Maternity Quality & Safety Programme

Annual Report

July 2015 – June 2016

WAIRARAPA maternity
Wairarapa Maternity Care

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Our latest annual report enables us to showcase the fantastic work that has been undertaken over the 2014-2015 years at our DHB through the Maternity Quality and Safety programme.

We can be rightly proud of our achievements and the wonderful collaborative approach that has sustained and championed our quality improvement initiatives. These initiatives support all maternity care providers to ensure maternity services and resources meet the needs of our women and their families in the Wairarapa community.

We have had many wins with our quality initiatives for example our BMI pathway which has enabled woman to discuss and be informed about the safest place for themselves and they baby to be born and the support around that.

Implementation of the local Maternal Mental Health Pathway which was lead by the MQSP in the Wairarapa and now sits across the 3 DHB in our region, CCDHB, Hutt Valley and the Wairarapa. This has meant woman can now be assessed in the Wairarapa by someone who is a specialist in maternal mental health and is also a resource for the community in accessing and facilitating the most appropriate care when needed and where. These are just a few of the initiatives that will make a huge difference for our women and their babies in our region.

So a huge well done to our midwives and consumers and doctors and all have been involved in moving forward these quality initiatives.

Chris Mallon	Alison Andrews	Michelle Thomas
Midwifery Director	Charge Midwife Manager	MQSP Coordinator

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PURPOSE

Our Vision:

Well Wairarapa - Better health for all

Mission:

To improve, promote, and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices

Values:

Respect – whakamana tangata

Integrity – mana tu

Self-determination – rangatiratanga

Co-operation – whakawhanaungatanga

Excellence – taumatatanga

Maternity Quality and Safety Programme

The purpose of establishing the Maternity Quality and Safety Programme (MQSP) is to find effective ways to strengthen clinical leadership, so that all maternity providers and consumers work together at the local level in a way that builds the workforce and improves safety and quality of maternity services for women and their babies, with a particular emphasis on integration of hospital and community services.

Maternity Annual Report

The purpose of the MQSP Annual Report is to demonstrate the implementation and outcomes of Wairarapa DHB's Maternity Quality & Safety Programme in 2015/2016, as required under section 2.2c of the Maternity Quality & Safety Programme Crown Funding Agreement (CFA) Variation (Schedule B42):

This is the fourth maternity services annual clinical report from Wairarapa District Health Board (WDHB) following the introduction of the Maternity Quality and Safety Programme (MQSP) in Wairarapa in March 2012 and covers the period from the 1st June 2015 to the 31st May 2016. This Annual Report:

- demonstrates the progress of the MQ&S programme against the Maternity Standards since its inception in 2012 with a focus on the work undertaken throughout 2015
- outlines the integration of the maternity quality and safety programme into the overall Wairarapa DHB Clinical Governance structure

- outlines the issues and challenges addressed through the programme
- describes the activities undertaken to strengthen and improve the quality and safety of the Wairarapa maternity services
- provides detail on local key performance indicators to measure service improvements
- demonstrates service responsiveness to consumers and our communities outlines the deliverables through the strategic plan for 2015-2016.

Background
Alignment with New Zealand Maternity Standards

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

Expectations of the New Zealand Maternity Standards:

Standard One: Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.	
8.2	Report on implementation of findings and recommendations from multidisciplinary meetings
8.4	Produce an annual maternity report
8.5	Demonstrate that consumer representatives are involved in the audit of maternity services at Wairarapa DHB
9.1	Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Wairarapa region
9.2	Identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs

Standard Two: Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage.	
17.2	Demonstrate in the annual maternity report how Wairarapa DHB have responded to consumer feedback on whether services are culturally safe and appropriate
19.2	Report on the proportion of women accessing continuity of care from a Lead Maternity Carer (LMC) for primary maternity care

Standard Three: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.	
24.1	Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility

SECTION 1: AIM/OBJECTIVES

1.1

AIMS

The aim of the Wairarapa Maternity Quality and Safety Programme (MQSP) is to guide and facilitate the implementation of the New Zealand Maternity Standards and to enable Maternity Practitioners and consumers to identify ways that the local maternity service can be strengthened through quality improvement initiatives. The quality improvement initiatives support all maternity care providers to work together to ensure local maternity services and resources meet the needs of families in our region.

1.2

OBJECTIVES

The objectives that the Wairarapa Maternity Quality and Safety Programme set in the implementation and conception period of MQSP have been achieved.

Ongoing objectives from inception have been to work towards the three New Zealand standards of maternity care as outlined above. To achieve these objective goals have been set through Annual Plans and outcomes monitored. Each year some goals will roll over as work continues and new ones are identified, for the 2015 year the following objectives will be further explored throughout the Annual Report:

- Development and implementation of a BMI pathway.
- Continual audit and review of Caesarean section, Induction of Labour and Vaginal Birth after Caesarean
- Adopt guidelines on External Cephalic Version, Induction of Labour and Vaginal Birth After Caesarean in the effort to reduce the caesarean section rate
- Ensure Maternity specific procedures and guidelines are updated and document controlled
- Propose the use of fetal fibronectin testing to reduce the transfer rate to tertiary level care
- Implementation of the local Maternal Mental Health Pathway
- Explore the possibility of refurbishing a multi purpose room into a primary birth room with adopting a home from home feel.
- Introduce HypnoBirthing classes to support women in their preparation for birth following a caesarean or traumatic previous birth
- Providing antenatal education for Māori /Pacifica population.

SECTION 2: SALIENT ISSUES

Outlined below are the salient issues and challenges related to the maternity services that have been identified as relating to the maternity quality & safety programme. The steps taken to address these issues have been undertaken to mitigate or reduce the impact of these issues/challenges.

Salient Issues	**Steps taken to address these**
BMI	A guideline has been finalized in consultation with Obstetricians, anaesthetists, midwives and consumers providing a clear process and pathway for women with raised BMI's. There has been consultation with the transferring DHB enabling a direct line for transferring and sharing of information. The consultation process between obstetrician, anaesthetist, LMC and woman provides a descriptive narrative for the information required to be shared in order for the woman to make an informed choice.
Auditing of C/S, IOL and VBAC's	A great deal of work has gone into the ongoing auditing of c/s, IOL and VBAC's through out the 2015/16 years. This provides the maternity service with an overall picture of the effects that changes are having on outcomes and further investigation into other areas if required.
C/S rates	Work to reduce the c/s rate has been ongoing since 2014, examples of this work is evidence based guidelines being implemented, care planning, auditing, seminars, HypnoBirthing, community education and trying to change the culture towards c/s.
Locum Obstetricians	Having a high use of locum obstetricians poses the challenge of ensuring they are familiar with local guidelines and procedures. An orientation pack is being designed for locum obstetrician/gynaecologist's so they are better prepared and are kept updated with changes within the service.

SECTION 3: DATA ANALYSIS

Wairarapa DHB is one of the smaller DHB maternity service providers in New Zealand that provides both primary and secondary care facilities. The DHB supported 411 births in 2015 from a population of just over 43,800. The maternity services are based at Wairarapa DHB in Masterton; this is the only birthing facility in the region, the number of homebirths for the district was 25 births for the year 2015.

WORKFORCE

We continue to have 10 LMC midwives with access agreements working in our region. All women pregnant in the Wairarapa have a LMC midwife who provides primary care with the support of the secondary care service as required, meeting standard 2, 17.2 in the NZ Maternity Standards. There are 16 core midwives that can provide the secondary care of women if they are handed over to secondary care and the LMC chooses not to continue midwifery care.

The Maternity Service also includes the following staff:

- Director of Operations, Surgical, Women's and Children
- 2 Obstetric Consultants including 1 who is Clinical Head of Department, Obstetrics and Gynaecology
- Midwifery Director (2 DHB)
- Charge Midwife Manager
- Midwife Educator and Maternity Quality & Safety Programme Co-ordinator
- Newborn Hearing screener and Co-ordinator
- 1 Antenatal and Parenting Education Midwives
- Midwifery and medical students on placement

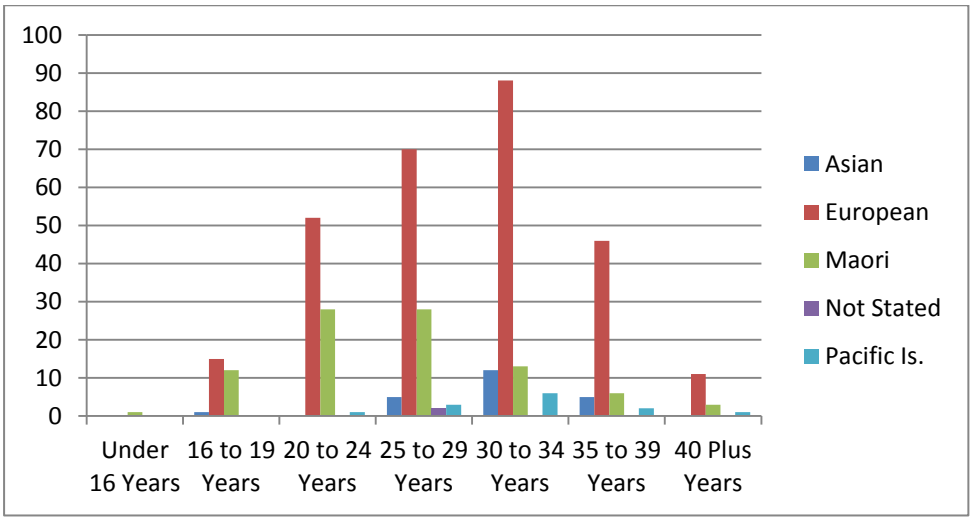
During 2016 we have been working on improving interpersonal relationships. Following work with the midwives around our expectations from each other regarding relationships and working together we developed the following midwifery vision statement which was launched on International Midwives Day this year:

> "We are a team of midwives who are professional, supportive and respectful of each others. We work collaboratively, are honest, trusting and positive in our working relationships. We celebrate our individual strengths and qualities, share information and are united in our goal to provide safe care to mothers and babies."

This statement has been framed and put on the wall in the unit.

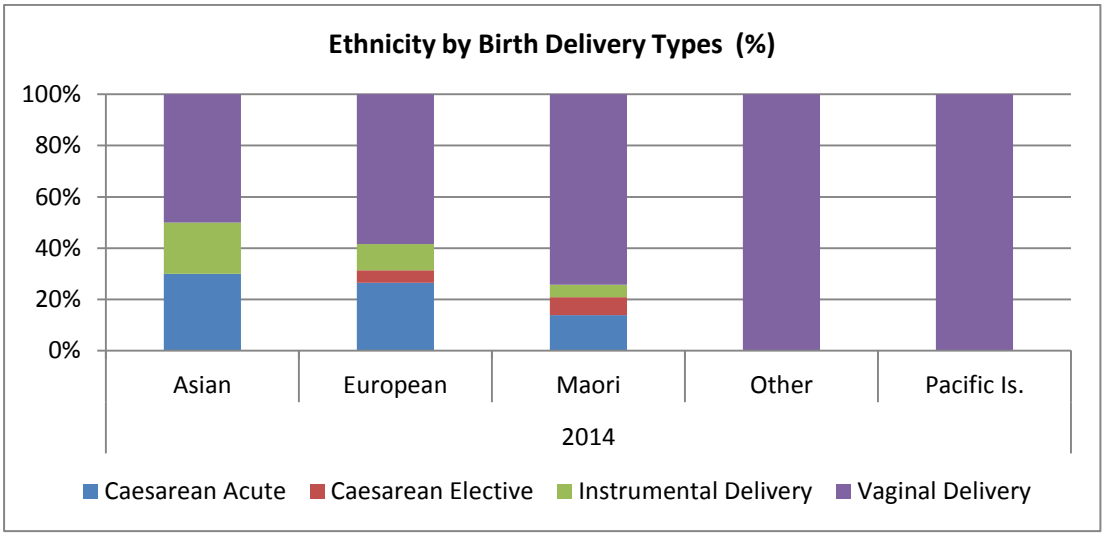
MATERNITY DATA

As shown in graph 3.1 below the diversity of ethnic groups residing in the Wairarapa is smaller than that of larger urban areas. Thus meaning that the cultural component of care provided to the birthing population is precise and of a high standard. Wairarapa has a similar proportion of Māori and a much lower proportion of Pacific people in comparison to the national average.



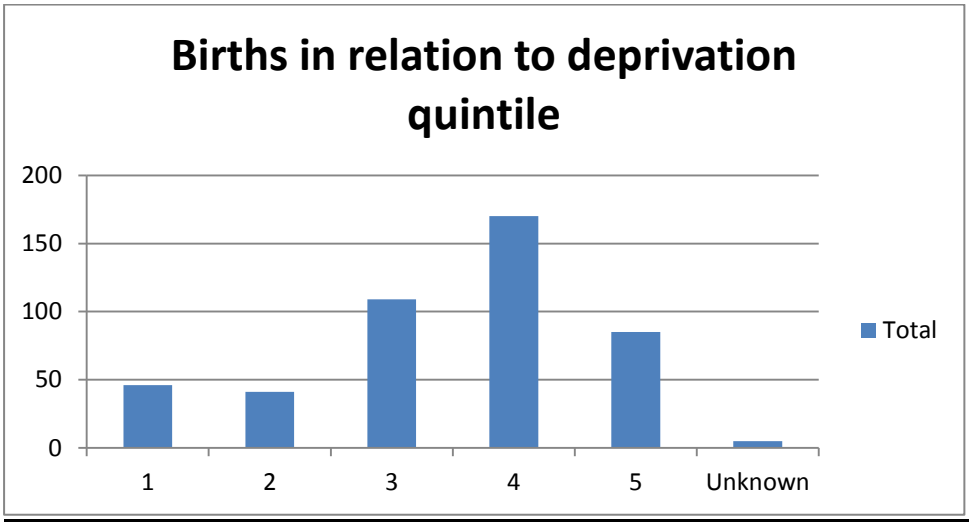
Graph: 3.1

Graph 3.2 below shows comparisons of mode of birth in relation to ethnicity has identified that the Asian population has an increase incidence of acute caesarean section and instrumental deliveries with Asian population increasing. However, there has been a significant change in the elective caesarean sections with none in 2015 for the Asian and Pacifica groups. Moreover, Pacifica women have had a positive 100% normal birth rate compared to Asian and European ethnicities.



Graph: 3.2

Wairarapa has a high proportion of women and whanau in the more deprived section of the population when compared to the national average; this is evident in graph 3.3 below. This may impact on birth outcomes as the health of this group is more likely to have complexities of health as a result of lifestyle choices/situations.

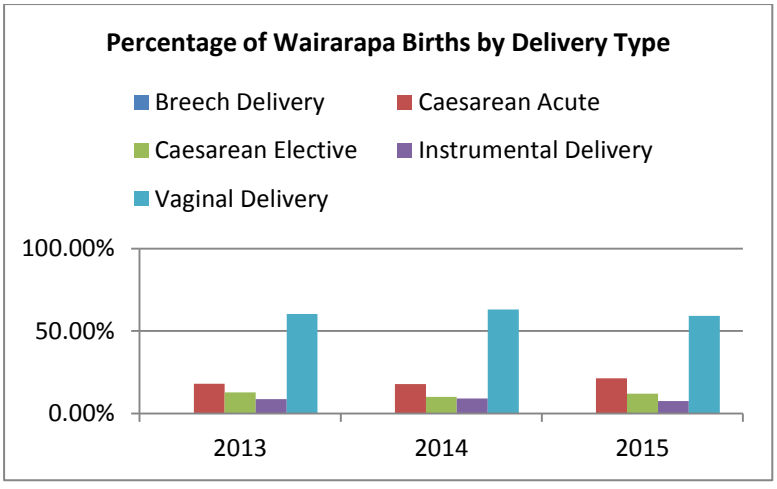


Graph: 3.3

BIRTH EVENTS

Graph 3.4 shows the comparison of data on mode of birth. According to the raw data there is no reduction on our cesarean section rate, we are continuing to audit and review this particularly in relation to the impact of a high use of locums on the service. This data is inclusive of the standard primiparae (which is discussed later in the clinical indicators) so gives an overall picture of birth trends within the DHB. However it has to be remembered that there has been a reduction in the birth rate over the past 3 years.

Graph: 3.4 Comparison of mode of Birth, years 2013, 2014 & 2015.



The average length of stay for women birthing at Wairarapa DHB is 2.73 days, which is relatively unchanged from previous years.

VBAC

Over recent decades there has been a rise in the number of births by Caesarean section in New Zealand which has lead to increasing rates of women presenting with a history of prior caesarean section. This population requires advice regarding options for future pregnancies: either planned trial of labour (VBAC) or elective caesarean section, with each option carrying its own risks and benefits.

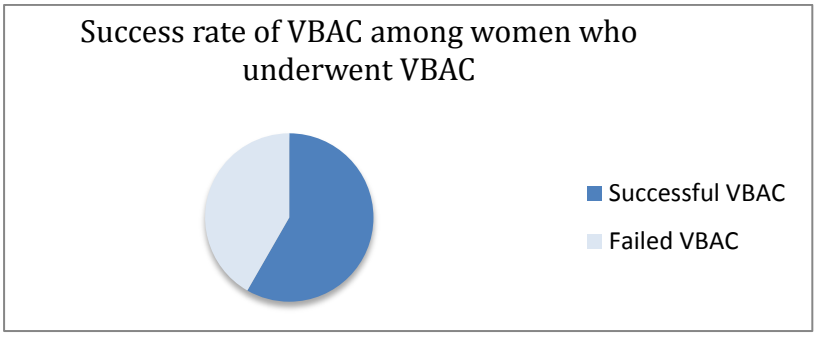
An audit undertaken of the birth register for the Wairarapa Maternity Service examined women with history of previous caesarean section who were selected for trial of labour to determine rates of successful VBAC.

Table 3.1: Results of the audit

Mode of delivery	2014		2015	
Vaginal	17	40%	14	58.3%
Instrumental	2	2%	0	0%
Emergency C-section	7	16%	9	37.5%
Elective C-section	17	40%	1	4.2%

There has been a 58% success rate reported for those achieving vaginal birth following a planned VBAC in the Wairarapa for 2015 compared to 40% for 2014. This shows an increase in successful VBAC's since the introduction of our VBAC and External Cephalic Version (ECV) guidelines. We have also seen a significant reduction in repeat elective caesarean sections. The increase in the percentage of emergency caesareans looks dramatic because our numbers are small, but has only increased from 7-9 women.

Graph: 3.5



Most repeat caesarean sections were performed for failure to progress – (60%). Multiple factors can impact on the likelihood of successful VBAC, particularly induction of labour, which can reduce success rates. It is worth noting that 70% of failed VBACs in 2015 had IOL.

Table 3.2

Indications for repeat caesarean section 2015	N(%)
Failure to progress	6 (60%)
Fetal distress	1 (10%)
Obstructed labour	1 (10%)
Breech diagnosed in labour	1 (10%)
Maternal request	1 (10%)

There is a small risk of uterine rupture in women who have trial of labour (<1%) compared to elective repeat caesarean section. During the period of study there were no documented cases of uterine rupture in this population. There were no maternal or peri-natal mortalities or morbidity recorded during this time.

The development of a local VBAC guideline and increased patient education has contributed to decreasing failure rates of VBAC which falls in line with recommendations by RANZCOG. Further work in the 2015/16 year has been that women are referred to clinic at 20 & 36 weeks gestation for VBAC consultation. They are offered the HypnoBirthing Course (discussed later in the document) and a VBAC leaflet has been designed. As of the 1st of July 2016 post caesarean section women will be offered a 6 week postnatal consult with the obstetrician in clinic to debrief on the birth and to discuss options for the next labour and birth. Encouraging the early positive thinking of VBAC, it will be interesting to see if this trend continues throughout 2016.

PMMRC

PMMRC investigations and submission of data occurs without fault in the instance of stillbirth or neonatal death. Due to the low birth numbers in our region the number of stillbirths is substantially less than other facilities. The PMMRC meetings are held as required and following the completion of all clinical investigations such as post mortem, etc. The meetings are well attended and in 2015 Dr Jane Zucollo from Wellington attended and presented a case which was exceptionally educative and it gave opportunity for discussion regarding the offering of post mortem for women and their whanau.

Stillbirths that were reported to PMMRC are as in table 3.3 below:

Stillbirths by Gestation	2013	2014	2015
20 – 30 weeks	1	1	1
30 + 1 – 35 weeks	1		
35 + 1 – 40 weeks	1		2
40 +weeks	1	1	

TRIMESTER OF REGISTRATION

As discussed in previous reports one of our initial initiatives was to engage with the community and GP's around the change in LMC's providing care in the region. This produced the Pregnancy Information Pack to GP services for the women that choose to source their GP as a point of first contact when pregnant. The change in LMC services saw an initial drop in the percentage of women registered in the first trimester, however there has been a significant improvement in this statistic over the 2014 year. There has also been an impact following the 2014 3DHB campaign around the first thing to do in the first 10 weeks of pregnancy.

Table 3.4

	Registered within the first trimester of pregnancy	All registered women	Rate (%)
2012	314	511	61.4
2013	196	499	39.2
2014	229	423	54.1

MATERNITY CLINICAL INDICATORS

The key maternity clinical indicators where Wairarapa DHB rates are higher than the national average are discussed below. These indicators provide some of the key work streams for quality initiatives within the MQSP in the Wairarapa.

Our continued work in striving to achieve optimal care for women and babies and reduce the cesarean section rate is unfortunately not reflected in our mode of birth. We have certainly identified the need to promote changes to the service and delivery of care in the community setting and through means of our consumers and advertising, thus assisting in the change of culture toward cesarean section birth.

A comparison of the induction of labours for 2013 3.1% and 2014 13.5 shows a significant increase. Table 3.5 below shows data collected over a 3 month period (May, June, July 2014) following the implementation of the Induction of Labour guideline.

The total number of births over this period was 102 with 15 of these being inductions, a rate of 14.7%.

Table 3.5

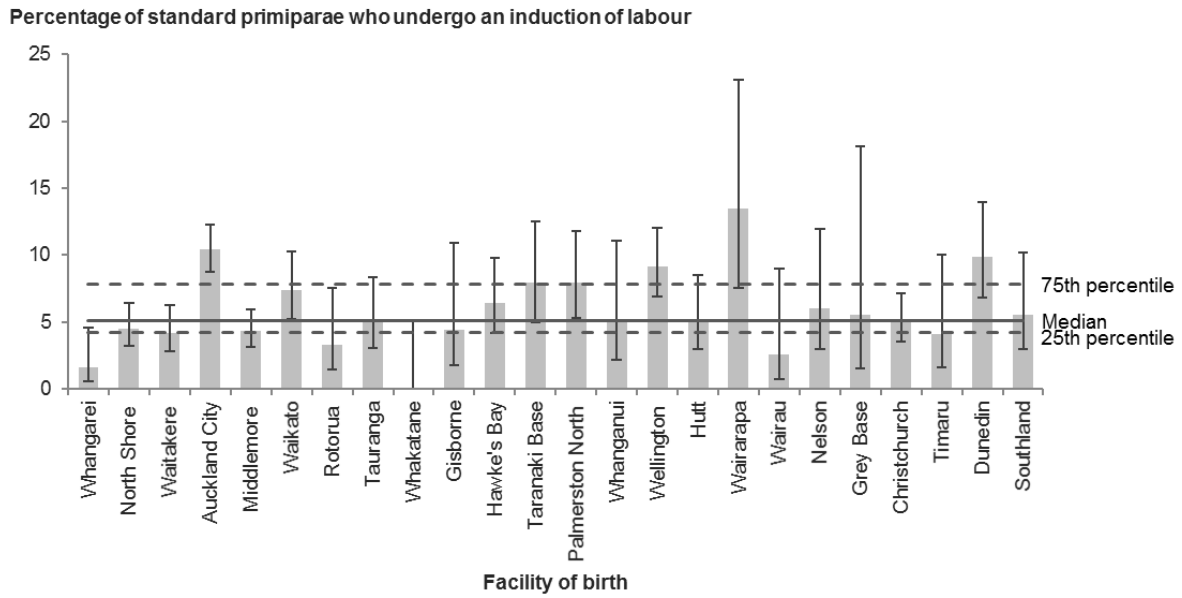
GESTATION	REASON	METHOD	OUTCOME
38+6	Anti C & Anti E antibodies	Prostin/ARM	NVB
41+5	Post dates	Prostin/ARM	NVB
37+5	Intrauterine Growth Restriction	Prostin/ARM	NVB
40+6	Meconium liquor on scan	Prostin	Instrumental
39+2	Cholestasis in pregnancy	Prostin/ARM/Synto	C/S
41	Post dates/VBAC	Foley catheter	C/S
41	Post dates	Prostin	C/S
40+1	Gest. Diabetes	Prostin	Instrumental
41+ 4	Post dates	Prostin/ARM	NVB
37+1	Intrauterine Growth Restriction/elevated AFI	Prostin/ARM	C/S
40+4	Polyhydramnious	Prostin/ARM	C/S
39+1	PIH, GDM on insulin	Prostin	NVB
41+3	Post dates	Prostin	Instrumental
41+3	Post dates	Prostin	NVB
41+3	Post dates	Prostin	Instrumental

NB:

- ARM = artificial rupture of membranes
- NVB = normal vaginal birth
- Instrumental = forceps or ventouse vaginal birth

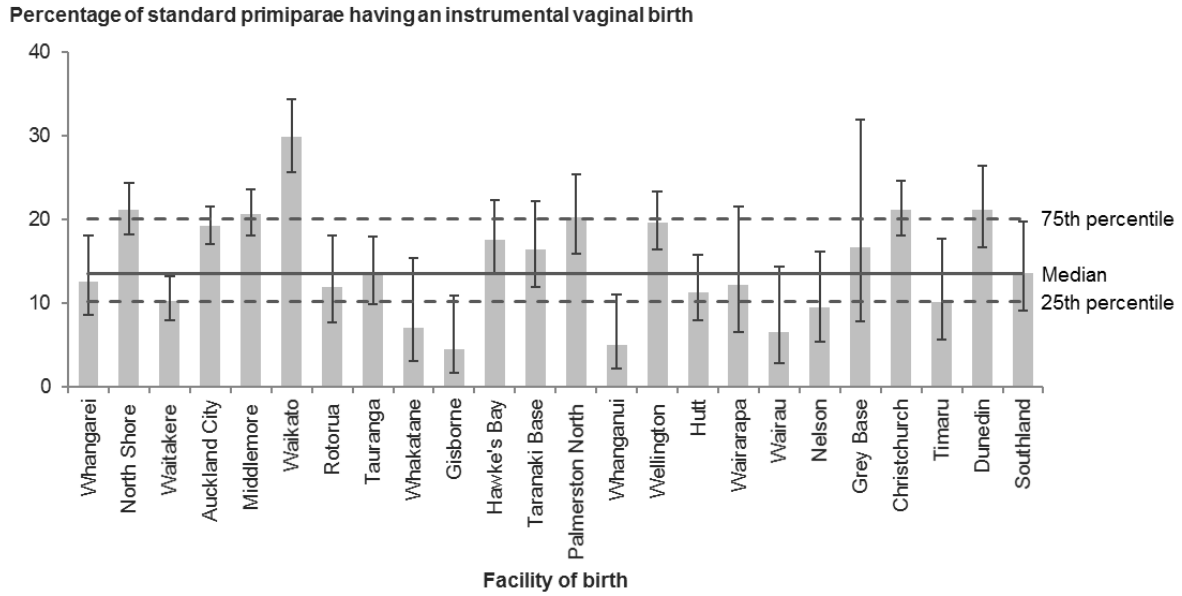
Of the 15 inductions 5 were pre 40 week inductions and were medically indicated with the remaining 10 being for post dates. For the 2015 year there was a decision to audit all inductions for the year and complete a robust analysis of the data which is currently being undertaken.

Graph: 3.6



The following graphs show a slight increase in instrumental and cesarean section births for 2015, it must be recognized though that with a very small number of births it only takes a few to change the percentage dramatically. With work continuing there is hope to ensure rates initially decline and remain at a level which is safely justified in our birthing population.

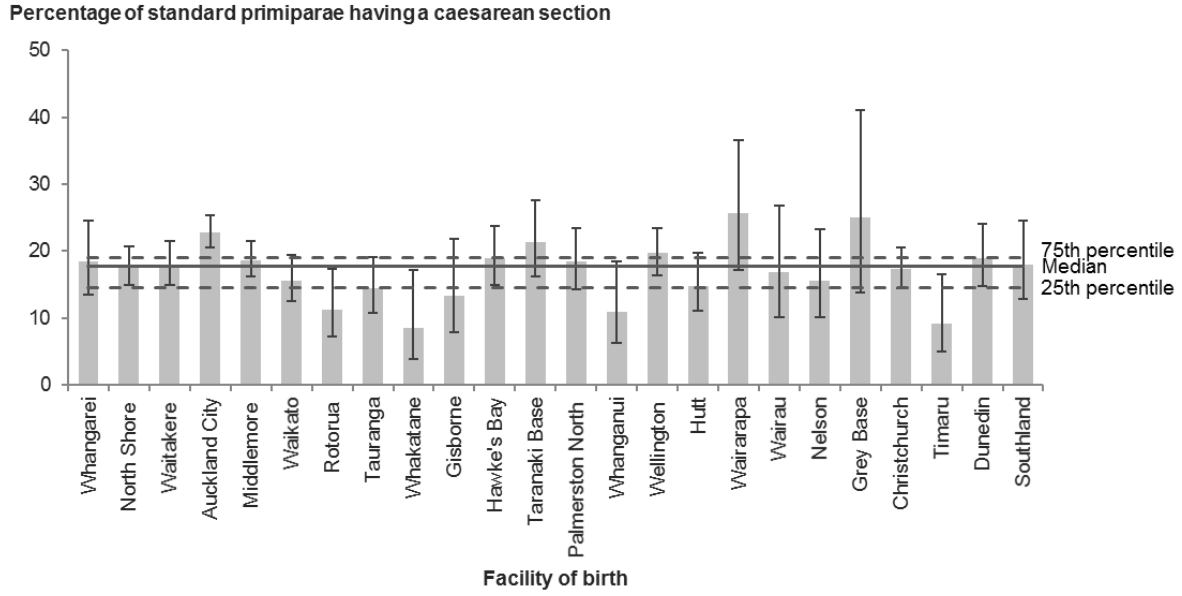
Graph: 3.7



A comparison of inductions between 2013 10.9% & 2014 12.2% shows an increase. This is likely to be linked to the increase of cesarean sections as evidence shows that the relationship between intervention and instrumental/cesarean section births is high.

Graph 3.8 shows below the rates between 2013 23.4% & 2014 25.7% supports the above statement.

Graph: 3.8



SMOKING RATES IN PREGNANCY

Smoking cessation continues to be a priority area for the Wairarapa. The success of a "Growing Love" quit support programme run by Whaiora our local Māori Health provider has been a great success. The programme saw a number of young smoking mum's attending and giving up by the end of pregnancy.

Table 3.6 below shows the number of identified smoking mothers who have been admitted to maternity. While the number of pregnant smokers has decreased there has also been a reduction in the number of women being offered advice to quit. This will be an area focused on more intently through the 2016 year. Te Hapu Ora education has undertaken training for midwives in the region and maternity staff has been reminded of their obligation to offer advice to women; it will be interested to see how this impacts on the 2016 data.

Table: 3.6

	Data				
Calendar Year	Hospitalised Smokers	Smokers Offered Advice	Inpatient Discharges Over 15	Rate of Smokers Offered Advice	Rate of Smokers to Inpatient Discharges
2013	75	74	454	98.7%	16.5%
2014	65	64	470	98.5%	13.8%
2015	60	48	458	80.0%	13.1%
Grand Total	**200**	**186**	**1,382**	**93.0%**	**14.5%**

PREGNANCY & PARENTING EDUCATION

Pregnancy & Parenting Courses are offered by the DHB and Parents Centre. The DHB courses are run by an experienced midwife with an interest in adult teaching, they are offered in a variety of ways from a set evening class at the DHB, sessions at the local Teen Parent Unit to a drop in centre facilitated alongside the local Māori Health Provider – Whaiora.

Numbers in attendance for the education offered are outlined below:

Reporting Requirement	
Total number of Group Education Programmes (as defined in 6.2) held in the reporting period.	8 +2 rolling programmes
Total number of completed Block/One Off Education Sessions (as defined in 6.2) held in the 2015 year.	1
Total number of clients (existing clients, plus all new cases) who were registered in the 2015 year.	108

Reporting Requirement	
Total number of clients (existing clients, plus all new cases) who were first time parents registered in the 2015 year.	98
Total number of clients aged 20 and under (existing clients, plus all new cases) who were registered in the 2015 year	19
Total number of clients (existing clients, plus all new cases) who completed at least 75 per cent of the programme in the reporting period.	68= 82%

The course has been changed to a Thursday night rather than a Wednesday; this does not appear to have affected attendance which has remained fairly consistent. There has been a significant increase of Māori attending classes (25% up from 5% the previous year)

Six women transferred to Tertiary level care/went into premature labour. Two women moved out of the area and two booked late onto the course. Twelve women booked onto the course but did not attend, however, these woman are not included in the numbers.

Specific Smoking Cessation education and support (Growing Love) are run by Whaiora and have had 60 referrals, funding will cease June 2016.

Table: 3.7

Ethnicity		% Total of Attendance
NZ European	71	66%
Maori	27	25%
Indian * - Sri Lanka	2	1.8%
SE Asian * - Filipino - Vietnamese - Cambodian	1	0.9%
Pacific Island	1	0.9%
Chinese	3	2.7%
Other Euro - French	2	1.8%
South African	1	0.9%
Total Attendance	**108**	100%

The opportunity to offer women with other services that could potentially improve outcomes for her and her baby is paramount in the education setting and thus identified in the table below whereby smokers were identified and offered smoking cessation service with an excellent uptake.

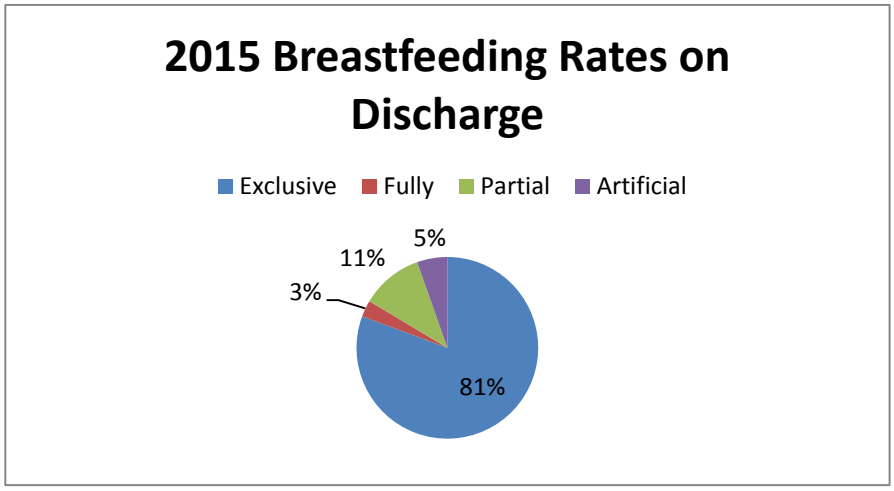
Table: 3.8

Number of women smoking during pregnancy by ethnicity	Number of women offered advice	Number of women referred to smoking cessation service
Maori	5	5
Pacific	0	0
Other	2	2
TOTAL	7	7

BREASTFEEDING RATES AT DISCHARGE FROM WAIRARAPA DHB

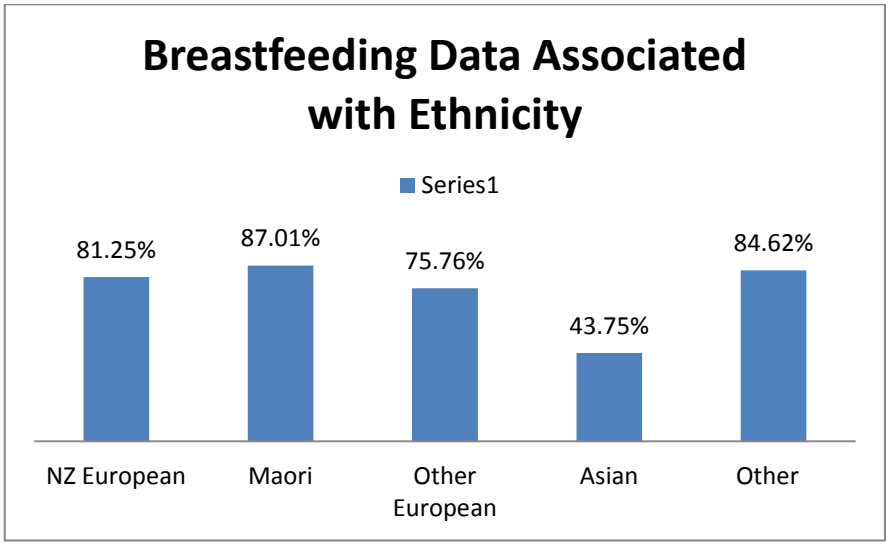
The 2015 exclusive breastfeeding rates on discharge from maternity services show an increase from 79% in 2014 to 81%. The commitment from the maternity service, women and their whanau is a credit to the success of women feeling fully supported to establish and maintain exclusive breastfeeding during their hospital stay, even in the SCBU department. The Lactation Consultant compliments the care of the midwife by educating and assisting women whom have complex breastfeeding problems to breastfeed. She provides this service in collaboration with the core midwives and LMC's and it is a universal approach to breastfeeding supporting our BFHI accreditation.

Graph: 3.9



As can be seen from the table below Māori have the highest exclusive breastfeeding rates on discharge from the unit. The Asian population has the lowest as they are more likely to be partially breastfeeding or artificial feeding.

Graph: 3.10



The Wairarapa DHB Annual Plan 2014/2015 states that "the urban areas of Wairarapa have a greater proportion of people classified as more deprived than the national average and it is well documented that Māori and people of low socio-economic status have consistently poorer health outcomes in comparison with the rest of the population. Across all groups, positive social change will drive improved health." Māori Health Indicators from October 2014 show that breastfeeding rates for Māori at six weeks are 67% and at three months are 58%. These rates are lower than the total population figures of 70% and 60% respectively.

As a result of this statistic key stakeholders in breastfeeding promotion joined to form a committee that would be "Breastfeeding Wairarapa". Breastfeeding Wairarapa's goal is to promote, increase and maintain high breastfeeding rates for all and encourage greater public awareness and community engagement in supporting families to breastfeed for at least six months, which will contribute to reducing health impacts later in life. The positive effects from breastfeeding can contribute to positive social change across the Wairarapa population and in particular among the most vulnerable.

Aligning with plans and goals of the organisations involved in Breastfeeding Wairarapa, this project led by Regional Public Health aims to provide breastfeeding support at a community breastfeeding service, through training of a Peer Counsellor Programme Administrator (PCPA) and subsequently, Peer Counsellors. This first uptake of training happened in May and June 2015, with a second training held in March and April 2016.

The PCPA have trained 20 local women to be peer counsellors who will then jointly staff the community breastfeeding service as volunteers on a rostered basis with support from clinicians. The service runs for two hours once a week in Masterton and once a month in Featherston.

SECTION 4: MQSP GOVERNANCE (MCGG)

4.1

MATERNITY CLINICAL GOVERNANCE GROUP

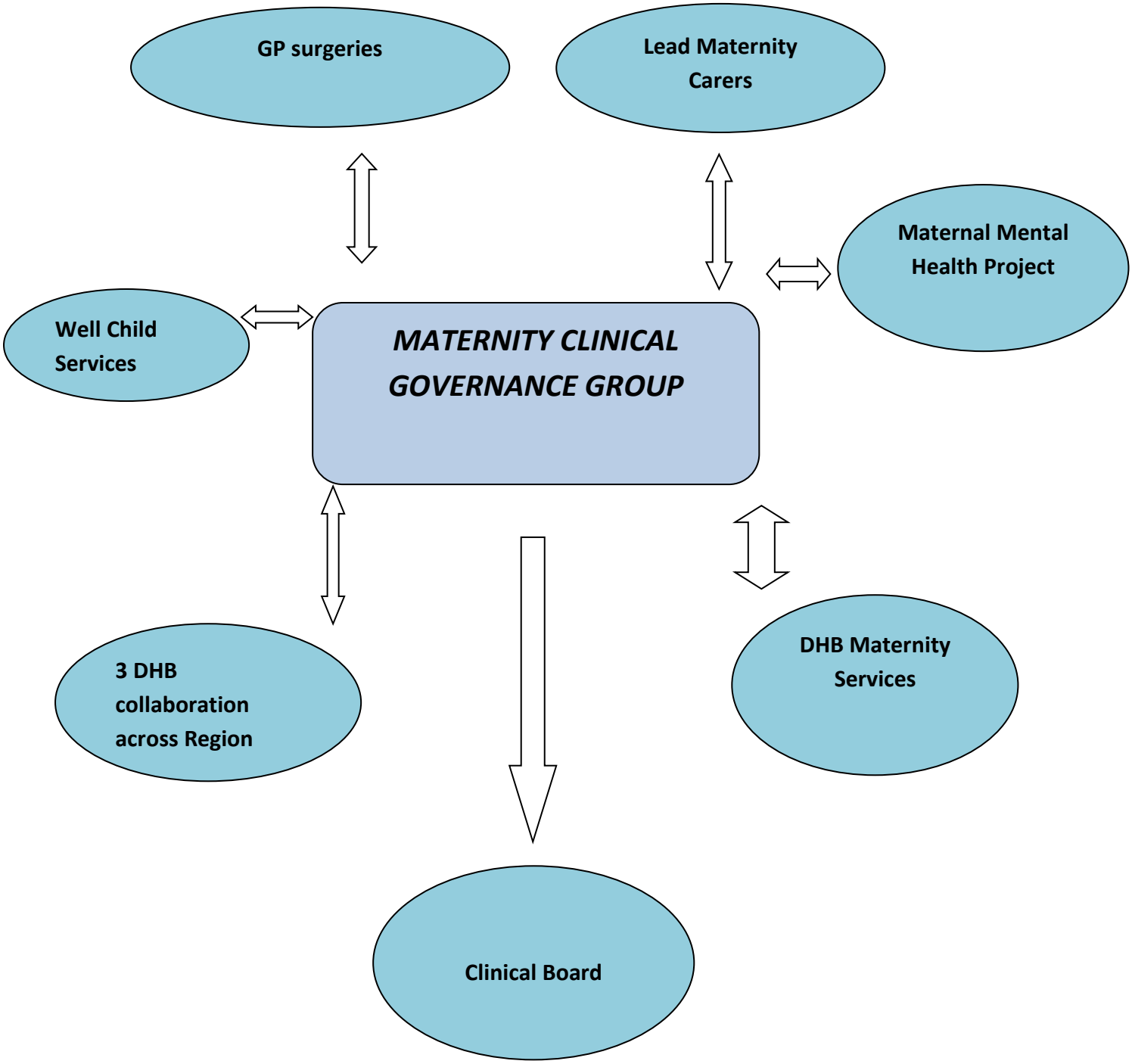
Wairarapa DHB established the Maternity Clinical Governance Group to oversee the Maternity Quality & Safety Programme. The group has had a very successful year of driving aims and objectives as set out for the 2013/2014 plan. The consumers have participated hugely in not only local issues but connecting also at a national level, which has had a positive impact on our group. The inclusion of our consumers and their valued opinions is paramount in how we progress forward in improving quality of care for our women and their whanau.

Māori representation continues to be strong on the group with a member from the DHB's Maori Health Directorate and the local Māori Health Provider along with 2 members being Māori. It is our vision that having this representation will enhance the relationships and services available to our Māori birthing population and their whanau.

As per the terms of reference there has been a change in midwifery representation with the replacement of members being staged to ensure the continuity of the group find the Terms of Reference in Appendix 2.

MATERNITY CLINICAL GOVERNANCE GROUP MEMBERS	
David Cook, Obstetrician	Alison Andrews, Charge Midwife Manager
Sarah Boyes, Director of Operations	Janeen Cross, Maori Health Directorate
Amber O'Callaghan, Executive Director Quality & Risk	Chris Mallon, Midwifery Director
Marilyn Smethurst, Core Midwife Rep	Monika Steinmetz, LMC Rep
Michelle Thomas, MQSP Coordinator	Kiri Playle, Consumer Rep
Anita Roberts, Consumer Rep	Emma Skudder, SIDU
Yvette Grace, Primary Health Rep	Eileen Fahy-Teahan, Whaiora
Michelle Sole, Plunket	

GOVERNANCE STRUCTURE



NATIONAL DIABETES GUIDELINE ROLLOUT

The development of the national diabetes guideline has ensured Wairarapa provides a uniformed approach towards the diagnosis and management of diabetes in pregnancy. It has also given us the opportunity to review services available to diabetic women and complete succession planning where required.

Local LMC's and GP's were notified of the guideline, reminded of the changes and expectation that these changes need to become routine practice. The laboratories were quick to make changes to the first antenatal bloods to include the HbA1c. LMC's and GP's have a clear pathway for referral to diabetic services and secondary care where necessary.

Moving forward the maternity service would like to develop a diabetic midwife role that will support the secondary care team and be a point of contact for women and LMC's. The wrap around service that this diabetic midwife will be able to provide will offer more than is available at present with an already stretched general specialist diabetic team. A job description has been drafted and we are hoping to establish this post within the year.

CONSUMER ENGAGEMENT

The Wairarapa region has been blessed with the commitment and passion of 2 amazing consumer representatives, who were invited to speak at the Mat Con 2015. It was with great pride that I stood alongside these 2 amazing women and spoke as our consumers are our every being.

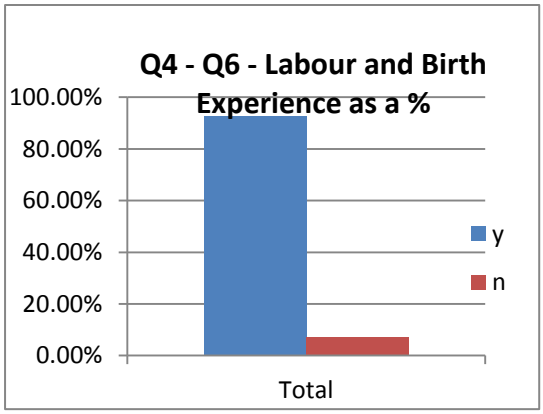
Both the Charge Midwife Manager and I have an open door policy which has helped aid good communication and positive actions when Kiri and Anita have ideas or thoughts. I certainly value their views and opinions and so access them frequently when we are reviewing leaflets, updating information on the maternity website or needing the thoughts of consumers in the community. This is clearly one of the advantages to having local born and bred consumers as they know so many people through their different networks. This means that their contact with the consumers of our maternity service is constant through one way or another.

Ensuring that our consumers feel involved in the group has been paramount, they have the opportunity to put forward agenda items, they have an allocated slot on the agenda, meetings are set for the year to accommodate them and their whanau/work life and they are treated as equals when in the meeting situation.

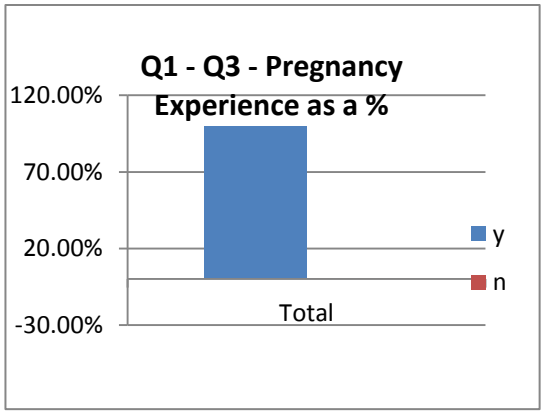
One consumer is Māori while our other consumer is not she works for the local Māori Health Provider and has crucial links with the Māori community both professionally and personally. A greater proportion of our small Pacifica community is engaged with the local Māori Health Provider and thus has a voice through our consumer working for the local Māori Health Provider. Pacific representation is something that we have identified as being positive for the engagement with the Pacific community and so will move forward with this over the next year.

The maternity service has a feedback form that is offered to women during their postnatal stay and collects data from the clinic setting, antenatal admissions, labour and birth, postnatal stay, and baby cares. The feedback is amazing and generally always states outstanding care is provided, any deviations from this provides us with the opportunity to address the issues with individuals or as a department if there seems to be any recurring themes or problems. The graphs below are a representation of the feedback and to relate the graphs to questions the consumer feedback form is attached as Appendix 1.

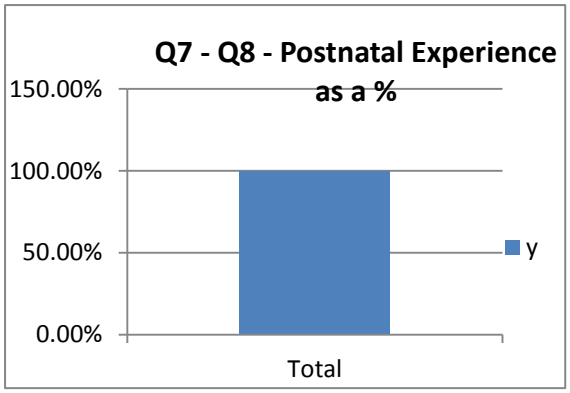
Graph: 4.1



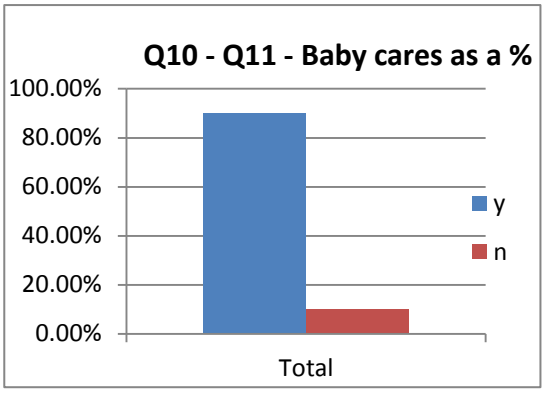
Graph: 4.2



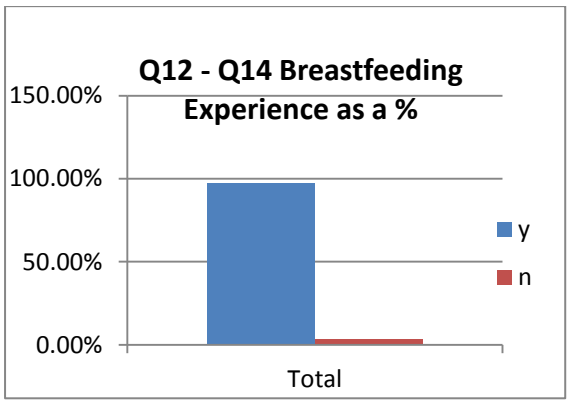
Graph: 4.3



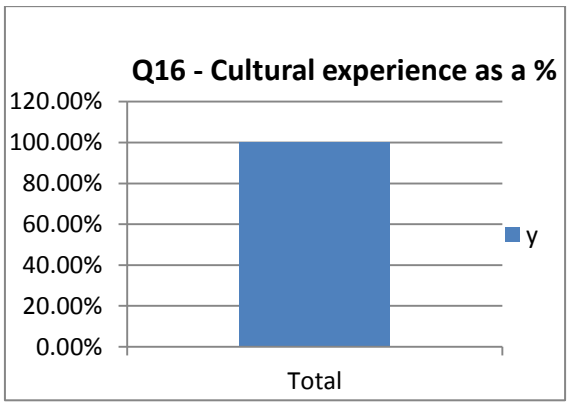
Graph: 4.4



Graph: 4.5



Graph: 4.6



MATERNITY WEBSITE

The maternity website has been live since Dec 2013 and table 4.1 illustrates the monitoring and usage of the website. The website displays information for pregnant women/whanau in relation to pregnancy, birth and postnatal. It links with support groups and many other services accessible to women, all LMC midwives are found on the website and are linked to the NZCOM 'Find your midwife' website. Out of interest when analyzing the hits of the website we have had international interest from all over the world!

Table: 4.1

	Acquisition			Behavior		
	Sessions	% New Sessions	New Users	Bounce Rate	Pages / Session	Avg. Session Duration
	1,782 % of Total: 100.00%	74.41% Avg for View: 74.41%		1,326 % of Total: 100.00%	66.39% Avg for View: 66.39%	2.37 Avg for View: 2.37 (0.00%)
1	Organic Search	1,208 (67.79%)	70.70%	854 (64.40%)	67.88%	2.11
2	Referral	357 (20.03%)	82.35%	294 (22.17%)	65.83%	2.69
3	Direct	189 (10.61%)	80.95%	153 (11.54%)	58.73%	3.37
4	Social	28 (1.57%)	89.29%	25 (1.89%)	60.71%	2.71

VULNERABLE WOMEN'S GROUP

The group has been functioning for 2 years and has brought together the collaboration and networking of a multi-disciplinary team. This multi-disciplinary approach has ensured the

appropriate care for their women and whanau is achieved. The Terms of Reference for the Vulnerable Women's and Unborn Babies Group are in Appendices 3. The tables below illustrate the breakdown of women who have been on the register and the services that have participated in the support and planning of their care during pregnancy and 6 weeks post birth.

Table: 4.7

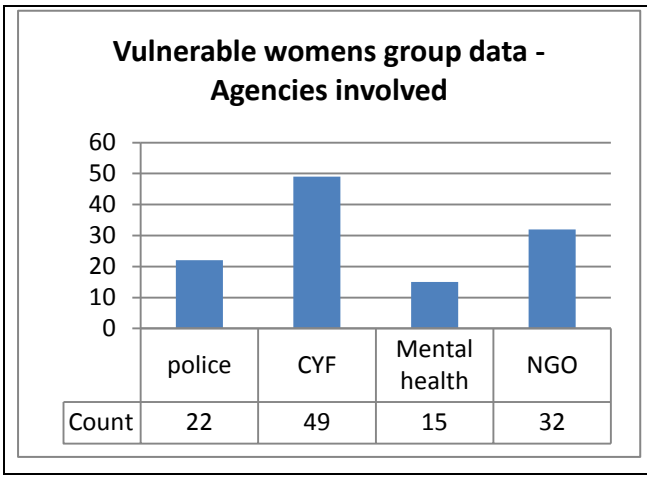


Table: 4.8

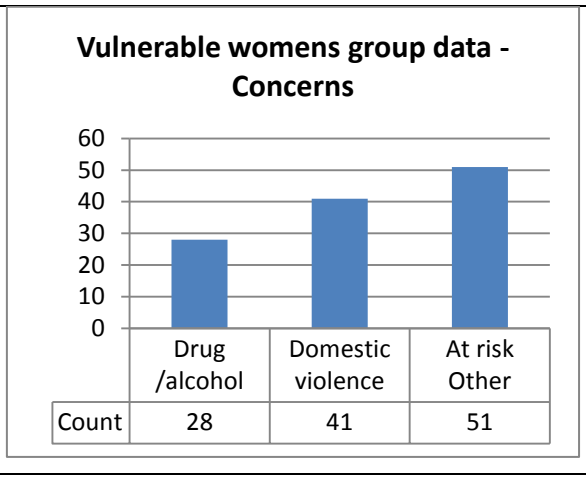


Table: 4.9

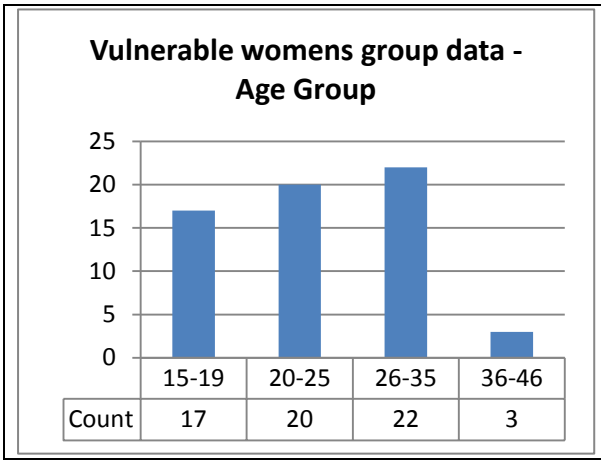
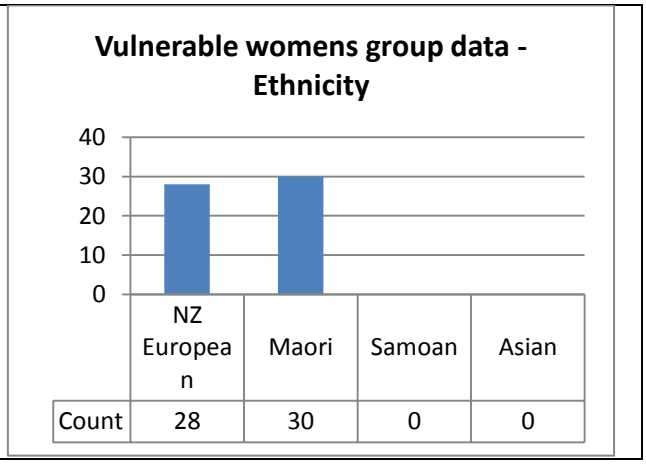


Table: 4.10



PRIMARY BIRTHING ROOM

Tūranga Matua, is the name of the new birthing room at Wairarapa Hospital. This was an initiative developed with the aim of promoting normal birth and providing a space that women could use which looked more homely. The room was opened with a formal blessing ceremony in April; the story from the DHB intranet and local newspaper is reproduced below.

"Tūranga Matua is part of the Maternity Unit and provides a comfortable, less clinical environment for women and families who want the security of hospital but a more homely atmosphere where they will give birth.
The room was blessed by kaumātua Rev. Mihi Namana and Mike Kawana. Mike provided the name

which came from a Wairarapa song that is around 300 years old. "It comes from a classical Maori oriori (song) well known throughout Wairarapa, Wellington, Hawkes Bay and Taranaki," he said. "It is like a prayer especially for childbirth and it talks about the birth of a child and the process of growing strong and gaining knowledge. Tūranga Matua, or rightful place in the world, connects the child to the world of knowledge, the world of understanding and the world of life."

Maryanne Monastra was one of the first women to use the birthing room.
She is with Lucy, Abbey, and Noah on the day of the official blessing.
Aunty Mihi Namana holds 6 week old Oliver.

Tūranga Matua is furnished with a sofa bed a comfortable chair as well as a birthing stool and swiss ball. In the next room there is a birthing pool if women choose to have a water birth and there is no clinical equipment on view.

Charge Midwife Manager Alison Andrews said, "The new primary birthing room is a calming more homely space for women. Our aim is to give women the best chance to give birth actively and naturally without intervention; like home but within the hospital."

Chris Mallon, Director of Midwifery, said, "The opening and blessing of our birthing room, Tūranga Matua, is an awesome achievement by all who have participated and supported this venture. The birthing room has a homelike setting and supports other options for managing the process of labour with a low intervention approach to labour and birth for wāhine whose pregnancies are without complications and want this option for their labour and birth. Well done and I am delighted to support this wonderful environment and choice for both women and midwives."

The most recent baby born in "Tūranga Matua"

SECTION 5: QUALITY IMPROVEMENT

FETAL FIBRONECTIN TESTING

Transfer to tertiary level care is sometimes necessary, but it was becoming apparent that a number of women were being transferred due to the potential risk of going into labour before 34 completed week's gestation. As well as the expense of transfer and the fact that a significant number were being transferred back to the region is was also, increasing anxiety and disruption for these families.

An analysis of the transfers out in 2014 who were <34+6 weeks gestation was performed. The estimated financial impact on Intra District Flow outflows and patient transportation costs was $39, 225. From 1st January- 1st December 2014 there were 21 in utero transfers out, 19 of these were for women <34+6 weeks gestation who were at risk of premature birth. Two of these episodes were for the same woman and 5 of these women returned to deliver in WDHB.

In 2015 we introduced Fetal Fibronectin testing to reduce the need for unnecessary transfer for women < 34+6 weeks gestation, and reduce cost to the DHB. Fetal Fibronectin testing kits are used to detect the presence of Fetal Fibronectin (fFN) in the vaginal secretions of women presenting with suspected preterm labour between 24+0 and 34+6 weeks gestation. The level of fetal fibronectin can help predict a woman's risk of going into labour. The impact of introducing this test will be that there is a reduction in the number of unnecessary transfers of women at risk of premature birth and the reduction in costs of transferring these women to a tertiary centre.

PREGNANCY & PARENTING CLASSES FOR MAORI

The Wairarapa District Health Board Maternity and Māori Health teams are collaborating to develop an aligned strategy to improve the health outcomes for whānau. We know that the solution needs to be the right fit for Wairarapa. It needs to consider workforce development, particularly with introducing more Māori health professionals into the field. The strategy also needs to look at the options available to whānau currently and should consider what is being done elsewhere.

Background

The Māori Health Directorate [MHD] set a goal for 15/16 to initiate an ante natal programme for whānau. The deliverable was to deliver a pilot ante-natal programme designed specifically for Māori mums and their whānau. This initiative came from a number of discussions between Māori Health, Maternity and our community.

Maternity and Māori Health met in April and discussed the issues and aspirations. It was agreed that the key factors were:

- Not a large uptake of Māori mums taking ante-natal classes
- Lack of tikanga-based programmes
- Lack of tikanga training for staff
- The need to increase exclusive breastfeeding rates from the six week and up until the six month period
- The need to reduce or eliminate smoking during and after pregnancy
- Reducing the rate of SUDI
- Reduced rate of caesarean births
- Lack of choice for whānau – e.g. no Māori midwives or educators
- A positive number of Māori undertaking peer counsellor training (Breastfeeding)

Moving forward there are potentially four areas we should focus on:

1. Working with whānau to improve Māori Health around pregnancy and parenting
2. Working with our staff (Maternity/LMC's) to ensure tikanga best-practice and support
3. Working towards providing tikanga programmes and/or tikanga practice here in the Wairarapa including an ante-natal programme
4. A workforce development strategy to encourage and support Māori health professionals into the Wairarapa District Health Board

This has been incorporated into our 2016/17 priorities and we will endeavour to make good progress on this over the next year with the newly appointed Leader of the Maori Health Directorate and his team.

MATERNAL MENTAL HEALTH PATHWAY

In 2014/15 work around the need for a Maternal Mental Health resource commenced as due to a lack of resources in the region the only way to access any support or care for pregnant or postnatal women was through the Adult Mental Health Services. Through the Maternity Clinical Governance Group a steering group was formed to work on implementing a service that would specifically address access to maternal mental health.

The steering group included; a Consultant Psychiatrist with a special interest in maternal mental health, the Adult Mental Health Project Coordinator, Maternity Quality & Safety Coordinator, Charge Midwife Manager, Clinical Psychologist Child Adolescent Mental Health, Primary Mental Health Nurse. The focus of the steering group was to design a flow chart for use by LMC's, GP's, Well Child Services and Obstetrician's, the simple layout would be a tool that offers the appropriate management/referral for the individual woman's situation. A draft was released to the MCGG, consumer representatives, LMC's and core midwives for feedback. During this process Adult Mental Health under the direction of CCDHB was able to confirm that there would be a 0.4 FTE for a Maternal Mental Health Clinician for Primary Care, a truly wonderful result for the Wairarapa Region.

The Maternal Mental Health Clinician was appointed in October 2015 and following a few further amendments to the Maternal Mental Health Pathway it was finalized (see Appendix 4). The Maternal Mental Health Clinician has spent a period of time engaging with the primary sector and introducing the pathway.

Review of the role and continuing development in a meeting set in May 2016 revealed the following data and progress:

- Consultation/liaison about client needs –37 women have had discussions or been provided with consultation from the Maternal Mental Health Clinician. This includes:
  - 13 clients with Adult Mental Health team, consultation provided with some face-to-face joint appointments with client and Mental Health clinician (sometimes psychiatrist, sometimes case manager/clinician);
  - 11 Face-to-face appointments with clients – 5 with Adult Mental Health; 6 in primary Care (alongside Primary Mental Health Nurse; with LMC, with Hospital social worker)
  - 7 consultations with assistance to co-ordinate referrals to relevant Mental Health Services
  - 6 consultations to Primary care (GPs or Community services)
  - 2 consultations with CAMHS

27 consultations have related to pregnant women
7 consultations have related to women in post natal period
3 pre-pregnancy consultations (with Psychiatrist)

- Feedback
  - Primary Mental Health Nurses advise that liaison and consultation (with some joint visits) has been helpful for their work with some clients. There have also been reports of positive responses from some medical centres about information provided for identified

client/s.

- Psychiatrist has continued to advise that current arrangements work well for clients of Adult Mental Health Services
- Informal conversations between Psychiatrist and CCDHB Manager has identified positive feedback about role/arrangements

There is yet to be a process of receiving feedback from the consumers who may have received input from the Maternal Mental Health Team in order to ascertain the accessibility, availability and comments on the service they have received.

HYPNOBIRTHING COURSE

In July 2015 a proposal was put forward by a local midwife (who was a qualified hypnobirth facilitator) to introduce HypnoBirthing Classes at the DHB. The aim is to help reduce repeat CS rates and increase the VBAC rate using a structured programme of education and support. Her proposal was based on the following data:

The overall Cesarean Section (CS) rate in Masterton in 2014 was 116 out of 438 births = 26.48%

The total number of repeat CS were 71 (inclusive of emergency and elective) making 61.2 % of the total CS rate. 43 of these women opted for elective CS i.e. they never attempted to VBAC, this equates to 37% of the total number of CS.

If 50% of those 43 women attempted VBAC, and of those 22 women 50% were successful, there would be an increase of 11 VBACs. This would reduce the number of CS from 116 to 105; a reduction of almost 10%.

This would have an impact of reducing the overall CS rate by 2.5% to 24% of all births, which would make a significant financial saving.

The free course, which is funded by MQSP, is provided for women who have previously birthed by CS and are suitable for VBAC. Couples are educated to be supportive and empowered to work together in the home, and hospital to create a positive, calm environment that maximises the chances of successful natural vaginal birth outcome. It is proposed that as the success rate for VBAC increases, the overall CS rate for the DHB is reduced along with the cost of repeat elective CS.

The courses started in April 2016 and there has only been one to date the next is due to start in July, the measure of the course is women and the partners anxiety level pre and post the course and then birth outcomes will be audited and measured to provide an evaluation and viability of the course.

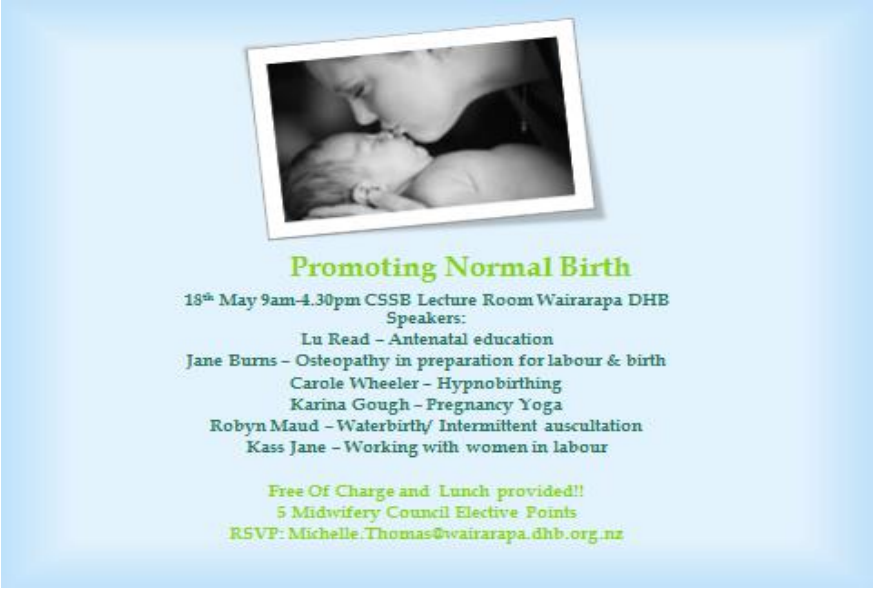
The leaflet given to women can be seen in Appendix 5.

PROMOTING NORMAL BIRTH WORKSHOP

The Cesarean section rate is a priority work stream for Wairarapa DHB. In 2015 we invited a guest speaker from Auckland to present a seminar on "Reducing Cesarean Section Rates". However this year we decided to approach our work towards this by hosting a workshop that evaluated our role in preparing women for labour and birth and the services available for women in the region. The aim of the day was to enable practitioners to review what they offer in their practice, the experience they have with alternative therapies, and how they can work with women and their whanau to facilitate physiological birth.

Guest speakers were invited to provide talks on antenatal education, osteopathy, hypnobirthing and yoga. They gave an overview of what they offer and how they work with women. The afternoon focused on water birth, skin to skin care, working with women in labour and intermittent auscultation.

The day had Midwifery Council accredited points and so had a good attendance from local LMC and core midwives plus LMC midwives from the Hutt Valley.



3 DHB CAMPAIGN

Capital & Coast, Hutt Valley and Wairarapa DHB have run an annual joint maternity campaign since 2014. The regional MQSP group of coordinators, consumers and midwifery leaders has been working over the past few months on the focus of the next campaign. The group has come up with a checklist of key things to do in pregnancy:

Pregnancy check list to cover the important steps to parenthood

Choose a Lead Maternity Carer (LMC)

The LMC's job is to make sure you get the pregnancy care and information you need

Consider where and how you would like to give birth

Talk to your LMC about the best place for you and your baby to birth

Take Folic acid until 12 weeks

To help develop your baby's brain and spine

Take Iodine

To help your baby's brain to develop

Consider screening tests

Talk to your LMC to work out what tests are best for you

Consider getting the influenza vaccine every flu season

To protect you or your baby from getting very unwell from influenza

Consider getting the whooping cough vaccine between 28-38 weeks of every pregnancy

To protect your newborn baby from whooping cough

Tell your family practice that you are pregnant

If you don't have a Family Doctor your LMC will help to get you one

Enjoy your pregnancy

Your LMC can discuss all these important decisions with you

The campaign will be marketed through different means of media advertising. Following consultation with local communications and funding departments the DHB's have agreed we will advertise through radio, newspapers and printed posters in the community as we have done in previous years. The posters in the community will give the opportunity for the coordinator to be

visible and spreading the word on this campaign locally. The posters will be put up in a huge variety of venues from pharmacies, GP surgeries, Kohanaga Reo's, childcare centers, libraries and Plunket.

Priorities, deliverables and planned actions for 2016/17				
Objective	**Action**	**Progress notes**	**Expected completion date**	**Completed date**
Ensure Maternity specific procedures and guidelines are updated and document controlled	○ Undertake stock take of Maternity procedures/guidelines and their currency ○ Establish a timetable for review ○ Consult with 2/3 DHBs to establish priority and shared guidelines	○ Spread sheet developed ○ 43 Guidelines uploaded onto intranet June 2016	Ongoing	
Refurbish LDRP to be a home from home environment enhancing the primary birth experience	○ Collate ideas and opinions regarding theme, colours and equipment from midwives ○ Get prices and work out budget that will be allocated from MQSP ○ Present to MCGG and consumers the idea and get feedback	○ Quotes in Dec 2015 for painting and equipment ○ Choices made and equipment ordered Jan 2016 ○ Painting commenced Feb 2016 ○ Equipment arrived March 2016 ○ Room Blessing April 2016	March 2016	April 2016
Maternity Expo	○ Invite stall holders such as quit smoking, well child services, osteopathy, yoga, Parents Centre, Women's Refuge, HypnoBirthing practitioner and Ipu Whenua to name a few. ○ Advertise in the community for health professionals and consumers.	○ Quote for venue booking received ○ To present the idea to the MCGG	Feb 2017	

Develop of Healthy Pregnancy Group	○ Generate a plan for funding of the healthy pregnancy group ○ Collaborate with dieticians, exercise coaches and smoking cessation in primary health	○ Discussed at MCGG ○ Survey available via survey monkey for consumer input into what they would like ○ Key points of keeping healthy in pregnancy and keeping body mass index manageable to be advertised to the community	March 2017	
Providing antenatal education for Maori/Pacifica population.	○ To provide an antenatal programme specifically aimed at the Maori/Pacifica women and whanau. ○ To collaborate with Maori Health Directorate and an individual from local Iwi.	○ Meeting has been had with Maori Health Directorate, Iwi, Midwifery Director, Charge Midwife Manager, Quality Leader and Antenatal Educators. ○ Set time line from outcomes of meeting held ○ Site visit to Waikato TBA	February 2017	

Did you find the ward clean and tidy?

☐ Yes ☐ No

Please comment:

Were the staff respectful of the cultural needs of you and your family / whanau?

☐ Yes ☐ No

Please comment:

What did we do well?

Is there anything we could do better?

When I think about my stay in hospital I feel (please tick):

Very satisfied | Satisfied | Neutral | Dissatisfied | Very dissatisfied

Do you have any comments you wish to share with us?

WAIRARAPA maternity
Wairarapa Maternity Care

Maternity Services Survey

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

We are committed to providing you and your family/whanau with the best possible care surrounding the birth of your baby. We value your input and feedback, as well as the time you take to provide comments on our service. We will use your feedback to help make improvements and develop our service to meet the needs of you and your family/whanau.

Pregnancy Experience

If you attended the hospital antenatal clinic, were you happy with the information and care you received by:

a) The hospital midwife? ☐ Yes ☐ No

b) The hospital doctor? ☐ Yes ☐ No

If you were admitted to hospital during your pregnancy were you happy with the information given to you and the care you received by:

a) The hospital midwife? ☐ Yes ☐ No

b) The hospital doctor? ☐ Yes ☐ No

Did you understand the information given to you in pregnancy about you and/or your baby by:

c) The hospital midwife? ☐ Yes ☐ No

d) The hospital doctor? ☐ Yes ☐ No

If you answered NO to any of the questions above, please explain why:

Is there anything you feel could have been done to improve your experience?

Labour and Birth Experience

If your LMC midwife required the assistance of the hospital midwives or doctors, were you happy with their input into your care?

☐ Yes ☐ No

Were you included in the discussions and decisions about your care during labour and birth?

☐ Yes ☐ No

Did you have skin to skin contact with your baby for 60 minutes after the birth?

☐ Yes ☐ No

If you answered NO to any of the questions above, please explain why:

Is there anything you feel could have been done to improve your experience?

Postnatal Experience

Were you included in the discussions and decisions about the care of you and / or your baby?

☐ Yes ☐ No

Did the hospital midwives provide enough help for you and your baby?

☐ Yes ☐ No

Were you offered enough pain relief after the birth?

☐ Yes ☐ No

Was the following information given to you about the care of your baby helpful?

a) Bathing ☐ Yes ☐ No

b) Feeding ☐ Yes ☐ No

c) Settling ☐ Yes ☐ No

d) Safe sleep positions in the cot ☐ Yes ☐ No

Did the staff talk about bed sharing and babies with you?

☐ Yes ☐ No

If you answered NO to any of the questions above, please explain why:

If you breastfed your baby, did you have the information and support you needed in hospital?

☐ Yes ☐ No ☐ N/A – I did not breastfeed

Were you given information about:

a) Baby feeding cues? ☐ Yes ☐ No

b) Correct positioning and latch? ☐ Yes ☐ No

c) Hand expressing? ☐ Yes ☐ No

If you needed help from the Lactation Consultant were you happy with the information and support?

☐ Yes ☐ No

If you answered NO to any of the questions above, please explain why:

APPENDIX 2

Maternity Clinical Governance Group

Terms of Reference

DHB GOAL:

An integrated Maternity Service that enables the best possible care and support for the women of the Wairarapa.

Members of the Maternity Clinical Governance Group (MCGG), including organizations and representatives external to the DHB agree to:

- Nominate an organization member to fully participate in the MCGG.
- Allow regular service delivery information and reports, to be shared with the MCGG to enable the service monitoring role of the Group.
- Maintain confidentiality of all information provided through the MCGG other than that which has been agreed by the Group as being available for public use.
- Through minutes, record the views of each member/organization on a matter, but agree to support the decision of the Group majority in recommendations and subsequent implementation.
- Full representation of the Group's recommendations to participating organizations and actively work to implement these where feasible.

The MCGG will make the assumption that inter agency and contract management relationship meetings will occur between organizations outside the parameters of the MCGGMCGG, as needed. Parties will agree to take issues that arise from these meetings to the MCGGMCGG where they impact on the integrated service and would benefit from the input of all participating organizations or require a systemic response.

BACKGROUND

Wairarapa DHB held a workshop with maternity staff and LMCs in October 2012 where the five principles were confirmed as a framework to develop the maternity service.

PRINCIPLES OF THE MATERNITY CARE FOR WAIRARAPA WOMEN

1. Develop an inclusive maternity service.
2. Evolve into a more women centred service.
3. Clarify/update the role and expectations of the core midwives.
4. Maintain a midwifery leadership voice within the DHB.
5. Identify workforce needs and recruit strategically (grow the workforce).

These principles were initially developed in a workshop led by the DHB in July 2011 that included maternity staff, obstetricians and LMCs.

PURPOSE OF THE GROUP

The Maternity Strategy Group (MCGG) is established as a collaborative leadership group responsible for guiding the development and delivery of integrated maternity services.

MCGG will monitor agreed quality performance indicators to ensure effective service delivery and the best possible outcomes for women and their babies.

The Group has an advisory role to Wairarapa DHB through the Clinical Services management team. It will provide advice to all relevant stakeholders on:

- The implementation of evidence based best practice in the delivery of maternity care.
- The performance of the participating members and associated organizations both individually and as a collective system of integrated services.
- Issues and opportunities in the maternity service and the wider health sector that provide opportunities to improve outcomes for service users and their family whanau.

RESPONSIBILITIES OF THE GROUP

The MCGG will:

1. Encourage collaboration and good working relationships between DHB staff including maternity staff, obstetricians and the Maori health team, together with LMCs, Well Child Providers, antenatal education providers and other relevant NGOs to ensure seamless service delivery for women.
2. Encourage active participation in the group by a consumer representative, as appropriate.
3. Facilitate service improvement initiatives and workforce development and ensure these are reflected in practice.
4. Advise on practice quality standards, evidenced based approaches and any other matters that will result in improvements in the delivery of maternity care.
5. Facilitate and enable integrated information system initiatives, in line with the MOH requirements.
6. Discuss and consider the application to the Wairarapa integrated service, any other issues facing maternity services that arise, and recommend changes to current service specifications, guidelines or other aspects of the service framework regionally, nationally or internationally.
7. Chair to report to Clinical Board quarterly updating on any improvements, processes and actions from this group meeting the requirements of the Maternity Quality & Safety programme.

COMPOSITION

The MCGG will include representatives from:

- DHB Maternity Service including Charge Midwife Manager, RM, Obstetrician.
- SIDU
- Maori Health Directorate
- A LMC representative
- Compass Health
- Well Child Provider/s
- Consumer representative, as appropriate

- Antenatal education provider, as appropriate.

Term of membership to the MCGG is initially for two years. Replacement of members will be staged to ensure the continuity of the group.

DHB representatives are confirmed/mandated by the Hospital Services Manager. Representatives from other organizations or providers are confirmed by their respective senior management or governance as appropriate.

All members will actively participate in the MCGG. A member who is unable to attend a meeting is able to be substituted by another person from their organization if arranged with the Chair of the group in advance. If a member of the group misses a number of meetings in a row, the group will consider asking them to be replaced by another person from their organization.

The MCGG is able to agree to co-opt members in order to ensure the group has the appropriate skills and expertise to progress the initiatives and work plan of the group.

MEETING FREQUENCY

Meetings will be held three monthly.

The group will review the frequency of meetings and agree to reduce them to no less than quarterly.

Ad hoc meetings may be called if required.

MEETING STRUCTURE

Communications

Request for agenda items will be circulated by the group administrator a week prior to the meeting.

Members who wish to raise an issue will place it on the agenda and provide a brief written summary of the issue that can be circulated by the administrator with the agenda and meeting papers three days prior to the meeting.

A progress report on agreed indicators will be circulated no less than three days prior to the meeting.

Minutes of the meeting will be drafted and circulated within five working days of the meeting.

Key messages from each meeting will be agreed and accompany the meeting minutes. These will be distributed to the group by the administrator and will be able to be shared with participating organizations and providers.

Confidentiality

Information and discussions are to be regarded as open unless otherwise stated. Any confidential material will be clearly marked 'confidential' prior to circulation. Any confidential issues will be minuted as such and must not be shared outside of the group.

Meeting Dates and Times

Meeting dates and times will be agreed with the group. It is anticipated that these meetings will not exceed two hours duration. Other contact is likely to be via email routes.

Quorum

The group will meet with a minimum number of members being agreed upon as 5

Working Together

The MCGG is an advisory body. The process should be collaborative and as inclusive as possible, and where advice cannot be acted on the DHB or participating organizations or providers will explain why.

Representatives will ensure members of their organizations are kept informed of the activities of the group and communications shared as required.

GROUP FUNCTIONS

Function	Group/People Responsible
Administrative support and co-ordination (meetings, agendas, minutes, general communications)	Debbie Beech
Chairperson	Michelle Thomas
Data provision	All participating organizations as agreed

MEMBERSHIP

Name	Role
Chris Mallon	Midwifery Director
David Cook	Obstetrician
Sarah Boyes	Director of Operations – Surgical, Women's & Children Health – HVDHB & WDHB
Alison Andrews	Charge Midwife Manager
Marilyn Smethurst	Core Midwife
Monika Steinmetz	LMC Representative
Michelle Thomas	Maternity Quality and Safety Coordinator
Janeen Cross	Maori Health Representative
Emma Skudder	Portfolio Manager, SIDU
Yvette Grace	Compass Health (PHO)
Eileen Fahy-Teahan	Tamariki Ora Nurse
Kiri Playle Anita Roberts	Consumer Representatives
Michelle Sole	Plunket
Amber O'Callaghan	Executive Director, Quality & Risk

SCHEDULE OF MEETINGS

- Meetings will be held three monthly

APPENDIX 3

09 June 2016

Wairarapa DHB Terms of Reference for the Vulnerable Pregnant Women and Unborn Babies Group

Purpose

To make a difference by identifying pregnant women with vulnerabilities, proactively wrapping services around them their newborn baby and their families, building partnerships with external agencies and ensuring transparent decision making process.

Background

The development of this group has been a gradual transition from that of an informal process to one that is more formal and will involve a multidisciplinary and multiagency approach where appropriate.

The strategic purpose of the Vulnerable Pregnant Women's Group is to enable the best possible outcome for vulnerable pregnant women and their families. To strengthen families / whanau by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.

This forum / group adhere to and work alongside the Memorandum of Understanding (MOU) between CYFS, New Zealand Police and Wairarapa District Health Board (DHB) in relation to child protection. The MOU identifies our formal commitment to collaborative practice in child protection between the three agencies, and extends it beyond the safety of children in the hospital. Additionally the DHB Child Protection and Neglect Procedures apply.

Principles / Functions of the Group / Forum

- Welfare and safety of the unborn child is paramount
- All women are entitled to mother (parent) in a supportive safe nurturing environment free from abuse, neglect and harm
- Families / whanau are supported to stay together and in particular the fostering of healthy attachments between baby and mother
- Information will be shared amongst the parties that will keep a woman and her unborn baby safe in a manner that is consistent with the current legislation
- Parties will communicate regularly in an open, honest, respectful and timely way.

- Safety issues that are identified will be shared as appropriate
- Effective multi-agency partnerships are facilitated through shared communication and a commitment to ensure health and safety outcomes for women, their babies and family.
- Provide early identification of pregnant women with vulnerabilities or risk
- Strengthen protocols and practices for the safe delivery and discharge of women and babies including collaboration with health, community and government agencies (CYF and Police), when a risk or concern has been identified for the woman and/ or their baby
- Be a point of reference and a forum for health professionals working with vulnerable women and unborn babies to discuss these complex cases
- Respect of cultural beliefs and values, women and their families are treated with respect and in a sensitive manner
- To support the child protection processes

Scope

Primary and Secondary providers who work with and care for vulnerable women and their families.

Membership

There will be a core membership group including the following

- Maternity Charge Midwife Manager
- Paediatric Charge Nurse Manager
- Woman and Children DHB Social Worker
- Maternity Quality and Safety Co-ordinator
- DHB / CYF Liaison social worker
- Child Protection Coordinator
- Maternal Mental Health Social Worker
- Family Safety Team member

With all cases referred associated key workers are invited to attend the meeting to discuss and be part of the planning, and may include the following

- Lead Maternity Carers
- Paediatrician
- G.P's
- Maori Health Directorate Member
- Whaiora
- Tamariki Ora and Wellchild, Whaiora and Plunket
- DHB Mental Health Team
- Community Mental Health and Addiction Services
- Family Safety Team – Police
- Child, Youth and Family social workers
- Rangitane
- Woman's Refuge
- Open Home Foundation
- Emergency Department Charge Nurse Manager

- Hauora

Group Processes

Facilitator

- Women and Children DHB Social Worker will lead the facilitation role.
- Maternity will chair meetings
- Minutes will be recorded which outlines the case discussed brief issues and will include a clear record of any actions / decisions made. Minutes to be available on the Maternity workspace within 4 working days after the meeting, and a copy of the plan/agreed actions to be circulated to those involved in the care of the woman.
- Invite participants relevant to cases discussed

Referrals

- Referrals can be made at any time to the Women and Children DHB Social Worker by anyone involved in the care of pregnant woman and their families.
- Ideally referrals should be made as soon as possible to ensure time for the supports and interventions if needed, to be put in place
- Completion of a written referral is necessary using the referral template and can either be emailed or forwarded in hard copy
- Key concerns need to be identified
- Existing key workers or agencies involved should be identified with their full name and contact details
- Once the referral is received the Women and Children DHB Social Worker will determine if the referral is appropriate or if further information / assessment is required prior to bringing to the group for discussion.
- A letter will be sent to the woman's GP advising of the referral
- LMC's and key workers can expect to be contacted and invited to the meeting specific to the woman they are involved with

Referral Reasons

A referral should be made when it has been identified that a woman would benefit from an intervention plan when one or more of the following risk factors are present. Consideration should first be given to the nature and magnitude of the issue and the impact of this upon the woman and her unborn child

- Concerns for the care and or safety of the unborn child
- Vulnerability of the woman
- Maternal comorbidities (medical)
- Social Work assessment
- Self-harm / Neglect of self
- Family Violence – consideration needed of the nature and magnitude
- Mental health concerns
- Drug and alcohol abuse
- Poor social circumstances

- Child, Youth and Family history

Meetings

- Team meets monthly on the 1st Thursday of the month at 9:45-11:30 in the Imaging room at the DHB
- Agenda will be sent out the Friday before the meeting
- Woman and Children DHB Social Worker will send out invitations to all key workers involved in the woman's care
- If invitees / members are unable to attend, apologies are to be sent, email update given to the chair on cases involved in.
- Discuss new referrals and develop plan accordingly
- Plan reviewed as required, but at least 3 times including just prior to the EDD and after delivery
- Documentation is clear and accurate and a copy of the plan is placed on the woman's clinical file under the Obstetric notes, in front of the white Ante-natal notes
- Minutes will be recorded in the maternity workspace and will include an agreed action plan. A copy of the plan/agreed actions to be circulated to those involved in the care of the woman.
- Decision to be made specific to each woman as to how the plan will be shared with them and their family as appropriate and who will be responsible to do this.
- Within 6 weeks after birth, woman and baby will be referred to the Community Paediatric meeting which meets monthly. The reason for this is to confirm engagement in services and ensure transparency. At this point the woman and baby will be closed on the Vulnerable Woman's Group list. Closed files are automatically archived on the workspace.

Plan

- The intervention plan to be shared with the Woman (and family if appropriate) unless it is deemed that sharing the plan would further place the Woman and unborn child at risk.
- The Woman's primary support will share the plan with her and partner if appropriate.
- If agreed a Report of Concern should be made as part of the decision, this will be made from the MDT team. A copy of this will be sent to the VIP coordinator who will ensure an antenatal child protection alert will be considered in accordance with existing DHB policy.
- Identified members of the group will meet when a Woman on the list is 36 weeks to undertake specific planning, address risks.

Confidentiality

- Minutes are to be available to the core group members and Maternity staff via the Maternity workspace. The action plan will be emailed to those additional key workers involved in the woman's care.
- As with other personal information and statutory requirements, all members and relevant stakeholders must comply with information service security agreements of their organisation.

Discharge

- A multiagency postnatal discharge meeting including family members (if appropriate) is held for those cases where it has been identified that a care plan is required for the safety of the infant, which needs to be understood and agreed to when Child Youth and Family are involved.
- The woman is discharged 4-6 weeks post-delivery, and will be transferred to the monthly Community Paediatric MDT
- A discharge sheet will be completed by Maternity and forwarded to the GP.

Review process / Audit requirements

The Terms of Reference will be reviewed annually by the core group in 12 months on 9 June 2017 by the core group members with feedback sought from attending key agencies, and then they will be reviewed annually.

Statistics will be kept, collated and reported on as per Ministry Of Health requirements.

A CPC spread sheet will be held

References / Related Documents

CYF, Police, WDHB Memorandum Of Understanding between Child, Youth and Family, NZ Police and Wairarapa District Health Board in relation to care and protection.

WDHB (2012)	Child Protection Alert Management Policy
WDHB (2010)	Family Violence Intervention Policy
WDHB (2012)	Child Protection and Neglect Policy
WDHB (2010)	Place of Safety Guidelines
WDHB (2011/12)	Maternity Quality and Safety Programme
WDHB (2011/12)	Emergency Safe Shelter Policy
WDHB (2010)	Partner Abuse Procedure

Social Work Assessment tool

Health Information and Privacy Code

Vulnerable Children Act 2014

Children, Young Persons and Their Families Act 1989

Perinatal Mental Health and Addictions Pathway:

A flow chart for health professionals caring for pregnant and postnatal women in the Wairarapa

Community supports

What community services are available for women requiring additional mental health support?

Who:	What they do:
• **Primary Care Services:** LMC / Midwife; G.P or Practice Nurse	→ Healthy pregnancy education & information, assessment, treatment, referral to other agencies e.g. PHO wellbeing services.
• **WellChild Providers:** ◊ Whaiora — Tel: 0800 494 246 ◊ PlunketLine — Tel: 0800 933 922	→ Whanau Ora community supports and resources.
• **Primary Mental Health Nurses** — Tel: 06 370 8055	→ Mental Health & Addiction triage, assessment & brief intervention
• **Post and Ante-Natal Distress** [PND] Wellington — Tel: 04 472 3135 www.pnd.org.nz	→ Provide phone support & online (closed Facebook page) support for women.
• **Wairarapa Hospital Social Work Department** — Tel: 06 946 9800	Provide a pregnancy counselling service .
• **SIDS & KIDS:** 24 hour Sudden Infant Death Helpline on — Tel: 0800 164 455 www.sidsandkids.org.nz	→ Provide support to those who have experienced pregnancy, baby or infant loss. Able to support access to local counselling (x 3 sessions)
• **SANDS**- Pregnancy, baby & infant loss support www.sands.org.nz	→ Provide support to those who have experienced pregnancy, baby or infant loss.

Advice

I'd like some advice about maternal mental health and addiction issues

Who:	What they do:
• **Contact the Perinatal Mental Health Consult - Liaison clinician for advice — Tel: 04 806 0002**	→ Consultation & liaison service including support and advice.
• General inpatient hospital staff should contact the Social Work Department — Tel: 06 946 9800	→ Assessment, treatment, referral to other agencies e.g. PHO wellbeing services.
• Care NZ Addictions Service — Tel: 0800 208 4278	→ Comprehensive assessment, community-based treatment, complex psychological interventions, medication, inpatient options.
• Te Hauora Waranga & Hinengaro Services (Addictions Service) — Tel: 0800 666 744	→ Community-based crisis respite and managed withdrawal services. Māori awhi (help) & cultural interventions.

Referrals

I'm concerned about a pregnant/ postnatal woman's mental health or addiction issues

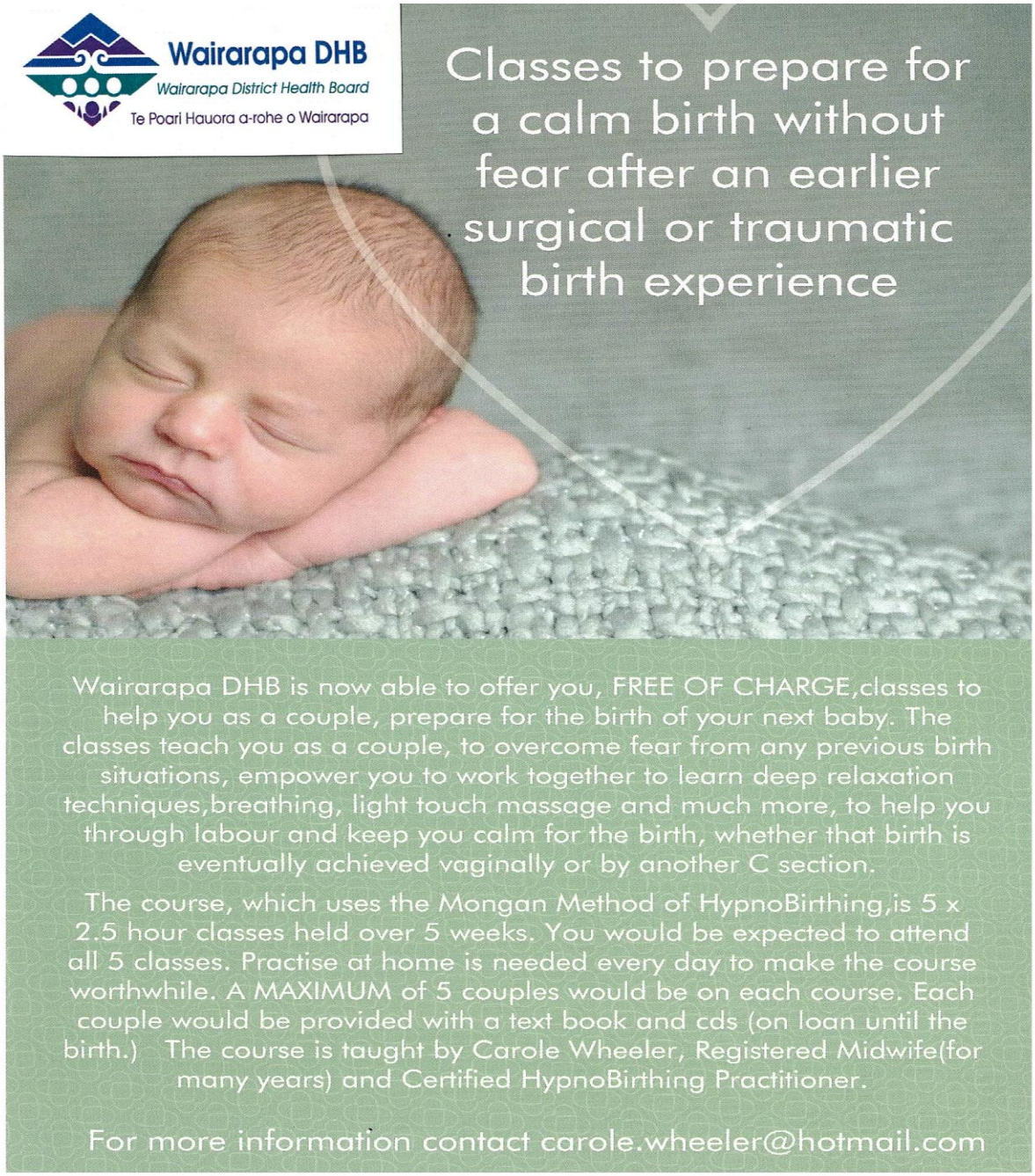
Who:	What they do:
• Refer to the Adult Community Mental Health Service — Wairarapa DHB; for women with moderate to severe mental health issues during pregnancy and up to 12 months postpartum — Tel: (06) 946 9805 Fax: (06) 946 9835	→ Referrals are discussed for acceptance/decline. Once accepted assessment and case management occurs (including review of medications). If the referral is declined, the referrer is advised and other support services or agencies are recommended.
• **If non-urgent, you can contact the Perinatal Mental Health Consult - Liaison clinician for advice — Tel: 04 806 0002**	→ Advice and support over the phone about the appropriate course of action.
• Care NZ Addictions Service — Tel: 0800 208 4278	→ Comprehensive assessment, community-based treatment, complex psychological interventions, medication, inpatient options.
• Te Hauora Waranga & Hinengaro Services (Addictions Service) — Tel: 0800 666 744	→ Community-based crisis respite and managed withdrawal services. Māori awhi (help) & cultural interventions.

Crisis Support

I need urgent support for a pregnant/postnatal woman's mental health or addiction

Who:	What they do:
• Specialist Adult Mental Health Services — **Tel: 0508 432 432**	→ Crisis assessment, triage and intervention e.g. arranging medication, respite or inpatient treatment as required. Triage also includes referral to other services e.g. CareNZ Addictions Service or Te Hauora Waranga & Hinengaro Service as required.

APPENDIX 4


Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa
Classes to prepare for a calm birth without fear after an earlier surgical or traumatic birth experience
Wairarapa DHB is now able to offer you, FREE OF CHARGE,classes to help you as a couple, prepare for the birth of your next baby. The classes teach you as a couple, to overcome fear from any previous birth situations, empower you to work together to learn deep relaxation techniques,breathing, light touch massage and much more, to help you through labour and keep you calm for the birth, whether that birth is eventually achieved vaginally or by another C section.
The course, which uses the Mongan Method of HypnoBirthing,is 5 x 2.5 hour classes held over 5 weeks. You would be expected to attend all 5 classes. Practise at home is needed every day to make the course worthwhile. A MAXIMUM of 5 couples would be on each course. Each couple would be provided with a text book and cds (on loan until the birth.) The course is taught by Carole Wheeler, Registered Midwife(for many years) and Certified HypnoBirthing Practitioner.
For more information contact carole.wheeler@hotmail.com