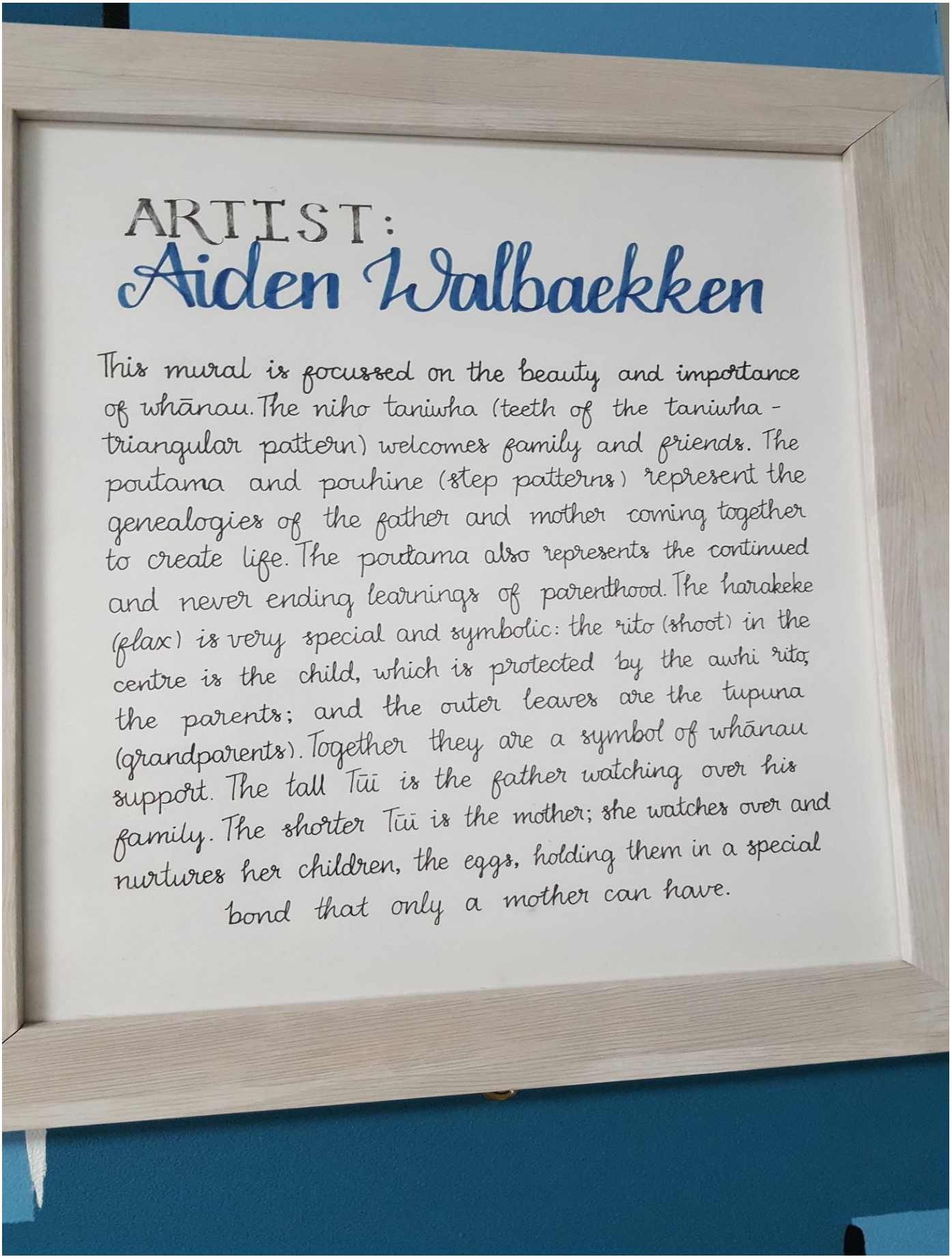
Hutt Maternity Quality and Safety Programme

Annual Report 2019



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Disclaimer – while effort has been taken to ensure accuracy of the information in this report HVDHB can't guarantee this.

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TABLES

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Special thank you to:
Maternity Clinical Governance Group members

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Thank you to the staff and families who generously agreed for their photos to be used in our publications

Foreword

"The Hutt Valley District Health Board is pleased to present the Maternity Quality and Safety Programme Annual Report for 2019/2020"

This year we report on a number of significant achievements and wish to acknowledge the Hutt Valley community, women and their whānau for working closely with the DHB to effect positive change. Strong governance to lead maternity improvement in 2019 saw the Chief Executive and Chief Medical Officer engaged with staff and community members through a project focussed on improving outcomes and has resulted in positive change. Leadership was strengthened with the appointment of a full-time Director of Midwifery and full-time Service Manager to commence in 2020.

Workforce recruitment and retention strategies commenced in 2019 and paved the way for a significant increase in our base staffing establishment for 2020-2021. The Ministry of Health signalled a major capital investment for redevelopment of our maternity facility and work on a business case to support this will be undertaken next year.

We have focused on areas where Hutt Valley is a clinical outlier and the increasing complexities of our birthing population. To support access to midwifery care in the first trimester we continued to work on reducing barriers for wāhine to engage early with a lead maternity carer. Care close to home, at marae based clinics and in local communities, has been embraced by women.

A joint regional initiative has seen the planned introduction of Maternal SEPSIS bundles for early identification of sepsis, and an update of the 5 things to do when you are pregnant check sheet, with the introduction of wallet sized cards placed in several key areas. Equipment enhancements commenced in the maternity unit focusing on primary birthing, whānau support and clinical safety.

Hutt Valley Consumers have formed the Hutt Valley Maternity Action Trust and this amazing group of people along with our MQSP consumers are assisting us to look critically at our performance in conjunction with National Clinical Indicator results and recommendations from the National Maternity Monitoring Group (NMMG) and Perinatal and Maternal Mortality Review Committee (PMMRC).

COVID-19 planning has been substantial since March 2020 and a robust plan is in place.

We pay respect to all professionals working in the regions maternity settings for your commitment to continually improve service delivery.

This report will be closely followed by the MQSP 2020/2021 report and our three year work programme.

Shelley James	**Karen Ferraccioli**	**Meera Sood**
Service Manager Women's & Children's Health	Director of Midwifery	Clinical Head of Obstetrics

Our Values at Hutt Valley DHB

ALWAYS CARING

CAN DO

IN PARTNERSHIP

BEING OUR BEST

Our aim is to make Hutt Valley DHB a place where our people love to work and where our patients receive the best possible care 'every person, every time'.

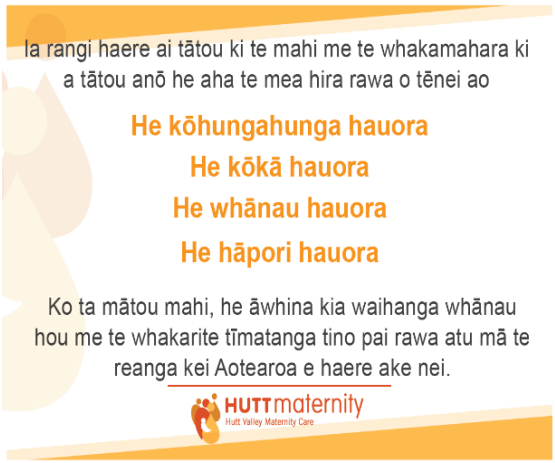
Together we have:

- Created a vision for people's experience working and being cared for here
- Shaped refreshed values and behaviours we do and don't want to see from each other
- Started to embed our values into how we work together to deliver a great service to our community.

Our Vision *Whānau Ora ki Te Awakairangi*

Healthy people, healthy families and healthy communities

Our Vision for Hutt Maternity



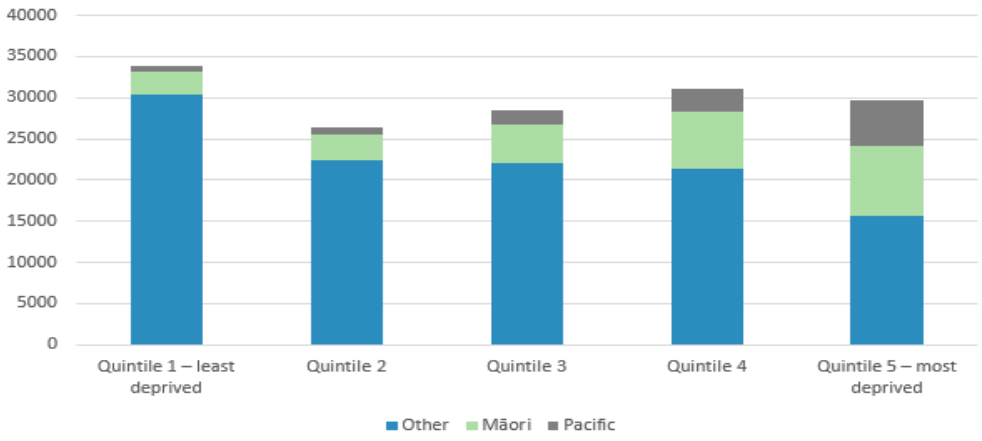
Our people Ō mātou hunga
Hutt Valley - Te Awakairangi

Te Awakairangi extends across Lower Hutt and Upper Hutt Cities and their local authorities. The name Te Awakairangi, originally given to the Hutt River, means esteemed or precious and is attributed to the first Polynesian explorer Kupe.

Our Population

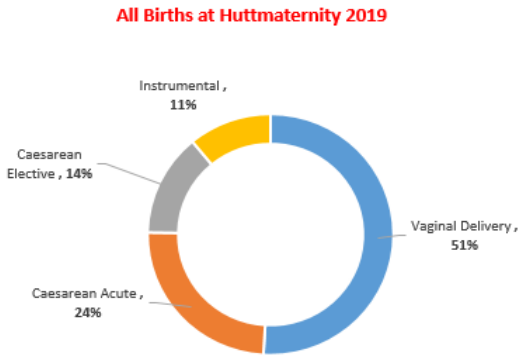
In 2019-2020 the Hutt Valley District Health Board population was around 154,000 with 18% of our population identifying as Māori, 8% as Pacific and 11% as Asian. This was a slightly higher proportion of Māori and Pacific people compared to the national average and fewer people in the 20-39 age group. (MOH 2019)[1]. Hutt has a relatively equal proportion of people in each section of the population, with a slightly higher proportion of people in the least deprived section. Health disparities linked to deprivation are evidenced in poorer health outcomes and we acknowledge our responsibility to design and deliver maternity services that are accessible and responsive to our population's needs.

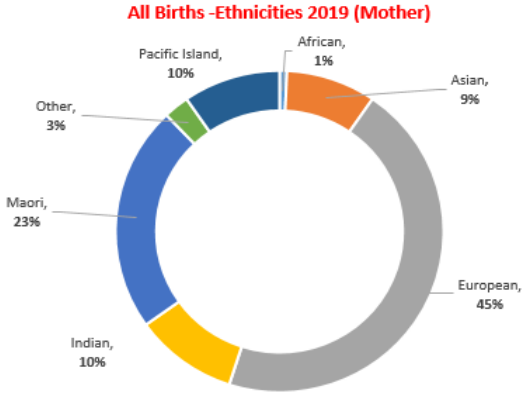
The above information has been sourced from the Hutt Valley DHB Annual Report 2019-20.

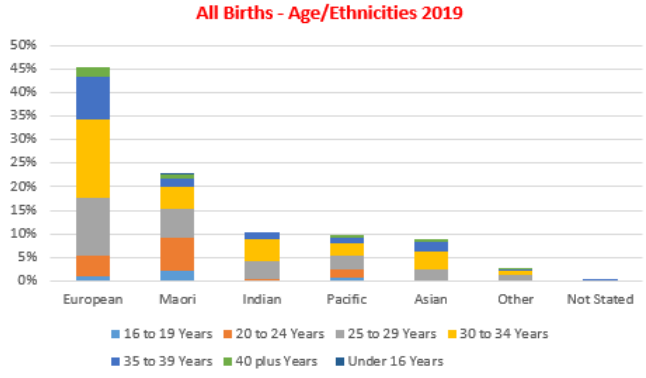


1. http://www.health.govt.nz/new-zealand-health-system/my-dhb/hutt-valley-dhb/population-hutt-valley-dhb *Accessed 6/5/19*

Maternity Population 2019







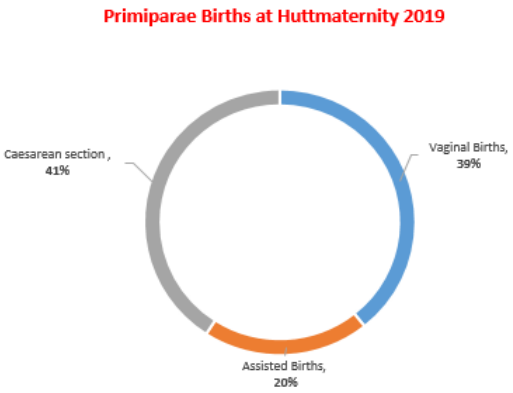


Table 1: Births in New Zealand and Hutt Valley by DHB and Primary Birthing Unit 2015-2019

	2015	2016	2017	2018	2019	The birth rate continued to decline at HVDHB with 2.7 % of all births in New Zealand in 2019 were at Hutt Valley DHB
Births in NZ (NZ Statistics) [1]	61038	59430	59610	58020	59,637	
Births at Hutt maternity	1856	1871	1848	1691	**1656**	
% of all NZ births in Hutt	3.0%	3.1%	3.1%	3.1%	**2.7%**	

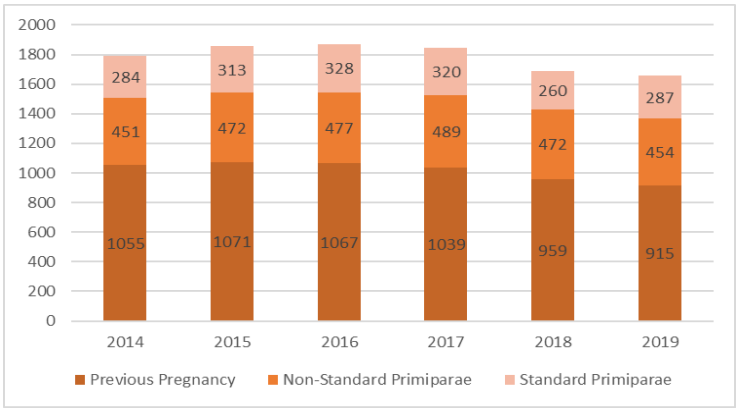
Table 2: Births at Hutt Valley DHB Facility

	2015	2016	2017	2018	2019	There were 208 Primary Births and 21 home births. The rate of still births remained fairly static. The rate of twin births remained fairly static.
Single Liveborn	1823	1843	1818	1666	**1629**	
Single Stillborn	13	7	11	7	**8**	
Twin Liveborn	20	22	17	17	**19**	
Twin Stillborn			2	1	0	
Total births at facility	1856	1871	1848	1691	**1656**	

Table 3: Births at Hutt Valley DHB (DHB area)

	2018	2019
Single Liveborn DHB	1666	1629
Single Liveborn Primary Unit	98	208
Single Liveborn Homebirth	30	21
Single Stillborn	7	8
Twin Liveborn	17	19
Twin Stillborn	1	0
Total births DHB area	1819	1866

Figure 1: Births in Hutt Valley DHB Facility by Parity



The number of women birthing categorised as Standard Primiparae[2] at Hutt Hospital has decreased by around 200 in 2019. A private primary birthing facility became available in the Hutt Valley during this time. The definition of standard primiparae are women who meet all of the following criteria: No previous pregnancy of 20+ weeks, Maternal age 20-34, Cephalic presentation, Singleton, term gestation and no recorded obstetric complications (that are indications for specific obstetric interventions).

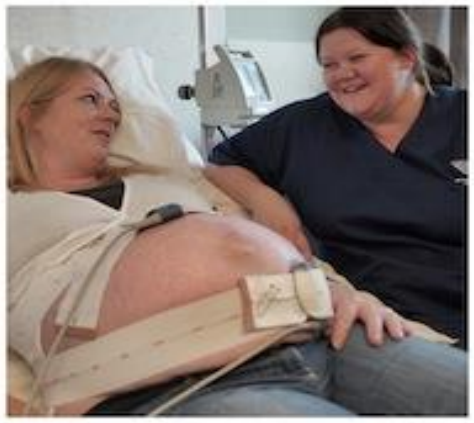
[2] Ministry of Health. 2019. *New Zealand Maternity Clinical Indicators 2017* Wellington: Ministry of Health pg. 8 accessed 15 May 2019

Table 4: Home Births in Hutt Valley DHB catchment	2015	2016	2017	2018	2019
Number of homebirths	60	41	47	30	21
Percentage of total birth number	3.1%	2.2%	2.5%	1.7%	1.2%

Our Maternity Facilities and Services

At Hutt Valley DHB we provide both primary & secondary level care. As a teaching hospital we support training for doctors, midwives and nurses. Our facilities are located at Hutt Hospital and include our Birthing Suite (8 rooms), Antenatal & Postnatal Unit (16 beds), Maternity Assessment Unit (MAU), Gestational Diabetes Clinic and Early Pregnancy Clinics. We receive referrals from Wairarapa DHB and Te Awakairangi (Melling Birth Centre).

Improvements to our facility and equipment commenced in 2019 with refurbishment of the maternity whānau room (courtesy of the Hutt Maternity Action Trust), the refreshing of two patient rooms and bathroom areas, purchase of new CTG machines and beds, a new staff kitchen area, breast feeding room for hospital staff and easy mobile storage for birthing suites and emergencies. The photo below shows a staff member and her baby enjoying the refurbished breast feeding room.



Comments from Tumeke cards:

"I am really grateful to live in the Hutt. I have had two excellent birth experiences and post-natal care at Hutt. The staff are excellent, the midwives are so lovely and the doctors are great! Thanks for all the hard work you put in."

" *I appreciated it when you listened to all my questions, your patience and knowledgeable answers. You bring humour to our appointments and made us feel at ease on what was an unknown journey"*

Maternity Assessments are undertaken in MAU with women for day cases, pre-eclampsia assessments, ongoing blood pressure checks, review following a hospital scan and Anti-D prophylaxis administration for women booked with the Hutt Community Midwife Team (CMT). Acute assessments throughout the day are for women referred by LMC's and women booked with the CMT can self-refer for any pregnancy concerns they have such as reduced fetal movements. Women who need assessment outside of the MAU hours of 0800-1630 Monday to Friday are seen in the Maternity ward.

During the changing levels of lockdown in early 2020 MAU continued to encourage women to attend for assessments. To mitigate potential risk we put in place stringent screening and assessment criteria and enforced social distancing in that women could be reassured their safety was a priority. With level 4 lockdown laboratory services at the hospital closed to the public, MAU midwives took all the blood samples needed for investigations. PPE was available to staff in the MAU and Early Pregnancy Assessment clinic. Training on the correct use of PPE was provided to staff.

Early Pregnancy Assessments include women experiencing pain and/or bleeding in early pregnancy who are seen for assessment and management, if less than 20 weeks' gestation. Referrals are from GP's, LMC's, and ED. Assessment includes ultrasound scans, serial HCG level monitoring and liaison with doctors around the management of the pregnancy.

Secondary Care Clinics are in place for women seen by a member of the Obstetric Team in the Obstetric Clinic in MAU. These women have been referred under the Guidelines for Referral and Consultation (2012) for an obstetric opinion. There continues to be an increasing trend of referrals to the Secondary Care Clinic. Childbearing women have increasingly complex maternity needs including those associated with increasing rates of maternal diabetes, advanced maternal age and elevated Body Mass Index. This may in part account for this increase.

During COVID-19 lockdown level 4 the obstetric clinics developed a new way of consulting with women who either declined to come into the hospital for their consultations, or the obstetrician felt that the women could safely have a virtual telephone consultation. The Obstetric department split into two teams to cover on call and clinics and the Senior Medical Officers (SMOs) would triage the clinic on the day prior and determine who should be seen and who would be able to have a virtual consultation.

The MAU midwives then contacted all the women booked into the clinic (either by telephone or text) and advised the women whether it had been recommended that they come in for a face-to-face consultation, or could have a virtual consultation over the telephone.

All follow up scan requests, blood tests and follow up appointments were then either booked on line or sent via fax/post by the clinic midwives.

As a result of this system the obstetricians continue to contact women by telephone who do not attend their clinic appointment on the day and offer a virtual telephone consultation, followed by a written plan of care sent to the woman and the LMC.

In February 2020 we commenced our first **Obstetric Community Clinic**, located at Pacific Health Services in Naenae. This clinic is led by an SMO and is aimed to provide a secondary care service for women who find it difficult to attend appointments at the hospital due to barriers of transport, financial barriers or childcare issues. We encourage LMC's to identify women who would benefit from being seen at this clinic and hope to extend this service to other communities.

We also provide a **HVDHB community based midwifery** service. The antenatal care is provided in home or clinic with the intrapartum service being provided by core midwives in the birthing suite. The team also provides antenatal and postnatal care for those women under our Secondary Care Obstetric team without an LMC midwife. The team is referred to as our Community Midwives Team (CMT) or our Primary Midwives Team (PMT).

The CMT provides a maternity service for some of the most vulnerable women in our community. Wider ranging social complexity increases their obstetric risk and requires additional resources to enable timely access to care. When required there is multi-disciplinary professional input and development of plans that deliver wrap around services involving cross sector collaboration. The CMT attend our fortnightly Maternal Care and Child Wellbeing Multi Agency Group meetings.

The CMT endeavour to remove barriers to women accessing robust and holistic maternity care. We hold our clinics within the communities we serve, as well as offering home visiting when required. Women are provided with continuity of care whenever possible throughout their antenatal and postnatal period.

Women requiring secondary care services receive clinical oversight by hospital obstetricians with midwifery care from LMC midwives or the HVDHB CMT alongside, as outlined in the Guidelines for Consultation and Referral (MOH 2012).

Birthing Suite is staffed by core midwives providing midwifery care for DHB primary and secondary care women. The midwives provide emergency care 24 hours a day, seven days a week and support LMC midwives as required. At the end of 2019 we introduced the Associate Clinical Midwifery Manager role. Rostered over 24 hours a day, based in the birthing suite, ACMMs provide senior midwifery leadership, support, management and co-ordination across the whole maternity unit. Medical staff, consisting of a Consultant Obstetrician, Senior Registrar or House Officer are rostered to cover an on call system 24 hours a day. In 2020 our Registrar and Consultant Obstetrician base numbers increased by 2.5 FTE.

COVID lockdown was a new and frightening time for staff and pregnant women in our community. Women laboured with only 1 support person, or no support, visitors were limited, children were

unable to meet their siblings or see their mum whilst they were in hospital and staff were fearful of being around people outside their bubble.

We worked hard to provide consistent information and messaging to women and the community; this was difficult as guidelines and the direction provided nationally needed to often change day to day. This also impacted the signage which needed changing each time new information was received.

Our LMC's and CMT were provided with sufficient PPE and training was given to staff on how to apply and remove PPE safely. PPE needed to be tightly managed on the maternity unit, to prevent loss, so that it was available when women were screened and met the criteria for possible COVID-19 infection.

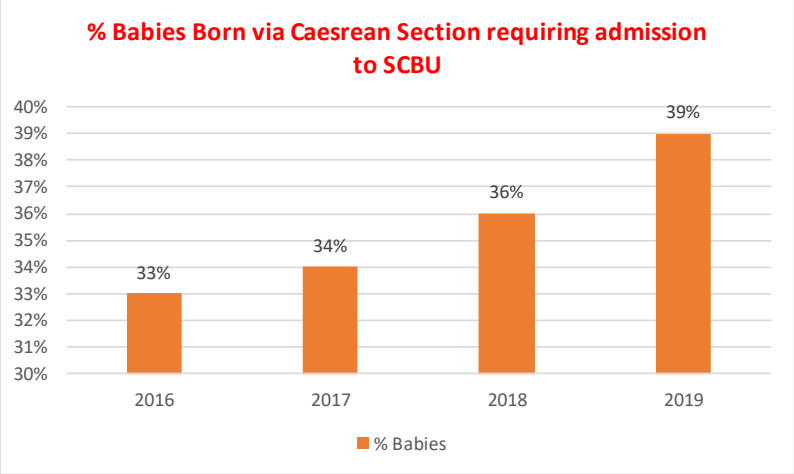
On the whole, the feedback from staff and LMC's was that they felt very informed and supported and whilst women were upset and fearful, they did enjoy the quiet time they got to spend with their new baby in the early days of life.

Anaesthesia and acute pain in the obstetric setting is provided through the Anaesthetic Department and includes a fortnightly obstetric anaesthesia high risk clinic, labour epidural service, anaesthesia for caesarean section and other obstetric procedures, post-partum pain service, multi-disciplinary input into case reviews and service development and teaching.

There is a close link between Maternity and Operating Theatre to ensure theatres are available when high risk women are in delivery suite. The use of tocolytics for in-utero resuscitation and positioning pillows for optimal positioning of women whilst being transferred to theatre have been introduced as standard when appropriate. An override call switch has also been installed on the Service lift to reduce the risk of delay in transferring to theatre in an emergency situation. A trial of Theatre Midwives was agreed as a permanent role in 2019. These midwives have a higher level of training around theatre processes and are available on site during the day and are called in overnight as part of the on-call theatre team.

Hutt Hospital has a **level 2 Special Care Baby Unit (SCBU)**, with 12-14 cots. This unit provides care for babies above thirty-two weeks' gestation. Babies under this gestation are transferred to the tertiary level Neonatal Intensive Care Unit at Capital and Coast DHB. Staff in SCBU and maternity work closely together to provide seamless care to māmā, pēpi and whānau. In 2019 there was an increase in the number of babies receiving care in SCBU, this links to both an increase in caesarean sections at Hutt Hospital and the number of small babies at term (refer to Clinical Indicators section).

Figure 2: Percentage of babies born via caesarean section requiring admission to SCBU.



In 2019 there were 220 admissions to SCBU with 40.4 % (n. 89) of these premature babies. 47 babies were transferred to CCDHB and 0 to Wairarapa DHB. CCDHB transferred 87 babies to us for ongoing care.

Our service is well supported by Allied Health professionals (Social Workers, Physiotherapists, Sonographers, Violence Intervention Co-ordinators, Smoke free Co-ordinators and Dieticians) and strong community providers (Antenatal educators, Pacific Health Service, Naku Enei Tamariki, Te Awakairangi Health Network and Marae based Kaimahi).

Workforce

The Hutt Valley DHB maternity service in December 2019 included the following clinical staff:

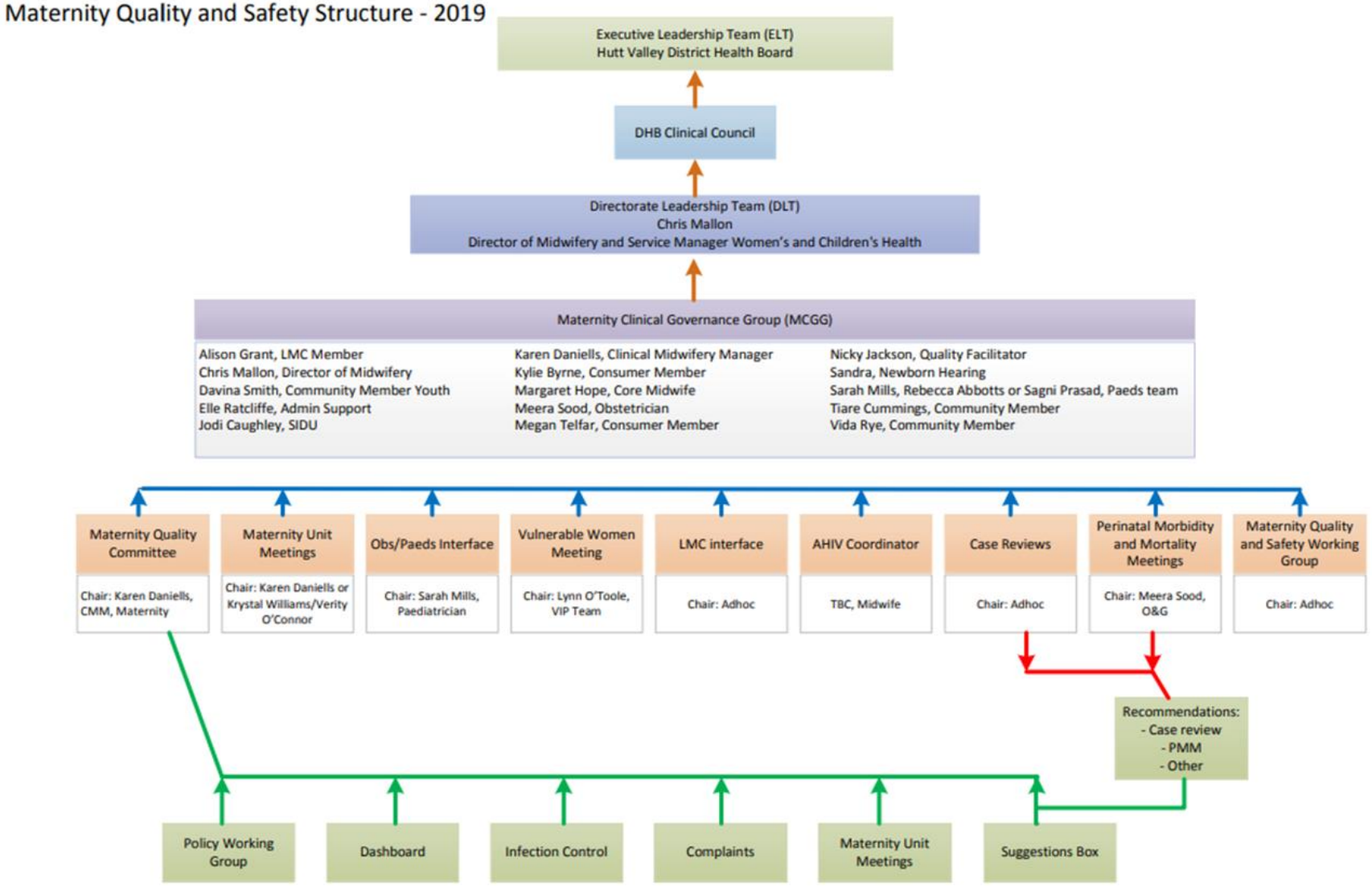
- Service Manager, Surgical Women's and Children's
- Clinical Head of Department, (CHOD) Obstetrics and Gynaecology
- Director of Midwifery (DOM) 0.4 FTE
- Clinical Midwifery Manager (CMM) 1.0FTE
- Associate Clinical Midwifery Managers (ACMM) (four) 3.0FTE
- Midwifery Educators (two) 1.0FTE
- Lactation Specialists (two) 1.5FTE
- Obstetrics and Gynaecology Consultants (six), Registrars (five), Senior House Officer (one)
- A core DHB employed team of approximately 42 Midwives, three Registered Nurses, two Enrolled Nurses giving 27.0 FTE and nine Healthcare Assistants 6.6 FTE
- Casual pool of 20 Midwives and one Nurse
- Administration 2.9FTE

In 2019 there were twenty six community based case-loading midwives (LMCs) with primary access agreements providing lead maternity care. The number of LMCs reduced by three in 2019 for a variety of reasons and one new graduate midwife joined a group practice. There were no LMC private obstetricians in the Hutt DHB area.

Maternity Quality and Safety

Te manaakitanga ō te whare tangata

Maternity Quality and Safety Structure - 2019



Maternity Quality and Safety Programme Purpose

The Hutt Valley MQSP serves to review and improve the quality and safety of maternity services as experienced by women, babies and their whānau in the Hutt Valley. To be successful, leadership supports and enables a collaborative multidisciplinary team approach to service provision, including the voice of consumers at all levels of service planning.

- Assess and report on our performance over the previous year.
- Provide information about the quality improvement work underway in the Hutt Valley area for women living and birthing in our district as well as the maternity workforce.
- Provide the Ministry of Health with the contractually required information as set out in Section 2 of the Maternity Quality Safety Programme (MQSP) Crown Funding Agreement Variation.
- Demonstrate self-audit of the New Zealand Maternity Standards.
- Provide feedback to the NMMG on their recommendations.
- Benchmark against New Zealand Maternity Clinical Indicators.
- Document Hutt Maternity's progress towards meeting the MQSP Work Plan objectives in 2019.
- Describe the work planned to improve the quality and safety of maternity services delivered in the 2019-2020 period.

Appendix Two provides detail on our MQSP 2018 – 2020 work programme and progress on delivery.

Hutt Valley DHB Maternity Clinical Governance Group 2019.

Consumer's voices and Hutt Maternity Action Trust

Consumer Feedback. Our quarterly consumer survey localises the National Consumer Survey Tool provided by MOH. The response rate in December 2019 was 37.7%. Women and their whānau also have the opportunity to provide feedback by hard copy and complaints are directed to our DHB quality team should this be requested. The identification of themes from our survey feed into MQSP objectives contributing to our ongoing workstreams.

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.

In November 2019 a public meeting was held to discuss HVDHB maternity services and the need for improvement following an external review undertaken in November 2018. The Hutt Maternity Action Trust was developed after this meeting and is in place to support new mothers, babies and providers of maternity services. The Trust organise various activities to nurture our midwives and the women they care for. Harnessing the energy of the Hutt community to support birthing women the Trust is well connected with consumers and maternity providers.

Consumer representation on MQSP, in co-design work and the 2019-2020 maternity project ensures a strong voice of those who use our maternity services.

http://www.huttmaternityaction.org.nz/

Maternity Clinical Indicators

The New Zealand Maternity Clinical Indicators

The New Zealand Maternity Clinical Indicators[3] present key maternity outcomes for each DHB region and maternity facility.

The purpose of the New Zealand Maternity Clinical Indicators is to:

- Highlight areas where quality and safety could be improved at a national level.
- Support quality improvement by helping DHBs to identify focus areas for local clinical review of maternity services.
- Provide a broader picture of maternity outcomes in New Zealand than that obtainable from maternal and perinatal mortality data alone.
- Provide standardised (benchmarked) data allowing DHBs to evaluate their maternity services over time and against the national average.
- Improve national consistency and quality in maternity data reporting.

These Clinical Indicators are evidence-based and cover a range of procedures and outcomes for mothers and their babies. Where possible, the New Zealand Maternity Clinical Indicators are aligned with international maternity indicators to enable international comparison. For the purposes of this report, we have produced data based on the Ministry of Health's (MOH) 20 New Zealand Maternity Clinical Indicators and commented on those where we are outliers compared to other DHBs.

MOH produce retrospective Clinical Indicator reports annually, the data provided is for the previous eighteen months. Hutt Hospital has 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.

[3] Ministry of Health 2019 New Zealand Maternity Clinical Indicators Wellington: Ministry of Health.

New Zealand Maternity Clinical Indicators

Table 5: New Zealand Maternity Clinical Indicators

	Indicator & HVDHB comment	**Trend**
1	Registration with a LMC in the first trimester of pregnancy *Improved from 2016 & 2017. HVDHB now at 71.3 & National average 72.7* *Need to continue focus of early registration support for Māori (56.5) & Pacific women (50.9*	>
2	Standard Primiparae who have a spontaneous vaginal birth	>
3	Standard Primiparae who undergo an instrumental vaginal birth *National average level 19.7 and HVDHB at 15.6*	<

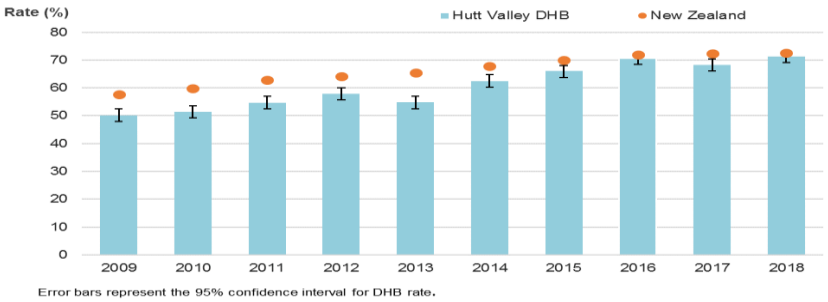
	Indicator & HVDHB comment	Trend
4	Standard Primiparae who undergo caesarean section *HVDHB at 23.5 in 2016, 19.4 in 2018 & National average 17.2%* *Note the overall HVDHB CS rate for all women is high in comparison to other DHBs*	<
5	Standard Primiparae who undergo induction of labour *HVDHB trending upwards*	>
6	Standard Primiparae with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy) *Less than national average*	>
7	Standard Primiparae undergoing episiotomy and no 3rd- or 4th-degree perineal tear *HVDHB decreasing*	<
8	Standard Primiparae sustaining a 3rd- or 4th-degree perineal tear and no episiotomy *HVDHB decreased to 6.4 in 2018 but above national average of 4.5*	<
9	Standard Primiparae undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear *HVDHB decreased to 2.6 in 2018 national average is 2.1*	<
10	Women having a general anaesthetic for caesarean section *HVDHB at 7.0 national average is 8.5*	<
11	Women requiring a blood transfusion with caesarean section. *Slight increase*	>
12	Women requiring a blood transfusion with vaginal birth. *Slight increase*	>
13	Diagnosis of eclampsia at birth admission	
14	Women having a peripartum hysterectomy. *HVDHB at 0.1*	>
15	Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period. *HVDHB zero*	
16	Maternal tobacco use during postnatal period *HVDHB is lower than the national average our focus of support for Māori as rate is higher*	<
17	Pre-term birth *HVDHB trending down at 7.7 remains above national average of 7.5* *Pre-term births are higher for Māori women when averaged for ethnicity 9.9 versus 8.1 Māori nationally.*	<
18	Small babies at term (37–42 weeks' gestation) *HVDHB 2.8 & below national average of 3.1*	<
19	Small babies at term born at 40–42 weeks' gestation *HVDHB above national average Māori & Pacific*	>
20	Babies born at 37+ weeks' gestation requiring respiratory support *HVDHB above national average Māori & Pacific*	>
Indicators for ongoing focus		

The top clinical indicators where we are performing well.

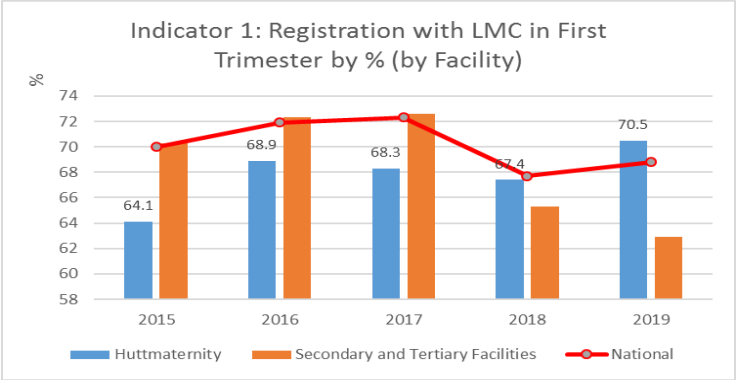
Indicator One:

Registration with a Lead Maternity Carer in the first trimester of pregnancy (by facility)

The overall registration with an LMC in the first trimester of pregnancy (Indicator 1) was 4.2 % better than the national average. We can still improve and need to do better for Māori & Pacific.



The collaboration with our local provider Te Runanganui o Te Atiawa is an initiative to encourage early engagement with an LMC through an accessible community based drop in clinic.



We continued to work with MOH to provide data for women under DHB care via the Primary Maternity Data Collection System.

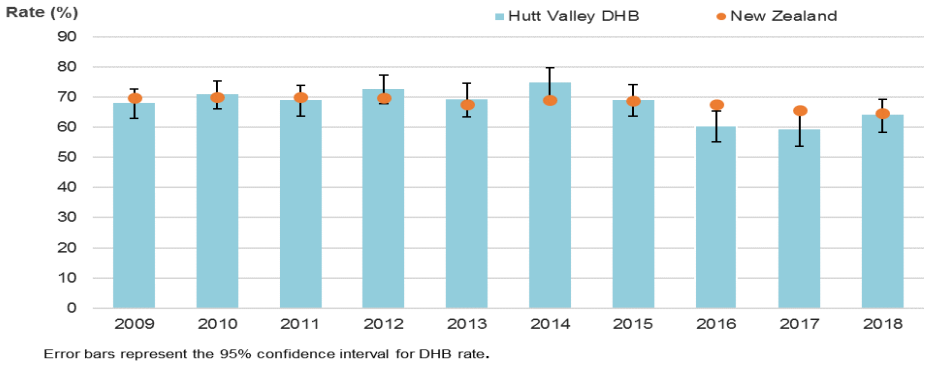
Table 6: Registration with LMC in First Trimester by % (by facility)

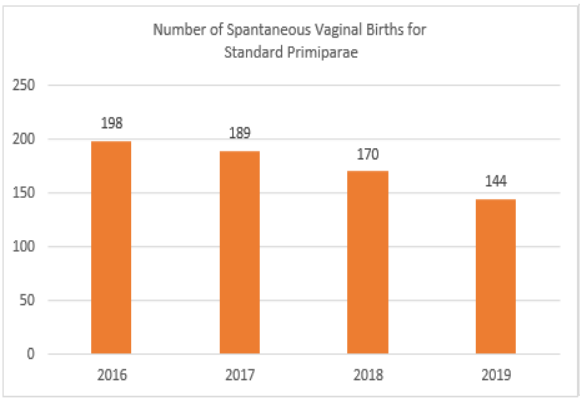
	2015	2016	2017	2018	2019
Hutt maternity	64.1	68.9	68.3	67.4	70.5
Secondary and Tertiary Facilities	70.3	72.3	72.6	65.3	62.9
National	70	71.9	72.3	67.7	68.8

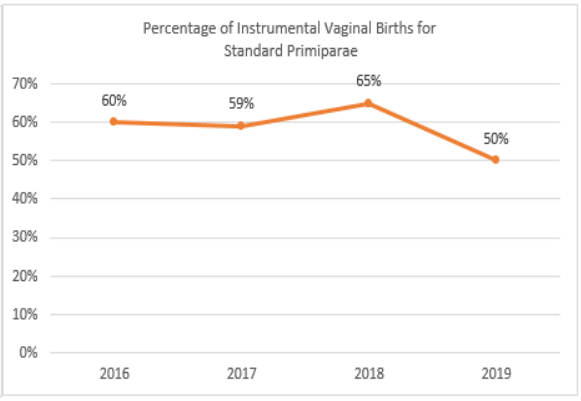
Indicator Two:

Standard Primiparae who have a spontaneous vaginal birth

Standard Primiparae women who had a normal vaginal delivery improved by 5.2% and is similar to the national average.



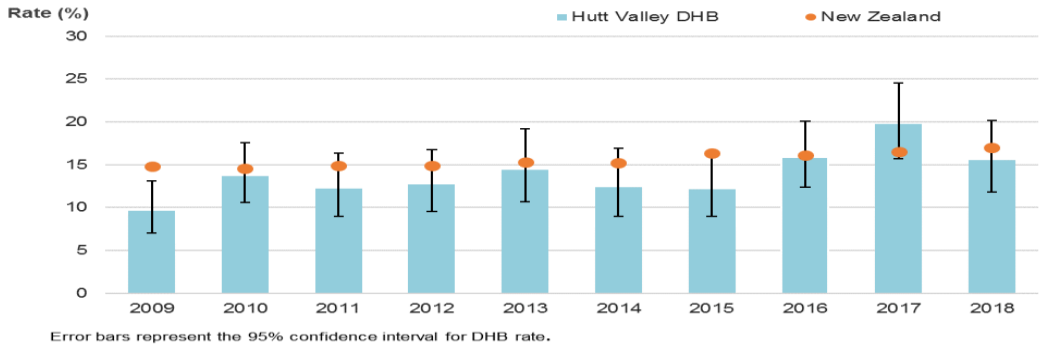




Indicator Three:

Standard Primiparae who undergo an instrumental vaginal birth

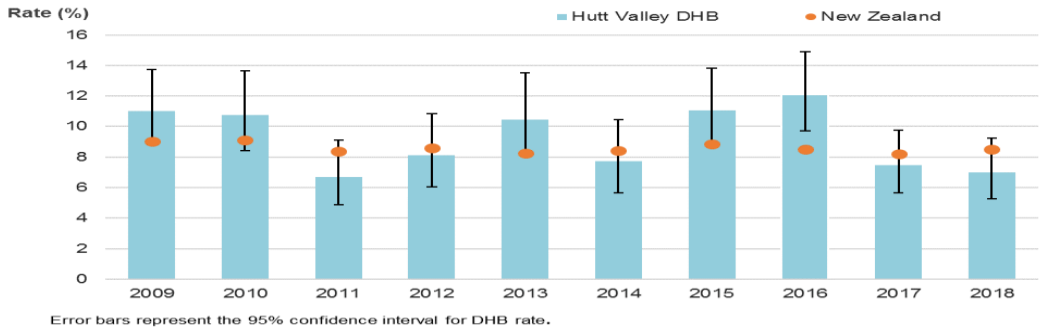
Instrumental vaginal birth - significant improvement for Māori and this fits with more Māori women delivering vaginally



Indicator Ten

General anaesthesia for all Caesarean sections (by facility)

The number of women having a general anaesthetic for Caesarean section reduced and is better than the national average by 1.5 %



Clinical indicators where we need to focus improvement.

Indicator Four:

Standard Primiparae who undergo Caesarean section

Caesarean section was 19.4 % at HVDHB versus 17.2 % nationally.

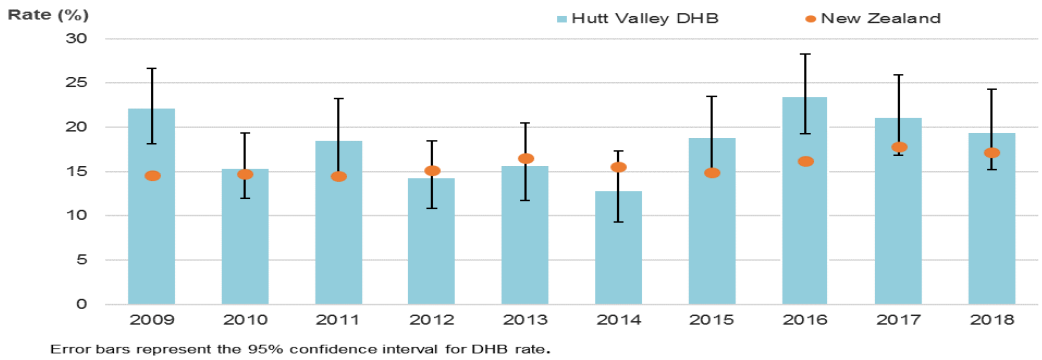
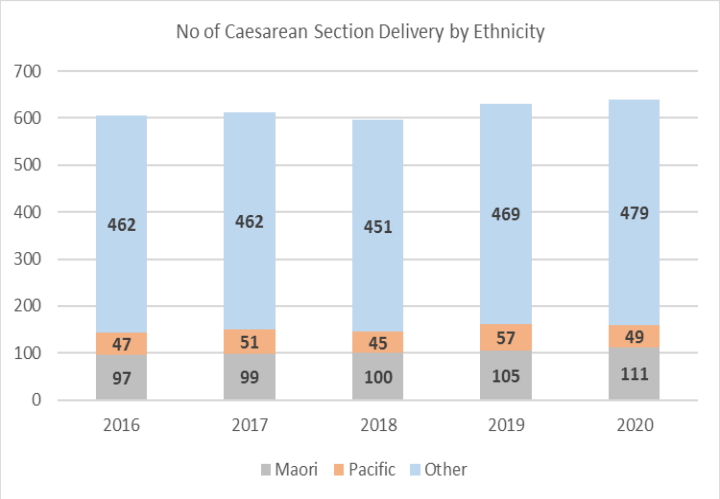


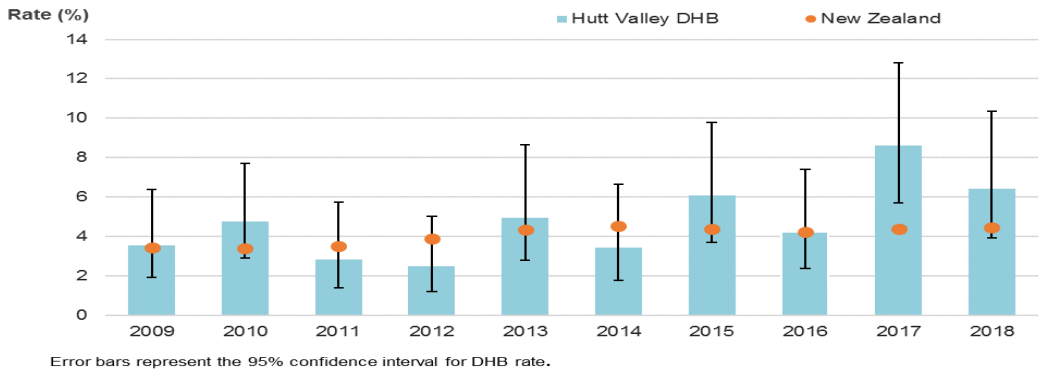
Figure 3: Number of caesarean deliveries by ethnicity 2016 – 2020.



Indicator Eight & Nine:

Standard Primiparae sustaining a 3rd- or 4th-degree perineal tear and no episiotomy
Standard Primiparae undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear

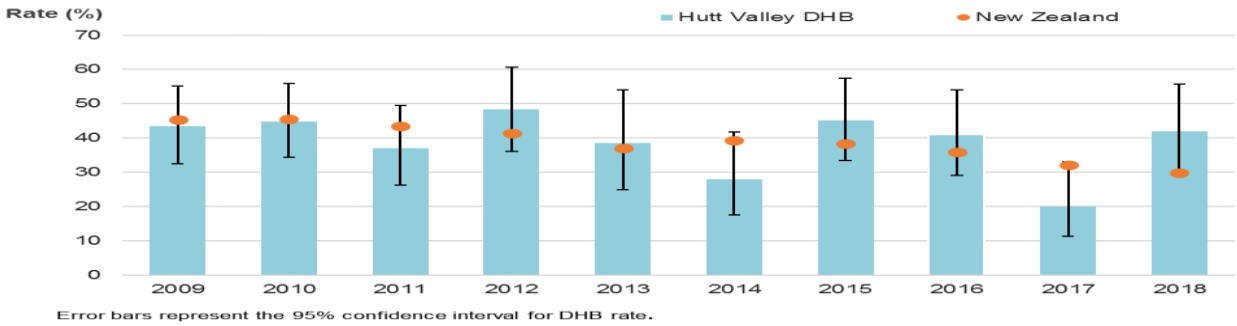
HVDHB 3rd. and 4th. degree perineal tear rates 2.6 % versus 2.1 nationally and with no episiotomy 6.8 % versus 4.5 % nationally.



Indicator Nineteen:

Small babies at term born at 40–42 weeks' gestation.

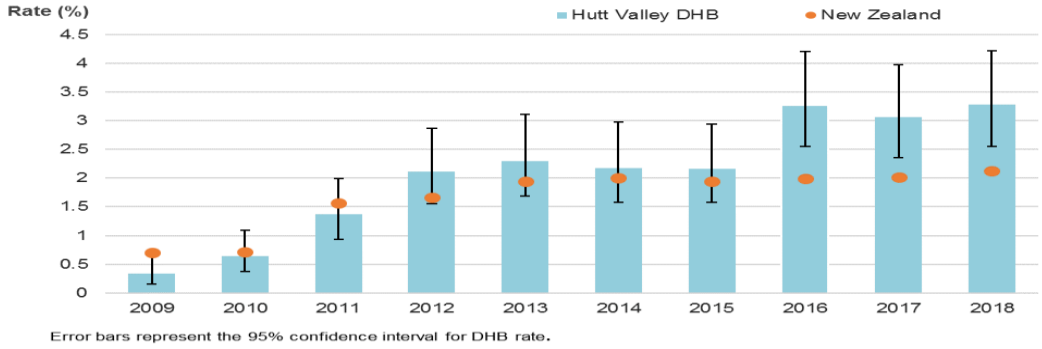
Small babies at term born at 40-42 weeks' gestation. HVDHB 42% versus 29.9 % nationally
A disproportionate number of small for date Pasifika, Māori and Indian babies born at 40 to 42 weeks' gestation. Pacific women require the most focus as 75 % versus 29.2 %.



Indicator Twenty:

Babies born at 37+ weeks' gestation requiring respiratory support

Respiratory support babies born at 37+ weeks all ethnic groups HVDHB 3.3% versus 2.1 % nationally and special focus needed for Pacific women



Hutt Valley DHB's Alignment with the New Zealand Maternity Standards

The New Zealand Maternity Standards provide guidance for the provision of equitable, safe and high-quality maternity services throughout New Zealand. They consist of three high-level strategic statements to guide the planning, funding, provision and monitoring of maternity services by the Ministry of Health, DHBs, service providers and health practitioners.

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

The HVDHB maternity service review was undertaken in 2018 and positive progress has been achieved in meeting recommendations. Multidisciplinary meetings are in place involving DHB staff LMCs and community based maternity practitioners - discussion and dissemination of data, guidance, guidelines, innovative practice, research and initiatives is occurring. The quality structure and maternity governance structure have sufficient links to ensure coherency, sharing of information and improvement activity.

Shared and interdisciplinary training and education opportunities, including fetal surveillance and management of obstetric emergencies is in place.

Our regular bi-monthly internal newsletter for core staff and LMCs keeps everyone connected and includes news items, education and training, staff news, upcoming meetings, recommendations, policy updates and meeting minutes. We have included short surveys for staff to encourage wider consultation on issues pertaining to our maternity services. We continue to look for ways to improve readership such as ensuring we have up-to-date emails, hard copies left in the unit and on noticeboards and incentivise readership such as through café voucher prizes. 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.

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

Information about our maternity services in Hutt Valley is on the DHB website. The majority of women receive care by the DHB's community midwifery team. The DHB supports access to LMC midwives and provides a direct phone link to key staff in the maternity unit. Updated lists of local midwives are provided on the Hutt Maternity DHB website. Wāhine are at the centre of our care.

Standard Three: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

Provision of HVDHB maternity service is guided by national documents available on https://www.health.govt.nz :

- The New Zealand Maternity Standards
- The National Maternity Monitoring Group
- Perinatal & Maternal Mortality Review Committee
- New Zealand Maternity Quality Indicators
- Report on Maternity

- Hutt Maternity engages in multidisciplinary audits of outcomes and transfer/ emergency processes

Ministry of Health 2011 New Zealand Maternity Standards: A set of standards to guide the planning, funding and monitoring of maternity services by the Ministry of Health and District Health Boards. Wellington: Ministry of Health.

Perinatal Mortality Cases

The **Perinatal and Maternal Mortality Review Committee (PMMRC)** is an independent committee that reviews the deaths of babies and mothers in New Zealand. The PMMRC provides a comprehensive reporting system, a network of nationally linked coordinators and a framework for assessing cases with the aim of progressively improving care. The PMMRC 13th Annual Report provided recommendations for action.

PMMRC. 2019. Thirteenth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2017. Wellington: Health Quality & Safety Commission.

https://www.hqsc.govt.nz/assets/PMMRC/Publications/13thPMMRCreport/PMMRC13thExecutiveSummary.pdf

The report demonstrates the need to increase understanding and research for adverse outcomes in certain groups. The PMMRC recognises the need to co-develop and implement models of care that meet the needs of mothers, through information, support and care that are acceptable to her. Monitoring of key indicators by ethnicity to identify variations in outcomes is described as important for DHBs to undertake. HVDHB has taken an equity lens in reviewing maternity clinical indicators and development of the MQSP work programme.

In line with the New Zealand Maternity Standards requirement of developing a systematic review process and PMMRC, our clinical team supports review and reporting of: Women admitted to ICU, Newborn babies transferred to CCDHB for therapeutic hypothermia and Babies that are stillborn or have died in the neonatal period (live born over 20 weeks and up to 28 days after birth).

HVDHB Perinatal Morbidity and Mortality Meetings are scheduled quarterly. The format has been changed to encourage community midwives to present their own cases and in 2019 included an education session on HIE of a second twin case presentation (as recommended as part of the root cause analysis). Multidisciplinary team education is in place and a focus on near misses, good catches in our care occurs at this forum. We continue to welcome Dr Kate Strachan Pathologist, at our quarterly meetings.

The morbidity experienced by women under our care is reflective of national findings i.e. sepsis, massive postpartum haemorrhage and consequence – peri-partum hysterectomy, eclampsia, severe pre-eclampsia presenting as HELLP syndrome and influenza.

Hutt maternity chose to investigate further cases where women had unplanned admissions to ICU over the period of November 2018 to November 2019 as recommended by the National Maternal Morbidity working group. The purpose of this review was to identify which cases were preventable and to recommend changes to our systems and identify sustainable quality improvement initiatives to reduce morbidity and potential mortality.

A project on maternal sepsis was undertaken regionally and is profiled on page 33 of our MQSP Annual Report.

Co-development of a care package to reduce the incidence of Sudden Unexplained Death in Infancy (SUDI) has been implemented. This involves a smoking cessation initiative in conjunction with Kokiri Marae, (Moe Ora mō ngā pēpi and Hapū Māmā Stop smoking programmes), Midwifery stop smoking Champions are on the maternity ward and in the Community Midwifery Team.

National Maternity Monitoring Group Priorities

The HVDHB MQSP work programme includes a focus on the NMMG workstreams as directed by the MOH.

One: Responding to Workforce Issues

A significant financial investment into our baseline establishment in 2019-2020 has enabled an active recruitment and retention strategy for our Midwifery and Medical staffing. New roles have been established to support women centred care such as the Midwifery Caesarean Section Team this means continuity of care for women and Midwifery presence from pre caesarean, during the birth and in the initial postnatal period.

Having experienced Associate Clinical Midwifery Managers working across every shift is proving beneficial for women and staff alike.

Monitoring workload demand through TrendCare assists daily and weekly planning and has assisted with Care Capacity Demand calculations and roster re-engineering. Our Midwifery staff are able to vary their shifts from 8 to 12 hours.

Creating a harmonious work environment, conducive to safe practice has seen a new staff room built and equipment purchases such as CTG machines. Staff are encouraged to be involved in decisions that affect their practice. It is genuinely important that the workplace is collaborative, staff feel safe and supported.

Two: Primary Birthing

As with other DHBs in the region we have focused on areas to increase the physiological birth rate at Hutt Hospital. Our consumer representatives initiated the use of the BUDSET evaluation tool and have made recommendations from this which will both enhance the unit and feed into our proposal for Primary Birthing space and equipment.

Our website includes information (based on the Ministry of Health information) on primary birthing and choices available for birthing in our district. The number of homebirths in the Hutt Valley has decreased over the last two years. Most women receive antenatal and post-natal care through the DHBs Community Midwifery Team.

A private primary birthing facility is located in Lower Hutt. A collaborative working relationship with the manager and staff is in place with policies on escalation and transfer.

Three: Investigation of standard primiparae's induction and caesarean rate

The caesarean rate in 2019 has continued to increase at Hutt Hospital and a substantive project is being explored for 2020-2021. An environmental scan has been undertaken of the differing approaches to optimise normal births at MidCentral and Capital & Coast DHBs.

Four: Access to postpartum contraception

The Hapū Ora clinic, our Marae based service provides an access point for care close to home. This is an initiative to reduce inequity and promote early registration with a Lead Maternity Carer. Alongside offering early pregnancy care and help to access a Lead Maternity Carer, access to postpartum contraception in the form of a long acting reversible contraceptive (LARC) method of Jadelle insertion has become one of the services accessible at this Marae based community clinic.

Women are also able to access Jadelle insertion on the maternity ward prior to discharge.

Five: Access to primary Maternal Mental Health Services

The Specialist Maternal Mental Health Team continue to support us with provision of non- acute mental health services. LMC's and Obstetricians can refer women into a local maternal mental health clinic run by a Specialist Maternal Mental Health Nurse and held twice a month in the Maternity Assessment Unit. Women can also self-refer to this clinic.

Our Community Support brochure highlights support available for women with mental health concerns. The Edinburgh Postnatal Depression Scale is accessible to midwives to use with their clients. Education on awareness of the Maternal Mental Health Pathway for our DHB was covered in the planned workshops on maternal mental health, dealing with trauma and a cultural view of mental health in February 2019.


Tatou wahine to tatou taonga
I need to:
• be listened to without judgement
• feel supported
• have a safe space
• know where I can get help
Let someone know if you are feeling down
Talk to your whānau, kaumātua/ kuia, Midwife, Well Child/Tamariki Ora provider or GP.
Free call or text
1737
to talk or text with a trained counsellor 24/7
HUTTmaternity
Hutt Valley Maternity Care

MQSP Progress 2019

Our MQSP progress report is presented in Appendix Two. In addition a key achievement has been working with our workforce and the wider community to establish and implement a robust maternity improvement project following on from our external review. Information on the project actions and governance can be found on page 29.

MQSP Activity 2019 (summary)

Ongoing work on our primary birthing room	Electronic Booking - Live	Jadelle Insertion training	GAP- Education for Champions	CCDM - Core Midwifery FTE increases
Success with our Midwifery recruitment & retention plan	Community & Lone worker policy	Refresh Staff Breast Feeding room	Oblige Trial Participation	Upgrade CTG machines
Update of our Care plan format	Our Hapū Ora Model	Internal Newsletter	Consumer Survey	Fetal Movement Poster Mamas Matter campaign
Initial work on Maternal Sepsis bundles	Maternity Dashboard	Consumers MCGG	Pēpi Pods	Whānau room upgrade
Improved storage in maternity ward	Clinics closer to Home	SUDI programme – smoking cessation	Maternal Green Prescription Programme	Maternity Action Trust support role
ACMMs 24 /7	CS Theatre Midwife Team	Patient Controlled Analgesia	Full time Director of Midwifery role	Full time Service Manager role
Increase in RMOs	Increase in SMOs	Safe Sleep - wahakura	Pop-Up and drop in Vaccination clinics	Increased Booking in first Trimester
Trigger Tools and reviews	Implementation of SAC & SERC recommendations	Midwifery New Graduate programme	Supported 3 RMs with Masters study	Wellkiwis Influenza Study

Improving Quality of Care

Te whakapiki ngā pukenga hauora

Implementing Recommendations from HVDHB 2018 Maternity Review

In November 2018, the DHB undertook an external review prompted by a number of factors including staff shortages, a high rate of complaints and adverse outcomes. Since this time, significant changes have been made across the service. Milestones have been reached in recruitment, resourcing, environment, clinical improvements, quality, safety and culture.

A strategy to address shortages in our medical and midwifery workforce has been implemented - the service now has two permanent clinical midwifery managers, a full-time midwifery educator, a permanent full-time director of midwifery, a permanent service manager, associate charge midwifery managers working across all shifts (24/7), two additional registrars and the addition of a seventh senior medical officer.

There is an international shortage of midwives and progress continues to be made with appointments through our ongoing recruitment strategy and campaign to increase base numbers. Through the Care Capacity Demand Management (CCDM) model, our budgeted base midwifery staffing level has increased.

A Single Stage Business Case (SSBC) to the National Capital Investment Committee to refurbish Hutt Valley DHB's maternity unit will be prepared in 2020-2021. The refurbishment will see four areas upgraded – Community Midwifery Team space, the Maternity Assessment Unit, Maternity ward (birthing and postnatal) and the Special Care Baby Unit.

The redevelopment of these services will improve the physical space to enable delivery of optimal maternity outpatient services, birthing and postnatal care, and special care for babies. Key themes of the redesign include designated functional spaces, an environment that reflects a person's journey, culturally responsive design and whānau inclusive spaces.

While significant milestones have been reached, the journey does not end here. Our focus extends beyond maternity services, to the broader maternal health system.

The hospital setting is only one part of the equation and we are also focused on improving equity and outcomes for Māori, Pacific and other families whose needs are not always met by traditional models of care.

Women's Health progress against recommendations (May 2020)

In late 2018 a review of the women's health service was commissioned as a result of concerns raised over staff shortages, HDC complaints, the caesarean section rate and newborns with suspected neonatal encephalopathy. The review report identified areas of risk and made 67 recommendations for improvement. There has been significant investment to address these since the report was released in mid-2019:

Area:	Achieved	In progress/to address as at May 2020
Workforce	Recruitment to vacant roles and increased FTE in senior medical staff, associate clinical midwifery management, quality and safety, midwifery education and health care assistants. Flexible midwifery staffing initiatives to provide cover for women unable to find LMCs, and for the December-January period. Recruitment strategies in place to attract qualified midwives.	Work with unions on SMO job sizing and RMO rostering. Resourcing of marae based community midwifery model. Staff and implement an outpatient hysteroscopy service.
Physical environment	Maternity inpatient ward improvements to date: New staff room for privacy and refreshment breaks. Essential equipment stocktake and gaps filled. New central storage room and emergency equipment bay. Painting and curtain replacements. Records storage.	Development of business case required to access up to $9.4million of central government funding for capital work. This will improve the physical space to enable delivery of optimal maternity outpatient services, birthing and post-natal care, and special care for babies.
Anaesthetics and theatre	Permanent funding of 2.0FTE theatre midwifery team following trial.	Development of optimal model of care and staffing allocation as part of the DHB-wide Theatre Optimisation Project.
Administration workflow	Analysis of administration tasks, needs and issues across all areas of the service. Identification of options to improve administrative workflow.	Selection and implementation of preferred solution for administration support – in alignment with the model of care developed as part of the capital business case.
Quality and Safety	Review and update of a number of clinical guidelines. Review of mothers admitted to ICU, babies with suspected NE, stillbirths, HDC cases.	Development of a strengthened clinical governance model, clinical guideline framework, systems for auditing and adverse event follow up, review of data collection processes.
Education	Weekly CTG (cardiotocography) multidisciplinary education meetings in place. Cultural safety and competence education programme trialled.	Development of education programmes for accurate clinical coding and foetal surveillance.
Corporate and senior leadership	Permanent Women's and Children's senior leadership in place and increased FTE for Service Manager and Director of Midwifery positions. Increased ELT visibility on the ward and engagement with service staff.	Increased visibility and clarity of maternity finances.

As we move into the future, the DHB remains focused and committed to continuous improvement and engagement with our staff, consumers and the wider community as we progress. Ongoing monitoring and review against maternity HDC recommendations and outcomes nationally, policy

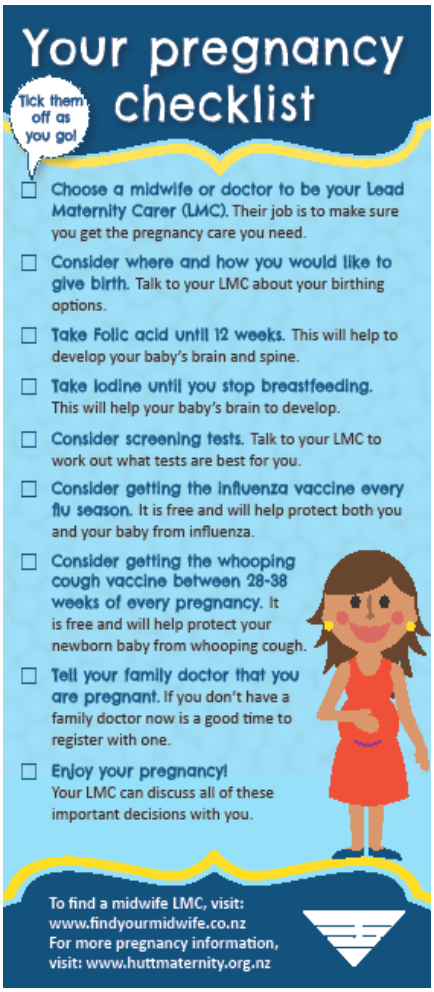
and guidelines review, morbidity and mortality review along with clinical audit will enhance our care for women.

Sub Regional 3DHB Campaigns

Each year Capital Coast, Wairarapa and Hutt Valley DHBs meet quarterly to discuss and share our ongoing projects. We plan an annual sub-regional campaign with a different focus each time. Recent examples include; "top five things to do when you find out you're pregnant", the “importance of baby movements” and a "pregnancy checklist".

There was also a focus on maternal mental health during 2019 with posters and cards distributed in the region as shown on page 27 of this report.

Five things to do when you are pregnant & pregnancy checklist



Baby movements

- Baby movements are usually felt between 18-20 weeks of pregnancy
- Baby movements are reassuring
- Get to know how and when your baby moves
- It's not normal for baby's movements to reduce before birth
- If your baby's pattern of movement changes or you are concerned – call your LMC

Never leave it until tomorrow

HUTTmaternity
Hutt Valley Maternity Care

To find a midwife LMC visit:

findyourmidwife.co.nz

for more pregnancy information visit:

huttmaternity.org.nz

Maternal Sepsis

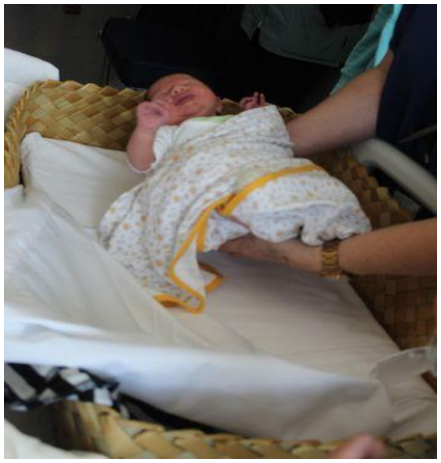
In early 2020 we adapted our emergency study days to include detailed scenarios on recognition and treatment of sepsis in peri-partum woman. We are in the process of developing a guideline to include in our sepsis bundle while we await the national guideline rollout.

In conjunction with CCDHB and Wairarapa DHB we anticipate that we can roll out provision of sepsis bundles and guidelines to key wards in Hutt Valley DHB where women who are currently pregnant or may have recently been pregnant are admitted.

SUDI Prevention Programme on the Postnatal

Ward

The development of a SUDI prevention programme was implemented in 2019. This quality improvement initiative was supported through the Fundamentals of Improvement course offered by the DHB and the aim of this programme is to ensure no at risk babies leave the postnatal ward without appropriate protection from SUDI It was co-designed with staff from the maternity unit as well as the Moe Ora mō ngā pēpi programme coordinator. The programme offers First Days Pēpi-Pods to all woman on the postnatal ward to use as needed for their stay. It also identifies eligible babies and then provides them with a wahakura or a Pēpi-Pod to go home with.



Care closer to Home – Hapū Ora

Hapū Ora, a drop-in clinic based at Lower Hutt's Waiwhetu Marae, is a collaborative Māori maternity service for whānau expecting a new baby. The drop-in service provides a continuum of care covering everything from midwifery to breastfeeding for new mothers and their whānau. The free services are run by mana whenua Te Runanganui O Te Atiawa with support from Hutt Maternity and Hutt Valley DHB.

Demand for Hapū Ora services has grown steadily since opening in 2017, with many Māori whānau finding the marae environment an ongoing source of comfort. The breadth of the Māori cultural knowledge available helps connect whānau with traditional practises such as ipu whenua, or the importance of tūpuna, and the natural benefits of generations of wāhine breastfeeding.

By encouraging whānau to engage with health services, they can be connected with a wide range of support including scans and medical tests. The focus is ensuring whānau engage early with lead maternity carers, offering long term reversible contraception postnatally, and carrying out appropriate referral to other services. "Our main priority is getting our people access to the services they need – the health of the people has dramatically improved."

Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP)

The aim of the programme is the early identification of permanent hearing loss in newborn babies. Through timely screening access and appropriate interventions, inequalities are reduced and the outcomes for these children, their families and society are improved.

Newborn babies in the Hutt Valley DHB area are offered screening through inpatient and outpatient services. The service operates six days per a week in the Maternity and Special Care units and three weekly outpatient clinics are run in the Audiology Department. We have a staff resource of two Screeners and one Screener/ Coordinator (2.3FTE).

The service continues to maintain a high level of performance across all monitoring areas. Percentage levels achieved in the key programme indicators;

- Diagnostic referral rate (1%)
- Decline rate (0.4%)
- Incomplete screening rate (0%)

Covid-19 response & recovery was completed at HVDHB in accordance with the National Screening Unit (NSU) COVID 19 UNHSEIP Recovery Plan & screening protocol.

In the six month period January to June 2020 a total of 974 families were offered newborn hearing screening and 972 (99.8%) completed hearing screening. There were only 2 (0.2%) declines recorded. There were an additional 3 babies referred directly to Audiology for whom screening was medically not appropriate. 20 of the 972 babies were DPOAE screened by Audiology as per the UNHSEIP recovery protocol. 897 (92%) were screened by the required <4weeks age adjusted and the remaining 75 (8%) were screened > 4 weeks age adjusted. There were no missed babies recorded. A total of 8 babies were referred for diagnostic audiology and all had diagnostic assessment completed by the required <3 months old. 2 were subsequently diagnosed with a permanent unilateral hearing loss.

The Level 4 lockdown on the 25th March saw a temporary pause to both our inpatient (IP) and outpatient (OP) screening services. IP screening resumed from the 30th March and service coverage was increased from 6 to 7 days a week to maximise IP capture before discharge. Our OP service resumed on the 7th May and saw a total of 132 screens being completed in clinic in that month. 102 of these were from the recovery screening waitlist which was prioritised to use additional space in the Hutt Hospital general outpatient area. Extra and longer clinics were scheduled as a result which saw completion of screening for 88% (90 babies) across the first 5 days of recovery clinics. 100% completion of recovery screening was achieved within 22 days, by the 29th May.

Overall across both the NBHS and Audiology service we completed a very successful and efficient recovery of our service. We would also like acknowledge the amazing cooperation and support we received from the Maternity, SCBU, LMC, and wider hospital teams, the NSU, and all the Hutt Valley families of newborns throughout this unprecedented time. Thank you.

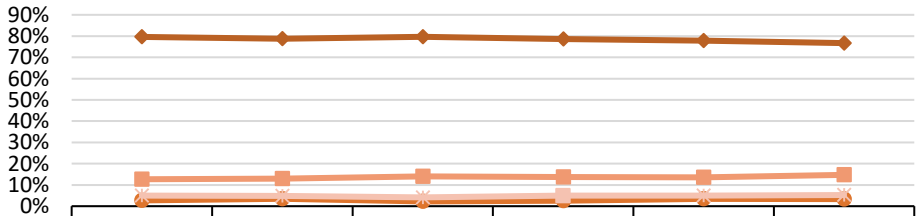
Baby Friendly Hospital Initiative

As a BFHI accredited Hospital our lactation consultants and staff work with mothers to support them with breast feeding in all clinical areas of the hospital campus. Our breast feeding support clinic is available to any mother and baby with breast feeding difficulties. Outpatient appointments are offered up to six weeks postnatally. We accept written or email referrals from the LMC (Lead Maternity Carer) or self-referrals. We also see women antenatally who have had previous BF issues.

If breastfeeding issues are thought to be related to the presence of a tongue tie, we have an assessment pathway to determine whether intervention is necessary. At Hutt maternity we are operating well within the accepted incidence of tongue tie.

Breast feeding education is in place for all our registered maternity staff. In November 2020 we have our next accreditation audit by the New Zealand Breastfeeding Alliance. We submit monthly statistics online to the NZBA. As well as BF classifications on discharge from hospital, they monitor our caesarean rate and late pre-term/low birthweight babies managed on the postnatal ward. In 2019, our exclusive breastfeeding rate at discharge was 75.3% and fully 3.68% with partial 15/7%.

Figure 4: Feeding percentage by Type



	2014	2015	2016	2017	2018	2019
Exclusive	79.62%	78.80%	79.61%	78.68%	77.90%	76.70%
Fully	2.69%	3.42%	2.25%	2.58%	3.44%	3.33%
Partial	12.67%	12.95%	14.01%	13.75%	13.63%	14.73%
Artificial	5.02%	4.83%	4.14%	4.98%	5.03%	5.24%

We use the Ministry of Health definitions to classify our infant feeding data. These are classified as:

Exclusive: the infant who has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breast milk (from the breast or expressed) and prescribed medicines (defined in the Medicines Act 1981) have been given to the baby from birth.

Fully: the infant has taken breastmilk only, and no other liquids or solids except a minimal amount of water or prescribed medicines in the past 48 hours.

Partial: the infant has taken some breast milk and some infant formula or other solid food within the past 48 hours.

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

https://www.moh.govt.nz/notebook/nbbooks.nsf/0/65454BE64D7D1C3ACC257A5C00089216/$file/Breastfeeding-definitions.pdf. Accessed 8/4/2021

Table 7: Breastfeeding type by Age of mother, Mode of Delivery and Gestation, Ethnicity at birth 2019

	Artificial	Exclusive	Fully	Partial	SCBU	Unknown	Total
	AGE						
Under 16 years		1		1			2
16 to 19 years	4	42	4	6	8		64
20 to 24 years	19	160	9	21	20	2	231
25 to 29 years	20	326	13	63	46	4	472
30 to 34 years	21	385	17	81	43	2	549
35 to 39 years	12	170	9	46	33	4	274
40 plus years	3	44	2	9	6		64
Total	**79**	**1128**	**54**	**227**	**156**	**12**	**1656**
	MODE DELIVERY						
Breech Delivery		1				1	2
Caesarean Acute	9	238	23	72	60	3	405
Caesarean Elective	13	154	3	46	10		226
Instrumental Delivery	8	116	6	31	21		182
Vaginal Delivery	49	619	22	78	65	8	841
Total	**79**	**1128**	**54**	**227**	**156**	**12**	**1656**
	GESTATION						
20 to 23 weeks						2	2
24 to 27 weeks				1	1		2
28 to 31 weeks					1	1	2
32 to 36 weeks	3	26	4	14	55		102
37 to 41 weeks	76	1087	49	211	93	3	1519
42 plus weeks		14	1	1	4		20
Not stated		1			2	6	9
Total	**79**	**1128**	**54**	**227**	**156**	**12**	**1656**
	ETHNICITY						
Māori	23	247	14	51	36	4	375
Pacific	16	106	4	17	16	1	160
European	34	535	21	83	74	5	752
Asian	4	87	5	38	11	1	146
Indian	1	118	8	30	12	1	170
Other	1	32	2	7	6		48
Not stated		3		1	1		5
Total	**79**	**1128**	**54**	**227**	**156**	**12**	**1656**

Maternal Mental Health

The Specialist Maternal Mental Health Service (SMMHS) is a community-based, tertiary mental health service. The focus is on providing support for women and babies within the Hutt Valley, Kapiti and Wellington areas.

Referrals for women living in the Hutt Valley can be made through Te Haika (mental health intake centre). Referrals can be made by a woman's midwife, GP or other health professional. Criteria for referral is women who are pregnant or post-partum with an infant up to twelve months, who are experiencing a moderate to severe mood disorder/mental illness; this may be new onset, or previous history re-triggered in the perinatal period. Women with an existing mental illness requiring consultation or advice related to conception or pregnancy can also be referred. Women who have miscarried or do not have the care of their child, or who are already being supporting by another mental health team do not come under this service.

The SMMHS also provides consultation and education support to all DHBs in the Central Region. This can include virtual multidisplinary meetings, case consultations, service development support and workshops.

The SMMHS service works closely with other health and social service providers who support women, babies and families. Wherever possible they support and promote education and awareness about perinatal mental illness.

Hutt Valley DHB also runs Maternal Mental Health clinics twice a month in the MAU. These clinics are led by a Maternal Mental Health Nurse and provide support and direction for both women and LMCs accessing the SMMHS.

Violence Intervention Programme (VIP)

Hutt Valley DHB's programme focuses on developing leadership, systems and our workforce to be responsive to victims of family violence. We expect family violence routine screening at health encounters of women 16 years and over, along with reporting of child abuse- non accidental harm, in the: Emergency, Maternity, Sexual health, Child Health, Mental Health and Addictions Service. An active MOH approved VIP training package is in place and run bi-monthly for staff working in the designated services. Our maternity workforce attendance at VIP training is currently around 35%.

Our HVDHB Maternal Care and Child Wellbeing Multi Agency Group (previously Vulnerable Women and Unborn Baby group) strengthens collaborative support to vulnerable pregnant women and their families. Membership is multi-agency. A key piece of work in 2019 was to implement the national Maternity Care, Wellbeing and Child Protection resource toolkit.

Hutt Valley DHB has also implemented the National Child Protection Alert System. If there are child protection concerns and the case is open with Oranga Tamariki, and/or a Report of Concern is completed by a health professional, a Child Protection Alert System (CPAS) multi-disciplinary team summary is completed on Concerto and the case is reviewed by the CPAS MDT and an antenatal alert may be created for the pregnant woman. This alert is reviewed within six weeks of the birth. An antenatal alert may be retained for future pregnancies or removed. The alert may also be transferred to the newborn.

Maternal and Early Child Health Provider Group (MECH)

The MECH Group is coordinated through the DHB's Strategy, Planning and Outcomes team and includes representatives from across maternal and child health providers, as well as Technical Advisory Services (TAS). The group's function is to support service development and integration across maternal and child health services. In 2018, the MECH Group continued to meet and supported a considerable amount of work across maternal and child health services. Work in 2018 focused on the implementation of the region's Sudden Unexpected Death in Infancy Prevention Programme, Well Child Tamariki Ora quality improvement work, newborn enrolment process quality improvements, breastfeeding improvement opportunities and the development of the DHB's First Thousand Days Partnership Project, among others.

Maternity Acupuncture Clinic

This onsite clinic provides free acupuncture care for pregnancy and postnatal related conditions. Women access this service directly, making an appointment through maternity administration staff. It is the only clinic of this type within a New Zealand hospital.

The main referral to the clinic is through midwives acting as Lead Maternity Carers (LMCs) recommending women to make an appointment. The majority of women present for treatment for back and pelvic and hip pain, and labour preparation. A range of other treatments are delivered that include treatment for nausea, heart burn, headaches or migraines, emotional concerns and insomnia.

Further details relating to these treatments have been reported as observation studies (Betts, McMullan, & Walker 2016; Soliday & Betts, 2018).

Maternal Green Prescription Programme

Maternal Green Prescription supports women through pregnancy and the post-natal period with healthy lifestyle behaviour change. The Maternal Green Prescription team continues to provide support for young mothers-to-be, Māori and Pasifika women, women at risk of diabetes and pre-diabetes, and women with increased BMI.

Clients are supported with goal-setting, provided with relevant information to assist them with personal goals and offered opportunities to participate in group walks, local events and healthy kai sessions.

Pop up Immunisations

This initiative was created to increase the uptake of flu and whooping cough vaccinations for pregnant women in the Hutt Valley by taking pop-up clinics out into the community. We felt that by making it easy and accessible i.e. no appointments, local venues and flexible days/times, that women would find it easier to get their vaccinations done. We wanted to provide an educational element as well, to advertise that this is recommended and safe to do in pregnancy. The service was set up by the Early Pregnancy Assessment Unit staff, with the support and involvement of Regional Public Health, and involved setting up informal clinics once a week, in public spaces distributed from Upper Hutt down to Wainuiomata. On the back of success in 2018 we focused 2019 on reaching our Māori and Pasifika women in local marae and community centres.

Pregnancy and Parenting Education

The main provider of parenting education within the DHB region, is BirthEd, a Hutt Valley DHB contracted service provider. Running a range of free courses from Upper Hutt to Petone, for women and their support partners, specifically designed for youth (Women under 24 years) and Māori women. Courses cover childbirth and early parenting education with support to women and their whānau, so they can make safe, well informed choices for themselves, for birth and their parenting. Women can self-book online or be referred by their LMC.

Breastfeeding is an important component of BirthEd's nine-week course outline and is taught by breastfeeding specialists. An additional 'master' three-hour breastfeeding course builds on the basic information, is well subscribed to, and open to antenatal and postnatal women. Other three-hour specialty courses focus on 'Your New Baby' and 'Homebirth' as an option, 'Baby Safety' and 'Out of the Blues' - postnatal distress and depression.

'Baby safety' conveys important key messages including shaken baby prevention, safe sleep, smoking cessation, postnatal distress and infant CPR and choking, delivered by a Red Cross instructor.

'Out of the Blues' provides vital information about the symptoms and coping strategies to support women and their partners with postnatal distress and depression.

The Marae-based antenatal course known as Kaupapa M.A.K.E (Māori Antenatal and Kaiāwhina Education) incorporates pregnancy, birthing and parenting education alongside weaving a kōnae (small basket) and whiri (cord tie) and demonstration of weaving of a wahakura (safe sleeping

device). Partners are catered for in the programme with a dedicated ‘men’s group’ and have their own break-away session to discuss the “what if stuff” while making Ipu Whenua, a container for the afterbirth. BirthEd works collaboratively with Te Kakano o Te Aroha Marae in delivering this three day course.

Well Child Tamariki Ora Providers

Tamariki Ora service providers in Te Awakairangi Hutt Valley include Tamariki Ora, Plunket and Thriving Cores.

All women birthing at Hutt Valley DHB are referred to the Well Child provider of their choice.

http://whanauoraservices.co.nz/services/tamariki-ora/

https://www.plunket.org.nz/

https://www.pacifichealthhutt.co.nz/well-child

Training, Development and Research

Education is an integral part of the Maternity Quality and Safety Programme. The DHB since 2017 has been a Midwifery Council of New Zealand approved provider of continuing midwifery education.

Midwifery Education

Combined Emergency Skills Day - 9 days of training in 2019

Feedback:

- Enjoy practicing.
- Lovely to meet with other midwives etc.
- Loved working in pairs.
- Really enjoyed breaking down the scenario into tasks great learning.
- Excellent learning from analysing the case and preparing for the emergency.
- Learnt heaps from other midwives on the course.

Maternal Mental Health - presented twice in 2019

The focus was on trauma specifically birth trauma.

Feedback:

- The session on Māori World View was excellent, informative and respectful.
- This course should be presented every year.
- Beautiful presentation and approach to teenager families.

Obstetric Doppler

Two sessions were delivered by the Radiology Department on the procedure and interpretation of the various ultrasound Dopplers relating to fetal wellbeing.

Prescribing update, Sexual health and communication in the teenage years and prescribing antibiotics.

This was well attended and received good feedback.

The midwives gained most from the infection control physician in the use of antibiotics and the development of resistance in the community.

Multi-professional Training and Quality Initiatives

ACC – NE joint treatment project. Multi-professional study days covering evidence based Initiatives.

Gestational Related Optimal Growth (GAP) Training from Perinatal Institute Educator.

Funding secured from ACC for champions to audit records and the education required to keep the programme sustainable.

Foetal Surveillance training and education

Multidisciplinary FSEP training is mandatory for all clinicians. We currently run the RANZCOG Foetal Surveillance education day annually, and staff are expected to attend every two years. The online OFSEPlus education package is freely available for staff to complete in alternating years.

A weekly meeting is well attended and we review interesting/ challenging CTGs. Our challenge is to promote the use of RANZCOG language to enhance a common understanding of the interpretation of the CTG, especially given the diverse training backgrounds of our midwifery and obstetric staff.

ACC are supporting this work stream by evaluating the effectiveness of the current available education and the logistics of rolling out a national education programme.

Universal Lactate Analysis

Focuses on the effectiveness of undertaking universal umbilical cord blood gas and lactate analysis on babies. Foetal scalp blood and umbilical vein and arterial blood lactate is used to help diagnose foetal hypoxia. An online education package as part of our operator certification process has been developed. Once certified, the operator is responsible for testing and result management.

Introduction of the Maternity Early Warning Score (MEWS)

Work continues on the roll out of the MEWS chart, with current discussion centring on logistics of implementing use across all parts of the hospital where pregnant or recently pregnant women receive care, including ED, ICU / HDU, MAU, and wards.

Introduction of the Newborn Early Warning Score (NEWS)

We are looking forward to roll out the NEWS as soon as the MEWS is embedded into practice.

PROMPT - 2 courses in 2019

"All staff involved in care of pregnant women should undertake regular multi-disciplinary training in obstetric emergencies."[1.]

[1] 7th Annual Report of the Perinatal and Maternal Review Committee 2011

Feedback:

- *I think it was fantastic.*
- *Cannot fault it, great course.*

An obstetrician, two midwives and an anaesthetist are attended the February Train the Trainer course in Melbourne.

Neonatal Life Support

This continues to be a popular choice for the multi-professional team. We have two midwives who are New Zealand Resuscitation Council (NZRC) Newborn Life Support instructors and we are hoping to increase this number in 2020. All maternity staff who attended in 2019 passed the written and practical assessment.

Mandatory for DHB employees

Online Education:

This is completed during orientation.

Intravenous Access, Phlebotomy and Cannulation

Certification is a requirement of the DHB.

Epidural Workshop

Together with the anaesthetic team we ran four epidural workshops. These are two hours long and include a session on aseptic technique demonstrated by the theatre educator. There is an ongoing session on patient controlled epidural analgesia (PCEA).

Violence Intervention Programme

All staff working in maternity are encouraged to attend this day. We have keen involvement from the midwives and are now booking the Obstetric team onto the course.

Midwifery Yarn - 8 sessions in 2019.

This is an informal session held on Tuesdays for an hour on requested topics. It may be case presentations, controversial topics and generally any area of interest. Midwives can knit, crochet and hopefully get to know each other as well. These were well attended.

Debrief and Individual Learning Plans

The role of the educator includes developing individualised learning plans with members of staff including the LMC midwives.

Registered Nurses Working in Maternity

The Midwifery Educator is working collaboratively with the nurse educator team to provide ongoing support for our nurses. Facilitated day for nurses on their role in maternity, emergency response to bleeding and a postnatal check.

Two Nurses are on their Leadership Professional Development and Recognition Programme (PDRP) and are involved in interdepartmental projects, and more plan to complete this process in 2020.

Orientation

There is a comprehensive orientation in place for all staff. The orientation programme is continually updated to ensure that consistent and current practice is shared.

Quality Leadership Programme

Hutt Valley DHB continues to support the Quality and Leadership Programme (QLP). We currently have fifteen midwives on the QLP pathway, six at Confident level and nine at Leadership level. The contribution to the unit made by midwives includes QLP activities such as Health and Safety, Infection Control and Hand Hygiene reps, audit activities and initiatives such as establishing new policies and guidelines. We thank all our midwives for the activities they undertake above and beyond the basic requirements of their job and for their effort and contribution.

Tertiary Education- Completion

Three Midwives in 2019 were engaged in Tertiary education and two midwives successfully completed their Masters in Healthcare (Midwifery).

Research, audit and clinical projects

In 2019 Hutt maternity participated in recruiting women for both the Wellkiwis influenza study and the Oblige Trial.

The Wellkiwis study follows newborn babies from birth until seven years of age. Participants and their whanau are closely monitored for any exposure to the influenza virus and how this influences their immune response. Ultimately the aim is to develop a more effective vaccination against all strains of influenza. https://www.wellkiwis.co.nz/

The Oblige Trial (Outpatient Balloon catheter and Inpatient prostaglandin Gel) randomised control trial compares differing methods of induction of labour to explore the effectiveness of more whanau friendly methods of induction. www.oblige.auckland.ac.nz

In addition, in the 2019 reporting year projects undertaken as part of Midwifery tertiary studies included fetal surveillance, water birth and observation of babies following instrumental birth, which have contributed to the education of staff and implementation of policies and protocols to improve the quality of the service we provide to women and babies.

Complaints – All events

Table 8: Complaints by Category

Department and General Event Type for 2019	Number of Events
Birthing Suite	**96**
Clinical Care/Service/Coordination	15
Facilities/Building/Property	1
Good Catch	2
ID, Documentation or Consent	1
Infection Control	1
Maternal/Childbirth	48
Medication	13
Nutrition	1
Patient Falls	2
Radiology	1
Safety/Security/Privacy	4
Skin Tissue	1
Staff and Others Health and Safety / Staffing	3
Surgical	2
Vascular Access and Parenteral Infusion	1
MAU	**1**
Safety/Security/Privacy	1
Post Natal Ward	**4**
Medication	2
Safety/Security/Privacy	1
Vascular Access and Parenteral Infusion	1
Grand Total	**101**

Trigger Forms/Event Reporting

In addition to the 3 DHB electronic SQUARE event reporting system, Hutt Maternity also maintains a weekly Trigger Review Group.

This Group, consisting of the Clinical Lead for Obstetrics, Clinical Midwifery Managers and a Women's and Children's service Senior Quality Facilitator review the circumstances around every Trigger Form that has been generated during the week and a review plan is decided. This can include; nil further action required, systems review, case review or referral on to the Review Steering Group for consideration of Root Cause Analysis (RCA).

Recommendations from these reviews are circulated to Maternity staff via internal newsletters and online staff folders in order to enhance learning opportunities.

What next in 2020/2021

We are committed to achieving equitable outcomes for women and babies and to do this working in partnership with Māori, pacific and Indian women. Improving the birthing journey from the first trimester onwards will reduce our caesarean section volumes and have a positive impact for women, babies, our system and resources.

- Continuing our focus on workforce retention and recruitment
- Exploring our options of enhancing community provision of maternity services to reduce barriers to access of care.
- Optimising birth
  - Use of acupuncture with Induction of labour.
- Maternity facility redevelopment.
- Implementing MQSP 3 year plan.

Appendix One: Abbreviations

ACC	Accident Compensation Corporation
ACMM	Associate Clinical Midwifery Manager
BF	Breast Feeding
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
BUDSET	Birthing Unit Design Spatial Evaluation Tool
CCDHB	Capital and Coast District Health Board
CMM	Clinical Midwifery Manager
CMT	Community Midwife Team
CTG	Cardiotocograph
CPAS	Child Protection Alert System
CS	Caesarean Section
DHB	District Health Board
DPOAE	Distortion Product Otoacoustic emissions
ED	Emergency Department
FSEP	Fetal Surveillance Education Programme
FTE	Full Time Equivalent
GAP	Growth Assessment Protocol
GP	General Practitioner
HDU / ICU	High Dependency Unit / Intensive Care Unit
HCG	Human Chorionic Gonadotropin
HDC	Health and Disability Commission
HIE	Hypoxic Ischaemic Encephalopathy
HELLP	Haemolysis, Elevated liver enzymes, Low platelet count
HVDHB	Hutt Valley District Health Board
LMC	Lead Maternity Carer
M.A.K.E	Māori Antenatal and Kaiāwhina Education
MAU	Maternity Assessment Unit
MCGG	Maternity Clinical Governance Group
MDT	Multi-Disciplinary Team
MOH	Ministry of Health
MQSP	Maternity Quality and Safety Programme
NE	Neonatal Encephalopathy
NMMG	National Maternity Monitoring Group
PBU	Primary Birthing Unit
PCEA	Patient Controlled Epidural Anaesthesia
PMMRC	Perinatal and Maternity Mortality Review Committee
PMT	Primary Midwife Team
PPE	Personal Protective Equipment
PROMPT	PRactical Obstetric Multi-Professional Training
RANZCOG	Royal Australian and New Zealand College of Obstetrics & Gynaecology
RMO	Registered Medical Officer
SCBU	Special Care Baby Unit
SMMHS	Specialist Maternal Mental Health Service
SMO	Senior Medical Officer
SSBC	Single Stage Business Case
SUDI	Sudden Unexplained Death in Infancy
VIP	Violence Intervention Programme

HUTT maternity
Hutt Valley Maternity Care

Maternity Quality and Safety

2018-2020 Programme Plan

(Established September 2018)

2019 progress report

Background

Hutt maternity 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, midwives and obstetricians, core midwifery staff, primary care, youth care, DHB Quality, Māori Health, Pacific Peoples Health and Strategy, Planning and Outcome (SPO) members.

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

It has been these influences that have guided Hutt maternity to develop its workstreams and objectives to date. A summary of objective status for the 2019-2020 period is provided below. Further information on the objectives and MQSP work previously completed is detailed in the Maternity Clinical Annual Reports for 2012 – 2017 inclusive; these are all available on the Hutt maternity website: www.Huttmaternity.org.nz

Moving forward, the variation to the 2012/13 Crown Funding Agreement, Schedule G4, outlines the specifications for the 1 July 2018 to 30 June 2020 period. The Maternity Clinical Governance Group (MCGG) have identified current objectives for completion and established three new objectives to align with the service requirements of the agreement under the group menu identified by the Ministry of Health planning workshops.

The MQSP Coordinator will facilitate all workstreams and monitor progress until completion, with the support of the Maternity Clinical Governance Group and management. Additional FTE to project lead our review of data integrity and intervention rates is being sought. A summary of the main phases of work under each of the projects and timeline of deliverables is provided.

2018-2020 Objectives and activities

Objective		Summary
1		**MQSP Activities**
	a.	Annual report compilation – Monitoring clinical indicators
	b.	Collection smoking cessation advice data (DHB team)
	c.	Contribution to Maternity Quality Committee
	d.	Document control – policies, procedures, forms, information for women
	e.	Facilitation of Maternity Clinical Governance Group
	f.	Self-Audit of NZ Maternity Standards by MCGG
	g.	Increasing registration with LMC in first trimester – Hapū ora, Te Ra 3 DHB sub regional meetings
	h.	Improving consumer engagement – Consumer representative meetings, Information for women, Consumer satisfaction survey, Facebook, Website maintenance
	i.	Assistance with other Quality Initiative projects – SUDI, Health & Quality Safety Commission review, Immunisation Outreach, Well Child Tamariki Ora interface.
	j.	Attendance other groups – MECH, Antenatal care pathway work, Green Prescription
	k.	Unit Enhancement
	l.	Planning for business as usual
2.		**Increasing physiological births** – intervention rate review
	a.	Acupuncture observational study
	b.	Primary birthing room at DHB
	c.	Review IOL decision processes
	d.	Review C/S decision processes
	e.	Oblige trial
	f.	Neonatal encephalopathy work

3. Supporting healthy weight gain in pregnancy for women with high BMI's

a. Establish new model of care

4. Data Integrity

a. Maternity dashboard data integrity improvements

b. Data to Mat ODS

c. Breastfeeding data (Including SCBU admissions)

5. Management of Consumer feedback and review

a. Refine process of addressing feedback and instigating recommendations

2018-2020 Objectives and Activities – Rationale and Evaluation

1. MQSP Activities – to embed activities as business as usual within HVDHB

a) Annual report compilation

As a requirement of MQSP Programme our Clinical Annual Report is produced each year. This includes interpretation and analysis of Maternity Clinical Indicator data and progress and outcomes of quality improvement projects. Several consultations with stakeholders before final sign off by our MCGG is undertaken. The report is facilitated by the MQSP Coordinator.

b) Collection smoking cessation advice data (DHB team)

This is a "business as usual' activity initiated in 2015, where mandatory data reporting to MOH on screening, brief advice and cessation support offered, is reported. This data is for DHB employed midwives providing pregnancy care. This is currently collected manually, however during 2020-2021 we will continue to work on developing a method of accurate collection of this data electronically.

c) Contribute to Maternity Quality Committee

The facilitator of the MQSP chairs the Maternity Quality Committee which feeds into the MCGG. This committee is the operational arm of maternity quality in the DHB, with MQSP administrative support for such activities as approval of audit applications, policy reviews and approval and day to day running of the unit, for example infection control, health and safety and new protocols.

d) Document Control

This is an ongoing activity to ensure policies and consumer information is reviewed and updated to align with latest evidence and is accessible. Our consumer representatives are involved in reviewing the consumer information which is highly valued. The medi-board display of information for women is in the Maternity Unit entrance and is maintained by our MQSP administrator. Our policy working group is being reinstated to support robust review and the most up to date evidence based information to base new policies on.

e) Facilitating Maternity Clinical Governance Group

Terms of reference for the Maternity Clinical Governance Group (MCGG) are reviewed biennially. The facilitation of this group is by the co-ordinator supported by the administrator for the Maternity Quality and Safety Programme (MQSP). Meetings are bi-monthly with the wider membership, with meetings on alternate months for the consumers, co-ordinators and management to progress consumer workstreams. This governance group has representatives from all disciplines; Obstetric, Paediatric, Midwifery, the Primary and Secondary sector and Consumers and the DHB Māori Health unit, Pacific Peoples Health, Quality team and Service Planning and Outcomes unit. This group feeds into the overall Clinical Council with our Director of Midwifery, sitting on both groups.

f) Self-Audit of New Zealand Maternity Standards

An annual process to guide remedial actions and setting of objectives for the Maternity Clinical Governance Group. Performed alongside review of programme plan midterm.

g) Increasing registration with LMC in first trimester

One such initiative to improve early registration and engagement with an LMC, is a collaboration with with Te Runanganui o Te Atiawa for a drop in clinic that has been operating since August 2017.

Hutt maternity has a presence at an annual local community festival – Te Rā o Te Raukura. Our goal is to increase the visibility of Hutt maternity services and promote early engagement with a LMC. Our Hutt maternity team offer pregnant women onsite Boostrix immunisation and plan to do this annually to bring these services closer to home.

h) Improving Consumer engagement

Such initiatives under this MQSP activity include: facilitation of bi-monthly meetings with consumer representatives and management. Consumers are involved with workstreams to improve communication and information for women and their whānau through production of information pamphlets and the use of Facebook and our website. Our consumer representatives have also been involved in improvements to the environment and will be instrumental in the planning for the refurbishment of the unit and creation of a primary birthing room. Our representatives have held coffee groups and have plans to keep seeking feedback from our community and ensure a good representation of all women and whānau. We have increased the number of consumers on our Maternity Clinical Governance Group to ensure a good representation of all women and whānau in this contract term. We plan to support them to access feedback from the wider community.

i) Assistance with other Quality Improvement projects

The MQSP is able to support other quality improvement projects such as Safe Sleep, pop up immunisation clinics, reviewing documentation to enhance communication and the Well Child Tamariki Ora interface.

j) Attendance other groups

The MQSP facilitator attends other groups such as the Maternity Early Child Health Provider group and three DHB Health pathways antenatal care development group, refurbishment steering group and quality improvements with TAS (Technical Advisory Service for central DHBs).

k) Unit enhancement

Facilitation of improvements to unit to increase user friendliness as guided by BUDSET evaluation for example signage, birth aids, storage redesign. This is part of our 2019-2020 refurbishment plan which is in progress. This evaluation was carried out by our consumers again to inform the refurbishment project.

l) Planning for business as usual

Such activities as annual report compilation, directing document control and quality actions around feedback are examples of how we plan to embed MQSP activities as business as usual.

2. Increasing physiological birth rate– intervention rate review

a) Acupuncture for women

Indicator five results since 2017 have demonstrated a rise in induction of labour rates in our standard primiparae women. We plan to work with our in-house Registered Acupuncturists and to capitalise on skills of some staff members, to offer acupuncture for women with with ruptured membranes at term (with no labour). An observational study and evaluation of this intervention as a way of reducing inductions of labour (and or unnecessary interventions), has been outlined as an action to meet the objective of increasing primary births in our unit.

Deliverables:
a) Formation of project team February 2020
b) Pilot May 2020
c) Evaluation July 2020

Evaluation:
a) Consumer survey, use of acupuncture clinic

b) Rate of uptake of acupuncture with preterm rupture of membranes,

c) Rate of spontaneous onset of labour following use of acupuncture

d) Length of active phase of labour

e) Rate of augmentation

f) Maternal fever in labour

g) Mode of birth.

b) Primary birthing room at DHB

Creation of a specific primary birthing room with wide planning consultation of staff, LMCs, Consumers and the wider hospital services. A concept design was produced and the project progressed.

Deliverables:
a) Business case to Board –October 2018 : Completed

b) Project team (part of overall unit refurbishment) November 2018

c) Commissioning work April 2019 : Undertaken

Evaluation:
a) Rate of spontaneous vaginal birth without intervention increases from 25.3% (2017 rate)

b) Consumer satisfaction survey

c) Review of induction of labour decision process

Ongoing monitoring of indication for induction and at which gestation inductions is occurring. This work also informs workforce planning and review of primary and secondary interface. Annual review of the process is to be carried out in 2020 at an operational level in the Maternity Unit.

Deliverables:
a) To be defined by project team

b) plan November 2018-completed

Evaluation:
a) Reduced rate of induction of labour for non-evidence based indication

b) Increased uptake of acupuncture for pre labour induction/augmentation (see objective 2a)

c) Review use of syntocinon and develop protocol.

d) Evaluate mode of birth following induction of labour

d) Review of caesarean decision processes

This is on-going work to streamline and reduce rates of caesarean and improve the journey for women needing to have both elective and acute caesareans. Other workstreams, such as the neonatal encephalopathy (see objective 2 g) will feed into this work. Another example of work to inform this workstream is a review of caesarean sections under General Anaesthetic. Patient Controlled Epidural Analgesia (PCEA) pumps have been introduced to our unit in April 2018. An evaluation of the introduction of PCEA is scheduled for 2020 in the context of reducing general anaesthetics for caesarean section. Other quality improvements are to be determined under a dedicated project using a PDSA methodology.

Deliverables: a) To be defined by project team - completed

b) November 2018 – in place

Evaluation: a) Consumer and staff satisfaction surveys – scheduled for 2019-2020

b) Reduction of rate of primary caesarean section rate.

c) Reduction of use of general anaesthesia for caesarean

f) Oblige trial

Hutt maternity are now participating in the Oblige (Outpatient Balloon vs Inpatient Gel) multi-centre randomised controlled trial. The primary hypothesis is that women having outpatient induction of labour with balloon will have a lower caesarean section rate, compared to women having inpatient induction of labour with vaginal prostaglandins.

Deliverables: as per multi centred trial timetable

Evaluation: Carried out by the Liggins Institute (The University of Auckland)

g) Neonatal encephalopathy – lactate testing evaluation Workstream

Hutt maternity expressed interest in participating in this evaluation project by the Neonatal Encephalopathy NE taskforce. This is to evaluate the benefits and effectiveness of undertaking universal cord lactate analysis on newborn babies in tertiary, secondary and primary birthing situations.

Dr Sarah Mills (Paediatrician/Neonatologist) has undertaken an extensive retrospective audit on Hutt babies and NE.

3. Promoting healthy weight gain in pregnancy for women with high BMI

a) Re-establish working party to establish new model of care

Improving services to women who have a high BMI (with and without gestational diabetes) is an area of focus. Although BMI has been removed as a clinical indicator, in 2018, our rates have further increased with 229 women having a BMI of >35. Ninety women were referred under referral guideline code 4017 (Morbid obesity BMI > 40 and Obesity BMI > 35).

Deliverables:
a) Re-establish working party October 2018
b) Assess need for further consultation October 2018,
c) Further consultation November December 2018
d) Planning implementation of new model of care January-March 2019
e) Implement new model April 2019
f) Evaluation December 2019 - (Currently off-track)

Evaluation:
a) Focussed consumer satisfaction
b) Increased attendance rates for referral guideline code number 4017
c) Increased rate of women with high BMIs having healthy weight gain during pregnancy

4. Data Integrity

a) Maternity dashboard integrity for clinical indicator data collection

Maternity dashboard created in 2019.

Deliverables: Dedicated project plan with lead to be devised.

Evaluation:
a) Random audit records of 90 women (5%) to ascertain conformity of data from concerto and data extracted for MOH

b) Data to Mat ODS

Coding investigation and audit

Evaluation:
a) No missing data identified in reports to MOH

c) Accurate smoking and breastfeeding data for all women birthing at facility

Evaluation:
a) Smoking status at booking identified for all women booked at facility
b) Review accuracy of data collected comparing Concerto discharges and data to Ministry of Health (including babies discharged from SCBU)

5. Management of consumer feedback and review

a) Refine process of addressing consumer feedback and review recommendations

We have collected consumer feedback by conducting electronic (and hard copy) surveying based on the MOH Maternity Consumer survey. We use the data for informing improvement in areas such as breastfeeding support. When women or their whānau wish to contact for further input into a complaint this is referred to our DHB Quality team. We need a review how recommendations from reviews are instigated.

Deliverables:
a) Meeting with quality team October 2018
b) Ongoing plan developed February 2019
c) Evaluation commenced August 2019

Evaluation:
a) Clear pathway consistently followed
b) Audit of recommendation instigation
c) Follow up feedback on review process from consumers

Timeline: MQSP Programme Hutt Maternity 2018-2020

Objective	Workstreams 2019-2020	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
1	**MQSP Activities**												
a	Annual report compilation										✓	✓	✓
b	Collecting smoking cessation advice data (DHB team)				✓			✓			✓		
c	Contribute to Maternity Quality Committee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
d	Document Control										✓		
e	Facilitating Maternity Clinical Governance Group (MCGG)	✓		✓		✓		✓		✓		✓	
f	Self-audit NZ Maternity standards by MCGG									✓			
g	Increasing registration with LMC in first trimester								✓				
h	Improving consumer engagement		✓		✓		✓		✓		✓		✓
i	Assistance with other QI projects	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
j	Attendance at other groups	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
k	Unit enhancement	✓	✓	✓	✓	✓	✓						
l	Planning for business as usual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	**Increasing physiological birth rate – intervention rate review**												
a	Acupuncture observational study	✓		✓									
b	Primary birthing room DHB	✓	✓	✓	✓	✓	✓						
c	Review IOL processes	✓											
d	Review C/s processes						✓						
e	Oblige trial					✓	✓	✓	✓	✓	Covid	Covid	Covid
f	NE taskforce lactate evaluation	TBA											
3	**Supporting healthy weight gain in pregnancy for women with high BMIs**												

a	Establish new model of care for women with high BMI/obesity	✓	✓	✓	✓	✓	✓						
4	**Data Integrity**												
a	Dashboard data for clinical indicator data collection	✓									✓	✓	✓
b	Data to MOH												
c	Smoking and Breastfeeding data				✓				✓				✓
5	**Management consumer feedback and review recommendations**		✓										

If you have any enquiries about this report, or wish to contact Hutt Valley DHB, please contact the Hutt Valley DHB Director of Midwifery:

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