, if you need help with developing a Multiagency safety plan, or advice on how to work through an issue that has arisen with a particular case involving the DHB
- Be available to work with Child, Youth and Family and DHB staff to resolve interagency issues or disputes.

Social Worker

The Hutt Valley DHB Social Work Department provides social work service to both inpatients and outpatients who are experiencing health related difficulties. Social workers advocate for and assist patients to access services or support within the hospital or in the community to maximise independence, wellbeing and coping abilities.

Our services also provide supportive counselling to assist patients to adjust to changes in physical health and provide support related to maternal mental health issues or pregnancy/birth related difficulties.

Operating Theatre

There is no operating theatre facilities attached to the Birthing Suite. Trial of forceps, caesarean sections and manual removal of placenta or any other theatre requirements need to transfer to the main DHB theatres.

SCBU

There is a level 2 Special Care Baby Unit, with 12 cots and 2 ventilators. This unit provides care for babies above 32 weeks gestation.

Acupuncture Clinic

A maternity acupuncture service has been operating within the Hutt Valley Hospital outpatient department since 2008, and officers women free acupuncture care for pregnancy and postnatal related conditions.

NEW ZEALAND SCHOOL OF ACUPUNCTURE AND TRADITIONAL CHINESE MEDICINE

This is the first and to date, the only clinic of this type within a New Zealand hospital. This clinic is managed by the New Zealand School of Acupuncture and Traditional Chinese Medicine (NZSATCM). Women access this outpatient's service directly, making an appointment through maternity administration staff. Treatment rooms are provided two afternoons a week for 30 weeks. NZSATCM fourth year acupuncture students provide treatment under supervision of professionally registered acupuncturists experienced in pregnancy related care. All women sign consent forms for treatment and data collection.

Number of women treated and referral pathways

One hundred and thirty-one women sought treatment in 2015 with 348 treatments delivered over the 30 weeks that the clinic operates. This is consistent with the numbers of treatments delivered in 2013 and 2014 (Table 24). This clinic is operating at maximum capacity with a waiting period, of two to four weeks for new patients.

Table 24: Number of Acupuncture treatments delivered

	2013	2014	2015
Number of women -initial visit	134	127	131
Total number of treatments delivered	370	408	348
Mean number of treatments per woman	2.8	3.2	3.8

The main referral to the clinic is through midwives acting as Lead Maternity Carers (LMCs) recommending women to make an appointment (Table 25).

Table 25: Referral to clinic by source

	2013 N =134	2014 N= 127	2015 N=131
LMC Midwife	94 (70%)	80 (63%)	97 (74%)
Self-referral (previous pt/friend /hospital website)	20 (15%)	23 (18%)	23 (18%)
Acupuncturist	2 (1%)	9 (7%)	3 (2%)
Antenatal /Physio/hospital	3 (2%)	10 (8%)	8 (6%)
Yoga	11 (8%)	5 (4%)	0

Treatment delivered

In 2015 a variety of treatments were provided on the woman's initial visit (Table 26). Figure 13 illustrates these treatments with a column labelled as 'primary' representing the presenting condition cited by the woman on her first visit as the main reason she was seeking treatment and a column labelled as 'secondary' representing those conditions also treated on this first visit following assessment.

It is of note that the majority of women initially presented for treatment involving labour preparation (pre-birth treatment), back and pelvic and hip pain. It can also be seen that there was there a range of other pregnancy related conditions women received treatment for after assessment on their first visit. This included treatment for nausea, heart burn, headaches or migraines, emotional concerns, insomnia and varicosities (which includes women presenting for treatment of vulvar varicosities, varicose veins and haemorrhoids). The heading for 'other' included women presenting with blood pressure problems, rib, abdominal and neck pain, carpel tunnel, anaemia, hay fever, sinus and bleeding in pregnancy.

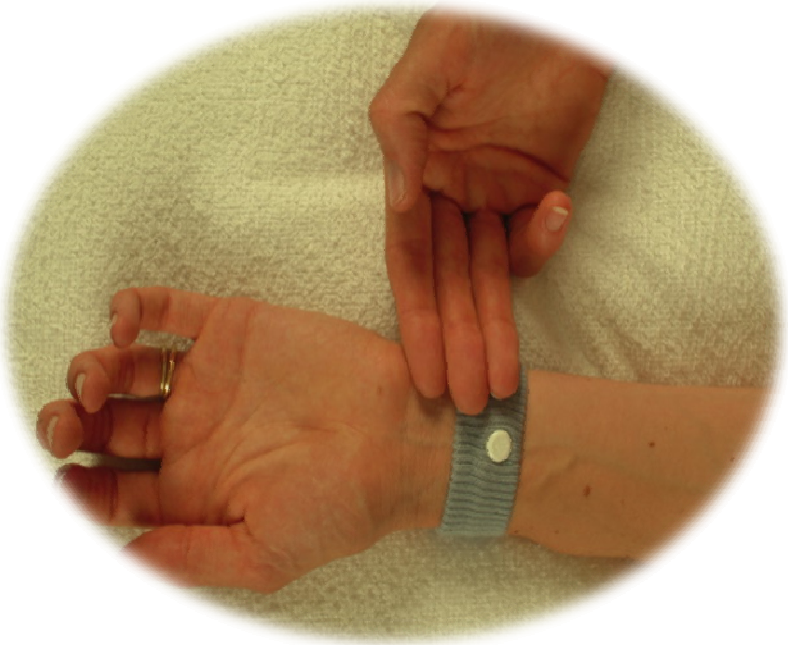
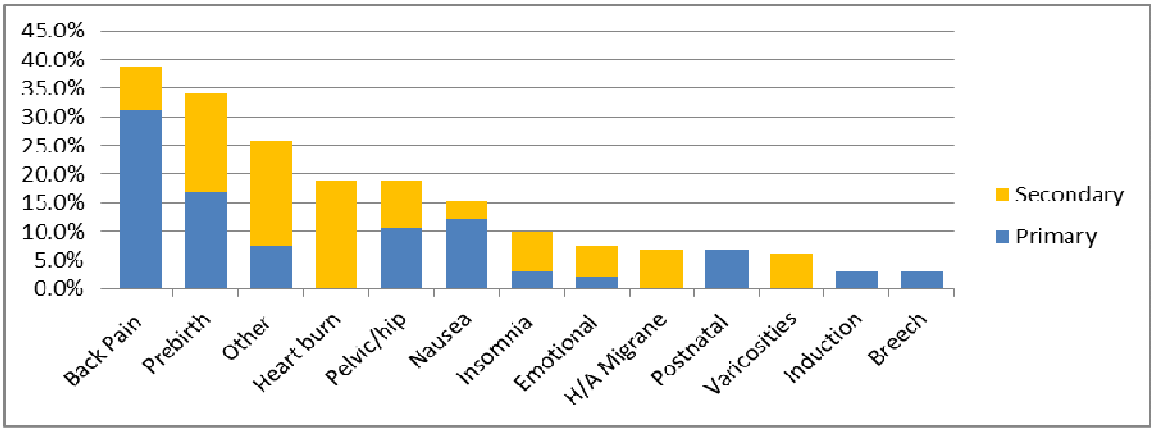


Table 26: Treatments delivered on Initial visit

Conditions	2015 (n=131)			
	Primary		Secondary	
	N	%	N	%
Pre - birth	22	16.7	23	17.5
Back pain	41	31.2	10	7.6
Pelvic/hip pain	14	10.6	11	8.3
Other	10	7.6	24	18.3
Nausea	16	12.2	4	3.0
Varicosities	0	0	9	6.8
Emotional	3	2.2	7	5.3
Breech	4	3.0	0	0
Induction	4	3.0	0	0
Insomnia	4	3.0	9	6.8
Headache/migraine	0	0	9	6.8
Heartburn	0	0	25	19.0
Postnatal	9	6.8	0	0

Figure 13: Treatments delivered on Initial visit



MYMOP data collection for Back and Pelvic/hip pain

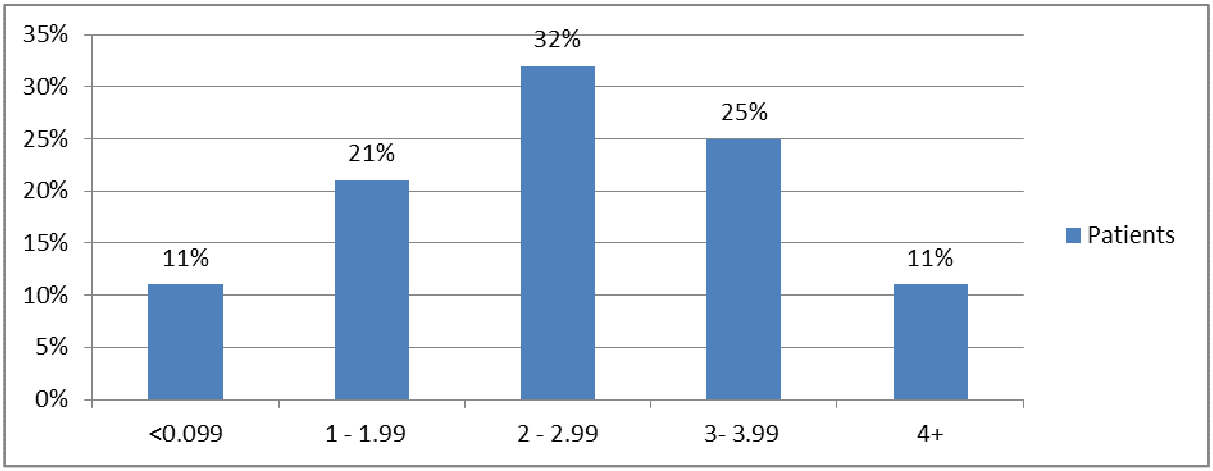
Back and pelvic/hip pain is a common complaint for women in pregnancy. It frequently interferes with a woman's ability to carry out every day living activities, continue working and quality of sleep. It is also usually increases in severity as the pregnancy progress until the baby is born. A Measure Yourself Medical Outcome Profile (MYMOP) form was commenced to collect women's treatment satisfaction for back, pelvic/hip pain following acupuncture.

MYMOP is a patient centred questionnaire that asks the patient to describe their problem in their own words and then rate it on a scale from 0 to 6. This is a scale with 0 being "as good as it could be" and 6 being "as bad as it could be." The same scale of 0-6 is used for any associated symptom, an associated activity they find difficult and a general wellbeing scale.

The questionnaire was completed during the first and then all subsequent visits. A mean change was calculated from the initial and final score to obtain a profile score. This represents a score that is clinically significant rather than statistically significant; with a reduced change above one representing a positive change seen as important to the patient receiving the treatment.

Of the 46 women who were eligible for MYMOP analysis, two forms were incomplete leaving 44 for analysis. Thirty nine women (89%) had a profile score that reduced by more than one point, which can be seen as being clinically significant - that is representing a change that is of importance to those women. Only five women (11%) gave scores that indicated they had not found the treatment resulted in changes they saw as meaningful (Figure 14).

Figure 14: Percentage of women with MMYOP profile scores (n=44)



Patient feedback and adverse events

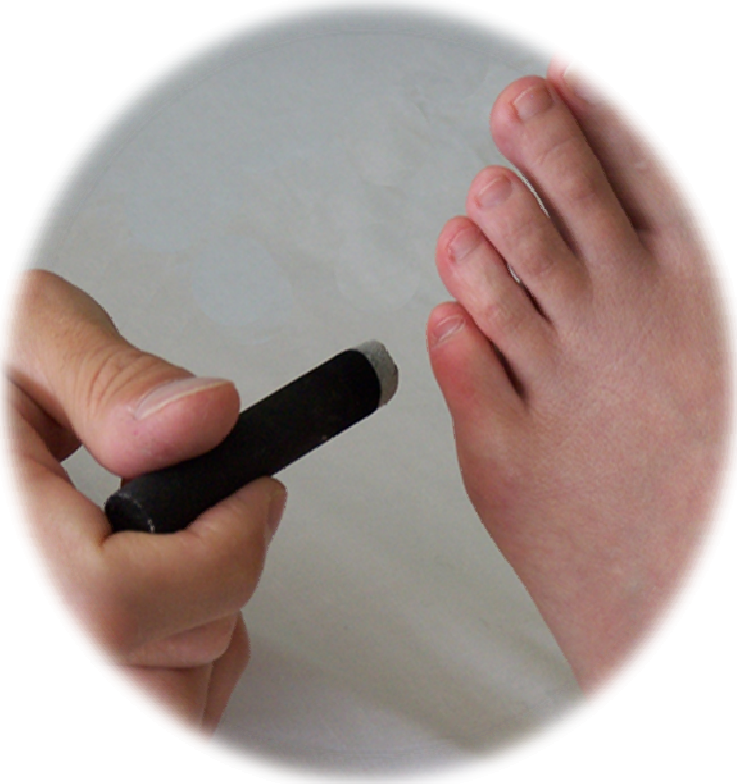
All women receiving three or more treatments were asked to complete an anonymous feedback form on their third visit to indemnify any concerns about the treatment they received. This form asked for comments about what had been beneficial or, not beneficial and if they had experienced any uncomfortable pain at needle site, bleeding or bruising from treatment, had felt faint during or after treatment, had symptoms that became worse or had any other concerns. From the 58 women receiving three or more treatments 53 (91.3%) completed a feedback form. No women indicated that they had experienced any adverse events. Ten women (17%) selected from a tick box that they had experienced a minor adverse event (pain at needle site or bruising from treatment). However all of these women left comments on the form indicating that this had not been a serious concern for them, with comments such as: “overall my experience has been a good one. Only once did I have bruising which wasn’t too bad!” And for a woman who had experienced pain at the needle site “It’s been great I would highly recommend people try acupuncture.”

The majority of the comments related to the improvement in their symptoms and how helpful they found the students. However seven (13%) also commented on how grateful they were that this service was available through the hospital “Long may it continue as treatment option at Hutt hospital for pregnancy troubles.”

At the time of writing this report it can be confirmed that this clinic continues to operate as a free outpatient service at Hutt Valley hospital. Data collection continues with demographic data now being collected for future reporting.

Our thanks to Debra Betts for providing the above information. Debra, along side her qualifications as RN, CHSc (Ac), PhD, is an Adjunct Fellow at the National Institute Complementary Medicine, Western Sydney University, the Director of Postgraduate Programmes New Zealand School of Acupuncture and Traditional Chinese Medicine, and Supervisor Hutt Hospital Maternity Acupuncture service

http://www.acupuncture.ac.nz http://acupuncture.rhizome.net.nz



Physiotherapy Services

There is an allocated Women's Health Physio working across the O&G department five days a week, at 0.8 FTE. This covers both inpatient and outpatient physiotherapy services. The Physiotherapist also runs a free Antenatal Stretch Class once a week.

Common reasons for antenatal referral include abdominal, back and/or pelvic pain, carpal tunnel syndrome and pelvic floor disorders. Postnatally women are referred for pelvic floor issues, third degree perineal tears and pelvic/ back pain.

Table 27: Physiotherapy Outpatient events (Antenatal and Postnatal)

	2014	2015
New assessments - Obstetrics	235	284
Follow Up assessments – Obstetrics	126	145
Total	361	429

Ionazone: the Allied Health Department also currently offer Ionazone treatment for women with painful nipples

Table 28: Ionozone Outpatient Events

	2014	2015
New	185	228
Follow Up	294	340
Total	479	568

Section Four: Maternity Services Clinical Outcomes 2015

This section outlines Hutt Maternity data based on the Ministry of Health's (MOH) twelve New Zealand Maternity Clinical Indicators. The data has been sourced from Hutt Valley DHB events, stored in the Hutt Patient Management System (WebPAS) and the Hutt Maternity Database (Concerto), and has been extracted from the National Minimum Dataset (NMDS) and coded using ICD-10-AM-v6. See Appendix one for more details.

MOH produce New Zealand Maternity Clinical Indicator reports annually, but are two years behind in the data they provide. We have developed an internal data report based on the above system that enables us to look at our data from the previous year in order to react more responsively, instigating audits and changes in clinical practice. We have retrospectively compared our reporting to that in the New Zealand Maternity Clinical Indicators to assess for major inconsistencies.

The data in this report is based on births at our facility and does not include homebirths, or births by women from HVDHB domicile who birth at other facilities. Due to this there will always be a slight difference in what is within our report and that of the MOH report.

The indicators from 2009 -2011 were:

1. Standard Primiparae who have a spontaneous vaginal birth
2. Standard Primiparae who undergo an instrumental vaginal birth
3. Standard Primiparae who undergo Caesarean section
4. Standard Primiparae who undergo induction of labour
5. Standard Primiparae with an intact lower genital tract (no 1st-4th degree tear or episiotomy)
6. Standard Primiparae undergoing episiotomy and no 3rd-4th degree perineal tear
7. Standard Primiparae sustaining a 3rd-4th degree perineal term and no episiotomy
8. Standard Primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear
9. Women having a general anaesthetic for Caesarean section
10. Women requiring a blood transfusion with Caesarean section
11. Women requiring a blood transfusion with vaginal birth
12. Premature births (between 32 and 36 weeks gestation)

Further KPIs were introduced in 2012 and resulting in a change in numbering:

1. Registration with a Lead Maternity Carer in the first trimester of pregnancy.
2. Standard Primiparae who have a spontaneous vaginal birth
3. Standard Primiparae who undergo an instrumental vaginal birth
4. Standard Primiparae who undergo Caesarean section
5. Standard Primiparae who undergo induction of labour
6. Standard Primiparae with an intact lower genital tract (no 1st-4th degree tear or episiotomy)
7. Standard Primiparae undergoing episiotomy and no 3rd-4th degree perineal tear

8. Standard Primiparae sustaining a 3rd-4th degree perineal term and no episiotomy
9. Standard Primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear
10. Women having a general anaesthetic for Caesarean section
11. Women requiring a blood transfusion with Caesarean section
12. Women requiring a blood transfusion with vaginal birth
13. Diagnosis of eclampsia at birth admission
14. Maternal tobacco use during postnatal period
15. Preterm birth

We aligned our reporting for the 2014 year with the 2012 Clinical Indicator numbers as outlined above.

There were again changes in the KPI for 2013:

1. Registration with a Lead Maternity Carer in the first trimester of pregnancy.
2. Standard Primiparae who have a spontaneous vaginal birth
3. Standard Primiparae who undergo an instrumental vaginal birth
4. Standard Primiparae who undergo Caesarean section
5. Standard Primiparae who undergo induction of labour
6. Standard Primiparae with an intact lower genital tract (no 1st-4th degree tear or episiotomy)
7. Standard Primiparae undergoing episiotomy and no 3rd-4th degree perineal tear
8. Standard Primiparae sustaining a 3rd-4th degree perineal term and no episiotomy
9. Standard Primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear
10. Women having a general anaesthetic for Caesarean section
11. Women requiring a blood transfusion with Caesarean section
12. Women requiring a blood transfusion with vaginal birth
13. Diagnosis of eclampsia at birth admission
14. Women having a peripartum hysterectomy (New)
15. Women admitted to ICU and requiring ventilation during pregnancy or postnatal period (New)
16. Maternal tobacco use during postnatal period
17. Women with BMI over 35 (New)
18. Preterm birth
19. Small babies at term (37-42 weeks' gestation) (New)
20. Small babies at term born at 40-42 weeks' gestation (New)
21. Babies born at 37+ weeks' gestation requiring respiratory support (New)

Indicator One: Registration with a Lead Maternity Carer in the first trimester of pregnancy.

Maternity provider at time of registration data is not collected by the DHB.

Historically we have had data on first trimester registration by Domicile from the National Maternity Monitoring Group (NMMG) and all registration timing, by Facility direct from Ministry of Health.

NMMG provided 2011 at 55%, and 2012 at 58% for first trimester registration by domicile.

MOH provided 2011 at 49%, 2012 at 54% and 2013 at 51% for first trimester registration by Facility. But they also provided data on registration details in the second, and third trimester and postnatally or unknown.

In 2014, 2012 data was made available as a new, New Zealand Maternity Clinical Indicator; recorded by facility, but only for LMC registration within the first trimester.

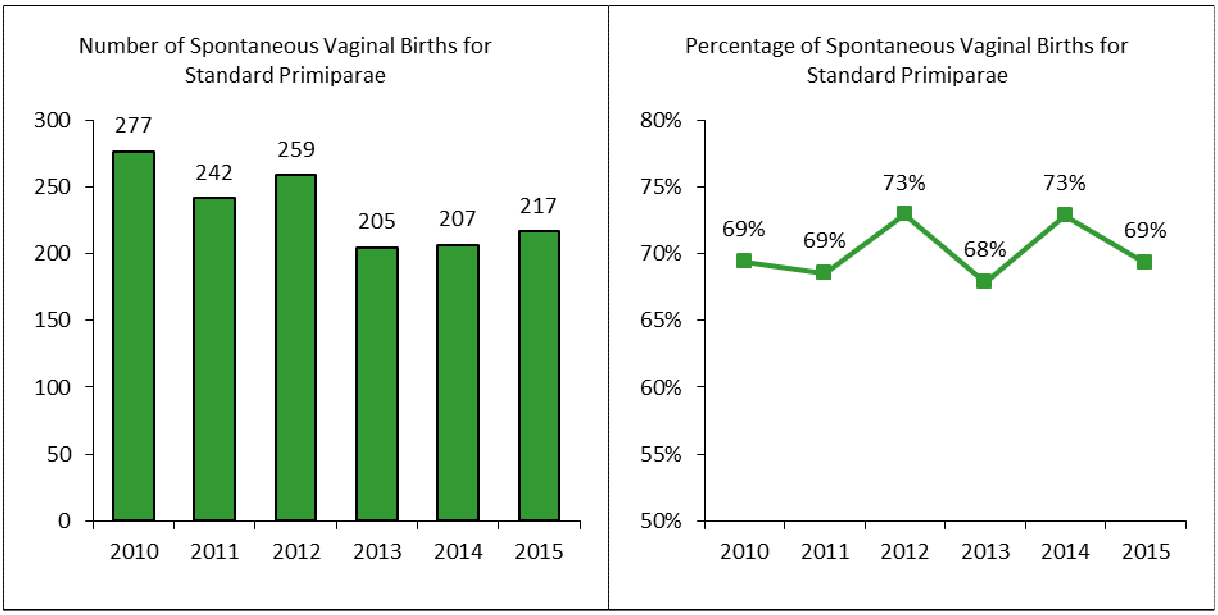
It is difficult to make comparisons between these data sets, but we are happy to see the percentage of women that registered with an LMC in the first trimester in 2014 has increased at 60.1% by facility, and is closer to the national average (67.7%) than previous years. We hope this is in response to the work invested in the "Top 5" campaign, Huttmaternity Website and Facebook page.

We have also continued to work with MOH to provide data for women under DHB care via the Primary Maternity Data Collection System, which should also improve data.

Table 29: Registration with LMC in First Trimester by %

	2012	2013	2014
Huttmaternity	55.9%	52.6%	60.1%
Secondary and Tertiary Facilities	64.2%	65.6%	68%
National	63.5%	64.9%	67.7%

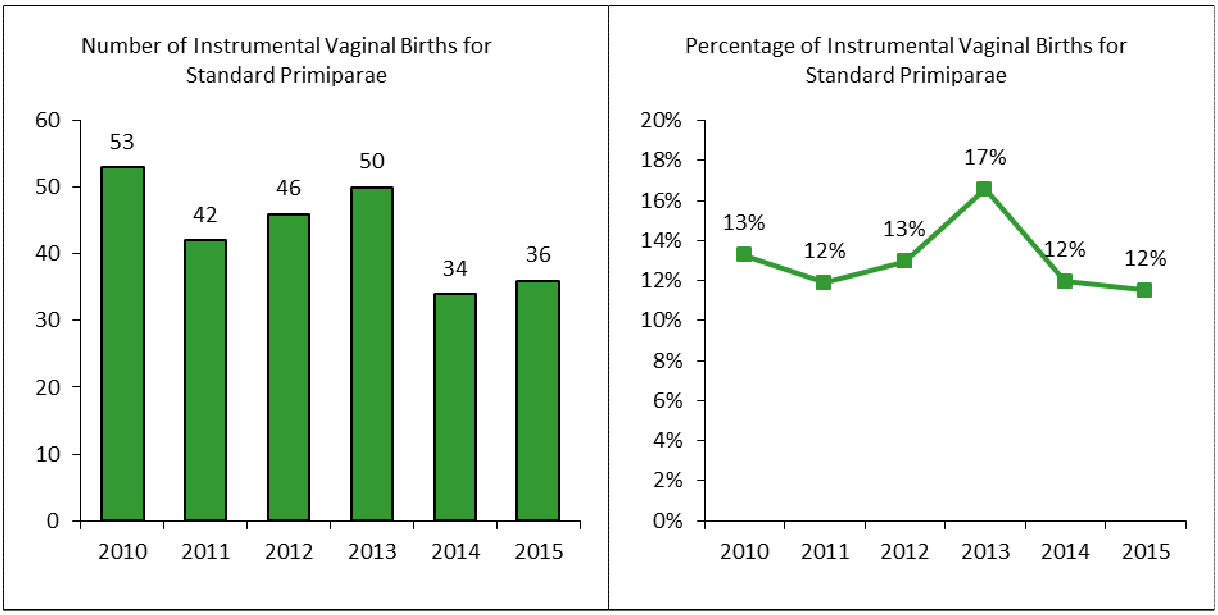
Indicator Two: Standard Primiparae who have a spontaneous vaginal birth



Numerator: Total number of standard primiparae who have a spontaneous vaginal birth at a maternity facility
Denominator: Total number of standard primiparae

Comment:
The National figure for 2014 is 68.9%, and Secondary and Tertiary Facilities provided by MOH is from 2014 sits at 63.6% for Standard Primip. We continue to track above the national and secondary/tertiary rates, although based on our provisional 2015 data we see a slight decrease that may not be statistically significant.

Indicator Three: Standard primiparae who undergo an instrumental vaginal birth

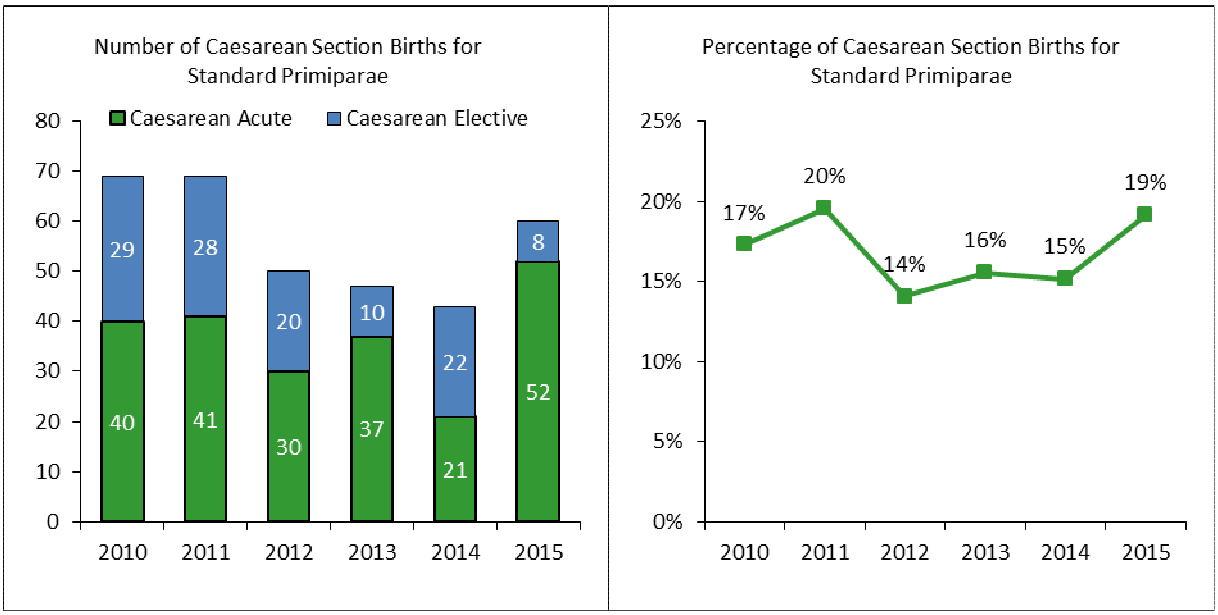


Numerator: Total number of standard primiparae who undergo an instrumental vaginal birth
Denominator: Total number of standard primiparae

Comment:
This indicator continues to track below the national in 15.2%, and secondary/tertiary rate at 17.8% for 2014.

"I wish to congratulate you & thank you for an excellent service. Despite having what could be described as a traumatic birth. I have to rate my overall experience as positive. Every single person was professional, friendly & set me at ease, from the HCA & cleaner to the medical staff"

Indicator Four: Standard primiparae undergoing caesarean section



Numerator: Total number of standard primiparae undergoing caesarean section
Denominator: Total number of standard primiparae

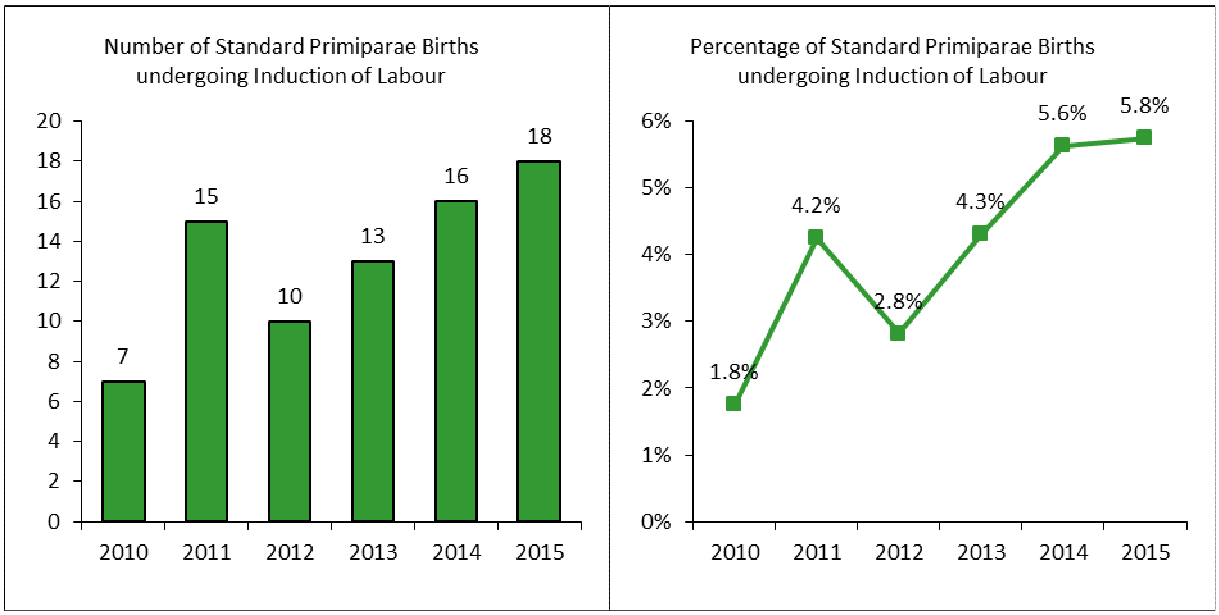
The national rate of Caesarean Section for 2014 was 15.6%, which we just meet. We note that not only has there been an increase in the overall number, but there has been in increase in the number of Acute Caesarean Sections in Standard Primips in the 2015, with our number at the highest since 2010. We are proposing an Audit to ascertain reasons this may be occurring. The Elective Caesarean rate has decreased and we wonder if a portion of these women are presenting and going to theatre acutely.

Table 30: Gestation of Standard Primiparae Undergoing Caesarean Section

	37	38	39	40	41	Total
Caesarean Acute	3	7	9	21	12	52
Caesarean Elective	1	4	3			8

Of the eight elective caesarean sections: one was for maternity anxiety and history of sexual abuse (39 weeks), one for placenta previa (37 weeks) and six for Malpresentation (4 at 38 weeks and 2 at 39 weeks gestation).

Indicator Five: Standard primiparae who undergo induction of labour



Numerator: Total number of standard primiparae who undergo induction of labour
Denominator: Total number of standard primiparae

Comment:
The above graph looks dramatic; however the raw numbers a very small. That National rate for 2014 is 5.6%, and we matched the national data.

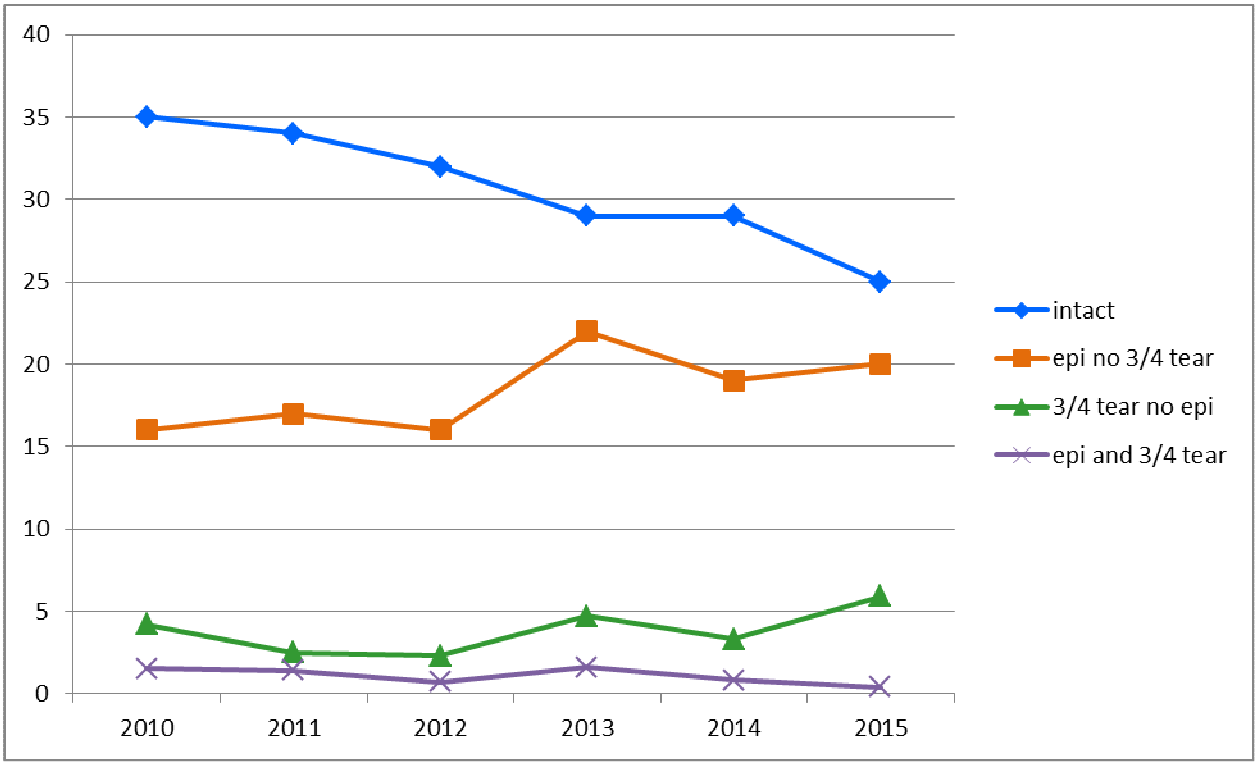
"I especially appreciated the professional, caring information if got from S and L (the doctors in delivery) who helped me make decisions about my care and made me feel really included in the 'induction of labour' process"

Clinical Indicators Six to Nine - Perineal Outcomes

Figure 18 presents an overview of the MOH New Zealand Clinical Indications 6 – 9, around perineal status at delivery for Standard Primiparae. This includes Intact, Episiotomy with no 3rd or 4th degree tear, 3rd or 4th degree team with no Episiotomy and those with both Episiotomy and 3rd or 4th degree team.

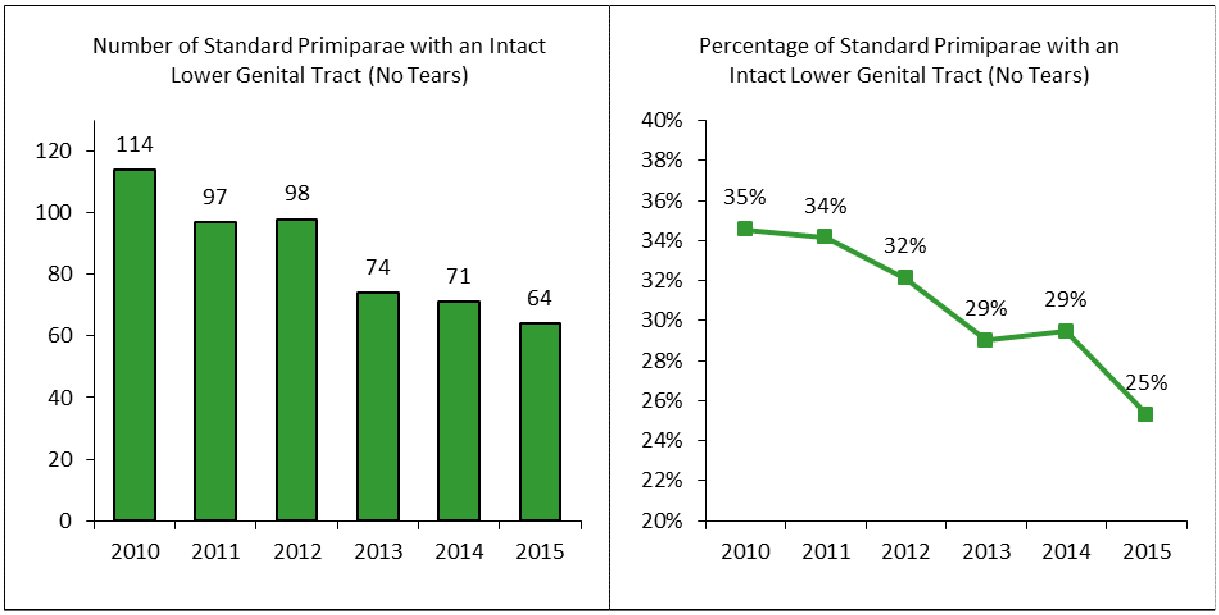
A further detailed break down of each indicator is on the following pages.

Figure 15: Overview of Perineal Status for Standard Primip



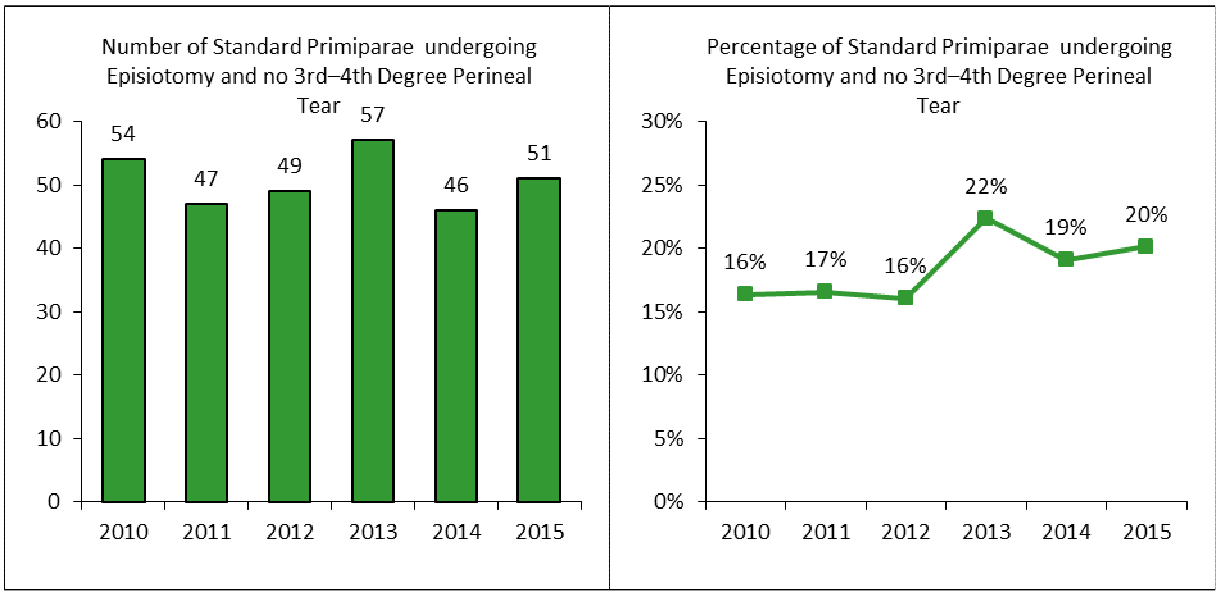
We are concerned that our rates for intact perineum are decreasing and we have had an increase in the standard primiparae sustaining a 3rd or 4th degree tear with no episiotomy. This information will be presented to clinicians and education regarding mediolateral episiotomy and perineal support undertaken.

Indicator Six: Standard primiparae with an intact lower genital tract (no 1st - 4th degree tear or episiotomy)



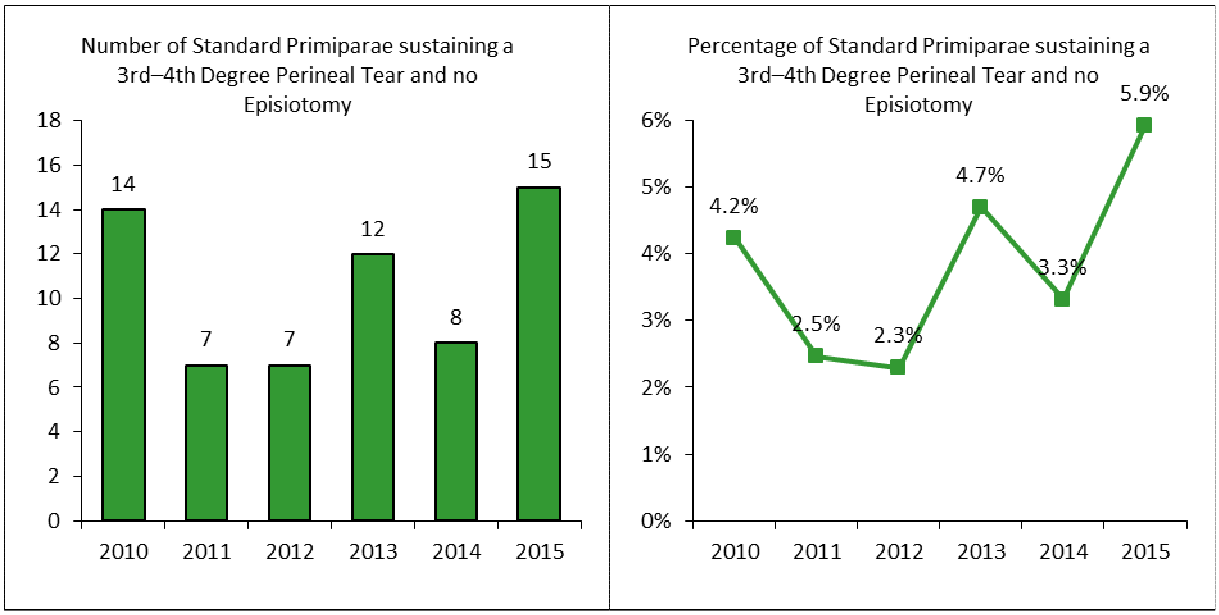
Numerator: Total number of standard primiparae with an intact lower genital tract with vaginal birth
Denominator: Total number of standard primiparae who gave birth vaginally

Indicator Seven: Standard primiparae undergoing episiotomy and no 3rd / 4th degree perineal tear



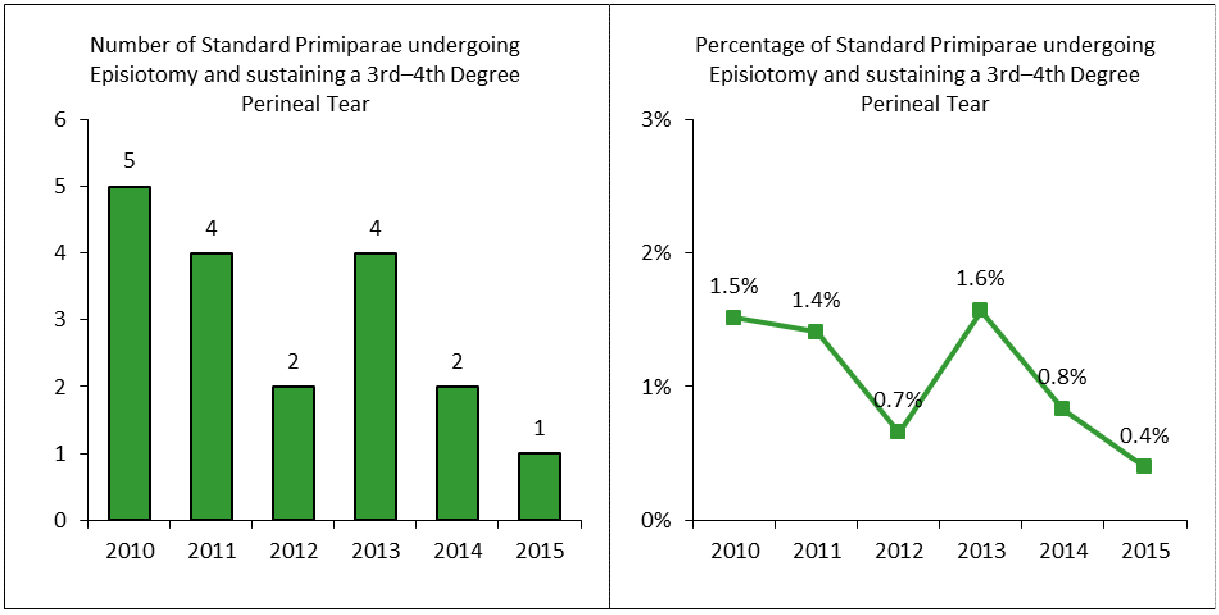
Numerator: Total number of standard primiparae undergoing episiotomy and no 3rd or 4th degree perineal tear with vaginal birth
Denominator: Total number of standard primiparae who gave birth vaginally

Indicator Eight: Standard primiparae sustaining a 3rd / 4th degree perineal tear and no episiotomy



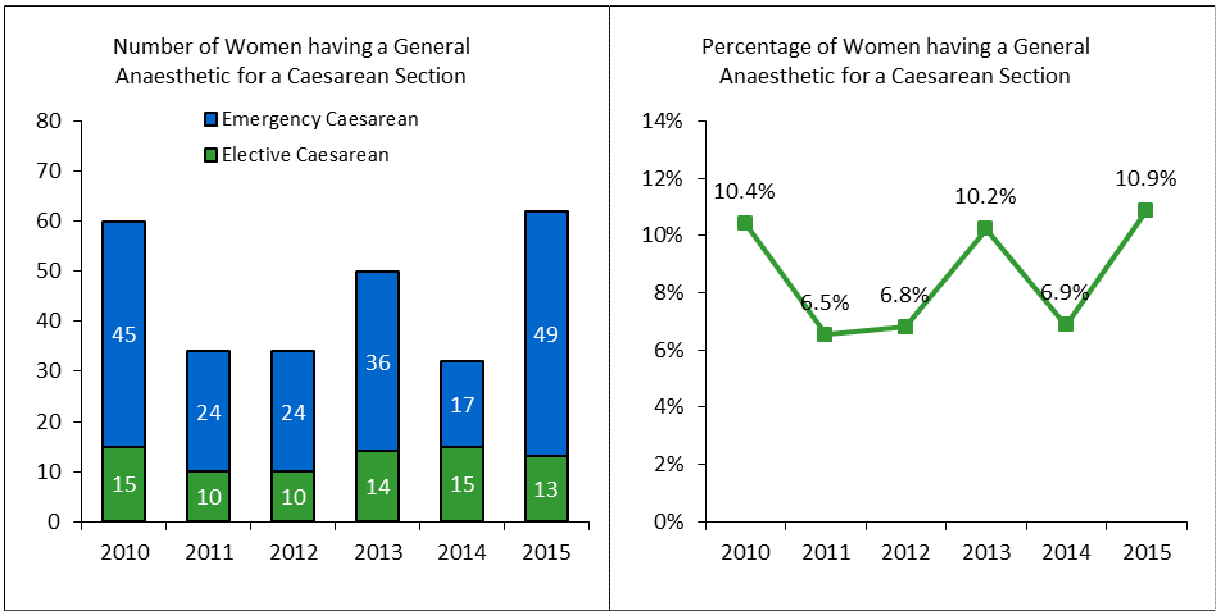
Numerator: Total number of standard primiparae sustaining a 3rd or 4th degree perineal tear and no episiotomy with vaginal birth
Denominator: Total number of standard primiparae delivering vaginally

Indicator Nine: Standard primiparae undergoing episiotomy and sustaining a 3rd / 4th degree perineal tear



Numerator: Total number of standard primiparae undergoing episiotomy, and sustaining a 3rd-4th degree tear while giving birth vaginally
Denominator: Total number of standard primiparae delivering vaginally

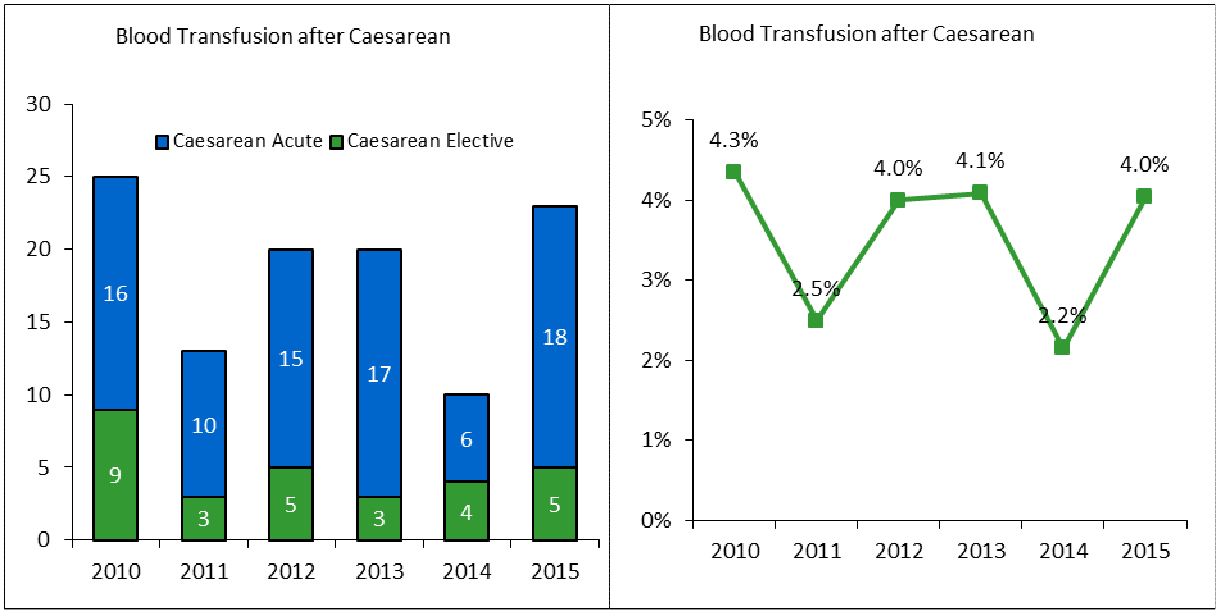
Indicator Ten: General anaesthesia for all Caesarean sections



Numerator: Total number of women having a general anaesthetic for a caesarean section
Denominator: Total number of women having a caesarean section

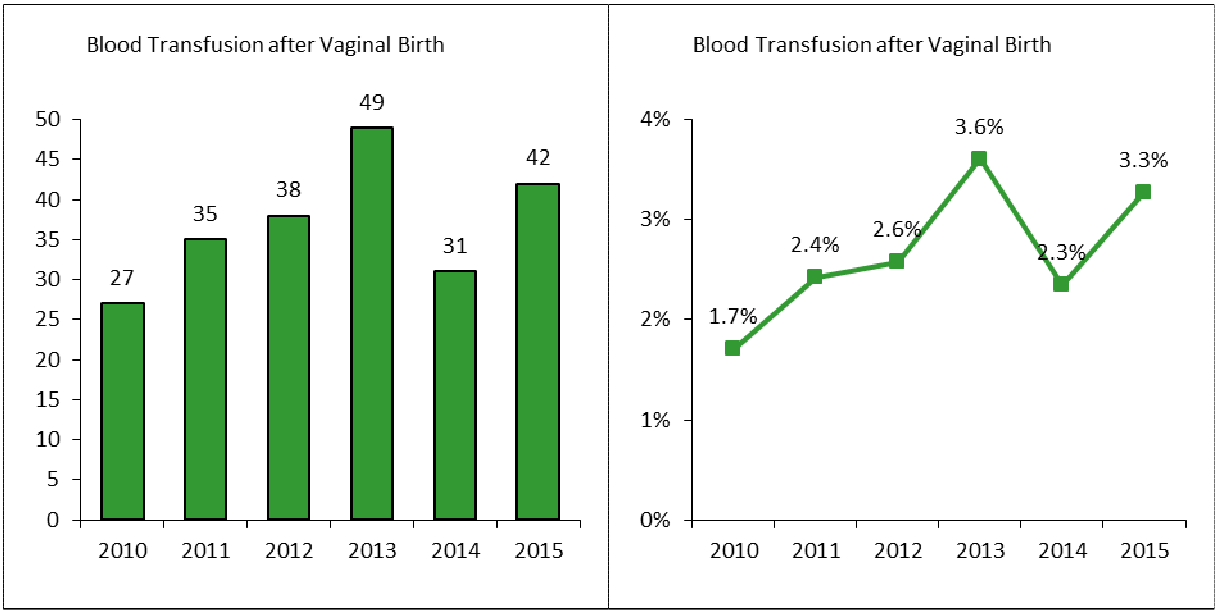
Comment:
The national average for 2014 was 8.4% and we were well under this rate. We note the increase in our data numbers for 2015 and have investigated the reason for C/S. There were very few questionable reasons, with most being clinical appropriate, and we are currently reviewing these cases. We are also liaising with our Anaesthetic Obstetric lead on this issue, as they are also undertaking audits in this area.

Indicator Eleven: Women requiring a blood transfusion with Caesarean section



Numerator: Total number of women requiring a blood transfusion with caesarean section
Denominator: Total number of women having a caesarean section

Indicator Twelve: Women requiring a blood transfusion with Vaginal Birth



Numerator: Total number of women requiring a blood transfusion with vaginal birth
Denominator: Total number of women who give birth vaginally

Comment:
We do wonder if our increased rate of blood transfusion is a reflection of antenatal anaemia. Huttmaternity is currently using Polymaltose Iron infusion which has a 50% reaction rate, and therefore poor application, we are investigating the feasibility of Ferrinject. We are currently auditing our 2015 figures for both indicator 11 and 12.

Indicator Thirteen: Diagnosis of Eclampsia at birth admission

This was a new Clinical Indicator introduced in 2013, with data for 2012-2013. Data provided by MOH from the New Zealand Maternity Indicators state there were no diagnosis of eclampsia at birth admission at HVDHB 2012 - 2014.

Indicator Fourteen: Women having a peripartum hysterectomy (NEW)

This is also a new indicator. The numerator: total number of women having an abdominal hysterectomy within 6 weeks after birth. There have been no women having a peripartum hysterectomy at Huttmaternity Facility for 2013-14.

Indicator Fifteen: Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period (NEW)

We currently do not collect data on this indicator, which was introduced to the New Zealand Maternity Indicators in 2013. MOH have provided data and there was one woman in both the 2013 and 2014 years. The numerator is Total number of women admitted to ICU and requiring over 24 hours of mechanical ventilation during admission any time during the pregnancy or postnatal period. These event would have undergone a case reviews.

Indicator Sixteen: Maternal tobacco use during postnatal period

It has been recognised in our previous reports it is very difficult to get robust data on smoking rates in pregnancy and behaviour change. Data on smoking status is collected in a multitude of repositories and these do not all have the same parameters.

We know from coded data that women delivering in Hutt Hospital and from MMPO data that LMC's and core midwives are consistent in asking about smoking status and offering quit advice.

Here at the DHB we are able to collate data on smoking status, at discharge from this facility.

Table 31: Smoker at time of Birth at Hutt Valley DHB Maternity Services by %

Delivery Year	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
2011	43%	14%	1%	0%	13%	3%	8%	18%
2012	42%	10%	1%	0%	9%	0%	0%	15%
2013	43%	13%	1%	1%	11%	0%	25%	16%
2014	38%	11%	0%	0%	9%	0%	11%	13%
2015	40%	9%	0%	0%	11%	3%	0%	15%

In the later half of 2015 we initiated mandatory data reporting to MOH on screening, brief advice and cessation support offered, and will have a full year data to report for 2016. This data is for DHB employed midwives providing pregnancy care.

Early last year the Smokefree coordinator provided training to midwives to enable them to provide free samples of the Quickmist nicotine oral spray to their clients.

The team attended and presented at the Huttmaternity Expo in July and were available to health professionals at the time to offer training opportunities and Quickmist.

Regional Public Health has made a submission to the Pharmacy Action Plan and in that submission pointed out the pharmacy are well placed to discuss quitting smoking with pregnant women as the will see women at confirmation and sometimes even during the planning of a family.

Regional Public health also lent its support to The Whakawhetu Seminar held in Wellington. This seminar showcased the needs around Sudden Unexplained death in Infants (SUDI) and covered a range of topics from wellbeing for mother and baby pre and post partum and included smoking cessation.

At a National level MOH introduced a Key Performance Indicator: Maternal tobacco use during postnatal period, into the New Zealand Maternity Clinical Indicators for 2012. This provides data on smoking status at two weeks following birth, of those women registered with an LMC. It does not currently include women who receive DHB funded Primary Care. The most recent data (2014 NZ Clinical Indicators) shows our rate at 10.2%, which is below the national average of 12.8%.

Table 32: Maternal tobacco use during postnatal period (2 weeks after birth), by facility

	2012	2013	2014
Number of smokers at 2/52	160	193	172
Number of all smokers	1750	1709	1686
Our rate %	9.1 %	11.3%	10.2%
All Secondary and Tertiary Facilities	12.8 %	12.6%	11.0%
All Primary Facilities	22.5 %	20.6%	20.2%
All home births	13 %	14.5%	12.2%
New Zealand	13.9 %	13.5%	12.8%

Numerator: Total number of women identified as smokers at 2 weeks after birth
Denominator: Total number of women with smoking status at 2 weeks after birth reported.

We are please to see a reduction in maternal tobacco use during the postnatal period in 2014.

Indicator Seventeen: Women with BMI over 35

Prior to 3/7/2014 HVDHB Data collection ranges for BMI were; <35, 35-49 or ≥50. This was changed to align with PMMRC criteria part way through the 2014 year. The below table is a mix of old measurements and new as aligned. 2015 is our first full year of data within the new ranges and is all women birthing at Huttmaternity regardless of parity.

Table 33: Body Mass Index for all Births in 2013 – 2015 Huttmaternity Data

	2013	2014 *	2015
< 35	1560	786	
>= 40		23	84
<= 18.4		29	28
18.5 - 24.99		418	833
25 - 29.99		242	534
30 - 34.99		110	230
35 - 39.99		48	119
35 - 49	258	116	
>= 50	17	6	
Unknown	15	12	28
Total	1850	1790	1856

This was introduced as a new indicator for 2013 by MOH and measures women with a BMI over 35. For 2013 they have provided the following data for standard primips.

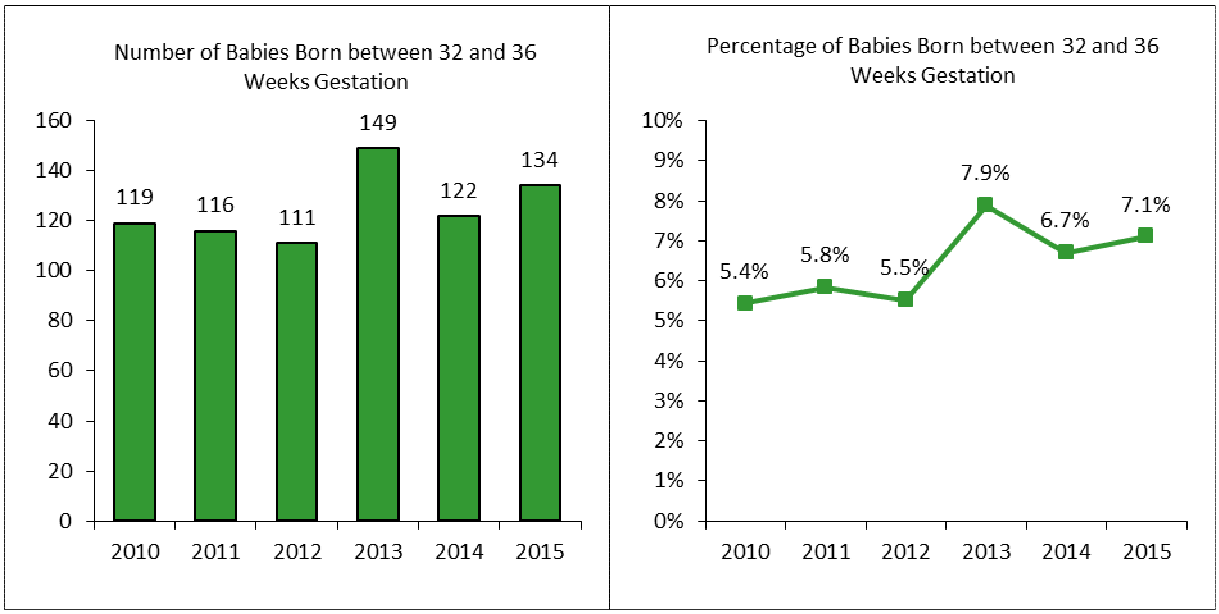
Table 34: BMI for Standard Primip

	2013	2014
BMI 36-40	104	103
BMI >40	78	59
Total	182	162
all women	1746	1718
our %	10.4%	9.4%
Secondary and Tertiary Facilities	8.6%	9.3%
National %	8.2%	8.8%

Numerator: total number of women with BMI over 35
Denominator: total number of women with BMI recorded.

Comment
As with other indicators such as tobacco use, this information is collected and reported with different ranges i.e. PMMRC and MOH. This makes it difficult to benchmark and compare our status. We do note that against the 2013 and 2014 data we have a high rate. This may significantly impact on our all other indicators i.e. C/S, IOL, GA C/S, and breast feeding. This may contribute to the increase in Secondary Care referrals and consultations.

Indicator Eighteen: Preterm birth



Numerator: Total number of deliveries at between 32 weeks 0 days and 36 weeks 6 days gestation
Denominator: Total number of hospital births

Comment:
In 2012 this indicator was further broken down to <32 weeks, and 32-36 weeks in the New Zealand Maternity Clinical Indicators, our above figures don't include the <32 week figures, this make it difficult to benchmark against MOH data.

Indicator Nineteen: Small babies at term (37-42 weeks' gestation) (New)

Another new MOH indicator since 2013. With rates of 2.4% for 2013, and 2.9% for 2014 we are tracking below the national average.

Indicator Twenty: Small babies at term born at 40-42 weeks' weeks gestation (New)

Table 35: Small babies at term, born 40-42 weeks gestation

	2013	2014
Huttmaternity	39%	30.6%
Secondary and Tertiary Facilities	34.9%	37.9%
National	36.7%	39.4%

Comment:
We are pleased to see a decrease in our 2013 average of 39% to 30.6% in 2014. This sits us below the national average of 39.4%.

Numerator: Total number of babies born at 40-42 weeks' gestation with birth weight under the 10th centile for their gestation
Denominator: Total number of babies born at 37-42 weeks gestation with birth weight under the 10th centile for their gestation

Indicator Twenty One: Babies born at 37+ weeks' gestation requiring respiratory support (New)

HVDHB aligns with that national rate of 2% for 2014 within this indicator.

Numerator: Total number of babies born at 37+ weeks' gestation requiring over 4 hours of respiratory support
Denominator: Total number of babies born at 37+ weeks' gestation

Section Five: Maternity Quality & Safety Programme Activities 2015

The Maternity Quality and Safety Programme (MQSP) have had a large number of quality initiatives underway for the 2015 year. This was a combination of building on work commenced in 2014, review of work undertaken to ensure embedded processes and new work streams.

For the new Maternity Quality and Safety Programme year, a three tier structure has been introduced: Emerging, Established and Excelling. Based on self assessment against the New Zealand Maternity Standards and our programme objectives, it was agreed between MOH and Huttmaternity we are in the Established Tier.

The 2015 year for the Huttmaternity MQSP has focused on consumer and sector engagement.

The MQSP at Hutt is supported by a Coordinator at 0.5 FTE, and Administration support at 0.5 FTE.

Consumer Members

In previous years we have struggled with retaining Consumers on our MCGG for the full term of membership. In June 2015 we advertised and recruited three new consumer members. This is an increase from previous years with the hope that it would offer better support, increased engagement at attending meetings and assistance with our work streams. After an orientation period with the main MCGG we held a work stream planning meeting with the Consumers. This enabled us to identify several streams and for each consumer to take a lead on MQSP Plans for the upcoming year, these are outlined in our Program Plan in Appendix One.

Governance and Clinical Leadership

There were some minor changes in the member composition of our Maternity Clinical Governance Group (MCGG), with new Paediatric Staff and Consumer Members. Our range of meetings and forums are well embedded within our governance structure and are working well.

Mid 2015 we reviewed our MCGG meeting requirements and changed from monthly meetings to every second month. We then initiated a Sector & Consumer Engagement Group which meets on the alternate months. This is to support progression of the Sector and Consumer work streams.

In June 2015 we had a change in Consumers members. At that time we proposed and successfully increased the number of consumer representation up to three members.

Towards the latter part of 2015 there was recruitment of a joint Director of Midwifery across Hutt Valley DHB and Wairarapa DHB.

The DHB is planning to establish a Clinical Council in 2016 and the Directory of Midwifery will be part of this group.

MCGG Members

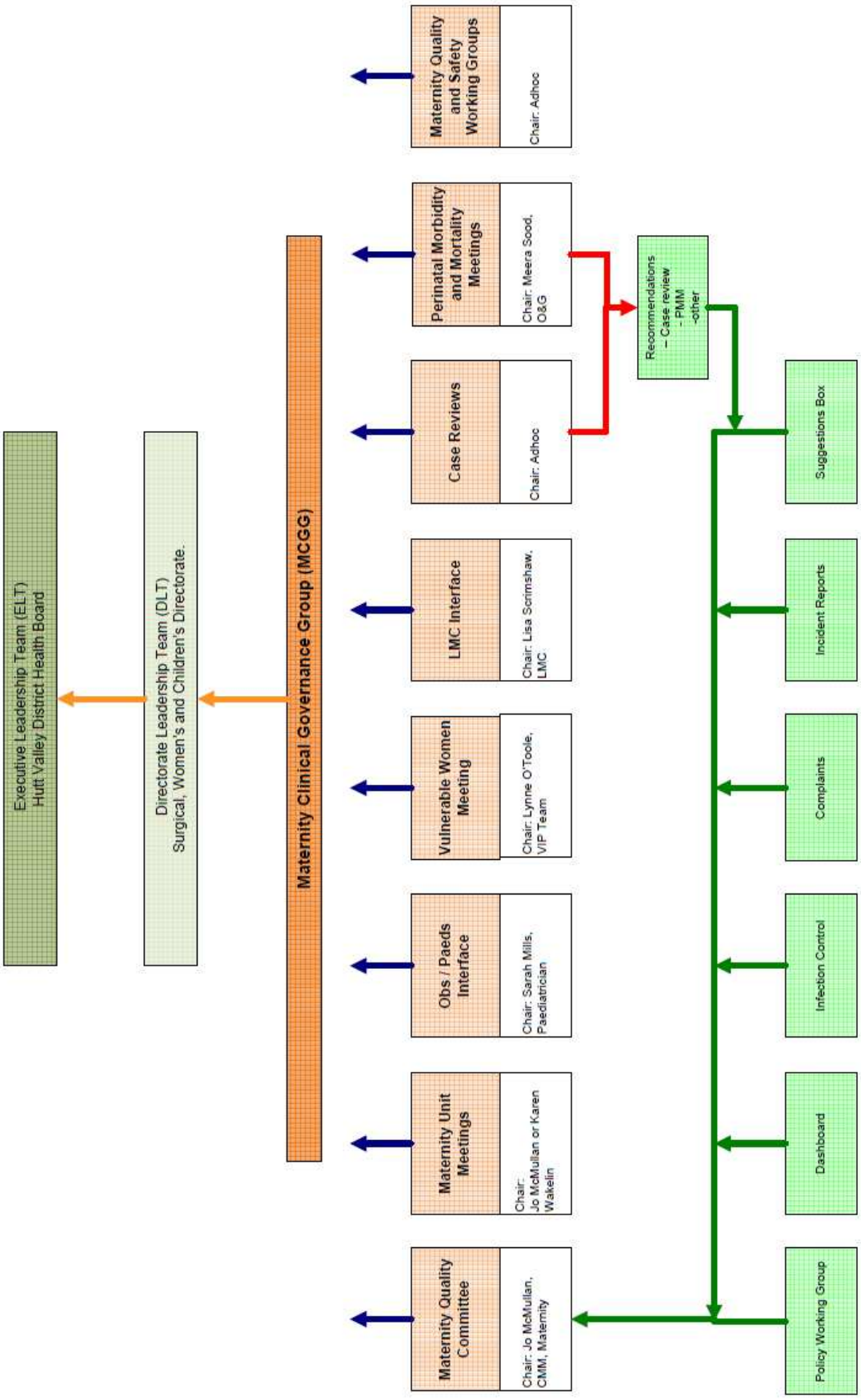
Left to Right are:

Chris Mallon, Director of Midwifery
Meera Sood, Obstetrician
Nicky Jackson, Sector and Consumer Member
Sagni Prasad, Paediatrician
Davina Smith, Primary Youth
Clare Dulver, Consumer Member
Megan Telfar, Consumer Member
Mere Te Paki, Primary Health Member
Margaret Hope, Core Midwife Member
Jo McMullan, Clinical Midwifery Manager
Emma Skudder, SIDU
Vida Rye, Consumer Member
Alison grant, LMC Member

Absent

Sarah Boyes, Director of Operations
Nicola Giblett, Quality Facilitator
Fuaao Stowers, Pacific Health Facilitator
Elle Ratcliffe, Admin Support, MQSP Programme
Joan Burns, Quality - DHB Quality Team

Maternity Quality and Safety Structure - 2015



Quality Initiatives

Breast Feeding Support Clinic and Lactation Consultant Services

A large portfolio of quality initiatives has been undertaken by the Breast Feeding Working Group. These have been outlined in the above section on Infant Feeding and Lactation Services.

Safe Sleep:

We rolled out the Shaken Baby Prevention Programme at Hutt Hospital on 26th May 2015; the 2 hour training session was well attended by staff and representatives from several local support agencies. The programme was also presented at the Grand Round that day with excellent attendance from several departments of the DHB. Progress to date is the purchase of several TV/DVD players via a grant to enhance the delivery of the programme. Approximately 50% of current DHB employed midwives have received the train the trainer programme. A significant improvement for the programme has been the embedding of the SBS documentation into the baby's clinical record. SBS is also now part of the core midwife orientation package, so any new midwifery staff receives the training package. There have been some movement with clinical champions - there are 5 clinical champions between SCBU or maternity inpatient services who currently provide train the trainer programme. There are still barriers to the training delivery – mostly around the ability to do a face to face training; therefore the online package is being marketed more frequently.

Maternity Assessment Unit and Community Midwives Team Health Check:

Our Maternity Assessment Unit (MAU) has been in operation since late 2010, with the introduction of phased work streams. Within MAU we have 3 foci, the Secondary Care Obstetric Clinic, and Early Pregnancy Assessment service and Obstetric Assessments. MAU has not had a review of pathways and processors during this time, although small changes have been made as needed. We have also had changes occurring within our Community Midwives Team. To assess these services we undertook a Health Check Dec 2014-Feb 2015, using the framework of four quadrants: Patient Experience, Process & Efficiency, Health Workplace and Value for Money. Staff were invited to feedback several ways, this information was collated and fed back to staff twice for further comment / input. From this stocktake there was a range of simple actions such as reminders of systems and processes, or communications, and eight recommendations that required further investigation or work planning. These formed the basis of some of the 2015 MQSP objectives. The actions/communications were apportioned a lead responsible to ensure follow up actions were completed. The recommendations were fed into a variety of working groups. The following are brief outlines of the recommendations and outcomes.

<u>Recommendation (A):</u> That the maternity management team continue to work with the Directorate Leadership Team (DLT) to investigate space opportunities for MAU. This may involve preparing a business care for the DLT, outlining the benefits, risks and costs of this. Suggested: CMM, Obstetric Head and Quality Facilitator

OUTCOME: Several options have been looked at within DLT level, but not viable for a variety of reasons. This is still on the pending list for the Director of Operations, Surgical, Women's and Children's.

<u>Recommendation (B):</u> That investigation is undertaken to review the Secondary Care Obstetric Clinics, including the clinic template, workloads and future planning, Day Case Assessment pathway, Roles and Responsibilities

OUTCOME: The capacity and demand of the Secondary Care Obstetric clinic has been reviewed, clinic templates altered and additional clinics arranged. Work on the Day Case assessment pathway has commenced with a review of the documentation. This is currently being trialled and will become a paperless pathway.

<u>Recommendation C</u>: To investigate Auxiliary support (Admin or HCA) in MAU. Currently trialling a new clip board system of duties for HCAs. Commence early November, Quality Facilitator to review prior to Christmas with stakeholders

OUTCOME: Admin support for operational work for MAU is via the Maternity Enquiries staff. Additional adhoc support is also available through the MQSP Support worker for pathway development or quality initiatives. There is no further capacity for an increase in FTE for administration. Alternatives were looked into and we have automated out Births Deaths and Marriages Notification process to electronic. This frees up time resources for Admin within Maternity Enquiries. Some paper work processes were reviewed and we now scan copies of manual referrals into our clinical management system. This means they are handled less and are easily accessible via concerto.

The HCA team are rostered to cover the ward and birthing suite, and we have on average 3 days a week a split shift HCA. This enables one HCA to support MAU with items like cleaning and re-stocking. A clip board system is in place, which works well, as both HCAs and MAU staff can see which activities have been completed.

Of note is the introduction of an Enrolled Nurse to support the midwife coordinating the Combined Antenatal Diabetes Clinic. This clinic has a multi team approach involving up to 6 health professions. This has been very successful.

<u>Recommendation (D):</u> That further investigations assess the facilities of the new WebPAS Referral Management System, as this may offer a better way of collecting patient events. Quality Facilitator to arrange.

OUTCOME: This was investigated, but offers no further benefits to the service. No further actions taken.

<u>Recommendation (E): (3, 4 & 5):</u> CMM to facilitate Audit notes for documentation of named Midwife and Doctor

OUTCOME: Several sets of notes were reviewed for women with our Secondary Care Team as LMC. This is between 3-5 each month. All women receive midwifery input from our Primary Midwives team and it was clearly documented on the booking sheet.

<u>Recommendation (F):</u> That investigation be undertaken to review the manual diary system, patient check in/out, and allocation of routine appointments, to an electronic version. Suggested: Quality Facilitator to lead this work stream

OUTCOME: Work on this recommendation is still to occur. It is a very complex system with multiple factors and pathways that interlink.

<u>Recommendation (G):</u> MAU Staff liaise with Obstetric Staff in a discussion about the day case record sheet vs direct electronic recording onto the discharge summary. Suggested a MAU Midwife leads this discussion.

OUTCOME: Preliminary discussion has been held and is not just focused on our Day Cases. We have several pathways in place that could be altered by some suggested changes. Some changes have occurred on our Day Case assessment and that is the first step in moving to a paperless system. This needs to be looked at in a wider context, again with multiple pathways that interlink.

<u>Recommendation (H)</u>: That all Maternity Services staff are rotated through MAU

OUTCOME: Midwifery staff is now placed on extended rotation through MAU. As part of this process we have been developing standard operating procedure manuals for our MAU. We have developed one for area specific information and for our Early Pregnancy Assessment Clinic. Still under development and due to be finished in 2016 are ones for our Secondary Care Obstetric Clinic and our Obstetric Assessment roles.

Work was also undertaken in conjunction with the Wellington Miscarriage Support Group to revise their Coping with Miscarriage booklet. Very minimal changes were made to the original booklet which is no longer available in printed version. We have made this available to women who attend our EPAC.

MAU TV:

Work continued in the establishment of a range of pregnancy and parenting health promotion messaging for the TV in MAU. This went live in January 2015, and will continue to be added to as information arises, it includes images, messaging and videos. MAU has a large number of women and families passing through the doors, a portion of which wait in the area where the TV is situated. This is a good opportunity to promote health and information regarding pregnancy.

Holly Walker Education Fund:

This fund commenced in 2014 at the generosity of a consumer member from our Maternity Clinical Governance Group, and continued until June 2015. Rather than receiving a koha for her participation in the MCGG, the funds were placed in an education trust. Any core staff member or LMC were able to apply for funding to attend training or education that had direct impact on care of women and babies. This sum of funding was also matched by an anonymous donor. Between September 2014 and March 2015 there were 13 individual applications and one group application of 14 individuals, to the fund. All were awarded full or partial funding for their education requirements. This fund was very successful as an additional source for Huttmaternity staff.

3DHB Campaign:

In 2014 we ran a successful regional campaign on the Top 5 things to do in the first 10 weeks of pregnancy. For 2015 our topic was Baby Movements. Again this was sub regional with a wide range of media formats utilised. We chose this topic of baby movement in line with the recommendations from PMMRC. By increasing recognition of fetal movements as an important indicator of fetal wellbeing we hope to decrease the number of stillbirths.

Audits:

We have devised an audit registration form to keep track of the audits being undertaken to ensure there are no double ups of topics (as has happened in previous years). The register audit form includes how the results will be disseminated across the service.

Audit: Incidence, initial management and follow up of the patients sustained 3rd an 4th degree perineal laceration during labour

Retrospective data over 6 months was assessed for the following variables: age, parity, mode of birth, use of episiotomy, place of repair OT vs DS, documentation, postop management, follow up, ongoing issues.

Results: 65.4 % of Pt sustained 3rd and 4th degree perineal tears were primiparous, the majority of the significant perineal laceration occurred during normal vaginal delivery, it was difficult to obtain the data on the delivery technique used ("hands on" vs. "hands off), the total number of episiotomies performed during the study period was 98/942 (10.4%) It is much lower then the rate of restricted episiotomy cited in the current literature(28.4%), and appears to be underutilized especially in VD, more then 50% of perineal lacerations were of 3b and higher degree(3b-44%, 3c 12%, 4th 3.8%), only 50% were repaired in OT, the overall documentation of the repair was adequate, but the use of the " perineal repair "column in the labor record was underutilized, the early post-operative management complied with guidelines, long term follow up needs to be improved, as only 50% of patients were seen in OPC (average time to follow up 2 months) Of those, 38.4% were symptomatic(perineal pain, dyspareunia, vaginal prolapse, flatus incontinence), however no further referrals or follow ups were arranged.

Recommendations

- Use of "hands-on" techniques and wider use of restrictive medio-lateral episiotomy
- Perform repair in OT if possible (as per guidelines)
- Consider introduction of "Episiotomy" (including technique and repair) and" OASIS" workshops for LMCs, core midwives, and junior medical staff.
- Supervision of junior staff to ensure correct technique
- Improve referral process to MAU

Huttmaternity Facebook:

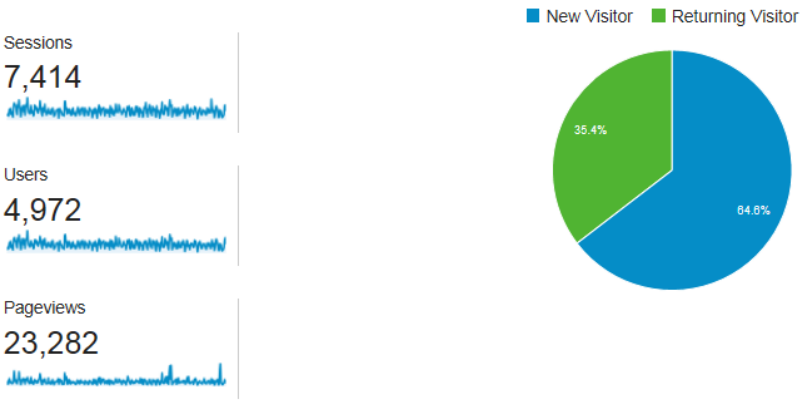
Our Huttmaternity Facebook went live in December 2014 just prior to Christmas. In hindsight this was probably not an ideal time with the holiday season. We had slow engagement with this over the 2015 year and in view of this ran a Christmas themed Photo Competition. The competition increased our engagement and created multiple conversations in this form of social media. Along side clinical staff, one of our Consumer members has taken a lead on this work stream.

Figure 16: Growth of Hutt Maternity's Facebook Page - 2015

Huttmaternity Website:

Over the later half of 2015 the Huttmaternity website had a revamp of look. This has made the site more user friendly with quick links. The complete content of the site was also reviewed and updated, and will be loaded in January 2016. We have also included a Health Professionals section which has links to our Policies, Publications and under development a training/education calendar. The calendar is due to go live late January/Early Feb 2016. The site also now includes a live feed to our Huttmaternity Facebook page. Below are the sessions, users and page view numbers for 2015. Our provisional numbers for early 2016 look promising with an increasing number of sessions, users and views. We look forward to reviewing the full 2016 analytics.

Figure 17: Hutt Maternity website engagement



Expo:

In July 2015 we held the inaugural Huttmaternity Expo. The aims of the Expo were to:

- encourage sector engagement and networking with maternity providers,
- encourage networking and understanding of NGOs and community groups available to women and families
- launch our Pre and Post Pregnancy Community Resources Directory

The Expo was held over 3 hours, with a rotating schedule of short education snap shots on Baby Safety, LMC Care, Early Pregnancy Loss, referral to Secondary Care clinics and Clinical Pathways, and ended with a multidisciplinary panel.

Power point presentations ran on slide shows across the 3 rooms with pregnancy care information, Huttmaternity website and Facebook pages and our top 5 Things to do within the first 10 Weeks.

Local NGOs and community groups were asked to display information about their groups. 58 groups were invited to participate with 37 confirmed attendances, and four wanting static display space only.

The feedback from NGOs, Community Groups and LMCs that attended was very positive. Unfortunately we did not get the number of GPs or Practice Nurses who we had anticipated, despite consultation and involvement with our local PHO. This has been taken on-board for the next Expo, as the resounding feedback was this should be an annual event.

Pre and Post Pregnancy Community Resources Directory:

Our directory is a collection of agencies, NGOs and community groups in the wider Valley region which provide a pregnancy or post natal based service. The directory is the first of its kind in this DHB for maternity users, although currently aimed at Health Professionals the directory is available anyone to access on our website. Future planning for 2016 is to adapt this for use by both Health Professionals and women and families. The directory is cross-indexed by category and A-Z for ease of use.

GP Notification of Registration for LMC care with DHB Primary or Secondary Care teams:

As a result of feedback from Primary Care we have developed an electronic system where the GP practice is notified when a women engages and is booked under the DHB Primary Midwives Team or Secondary Care Team. Although this is a small portion of the women in the Hutt Valley it is step forward in creating links between GPs and the DHB maternity services.

Document Control:

It was identified early in 2015 we did not have a robust system in place for policy review and access for staff. There had been some systems established but a lack of coordination by key people, who understood where / what needed reviewing next and an adhoc approach was used. Policies were often difficult to find due to the way they were named and filed. There were multiple hard copies of different versions of policies in folders around the unit.

A clear robust system was identified and agreed. Work was undertaken to refine the database of policies with review dates and named facilitators. All policies underwent a quick review around the name, expiry, and facilitator. The policies now sit on a computer drive accessible by all staff and on the Huttmaternity website for all to access. There are links from the main DHB website to the Huttmaternity site for external department users.

Alongside the above work at DHB level our copying/printing services are moving to an outside contract. This has been an opportune time to review all forms, patient information and standard operating manuals.

We have initiated a cataloguing and version control system which aligns with the system for our policies. Each policy, document or form etc. is numbered using a coded system. Forms and patient information pamphlets have been associated to relevant policies and review dates aligned.

These systems ensure a robust revolving system for reviewing all Huttmaternity documents in a timely manner. This work stream will continue into the first quarter of 2016.

Automated Births, Deaths and Marriages Report:

In order to have a more robust process for Notifications of Births of babies born at our facility, we established a system, where the data is directly extracted from our clinical documentation and submitted to BDM electronically. Clinicians no longer manually complete the BDM form resulting in less paper and paperwork, and freeing up clinician time. Our administration run this report 2-3 times a week, which takes approximately 15 minutes, as compared to an hour a day previously, and time chasing missing/incomplete forms from clinicians. We still have the occasional issue, but these are far less complex and time consuming than previously. This is now embedded as business us usual, and there are several administration staff able to undertake this activity.

Newsletter review:

When we commenced the MQSP we investigated ways to communicate with primary practices and stakeholders. We created an external newsletter, which is produced 3-4 times a year. This was reviewed in 2015 and felt inadequate to meet the more frequent communication requirements for core staff and LMCs of the day to day operation issues within the service. We now produce an internal newsletter for core staff and LMCs which is emailed out on the first and third Fridays of the month. There are multiple contributors to these newsletters and it is open to everyone to submit items. By having this planned approach it has reduced the amount of information sent out separately. We include items like: News items, Education and Training, Staff News, Upcoming meetings, Recommendations, Policy updates, and meeting minutes. Our external newsletter continues to primary practices and other maternity stakeholders.

Screening, Diagnosis and Management of Gestational Diabetes in New Zealand; A clinical practice guideline:

These national guidelines were released in December 2014 with an expectation they would be implemented by June 2016. Huttmaternity has spent the intervening time reviewing its pathway, protocols and policy around GDM, and making appropriate changes by the Antenatal Diabetes and Obstetric Team. This work has been lead by the midwife who leads our AND Clinic.

Communications around changes to policy and pathway have been undertaken. Practitioners have been asked to manually add HBA1C to first antenatal bloods, then from 1/2/16 HBA1C as part of first antenatal blood work up is to commence at the community laboratory.

GP Notification of Registration for LMC care with DHB Primary or Secondary Care teams:

As a result of feedback from Primary Care we have developed an electronic system where the GP practice is notified when a women engages and is booked under the DHB Primary Midwives Team or Secondary Care Team. Although this is a small portion of the women in the Hutt Valley it is step forward in creating links between GPs and the DHB maternity services.

Dashboard:

As our programme has developed we have undertaken a review of our Maternity Dashboard. This was to make changes in the different views of data, our own KPIs and MOH, and benchmarking against our own statistics. This involved a dedicated team from IT and maternity, to undertake changes in our clinical documentation and the dashboard. Unfortunately to make improvement we had to disable the dashboard during this time, and we have been unable to monitor many of our KPI for this timeframe. Our Dashboard is a visual snap shot and alert system for monitoring KPIs.

This is not live data, but our Dashboard will look like this:

Figure 18: Dashboard example (Not live data)

Maternity KPI: HVDHB All	2014 Jan	2014 Feb	2014 Mar	2014 Apr	2014 May	2014 Jun	2014 Jul	2014 Aug	2014 Sep	2014 Oct	2014 Nov	2014 Dec	Total
01 Number of babies born	148	153	169	163	151	149	130	150	137	167	151	168	1,836
02 Number of women delivered	145	151	162	161	149	146	129	148	137	164	149	168	1,809
03 Spontaneous Vaginal Birth	93.2% 138	92.8% 142	89.9% 152	90.8% 148	90.1% 136	91.3% 136	73.1% 95	62.0% 93	68.6% 94	65.3% 109	64.9% 98	58.3% 98	1,439
04 Instrumental Vaginal Birth	6.08% 9	5.23% 8	8.88% 15	7.98% 13	9.93% 15	8.72% 13	7.69% 10	10.0% 15	9.49% 13	5.99% 10	11.3% 17	10.7% 18	156
05 Caesarean Section	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	18.5% 24	27.3% 41	21.2% 29	27.5% 46	23.8% 36	28.0% 47	223
06 Acute Caesarean Section	18.2% 27	14.4% 22	9.47% 16	14.1% 23	14.6% 22	14.1% 21	12.3% 16	15.3% 23	16.1% 22	13.8% 23	13.9% 21	16.7% 28	264
07 Elective Caesarean Section	10.8% 16	8.50% 13	17.8% 30	12.3% 20	7.95% 12	10.7% 16	10.0% 13	12.7% 19	9.49% 13	16.8% 28	12.6% 19	11.3% 19	218
08 Induction of Labour	24.3% 36	30.1% 46	19.5% 33	20.9% 34	21.2% 32	21.5% 32	22.3% 29	24.7% 37	17.5% 24	21.0% 35	20.5% 31	23.2% 39	408
09 Vaginal birth after CS	2.03% 3	4.58% 7	0.59% 1	0.61% 1	2.65% 4	0.00% 0	1.54% 2	1.33% 2	2.19% 3	1.20% 2	1.32% 2	1.19% 2	29
10 Epidural	27.7% 41	29.4% 45	24.9% 42	24.5% 40	30.5% 46	24.8% 37	20.8% 27	28.0% 42	33.6% 46	26.9% 45	33.1% 50	28.6% 48	509
11 Third or fourth degree perineal tear	0.68% 1	3.92% 6	2.37% 4	2.45% 4	1.32% 2	6.04% 9	1.54% 2	0.67% 1	2.92% 4	0.60% 1	2.65% 4	0.00% 0	38
12 Maternal admission to ICU	0.00% 0	0.65% 1	0.00% 0	0.00% 0	0.00% 0	1.34% 2	0.00% 0	0.67% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4
13 Estimated blood loss > 1 litre	1.35% 2	1.96% 3	4.14% 7	1.84% 3	3.31% 5	3.36% 5	1.54% 2	1.33% 2	2.92% 4	1.20% 2	1.32% 2	1.19% 2	39
14 Blood transfusion with CS	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.60% 1	0.00% 0	0.00% 0	1
15 Blood transfusion with VB	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.77% 1	0.00% 0	0.73% 1	0.60% 1	0.00% 0	0.00% 0	3
16 Admission to SCBU	13.5% 20	8.50% 13	8.88% 15	7.98% 13	15.9% 24	7.38% 11	9.23% 12	11.3% 17	8.03% 11	12.6% 21	11.9% 18	12.5% 21	196
17 Stillbirth	0.68% 1	1.31% 2	1.18% 2	0.61% 1	0.00% 0	0.00% 0	0.77% 1	0.67% 1	0.73% 1	1.20% 2	0.00% 0	2.38% 4	15
18 Neonatal death	0.68% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1
19 Preterm birth	7.43% 11	5.88% 9	6.51% 11	8.59% 14	4.64% 7	4.03% 6	6.15% 8	6.67% 10	2.92% 4	7.19% 12	5.30% 8	4.17% 7	107
20 Exclusively Breastfeeding	72.3% 107	72.5% 111	72.2% 122	69.3% 113	73.5% 111	73.8% 110	71.5% 93	68.7% 103	70.8% 97	68.3% 114	69.5% 105	76.2% 128	1,314

Primary Maternity Data Collection System

Huttmaternity established our process and system to provide Primary Maternity Data via the SIMPL portal to MOH in 2014 as per our contract agreement and embedded it as business as usual. We currently collect all mandatory data fields manually and data enter these into SIMPL. In late 2015 we received communications from MOH re our data reporting uptake and auditing issues. There is a discrepancy between the number we have processed, over 3,500 entries, and those received by MOH into their dataset. We have been working with MOH to try and understand the complexity of the data entries, and solve why there are discrepancies.

An example of this is around community based LMCs such as private obstetricians entering data into Health Pac, and the DHB also entering data about the same women, as the private obstetricians contract us to undertake labour/birth and post natal care.

We continue to enter all known data, while working with MOH to solve these issues.

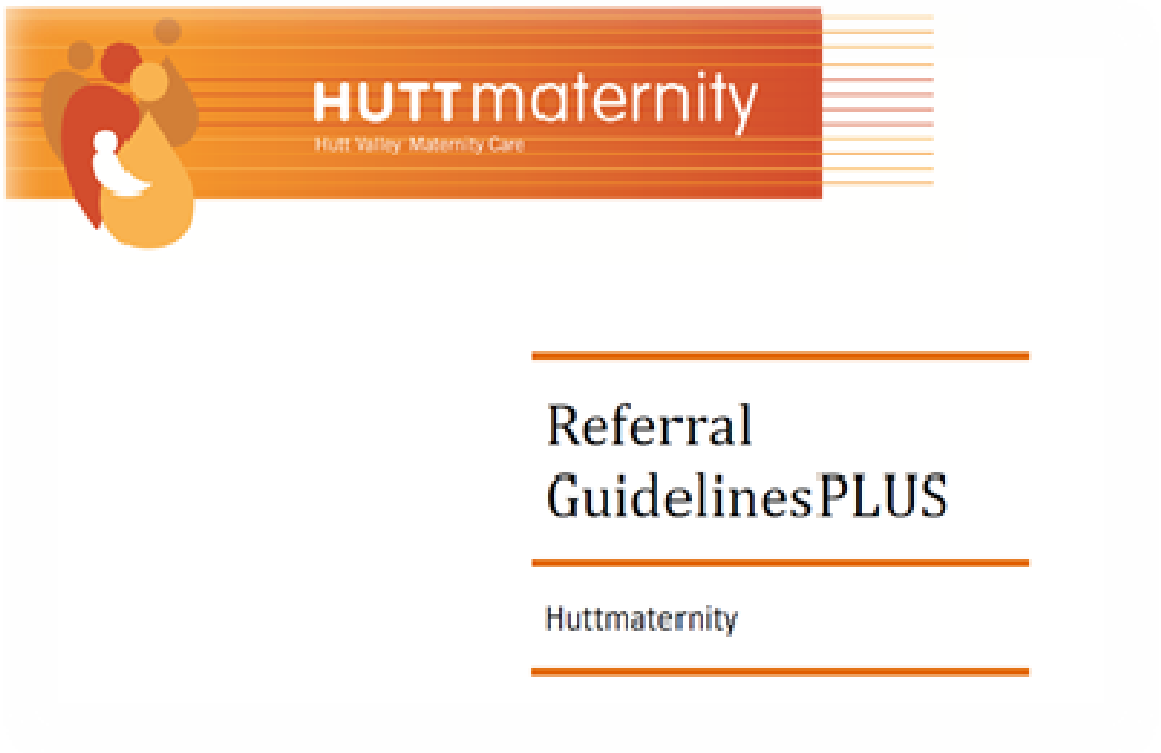
Staff Flu Vaccinations

Huttmaternity are please to report that our Midwives (Core and LMC) have the highest rate of Flu vaccination for 2015.

Referral Plus:

Under development this year was our Ref Plus. Based on a version at Waitemata DHB, this is an additional guideline tool for LMCs and Primary Care regarding referral to Secondary Care Obstetric Services. The Huttmaternity Ref Plus expands MOH Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) with localised information, guidelines on when to refer women, clinical recommendations and rationale. It encompasses all the referral reasons to Secondary Care Obstetric Services Clinics, with the aim of encouraging timely referrals. The draft went out for feedback in the last quarter of 2015. This is an additional tool to sit along side the Referral Guidelines and will start the basis our Health Pathways for Obstetrics at Hutt Maternity.

We are aiming for a January 2016 launch, when it will be widely circulated to stakeholders and available on our Health Professional Section on the Huttmaternity Website.



Section Six: National Maternity Monitoring Group Priorities

Along side our own MQSP Objectives we have allocated high priority to the National Maternity Monitoring Group (NMMG) work streams. NMMG have both recommendations of work streams and priorities. We have outlined our progress or plans to date, in each of these priorities.

Timing of Registration with an LMC – expanded to look at first antenatal assessment:

This year we continued to promote our "Top 5 things to do in the first 10 Weeks" campaign, we finalised our update on the Huttmaternity website including links to LMC availability and the Findyourmidwife site. Over the year on going work establishing our Huttmaternity Facebook page has also continued.

July 2015 saw our inaugural Huttmaternity Expo where our Clinical Head of Department ran a presentation to GPs on First Antenatal Care. Feedback from the Expo was positive, so we will be running again in 2016. We have engaged with the PHO to find out what they want from us as a service around care of pregnant women and families.

We will be launching our RefPlus, which is an additional tool to the Referral Guidelines on what and when to refer. It is the starting point for Clinical Health Pathways for Obstetrics. Our external newsletter in September ran a Clinical Update on early pregnancy diagnosis and miscarriage management.

We did two "out and about" with GP practices in June and September, including information for antenatal screening, the National Guideline for management of Diabetes, food safety, folic acid and iodine, our "Top 5 campaign" and launch of our Pre and Post Pregnancy Resources Directory.

Clinical Coding:

We have great links with our clinical coding team. When we reviewed our Dashboard and associated electronic templates, coding were asked for their input. All their suggestions were adapted and integrated into our changes. We are planning a review of unnecessary admissions to our Maternity Assessment unit for 2016. There is a portion of women we admit in order to obtain electronic records. As there have been changes in the IT systems, we can now review our processes. We will be building electronic templates for this portion of women and coding will be involved in their development.

Variation in gestation at birth:

In 2014 we ran a large audit looking at Premature Labour between 32 – 36+6 weeks' gestation and mode of delivery including induction of labour and caesarean section. We have done no further studies. For this Annual Report (2015) we have included gestation in our data where possible. We have also instigated an Audit on gestation at induction of labour and caesarean section for 2015 data.

Maternal Mental Health:

As a sub region there was development of the 4 box referral pathway.

Huttmaternity also now have satellite clinics from regional maternal mental health services run by a Clinic Nurse Specialist. This has been well received by practitioners. The clinic commenced in Feb 2014 and there were 23 recorded events/assessments for that calendar year (11 months). In 2015 this has almost double to 52 events/assessments. Already in 2016 we can see an increase in the numbers for Jan-March. A portion of these women will also been seen by our Obstetric team at a consecutive appointment, thus reducing the amount of times she needs to come to the hospital.

Connecting and Supporting Consumer members:

This has been discussed further up in our report. We now have 3 consumer members, an increase from previous years. They consumers have access to business cards, and an email address separate from the DHB. Our consumers are encouraged to attend the national forum each year at the cost of the DHB. In 2016 we have planned work streams for the consumers and each is taken a lead on a project. Our consumers are paid to attend meetings, and receive payment for work done outside of scheduled meetings.

"I wish to praise the services provided by Hutt Hospital Staff. My visit to this hospital was my first visit for my first baby. I believe that I received very good service from all of the midwives that were on duty for my duration of stay. The midwives and doctors were very encouraging during my labour"

Section Seven: Perinatal and Maternal Mortality Review Committee Recommendations at Huttmaternity

PMMRC is an independent committee that reviews the deaths of babies and mother in New Zealand. Every year the PMMRC release a range of recommendations. The following are recommendations from the 9th Annual Report release in 2015, and actions undertaken at Huttmaternity in direct relation to each recommendation.

Perinatal mortality

1. **That all maternity care providers identify women with modifiable risk factors for perinatal related death and work individually and collectively to address these.**

   a. **Improving uptake of periconceptual folate**
   Huttmaternity in conjunction with Wairarapa and CCDHB had a media campaign including radio, street posters, newspaper articles to promote 'the first 5 things to do in the first 10 weeks of pregnancy' that included the uptake of folic acid. This topic is also addressed, for pre-pregnancy care, on our website.

   b. **Pre-pregnancy care for known medical disease such as diabetes**
   Our website also addresses the importance of contacting your GP or specialist if considering becoming pregnant if there is an existing medical issue.

   c. **Access to antenatal care**
   The first of the recommendations in our '5 things' campaign was to find a lead maternity carer. This is backed up on our website with access to find a midwife website and our DHB list of LMC availability. Hutt Valley DHB has a primary team available to care for those women unable to find a midwife.

   d. **Accurate height and weight management in pregnancy and advice on ideal weight gain**
   Our booking in documentation has an area for LMCs to document height and weight. We have recently audited the notes and are planning to present the results and education at the next PMM in April. We are awaiting the roll out of the 'health for life' project for clinicians to gain some practical skills in engaging women in weight management and exercise, yet again our website addresses nutrition and exercise.

   e. **Prevention and appropriate management of multiple pregnancy**
   Appropriate management of multiple births is addressed in our 'Referral plus' guidelines launched 2015. 'Referral plus' is a localised version of the national referral guidelines that includes further guidance of when to refer women and what they might expect e.g. guidance relating to chorionicity. 'Referral plus' has been produced as a hard copy for all our primary internal and external stakeholders and is available on our website in the health professionals section.

   f. **Smoking cessation**
   Smoking cessation is addressed in our '5 things' campaign and website. Smoking status is addressed by our clinicians at contact however we need to revisit how we could improve our statistics especially pertaining to Maori. We are reporting

smoking status and advice for cessation support in both our annual report and most recently to the tobacco advisory sector at MOH. The data provides us with an opportunity to look at our practice in detail.

g. **Antenatal recognition and management of fetal growth restriction**
'Referral plus' addresses IUGR. All LMCs are encouraged to generate GROW charts from 26/40 and these are required for obstetric consultations.

h. **Prevention of preterm birth and management of threatened preterm labour**
Fetal fibrinectin has been introduced into the unit to be used as a tool to rule out premature labour. We audited 2013 data in 2014/15 and increased the focus on women with a past history of premature labour with more active management in an attempt to prevent recurrence i.e. cervical length assessment and vaginal progesterone 'Referral plus' addresses history of premature birth. Management of preterm labour is a recently reviewed policy.

i. **Following evidence-based recommendations for indications for IOL**
Presently we are reviewing the indications for induction of labour (IOL). Our maternity dashboard has just been reconfigured and displays our rate of IOL so we can gauge whether we are within normal limits not only for the standard primp but all other women being induced.

j. **Advice to women and appropriate management of decreased fetal movements**
Last year the 3 DHBs ran another campaign regarding baby movements, again this was advertised on posters, radio interviews Maori and Pacific, on our website, newspapers including translated into Punjabi for the local Indian community.

Alongside our Huttmaternity website we manage a Facebook page that we use as a health promotion avenue to provide messaging including smoking cessation, our campaigns and anything pertinent to health and wellbeing of mothers and babies.

2. **Offer education to all clinicians so they are proficient at screening woman, and are aware of local services and pathways to care, for the following:**

a. **Family violence**
The VIP programme is offered in the Hutt DHB for all clinicians and hospital documentation has mandatory areas to indicate screening has occurred.

b. **Smoking**
Smoking cessation education is readily available through Regional Public Health: Our smokefree coordinator is available to provide one on one education for health practitioners or a regularly monthly session can be attended. Te Hapu Ora programme is running several workshops a year for midwives.

c. **Alcohol and other substance use**
In 2015 HVDHB ran study days 'the hard stuff' to address alcohol and substance abuse and mental health issues. It was open to core and LMCs.

In 2015 we ran a 'maternity expo' as an opportunity for internal and external providers to network. The expo was held one evening with about 30 stalls, obstetric and midwifery short presentations and plenty of time to network. The 'expo' was arranged in conjunction

with the local PHO and all General Practices were invited however not many attended. We intend to run another expo this year and will liaise with the PHO to try and have better engagement with our health practice colleagues. A maternity resource directory was launched and provides a comprehensive list of community providers pertaining to pregnancy and early parenthood. The hard copy directory was circulated to all primary stakeholders and now 'live' version is available on our website.
We produce a fortnightly internal newsletter that is circulated to our internal stakeholders including LMCs to advertise education opportunities and our website posts the education calendar.

3. **That multi-disciplinary fetal surveillance training be mandatory for all clinicians involved in intrapartum care**

    a. **This training includes risk assessment for mothers and babies throughout pregnancy as well as intrapartum observations**
    The RANZCOG Fetal Surveillance Education Programme (FSEP) is available across the central region DHBs. Core midwives are expected to attend the FSEP workshop face to face once every 3 years and the online programme the next year and we are awaiting an intelligent intermittent auscultation workshop to make up the three yearly cycle. LMCs and obstetric staff are encouraged to attend/ undertake the online programme or workshop.

    b. **The aims include strengthening of supervision and support to promote professional judgment, interdisciplinary conversations and reflective practice.**
    There is a weekly multidisciplinary CTG meeting to discuss CTGs from emergency caesarean sections or abnormal CTGs of interest.

4. **There is observational evidence that improved detection of fetal growth restriction, accompanied by timely delivery, reduces perinatal morbidity and mortality. The PMMRC recommends that assessment of fetal growth should incorporate range of strategies including:**

    a. **Assessment and appropriate referral for risk factors for fetal growth restriction at first antenatal visit and throughout pregnancy**
    (Covered in 1g)

    b. **Accurate maternal height and weight at first antenatal assessment**
    (Covered in 1d)

    c. **Ongoing assessment of fetal growth by measuring fundal-symphysis in a standardized way, recorded at each antenatal appointment, preferably by the same person**

    d. **Plotting of fundal height on a tool for detection of fetal growth restriction from 26 weeks gestation.**
    (Covered in 1g)

    e. **If fetal growth restriction is confirmed by ultrasound, appropriate referral and assessment of fetal and maternal wellbeing and timely delivery are recommended. The NZ maternal fetal medicine guideline (2013) describes**

criteria for the management of small for gestational age pregnancies after 34 weeks.
(Covered in 1g)

5. **Seasonal or pandemic influenza vaccination is recommended for all pregnant women regardless of gestation and for women planning to be pregnant during the influenza season.**

   a. **Vaccination is also recommended for maternity care providers to reduce the risk to the woman and babies under their care.**
   All maternity staff including LMCs are offered flu vax every year. In 2015 Hutt maternity service had the highest uptake in the hospital. We have a registered nurse trained as a vaccinator in 2015 who will be available to vaccinate all maternity personnel this season.

   b. **The PMMRC recommends that the MOH consult with women and maternity care providers to address barriers to the uptake of influenza vaccination in pregnancy and implement strategies to increase access to and awareness of the benefit of vaccination.**
   The 2016 maternity campaign will address the importance of the influenza and whooping cough vaccines. This is in progress and will be launched April 2016.

6. **All pregnant women with epilepsy on medication should be referred to a physician.**

   a. **Women with a new diagnosis of epilepsy or a change in seizure frequency should be referred urgently**
   'Referral plus' addresses epilepsy and we have a medical physician with obstetric experience who is available for referrals and to discuss any cases of note.

7. **Widespread multidisciplinary education is required on the recognition of neonatal encephalopathy with a particular emphasis on babies with evidence of intrapartum asphyxia. This should include:**

   a. **Recognition of babies at increased risk by their history, signs suggestive of encephalopathy, knowledge of clinical pathways to induced cooling if required.**
   At the November 2015 PMM there was a presentation on NE

8. **That all DHBs review local incident cases of NE. the findings of these reviews should be shared at multidisciplinary local forum and form the basis of quality improvements as appropriate.**

   In January 2016 a NE pathway was outlined to ensure cases are captured. We have held our first multidisciplinary clinical review with obstetrics, paediatric and theatre triggered by a baby sent for cooling, following the new pathway. Recommendations are being collated and will be disseminated to all stakeholders via internal newsletter and paediatric channels.

Section Eight: Quality and Safety

Compliments

We have had 18 praises registered with the DHB Quality Team for 2015. The themes of these compliments relate to care and staff professionalism:

"I stayed in hospital … having my first baby & the entire time I stayed all midwives were so supportive to my husband and I"

"Thanks you very much to all midwives & Drs you do an amazing job!"

"They all deserve congratulations and we were very grateful for the professional, yet kind way they were involved with our baby's first few days"

Complaints

In the 2015 year there were 18 complaints registered with the DHB Quality Team. These can be summarized into the following categories:

Table 36: Complaint numbers by Category

Communication:	6
Standard of Clinical Care	7
Delay/Cancellation	3
Environment:	1
Access	1

All complaints were responded to in writing. If appropriate, a meeting was held with the complainant and their family, and clinical staff.
Our compliments, complaints and recommendations from all sources are reviewed by the Maternity Quality Committee. Appropriate actions are planned, documentation altered as needed and decisions communicated to relevant parties. Feedback from the Maternity Quality Committee is a standard item on our MCGG agenda.
All compliments and complaints are co-ordinated through the DHB Quality Team. There is a suggestions box at the Maternity Unit reception.

A planned work stream for 2016 is to initiate a consumer survey using the National Consumer Survey Tool provided by MOH. Our plan is to have quarterly or six monthly reporting on the responses to be able to act sooner. This may either reduce the number of complaints received or potentially increase the numbers. This will be looked at as part of the review process.

We have a main DHB generic Health Care Events reporting system and a complementary process to capture specific maternity events. See our pathway below.

Health Care Events

For our internal event reporting there were 46 inpatient and ward events, and 14 events for employee and affiliates. These include such events as needle sticks, slips and trips, and strains. A concerning development has been the reporting of 3 events concerning verbal abuse of staff. This issue is of concern across HVDHB and staff are encouraged to report incidences of abuse in order that they receive appropriate support. All events are reviewed by the Clinical Midwifery Manager and line managers as appropriate.
The main categories of the events concerning the ward environment and inpatients were:

- Care service coordination issues: These include such issues as equipment problems and handover between staff members.
- Equipment staffing and resource: Events concerning the availability of staff or equipment, and equipment failure.
- Medication and Fluid events
- Maternal and Childbirth: Where the process did not go smoothly due to staffing or equipment issues

Trigger List/Event Reporting – a quality initiative 2015

In mid 2014 we reviewed our pathway for events and reporting, looking at events that are not collected on the DHB Health Care Events (HCE) reporting system. Our aim was to improve services and learning opportunities based on these events. We developed a localised Obstetric Trigger list, which underwent a trial phase October - December 2014. This was reviewed early January and we launched out live phase.

Minimal changes were made to the trigger form content, but some minor pathway changes occurred with the aim of increasing the uptake of trigger forms completed. This has refined the processed and improved the number of events being reported. Each event is reviewed by the Weekly Trigger Review Group and a review plan decided. Options include; nil action required, systems review, case review or refer on to the Review Steering Group for consideration of RCA.

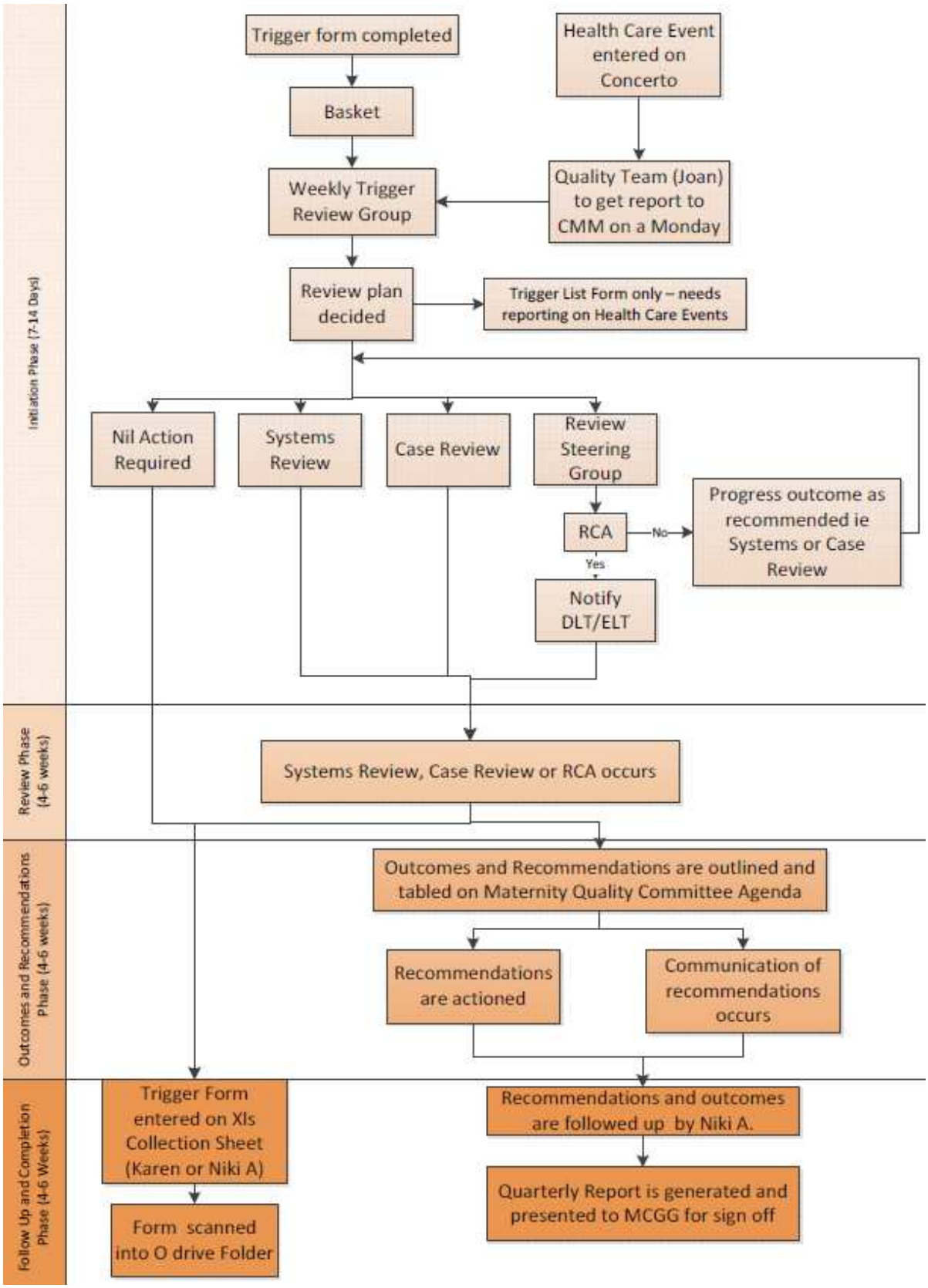
The Trigger pathway review also enabled us to further define cases for review and an RCA process at DHB level. This pathway currently sits alongside our DHB Health Care Events. We have also put suggested timelines against the pathway steps.

The DHB is updating its electronic reporting system/pathway in 2016 and the Obstetric Trigger List has been incorporated in this pathway.

Trigger Reports are produced quarterly on the number of events and outcomes which are presented to the MCGG and circulated to Obstetric stakeholders. Early 2016 will see our first annual Trigger Report Summary.

The process of introducing a Trigger list and revising the pathway has enabled us to review and tighten the pathway around events, reporting, review and actions pertaining to these. 2015 has seen us embed these processes as business as usual.

Trigger / Event Reporting Pathway - Huttmaternity



Clinical reviews and recommendations from 2014

The use of the trigger form process has instigated increased numbers of clinical reviews than previous years. There have been 7 case reviews over 2015. Some which have showcased good practice and staff have been commended; significantly this has included improved management of PPH.

The recommendations from the reviews all have aspects of increasing effective communication. Of note other recommendations included strengthening care-planning (development of care plans in progress); SMO oversight of RMOs (policy outlining mandatory attendance by SMOs); regular emergency drills (in place), the need for midwifery coordinator afterhours (in progress); best practice changes to policy (management of hypertension policy revamped); improving use of the referral guidelines (socialisation of Refplus to LMCs); encouragement of RANZCOG FSEP for individual practitioners.

Serious Events

HVHDB Maternity Service had 2 adverse sentinel events in the 2015 year. Both events have been reviewed and have been reported to the HVDHB Patient Safety Group for final SAC Rating.

Perinatal Mortality Cases

In 2014 in response to concerns from the community regarding place of care for women and families experiencing fetal loss beyond 13 weeks gestation, our birthing suite is now the point of care. In 2015 we have cared for 8 early losses.

There were twelve stillbirths and two neonatal deaths. The age range of the mothers was 23-43 years with representation across Maori, Pacifica, New Zealand European, South American and Indian ethnicities. This included 7 multips and 7 primips, only 2 were current smokers. One mother was classed as morbidly obese. Eleven post mortems were requested. There were a variety of reasons for the fetal demise with no trend. There were no maternal deaths in 2015.

The small numbers do not allow for any statistically significant analysis, however, we are cognisant of the PMMRC recommendations and endeavour to incorporate any recommendations into practice.

Section Nine: Forward Planning 2016-17

As part of the Maternity Quality and Safety contract we submitted a 2 year plan to MOH. See Appendix One.

Appendix one:

HUTT maternity
Hutt Valley Maternity Care

Maternity Quality and Safety

2 Year Programme Plan

Revised January 2016

Contents

Background

Huttmaternity has engaged in quality and safety activities since 2011, initially as a 'Demonstration Site' for MOH, the prequel to the formal Maternity Quality and Safety Programme (MQSP) which rolled out nationally in 2012. Over this time we have made great inroads in establishing a quality and safety framework led by our Maternity Clinical Governance Group (MCGG). Our MCGG consists of clinical leaders from Obstetrics and Paediatric services, consumers, LMCs, core staff, primary care, youth care, DHB Quality, Pacific Health Unit and SIDU members

Foundation work was undertaken to review our forums and quality structure, education framework, data monitoring and consumer engagement. Further work was undertaken and has been ongoing within the umbrella of the seven elements introduced in the "Implementing the MQSP a Guide" document from MOH in 2012.

A review of the MQSP took place in 2014/15 and ongoing Service Specifications are aimed at 3 tiers: Emerging, Established or Excelling. Huttmaternity and MOH have agreed that we are in the "Established" tier.

The MQSP has multiple influences at both national level with MOH and the National Maternity Monitoring Group (NMMG) work streams, National Clinical Indicators, the New Zealand Maternity Standards, and at local level with service requisites.

It has been these influences that have guided Huttmaternity to develop its work streams and objectives to date. Further information on the objectives and MQSP work previously completed is detailed in the Maternity Clinical Annual Reports for 2012, 2013 and 2014; these are all available on the Huttmaternity website:

www.Huttmaternity.org.nz

Moving forward into the end of 2015 to 2017 period we have identified current objectives for completion and established new objectives with a localised focus. The below objectives are in no significant order or priority, see the timeline for further detail.

The MQSP Coordinator will facilitate all work streams and monitor progress until completion, with the support of the Hutt Maternity Clinical Governance Group.

Summary 2016 Activities

Objective	Summary
1	Breast Feeding Working Group streams
2	Huttmaternity Website Update
3	Consumer Work streams
4	Referral Plus launch
5	Document Control
6	Implementation National Guidelines for GDM
7	Maternity Assessment Unit Health Check outcomes
8	Huttmaternity Dashboard update
9	Annual Report 2015
10	Huttmaternity Expo
11	3 DHB Regional Campaign
12	Self Audit against NZ Maternity Standards and corrective measures
13	Clinical Indicators Audit

Summary 2017 Activities

Objective	Summary
2017 / 1	Huttmaternity Expo
2017 / 2	Annual Report 2015
2017 / 3	3 DHB Regional Campaign
2017 / 4	Self Audit against NZ Maternity Standards and corrective measures

Detailed Objectives, Activities and Rationale

1. Breast Feeding Working Group Streams

The demand for lactation services across the spectrum of clinical lactation advice, BFHI accreditation and breastfeeding education exceeded the FTE hours available.

a. To rationalise the LC workload we have developed a service guideline incorporating access criteria and clinical tools for DHB staff and LMCs. This will be launched January 2016.

b. In conjunction with the service guideline the LCs have produced a draft patient information flip chart, aimed at supporting women with establishing breast feeding. This will be launched January 2016.

c. Moving into 2016 we will be reviewing our current data collection and reporting systems for the Huttmaternity Clinical Annual Report and any BFHI requirements. This will occur over Feb-Jun 2016.

d. Huttmaternity implemented and established a Breast Feeding Support Clinic in response to increasing consumer demand. Utilising a PDSA cycle the service was reviewed. Our main work phases were to undertake a stocktake and GAP analysis of the clinic, with identification of areas for improvement. These were documentation, access to service, and data collection. In response to the identified issues we have developed electronic documentation on Concerto, a service guideline complete with access / referral criteria, clinical tools and a data collection system which will be live by the end of January 2016.

The Breast Feeding Working Group consists of Lactation Consultants, Midwives and Admin support.

2. : Huttmaternity Website Update

The Huttmaternity Website went live in 2013. As part of the implementation of the site a review was planned within 2 years. The review has been a three step process with the first changes in our site framework making it more user friendly. The second phase has been to review the content, and the third component has been the introduction of a section for Health Professionals

a. Content update will be completed by the end of January 2016.

b. Additional pages to the Health Professionals section to include a calendar of events and education will be completed Jan-March.

There has been a wide range of team members in this work stream, ranging from clinicians, consumers, admin, IT and Communications.

3: Consumer Work Streams planning

Our Maternity Clinical Governance Group has struggled to maintain stable consumer membership. It has been difficult to establish consumer involvement in MQSP activities due to this. In 2015 we recruited four new consumer members, and a work stream planning meeting occurred late October 2015. We have outlined some activities in our timeline, but the work plan is still to be finalised. A meeting has been arranged for January to outline further work required in the suggested streams.

This work will be lead by our Consumer members, supported by the MSQP Coordinator and Admin Support.

4: Referral Plus

To enhance use of the referral guidelines and encourage appropriate referral and timely access to services, we adapted the Waitemata DHB Referral PLUS document.
Our Obstetric Lead consulted with the Obstetric, Paediatric, Anaesthetic and Medical teams to localise this document. The document is currently in consultation phase with the wider stakeholders for feedback. Following any feedback it will be launched early 2016.

This team consists of the CMM, DOM, Obstetricians, Paediatricians, and Anaesthetics.

5: Document Control

A lack of robust process around our document control has been noted. Maternity documents and forms, either paper or electronic, are stored in a variety of places not necessarily accessible by all staff. Work has commenced with identifying all current documents in either paper or electronic versions, developing a master register and review plan. In the upcoming 6 months all documents will be allocated a facilitator, review date and version control. This project aligns with a DHB shift to an external provider, and will be undertaken between Jan-Jun. The team is facilitated by the MQSP Coordinator and includes Maternity Enquiries staff, MQSP Admin support and a wide range of clinicians.

6: Implementation national Guidelines for GDM

National Guideline for implementation as per service specifications contract.
The guideline will be implemented by 1 April 2016. This is being lead by the Midwife that Coordinates our combined Obstetric and Diabetes Clinics and involves a wide range of clinicians and support staff.

7: MAU SOPs developed

Our Maternity Assessment Unit opened in October 2010. A Health*Check* was completed in January 2015. Fifteen recommendations were incorporated into the work streams of the Maternity Quality and Safety Programme and fourteen have been actioned. The last recommendation is development of standard operating procedure manuals for the MAU staff roles which is underway and due to be completed by June 2016. This stream is being lead by a core Midwife, supported by the MQSP Coordinator.

8: Huttmaternity Dashboard

Huttmaternity developed a Dashboard as part of its Demonstration Site work. There have been subsequent changes with KPI at local and MOH level. Work has commenced to align our KPIs with that of MOH and the National Clinical Indicators; this will enable better response to clinical data and performance. We have completed: analysis of our current dashboard and changes required; liaison with business analysis/developers; changes made to back ground electronic documents and IT repositories. Our Dashboard is currently at testing phase and we aim to have a live dashboard by December 2015.
This project has been lead by the CMM and MQSP Coordinator.
Note: the Dashboard has been approved by Huttmaternity, but is currently awaiting IT sign off to be moved to our LIVE system.

9: Clinical Annual Report 2015

As a requirement of MQSP Programme we produce a Clinical Annual Report each year. Work commences with the draft early each year with several consultations reviewed by stakeholders before final sign off by our MCGG. The Report is due to MOH by 30th June each year, and facilitated by the MQSP Coordinator. With sign off from the Maternity Clinical Governance Group.

10: Huttmaternity Expo 2016

An inaugural Expo was held by Huttmaternity in July 2015 with great success. Feedback on the opportunity for stakeholder networking was positive, and for the education sessions held. It was clear from the feedback that the Expo needed to be an annual event. At the time we launched our Pre and Post Pregnancy Resources Directory. Moving into 2016 and 2017 we will plan and repeat the Expo, taking into consideration feedback from 2015. This will be lead by the same core midwife that facilitated the 2015 Expo, the MQSP Coordinator and admin support worker, and the consumer members of MCGG.

11: 3DHB Regional Campaign 2016

We have run successful media campaigns including the Top 5 things to do in the first 10 weeks, in 2014, and Baby movements in 2015. It has been confirmed at the Central Region Midwifery Leaders meeting that these campaigns will continue at the regional level with an agreed theme. Development of key messaging and visuals will occur at regional level and the each DHB will run the campaign to coincide with Mothers Day and International Midwives day on an annual basis. The stream is lead by the CMM.

12: Self Audit and corrective measures against the New Zealand Maternity Standards

NZ Maternity Standards have been provided as a self audit tool at national level. Huttmaternity will apply the self audit each year and decide remedial actions if any and how they will be undertaken. This will occur annually about July/August, lead by the MQSP Coordinator and reported to the MCGG.

13: Clinical Indicators Audit

It is recognised by both Huttmaternity and MOH that we are outliers in the NZ Clinical Indicators around Blood Transfusion, and an Audit will occur ideally within the first 6 months of 2016. The leads for this stream will be the CMM and Obstetric Lead.

Timeline: MQSP Programme Huttmaternity 2016

Objective	Item	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	**Breast Feeding Working Group**												
	a. Lactation and BFSC Guideline Launch	✓											
	b. Patient Information Launch	✓											
	c. Identification of Data and Reporting Requirements		✓										
	Establishment of data captures and systems			✓	✓								
	Data and Reporting produced					✓	✓						
2	**Huttmaternity Website Update**												
	a. Upload of Content changes	✓											
	b. Collation of Events / Education Calendar	✓	✓	✓									
3	**Consumer Work streams**												
	a. BUDSET audit Report / Recommendations	✓											
	b. Facebook – on going maintenance and support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	c. Evaluating the National Maternity survey	✓	✓										
	d. Development of systems for National Feedback Tool and Consumer Feedback mechanism at Huttmaternity		✓	✓	✓	✓	✓						
	e. Pre and Post Pregnancy Resources Directory Review							✓	✓	✓	✓	✓	✓
	f. Review of Patient Information content							✓	✓	✓	✓	✓	✓
5	**Document Control**												
	Version Control and alignment of Documents	✓	✓	✓	✓	✓	✓						
6	**Implement Guidelines for GDM**												
	Planning phase for implementation	✓	✓	✓									
	Go Live				✓								

Objective	Item	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
7	**Maternity Assessment Unit Health Check**												
	Development of Standard Operating Procedures Manual for Obstetric Assessments and Secondary Care Clinic	✓	✓	✓	✓	✓	✓						
8	**Huttmaternity Dashboard**												
	Go Live	✓											
9	**Annual Report 2015**												
		✓	✓	✓	✓	✓	✓						
10	**Huttmaternity Expo**												
					✓	✓	✓	✓					
11	**3 DHB regional Campaign**												
				✓	✓	✓							
12	**Self Audit against NZ Maternity Standards**												
	Undertake Self Audit							✓					
	Remedial Actions from Audit								✓	✓	✓	✓	✓
13	**Clinical Indicators Audit**												
	Identify and undertake audit with recommendations		✓	✓	✓	✓	✓						
	Remedial Actions from Audit						✓	✓	✓				

Timeline: MQSP Programme Huttmaternity 2017

Objective	Item	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Huttmaternity Expo												
					✓	✓	✓	✓					
	Annual Report 2016												
		✓	✓	✓	✓	✓	✓						
	3 DHB regional Campaign												
				✓	✓	✓							
	Self Audit against NZ Maternity Standards												
	Undertake Self Audit							✓					
	Remedial Actions from Audit								✓	✓	✓	✓	✓

Appendix One MQSP Plan 2015-17: Actions and Tasks for Objectives 2016

The following outlines a further break down of the actions and tasks for the MQSP Objectives 2016, with an allocation of persons responsible. Ultimately all works streams are facilitated by the MQSP Coordinator.

No.		Theme	Timeline	Actions	Who	Comments
1	Breast Feeding Working Group Streams					
	a	Lactation and BFSC Guideline Launch	Jan	hard copies for LMC baskets	Nicola	
				internal newsletter	Elle	
				BF network	KA and AM	
				LCS to core and lmc meetings	KA and AM	
				Primary Midwives / MAU	Rach	
				Load to Website under Policies	Elle	
	b	Patient Information Launch (Flip Charts)	Jan 11th	photocopy - Debbie	Nicola / Elle	
			Jan 18th	lam and cut	Nicola / Elle	
				Jump Rings	Nicola	
				Secure in wards - BEIMS	AM	
	c	Identification of Data / Reporting Requirements (A/R and BFHI)	Feb	Meet with KA and AM	Nicola/KA/AM	
		Establishment of data caputures and systems	Mar-Apr			
		Data and Reporting produced	May-Jun			
	d	TT Data report	Jan		Rach / Nicola	With Karel
2	Huttmaternity Website Update					
	a	upload of content changes	Jan		Elle	
	b	collation of events / education calendar	Jan-Mar	Contact educators, Obs Teams	Nicola	email sent 5/1/16
		Write up and upload to website		draft up, check, load	Nicola / Elle	
3	Consumer Work Streams					
	a	BUDSET audit Report / Recommendations	Jan			Planning meeting 14/1/16 for all
	b	Facebook – on going maintenance and support	Jan-Dec			
	c	Evaluating the National Maternity survey	Jan-Feb			
	d	Development of systems for National Feedback Tool and Consumer Feedback mechanism at Huttmaternity	Feb-Jun			
	e	Pre and Post Pregnancy Resources Directory Review	Jul-Dec			
	f	Review of Patient Information content	Jul-Dec			
4	Referral Plus					
			Dec/Jan	Hard copies for LMC baskets / M/	Nicola / Elle	

5	Document Control		Jan-Feb			
		Format Forms			Nicola / Elle	
		Sort Ricoh Pathway			Nicola / Elle	Email Amanada Grant, Meeting 12/1/16
6	Implement Guidelines for GDM					
		Planning phase for implementation	Jan-Mar			
		Policies		Reveiw	Jenny R	
		Flow Chart		update	Nicola/Jenny	
		Lab forms			Nicola	
		Comms to stakeholders and go Live	Apr			
7	MAU Health Check					
		Development of SOPs for Obs Assessment and Secondary (	Jan-Jun	Collate information / drafts from M	Nicola / Judy A	
8	Huttmaternity Dashboard					
		Go Live	Jan-Feb		Jo / Nicola	With Karel
9	Annual Report 2015					
		Draft			Nicola / Elle	
		Data				
		Photos				
		Circulation				
		MCGG sign Off and to MOH	30th June			
10	Huttmaternity Expo		Apr-Jul		Nicky J / Consumers	
		Plan and Book				
11	3DHB Regional Campaign		Mar-May			
		Theme, Plan			Jo	
12	Self Audit against NZ Maternity Standards				Jo / Meera / Nicola / Elle / Chris M	
	a	Undertake Self Audit, review and plan actions	Jul-Dec			
13	Clinical Indicators Audit				Jo / Meera	
	a	idenfity and undertake audit with recommendations	Feb-Jun		? Niki A	? Robyn M and Liz Hayes
	b	remedial actions from audit	Jul-Aug			

Appendix Two: Data Information

Data Sources- we have made no changes since the establishment of our 2012 clinical annual report which used the following data information in its development. Although the indicator numbers have changed the Coding Rules have remained aligned with the Clinical Indicator Description.

Data for birth numbers and clinical indicators was sourced from hospital events stored in the Hutt Patient Management System (IBA) and the Hutt Maternity Database (Concerto). Data from the Hutt PMS is reported to the National Minimum Dataset (NMDS) and coded using ICD-10-AM-v6 clinical codes. Therefore the coding rules followed for extracting patients to meet the specifications of this report were obtained from the Ministry of Health's Analytical Services team.
Data captured in the Maternity Database is sourced from online forms completed by Maternity staff during the patient admission and the clinical summary completed by the consultant after patient discharge. This data was used to determine the parity of the patient and provide detailed Breast Feeding reporting as this information is not available using clinical codes.
For this report, all women discharged following a publicly funded hospital birth in 2012 and all babies live-born in hospital in 2012 were selected based on the rules listed below. Specific conditions and procedures (including birth type) were identified using ICD-10-AM-v6 clinical codes.

Coding extract rules for Mothers
All records (including privately funded) where any of the following codes are present, and where Delivery date (DPD, if null then ESD) is between 01/01/2012 and 31/12/2012:
Z370 to Z379 (ICD-10-AM-v6, outcome of delivery)
O80 to O82 (ICD-10-AM-v6, delivery diagnosis code)
9046700, 9046800, 9046801, 9046802, 9046803, 9046804, 9046805, 9046900, 9046901, 9047000, 9047001, 9047002, 9047003, 9047004, 1652000, 1652001, 1652002, 1652003 (Blocks 1336 to 1340) (ICD-10-AM-v6, delivery procedure code)

Coding extract rules for Babies
Please extract all records (including privately funded) where Event start date is between 01/01/2010 and 31/12/2010 and at least one of the following criteria is met:
Any diagnosis code is equal to Z380 to Z388 (ICD-10-AM-v6, Live born infant)
Event type = BT

Standard Primiparae
Must meet all the following criteria:
No previous pregnancy of 20+ weeks, and
Maternal age 20-34, and
Cephalic presentation, and
Singleton, and
Term gestation, and
Without specified medical complications

New Zealand Maternity Clinical Indicators

Indicator	Numerator	Denominator	Coding Rules
Standard primiparae who have a spontaneous vaginal birth	Total number of standard primiparae who have a spontaneous vaginal birth	Total number of standard primiparae who give birth	Standard primiparae with a 9046700 procedures or O80 diagnosis.
Standard primiparae who undergo an instrumental vaginal birth	Total number of standard primiparae who undergo an instrumental vaginal birth	Total number of standard primiparae who give birth	Standard primiparae with one of the following procedures 9046800, 9046801, 9046802, 9046803, 9046804, 9046805 9046900, 9046901 or a diagnosis of O81.
Standard primiparae who undergo Caesarean section	Total number of standard primiparae who undergo Caesarean section	Total number of standard primiparae who give birth	Standard primiparae with one of the following procedures 1652000, 1652001, 1652002, 1652003 or a diagnosis of O82
Standard primiparae who undergo induction of labour	Total number of standard primiparae who undergo induction of labour	Total number of standard primiparae who give birth	Standard primiparae with one of the following procedures 9046500, 9046501, 9046502, 9046503, 9046504, 9046505.
Standard primiparae with an intact lower genital tract (no 1st to 4th degree tear or episiotomy)	Total number of standard primiparae with an intact lower genital tract	Total number of standard primiparae giving birth vaginally	Standard primiparae excluding 9047200 procedures and excluding O700, O701, O702, O703, O709 diagnosis.

Indicator	Numerator	Denominator	Coding Rules
Standard primiparae undergoing episiotomy and no 3rd- or 4th-degree perineal tear	Total number of standard primiparae undergoing episiotomy and no 3rd- or 4th-degree perineal tear while giving birth vaginally	Total number of standard primiparae giving birth vaginally	Standard primiparae with 9047200 procedures but no O702 or O703 diagnosis.
Standard primiparae sustaining a 3rd-or4th-degree perineal tear and no episiotomy	Total number of standard primiparae sustaining a 3rd- or 4th-degree perineal tear and no episiotomy	Total number of standard primiparae giving birth vaginally	Standard primiparae with O702 or O703 diagnosis and no 9047200 procedure.
Standard primiparae undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear	Total number of standard primiparae undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear while giving birth vaginally	Total number of standard primiparae giving birth vaginally	Standard primiparae with a 9047200 procedures and O702 or O703 diagnosis.
General anaesthesia for Caesarean section	Total number of women having a general anaesthetic for a Caesarean section	Total number of women having a Caesarean section	All Caesarean Births (1652000,1652001,1652002,1652003 or O82) with a 92514XX procedure
Postpartum Haemorrhage and Blood transfusion with Caesarean section	Total number of women who undergo Caesarean section who require a blood transfusion during the same admission	Total number of women who undergo Caesarean section	All Caesarean Births (1652000, 1652001, 1652002, 1652003 or O82) with one of the following procedures 1370601, 1370602, 1370603, 9206000, 9206200, 9206300, 9206400 and a diagnosis of O72.0, O72.1,O72.2 or O72.3

Indicator	Numerator	Denominator	Coding Rules
Postpartum Haemorrhage and Blood transfusion with vaginal birth	Total number of women who give birth vaginally who require a blood transfusion during the same admission	Total number of women who give birth vaginally	All Vaginal Births (9046700 or O80) with one of the following procedures 1370601, 1370602, 1370603, 9206000, 9206200, 9206300, 9206400 and a diagnosis of O72.0, O72.1,O72.2 or O72.3
Premature births (between 32 and 36 weeks gestation)	Total number of babies born at between 32 weeks 0 days and 36 weeks 6 days gestation	Total number of babies born in hospital	

If you have any enquiries about this report, or wish to contact Hut Valley DHB, please contact the Hutt Valley DHB Clinical Midwifery manager on:

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HUTT maternity
Hutt Valley Maternity Care