MATERNITY QUALITY & SAFETY PROGRAMME

Annual Report

July 2017 – June 2018

WAIRARAPA maternity
Wairarapa Maternity Care

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

EXECUTIVE SUMMARY

I am extremely proud to present the Wairarapa DHB MQSP 2017/18 annual report with my colleagues.

This has been another year of great achievements for the MQSP team meeting the needs and improving services for women, babies and whānau in our community. The input and engagement from our consumers reflects the positive attitude the maternity service has toward the voice and opinions of consumers. Work streams such as the reduction of the cesarean section rate for standard primipara continues with the lowest year so far in 2016 data, this is a huge and a whole team achievement that has been totally supported by everyone from the women and their whānau, our clinicians, Board and ELT.

Another year of challenges with midwifery workforce changing in the region, however with support from Executive Leadership Team and an evolving concept of primary care services for women unable to access an LMC midwife the maternity service has yet again stepped up to demands of the region with fabulous outcomes. Enforcing the importance we all have for our community, our women and their babies having access to the care they need.

Chris Mallon
Midwifery Director

Contents

Purpose of the Wairarapa MQSP Programme

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 2017/2018, as required under section 2.2c of the Maternity Quality & Safety Programme Crown Funding Agreement (CFA) Variation (Schedule B42):

This is the sixth maternity services annual clinical report from Wairarapa District Health Board (WrDHB) following the introduction of the Maternity Quality and Safety Programme (MQSP) in Wairarapa in March 2012 and covers the period from the 1st June 2017 to the 31st May 2018. However for the purpose of the data sourced it comes from a variety of locations and covers differing time frames, in the instance of

maternity clinical indicators it covers the 2016 annual year, maternity data is 2017 annual year and MCGG project work covers the 2017/18 financial year.

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 2017/18
- 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 2017-2018.

The background to this Annual Report aligns with the New Zealand Maternity Standards and has been developed to meet the expectations of the New Zealand Maternity Standards (See in Appendix 1).

Section 1: Aims and 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 2017/18 year the following objectives will be further explored throughout the Annual Report:

- Workforce sustainability and service provision
- Continual audit and review of Caesarean section, Induction of Labour and Vaginal Birth after Caesarean (VBAC)
- Ensure Maternity specific procedures and guidelines are updated and document controlled
- Pēpē Ora Expo
- Hypnobirthing classes
- Providing antenatal education for Māori / Pasifika 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
No electronic system in the maternity unit for either capturing data or admission to discharge planning.	It is identified on the WrDHB Risk Register and an application has been put forward to IT Services to introduce an interim measure until the national MCIS programme is available. WrDHB introduced WEBPAS in November 2017 which has had a number of ongoing issues. Work for any form of electronic system for maternity has been put on hold until WEBPAS is functioning well. The basis of an inpatient system that identifies women and cares/education/discharge processing will be an initial stage that is yet to be confirmed as a project roll out with IT services.
Auditing of C/S, IOL and VBAC's	WrDHB is very proud of the work that has been undertaken in aid of reducing the c/s rate as a whole. In view of the time undertaken to audit and analyse data there has been a decision made to undertake spot audits of c/s and IOL should there be months of increased rates. The fortnightly team review of c/s has continued with the obstetricians, Charge Midwife Manager, MQSP Coordinator and antenatal clinic midwife, which continues to provide an opportunity to have constructive conversations in our continuation to provide quality care.
Inability to ascertain fetal distress during labour with anything other than CTG monitoring	Obstetric resourcing has been reviewed and with a new obstetrician due to start In July 2018 the service will endeavor to consider the training and application of fetal lactate being another tool used to inform fetal wellbeing during the intrapartum period if the CTG shows marked abnormal changes.
High use of locum obstetricians and the need to ensure	Locum obstetricians are necessary to ensure the functioning of the secondary care service at WrDHB. With the recruitment of another obstetrician to the service, there should be a lesser need to require locum obstetricians as frequently as has been previously.

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 491 births in 2017, an increase of 16% from the 2017 year. The maternity services are based at Wairarapa DHB in Masterton; this is the only birthing facility in the region though a number of LMC's support home birthing and the number of homebirths for the district was 30 (5.6%) births for the year 2017.

INTERIM CARE PROVISION

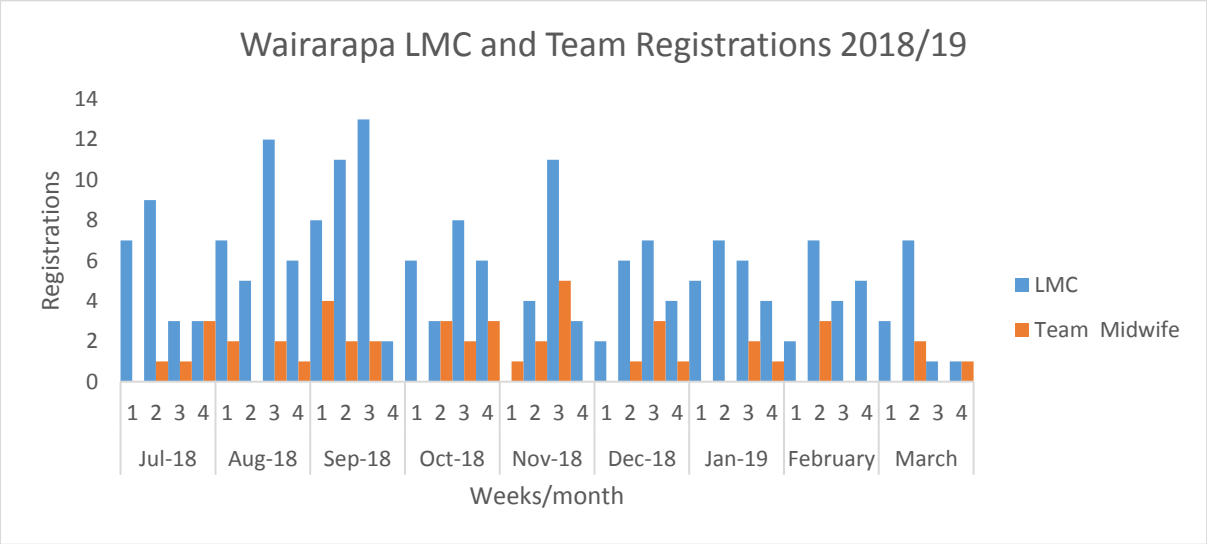
Midwifery

There have been a number of changes in Masterton Maternity unit since 2017; the first and most significant was a change in workforce, we were operating our core midwifery workforce on – 3FTE, no casual pool to rely on, a tired and aging workforce and seriously low morale. As midyear 2017 approached we then lost a significant section of our LMC workforce, due to burn out, change of career, relocation and by July had only 4 case loading midwives, but a rising birth rate due to increasing population to our rural area, so we began work on a significant contingency plan.

Rural recruitment advertisements brought no joy, we advertised nationally and overseas with mixed results and a high turnover of staff 58%, so resorted to an agency which did secure 2 midwives however one did not settle and resigned after 6 weeks. It was fortuitous that the population to our area grew as it brought with it new midwives to the area, so some intensive recruitment began and our casual pool grew alongside this. As we began to fill our FTE and see the light at the end of the tunnel, the following months we then experience x 4 resignations of core RM staff to become LMC (great that the midwives stayed in the area, although one is now signed off medically), x 3 RM retired, x 1 RM began maternity leave and devastatingly to all of our midwives one of our own tragically passed away.

A process began through HR and ELT including our CEO, who were very supportive and approved for us to appoint an Antenatal Clinic Midwife above our current fixed FTE, as we were now required to book women unable to access an LMC in the community, through the DHB under the 'team' of core midwives. There was then some flexibility to roster extra staff and have 3 RMs on predicted high acuity days (instead of 2) so we could safely manage to labour and birth 'team' ladies and cover ELCS and IOL.

Graph 1.1: Registered number of women

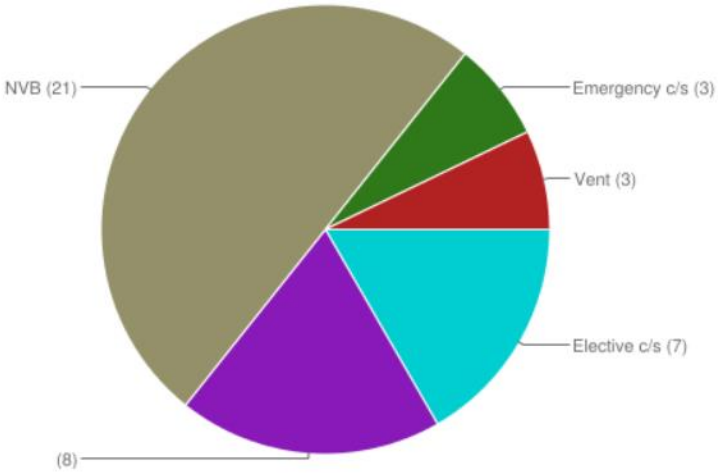


This was a big challenge to staff who had not worked in this capacity for some time and felt rusty, so we put in place microteaching sessions weekly to cover secondary care provision and management – triage of a high acuity ward and escalation plans should more than 2 team ladies labour at the same time.

There was an unsettling period of instability as we got the balance right and continued to recruit, and we tried to improve our record keeping and data collection to both recognize the extra work and capture times of predicted high acuity e.g. Christmas time or LMC annual leave.

Since commencing care for team women, we have been able to capture data showing outcomes for women and this reflecting the high standard of care that has been achieved. As a service, we have endeavored to ensure continuity of carer throughout the AN period, known carer in labour and birth where possible, and continuity of carer in the PN period. Though this does not meet the NZ maternity model of care, we have designed a model based on the continuity of carer in modules that meet the needs of women and have positive results and increased job satisfaction for the DHB midwives.

GRAPH 1.2: Birth outcomes for women birthing Aug – Dec 2017



8 unaccounted for are women that miscarried or had a locum LMC pick up their labour and birth care claiming independently.

Outcomes

So now in 2018 staffing is at full FTE with pregnancy and parenting and hypnobirthing courses continuing to be provided by the DHB, the workforce is stable and current turnover is 16%. The role of the ANC midwife has evolved phenomenally and this midwife now runs the Obstetric clinic, Midwifery clinic, liaise with Diabetic specialist and referral specialist, liaise between LMC and women, GP and well child services, triage appointments and follow up results. The role will in the future encompass a miscarriage pathway to improve access for women experiencing pregnancy loss, as currently the only option is to sit in ED. We are also training to provide a Jadelle clinic – long term reversible contraception as the Wairarapa do not have family planning services.

A business case has been put forward to employ a HCA which will allow time for the midwives to be midwives as the HCA role will take care of stores/ordering/cleaning/ beds and linen, answering the door and assisting families, facilitating breast pump and birthing pool hire and will undergo Breastfeeding peer support training to further support our new families.

As yet an on call arrangement for midwives has not been fully reached to allow for roster development and flex in the event of high acuity, but the tools we are developing to forecast workload may assist current strategy and acknowledge the use of the extra funding we have generously been afforded to provide a more stable, professional and sustainable service to the Wairarapa community.

Obstetric

In a small rural setting there is a double edge sword that we are continuously dealing with and that is one of ensuring we provide a quality service and meet the needs of consultants to be exposed to

We have recently recruited a new O&G which means we have 3 obstetricians working a roster which will enable a better coverage of oncall by local obstetricians therefore a reduction in locum use aside from leave cover. This will also allow a day per week allocated to training and education professionally and with a multi-disciplinary team approach.

The Maternity Service consists of the following staff:

- Midwifery Director (2 DHB)
- Executive Leader Integration, Allied & Community
- 3 part-time Obstetric Consultants
- Charge Midwife Manager
- Midwife Educator and Maternity Quality & Safety Programme Co-ordinator
- Antenatal clinic midwife
- Lactation Consultant
- Newborn Hearing screener and Co-ordinator
- 1 Antenatal and Parenting Education Midwife
- Midwifery and medical students on placement

Team Spirit

The team works in a collegial way and has participated in many events that have occurred over the year showing the spirit of celebration and success that we strive to achieve.

This lovely lady is Pat Collins, one of our wonderful midwives, who celebrated her 40th year of working with the DHB. "She's had 40 years working in Masterton, and 45 years working as a midwife," says Kirsty Mitchell, Charge Midwife Manager. "And all in all, 52 years in nursing." "What an amazing woman!"

“International midwives day” the opportunity for the world to celebrate the wonderful job that midwives doing working with women and families to have a healthy pregnancy, a positive birth experience and transition to parenthood. Above is a group of local midwives from LMC practice, core and students coming together in celebration.

Celebrated annually around the globe, Pink Shirt Day began in Canada in 2007 when two students took a stand against homophobic bullying, mobilising their whole school, after a peer was bullied for wearing a pink shirt.

In New Zealand, Pink Shirt Day aims to create schools, workplaces and communities where all people feel safe, valued and respected.

This collection of beauties to the right is the Midwifery team, celebrating Pink Shirt Day.

Left: Monika Steinmetz LMC midwife who received a beautiful arrangement of goodies following being nominated as one of our wonderful community midwives by consumers.

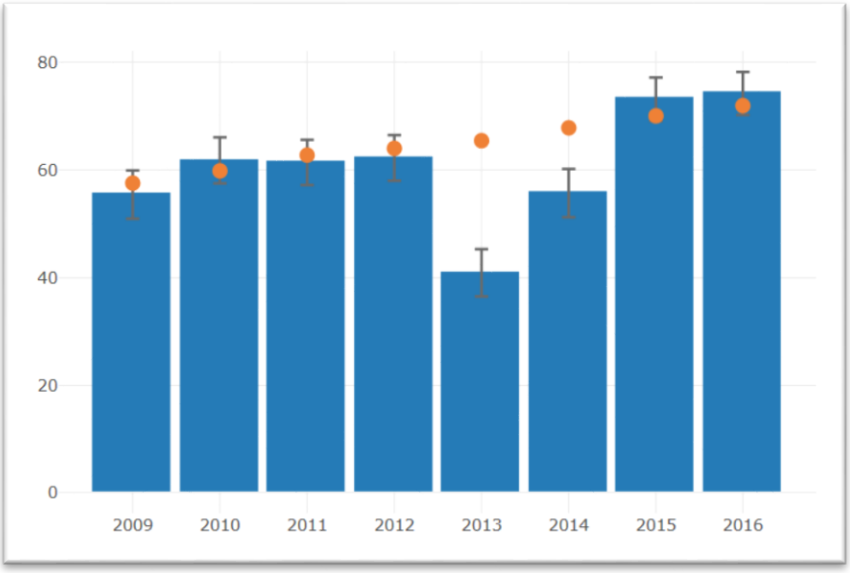
Right: Charge Midwife Manager with a wonderful assortment of knitting from a local knitting group. The maternity unit and Special Care Baby unit appreciate the hard work and voluntary efforts put into providing whānau with woolen garments.

MATERNITY CLINICAL INDICATORS 2016

The key maternity clinical indicators are discussed below identifying key indicators where there have been subtle improvements or identified areas that have become key work streams for quality initiatives within the MQSP in the Wairarapa.

Clinical Indicator 01: Registration with an LMC in the first trimester of pregnancy

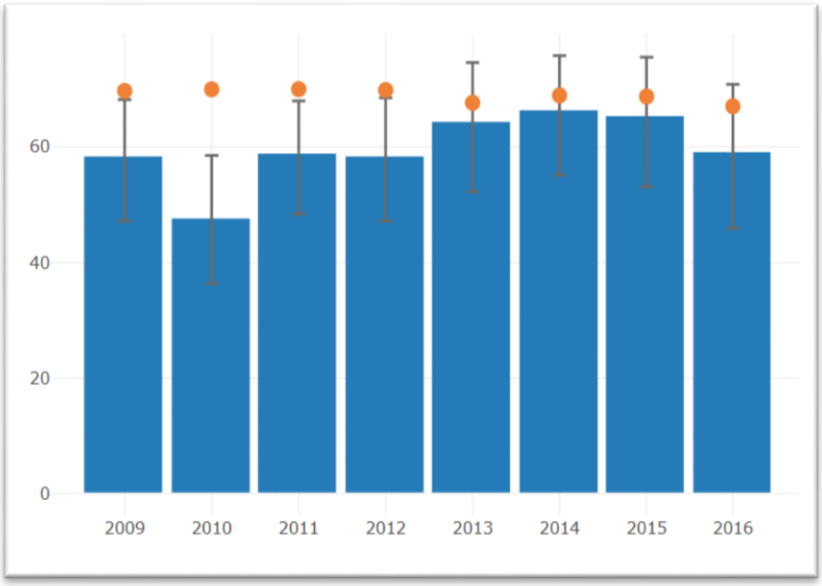
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



WrDHB continues to promote and advertise the importance of registration in the first trimester. The availability of Pregnancy Information Packs in the GP surgeries throughout the region continues. A change in LMC workforce in Oct 2017 has seen the DHB providing primary care to a significant higher number of women that spend many weeks trying to seek an LMC before accessing the DHB. Projection is that this clinical indicator may increase in 2017 while our promotion continues.

Clinical Indicator 02: Standard primiparae who have a spontaneous vaginal birth.

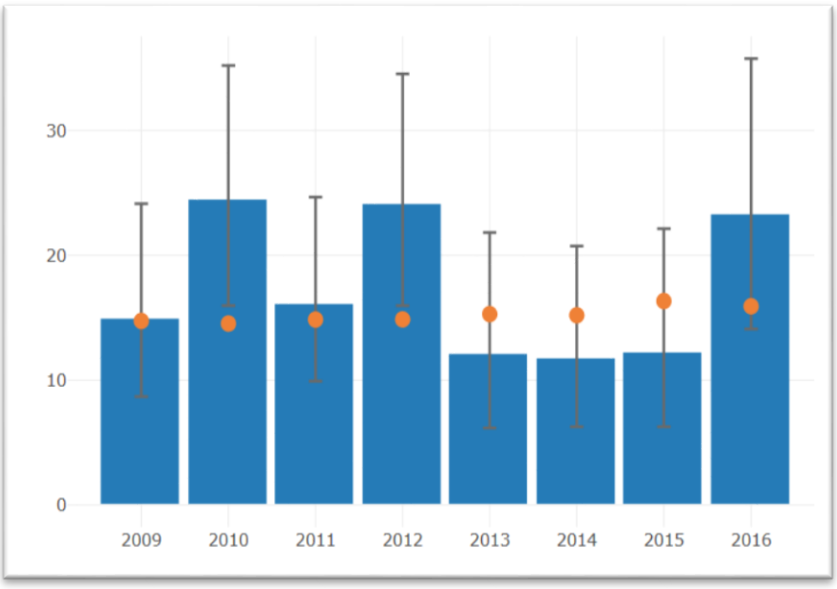
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



Interestingly with all that the maternity service offers in promotion of normal labour and birth there has been a slight decrease in the normal birth rate as identified in the graph to the left however in analysis with clinical indicator relating to instrumental birth the vaginal birth rate continues to increase while decreasing the cesarean section rate. WrDHB continues to improve the availability and access to equipment encouraging active labour and birthing techniques in forward planning.

Clinical Indicator 03: Standard Primiparae who undergo an instrumental birth

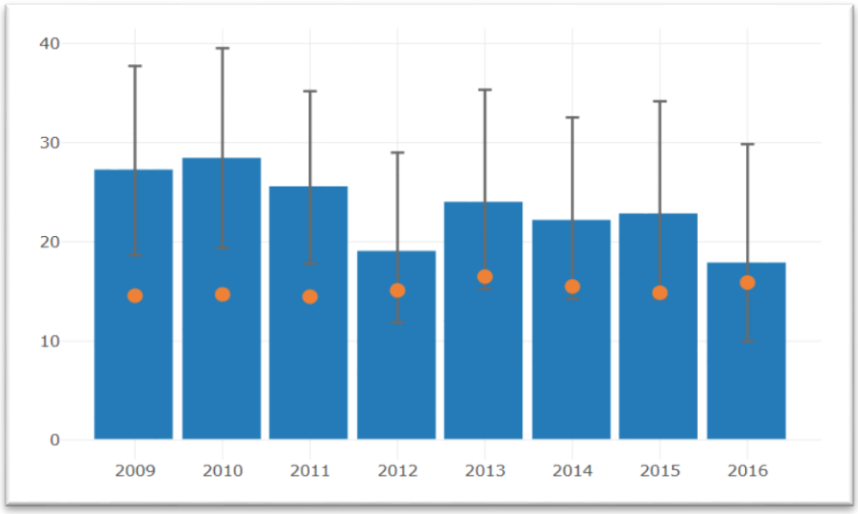
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



An increase in the instrumental birth rate signifies the reformed attitude to work with women in achieving a vaginal birth. While promoting active labour epidural continues to be a choice for women which in hand increases risk of instrumental birth. With this increase there has been no evidence of increased morbidity rates in infants or an increase in the admission to the Special Care Baby Unit.

Clinical Indicator 04: Standard Primiparae who undergo a cesarean section

Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016

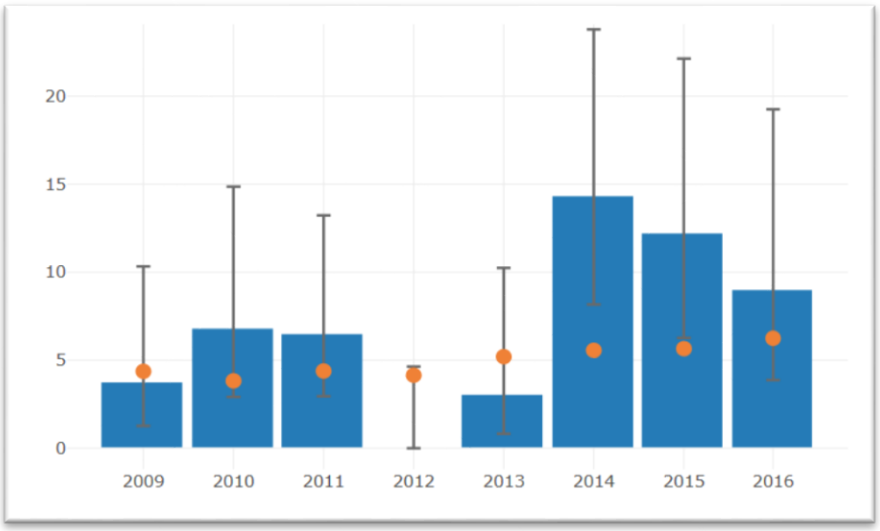


The continued reduction in the cesarean section rate for the standard primiparae is something that WrDHB is very proud of. Obstetricians and midwives strive to achieve positive birth experiences for the women and their whānau.

The commitment of local obstetricians, Chief Medical Officer, Director of Midwifery, Charge Midwife Manager and MQSP coordinator in reviewing all cesarean sections means that monitoring of care and outcomes is undertaken in a collegial way and productive in our work of reducing cesarean sections.

Clinical Indicator 05: Standard Primiparae who undergo induction of labour

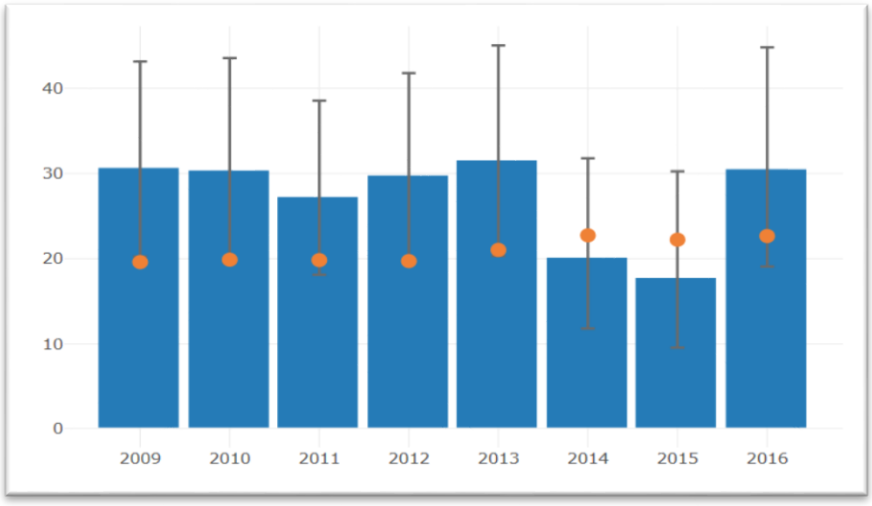
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



It is pleasing to see WrDHB closer to the national average for induction. Our numbers continue to be small and inductions in this group of woman is post dates.

Clinical Indicator 07: Standard Primiparae undergoing episiotomy and no 3rd or 4th degree perineal tear

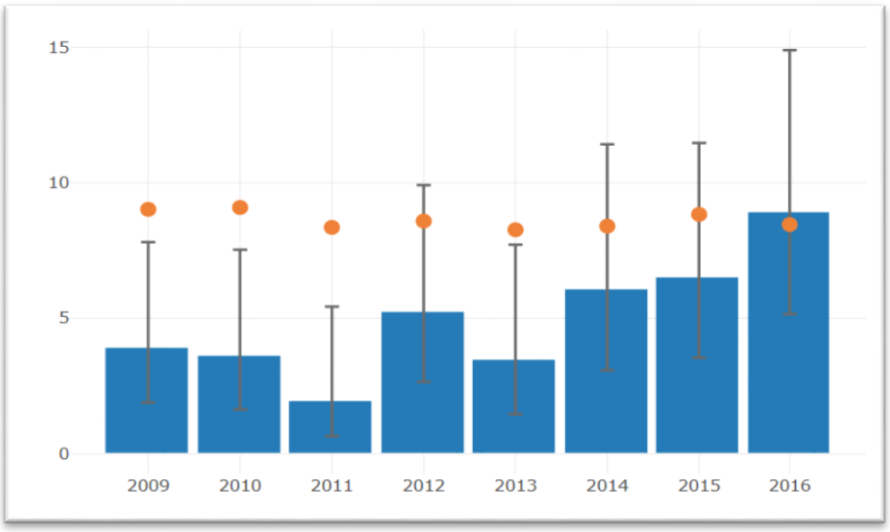
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



With the increase in instrumental birth there has been a natural increase with episiotomies performed.

Clinical Indicator 10: Women having a general anaesthetic for caesarean section

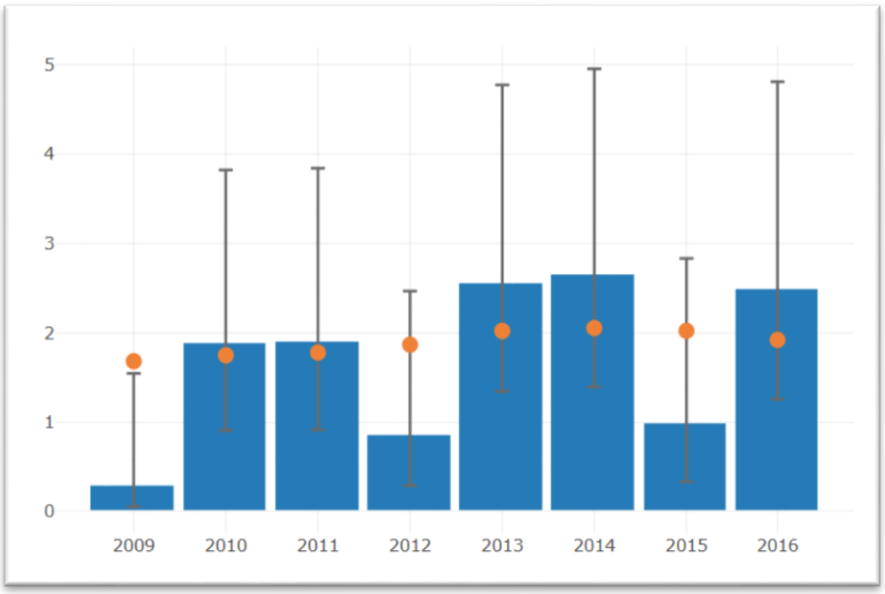
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



An increase in general anaesthesia is a reflection of individual practices in the anaesthetic team. This has now been resolved and we anticipate a reduction in following years.

Clinical Indicator 12: Women requiring a blood transfusion with vaginal birth

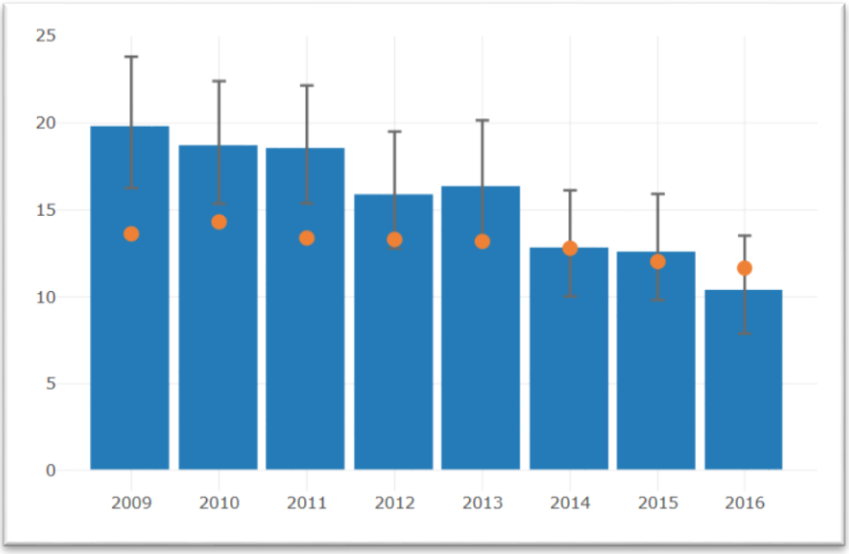
Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016



An increase in blood transfusions has resulted in a review of third stage management.

Clinical Indicator 16: Maternal tobacco use during postnatal period

Rate (%) of women giving birth (all ethnic groups), residing in the Wairarapa DHB area, 2009–2016

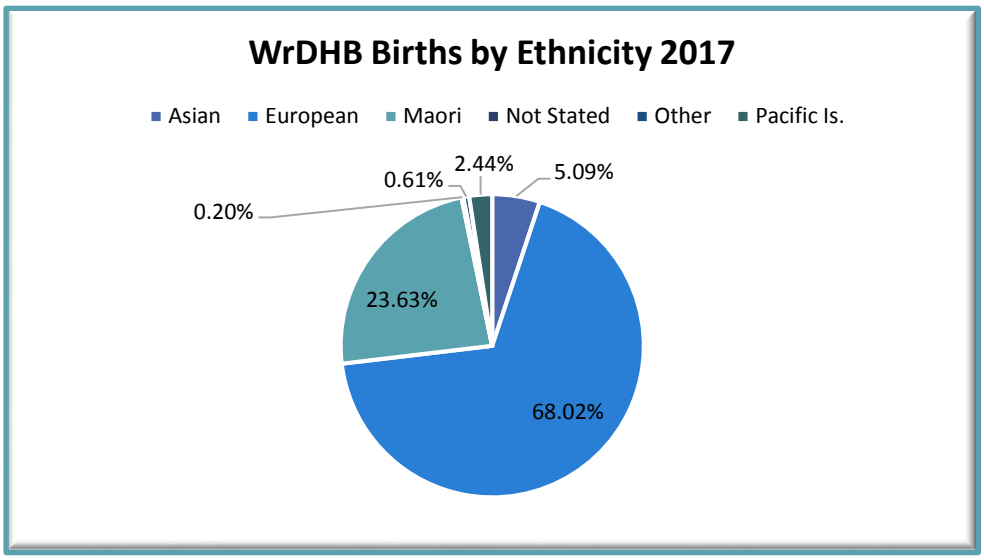


Overall there has been a reduction in maternal tobacco used in the postnatal period, however Māori continue to have higher smoking rates overall.

MATERNITY DATA 2016

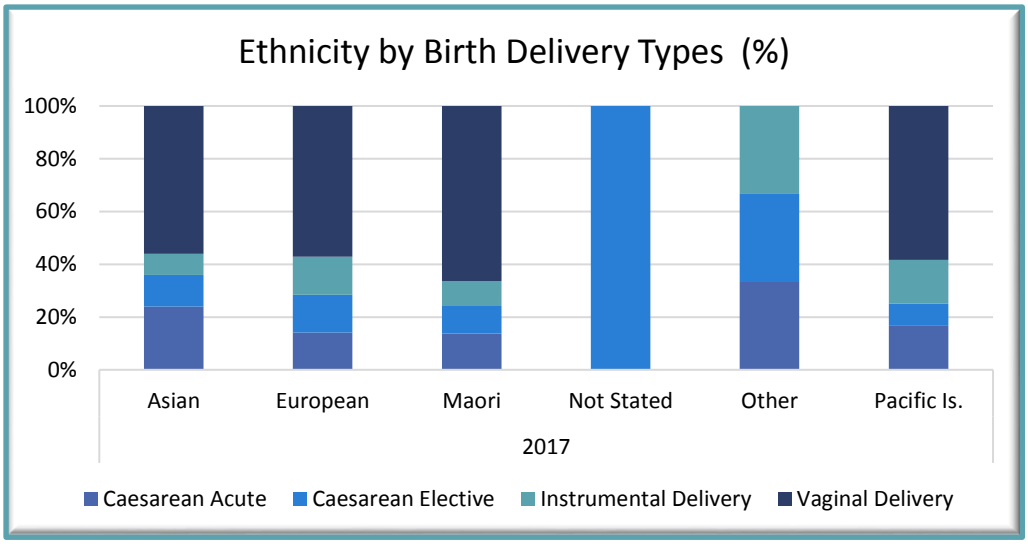
As shown in graph 3.1 below the diversity of ethnic groups residing in the Wairarapa is smaller than that of larger urban areas. It remains relatively unchanged from previous years and we aim to achieve a cultural component of care provided to the birthing population is precise and of a high standard. 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 and it has identified that the Asian population has an increase in the incidence of elective caesarean section with a reduction in acute caesarean sections. Māori continue to have the best normal birth rate overall and increasing each year.

Graph: 3.2

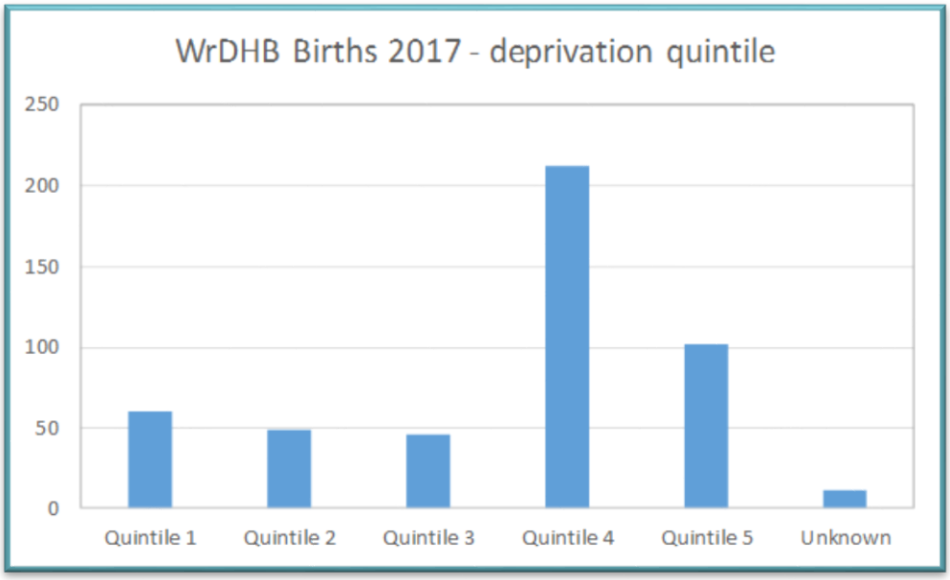


Wairarapa has a high proportion of women and whānau in the more deprived section of the population when compared to the national average; this is evident in graph 3.3 below. Evidence shows that social deprivation has a direct impact on birth outcomes as the health of this group is more likely to have complexities of health as a result of lifestyle choices/situations. An excellent programme run as a sub-regional programme is Maternal Green Prescription (MGRx) it is a free programme to promote the health and well-being of pregnant women (and their child) through improved nutrition and increased levels of physical activity. The team of Healthy Lifestyles Co-coordinators work with women to encourage positive healthy lifestyle changes that will benefit their growing baby and whole whānau.

Referrals are prioritised with particular reference to:

- Pregnant women diagnosed with pre-diabetes (HbA1c 41-49)
- Pregnant women at risk of pre-diabetes
- Māori and Pasifika mothers
- Young mothers <24 years
- Body Mass Index (BMI) >30

Graph: 3.3



BIRTH EVENTS

Promoting active labour and birthing with the introduction of Tūranga Matua (our primary birthing room), normal birth workshops and the focus to promote active labour over the 2016/17 years has found the cesarean section rate has remained static. The total cesarean section rate for 2017 was 27.9% but of that 13% of these were elective cesarean sections compared to 40% of elective cases in 2016. The majority of elective cases are for medical indications and previous cesareans of >2.

Graph: 3.4

The leading cause for emergency cesarean sections continues to be fetal distress followed by obstructed labour during first and second stage. As a service the need to address the introduction of fetal blood sampling during labour continues to be a priority. With the service now resourced with 3 obstetricians

there will be an opportunity to offer intrapartum cord lactate sampling with the assessment, management and follow up required during labour. The Executive Leader Medical Services and obstetricians are planning how this can be introduced and well-resourced so another tool is available to determine fetal wellbeing. With the anaesthetic services at its full capacity access to epidurals is much improved and will therefore be well utilized alongside augmentation of labour to improve outcomes of obstructed labour for a proportion of women.

The average length of stay for women birthing at Wairarapa DHB is 2.66 days, which is a slight reduction from previous years.

Vaginal Birth After Caesarean

Wairarapa MQSP Programme has invested a great deal of interest and time in the hope to increase Vaginal Birth After Caesarean (VBAC) uptake from consumers and improve outcomes and satisfaction. There has been the introduction of the VBAC guideline, funded Hypnobirthing Course, obstetric consultation at 20 weeks and 36 weeks gestation in preparation for VBAC and the 6 week postnatal obstetric consultations following emergency caesarean sections, debrief opportunity for the woman and her whānau.

The positive approach to VBAC has meant that women feel empowered to make an informed decision around the mode of birth for their next pregnancy and birth with the support of the LMC's and obstetricians. Acknowledging the impact that previous caesarean sections have on women and her physical, spiritual and mental wellbeing has an ever lasting impression on her journey in motherhood.

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. Data is submitted to the PMMRC through the online process and meetings are held 1-2 times per year dependent on when stillbirths occur. Morbidity reviews are undertaken as part of the monthly audit education sessions to aid learning for all of the multidisciplinary team. 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 Dr Jane Zucollo attended presenting all the post mortems that were undertaken and importance of postmortem discussions, details of baby at birth and presentation for the post mortem. Post mortem uptake for the stillbirths in the Wairarapa region continues to be relatively good

Table 3.5

Stillbirths by Gestation	2014	2015	2016	2017
20 – 30 weeks	1	1	2	3
30 + 1 – 35 weeks				
35 + 1 – 40 weeks		2	2	
40 +weeks	1			1

As per recommendations from PMMRC 2016/17 WrDHB is yet to introduce the PROMPT training as a multidisciplinary level, with an extra obstetrician on the team it is the intention of the DHB to get one obstetrician trained to help the educator facilitate the day with the input from anaesthetics and paediatrics. Midwives do undertake an annual training of obstetric emergencies which is scenario based training and there has been a variety of extra topics over the preceding years such as hypoglycemia, regional anaesthesia anaphylaxis, septicemia all of which have been well received.

In the instance on neonatal encephalopathy there have been none that we have had to report during the 2017 year, however as a DHB are willing to provide the data to PMMRC with support of CCDHB as these babies would be transferred to their care. Reviews of these cases would be undertaken with a multidisciplinary approach with learnings and recommendations shared.

SMOKING RATES IN PREGNANCY

The commitment to ensure a positive change in smoke cessation among the Wairarapa community is paramount in the care provided by all health professionals involved in the care of wāhine and their whānau. There is now a smoke cessation champion within the maternity unit whom is passionate about supporting and encouraging hapū māmā and their whānau to be aiming toward smoke free pregnancies and no exposure to 2nd hand smoke for pēpē. While the maternity unit continues to meet the maternity health target each month they have also displayed the positive approach to brief advice and referral to cessation services through the antenatal clinics that are being run to provide care to the over flow of women unable to source an LMC.

Table: 3.6

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%
2016	56	47	472	83.9%	11.9%
2017	85	79	553	86.8%	15.4%

Hapū Māmā

Hapū Māmā is an incentivized programme for pregnant mums or mums of babies up to the age of 1 and it has been developed with a whānau approach and offers support for whānau members that are there supporting the mum on her path to becoming smoke free.

A review has been completed and shows the following:

- a consistent amount of referrals were being received from a variety of sources.
- the hapū māmā were staying on the programme for longer
- more whānau support people were engaging on the programme
- Masterton is well represented but more marketing needs to be done in South Wairarapa.
- the programme is reaching Māori

Table 3.7 Hapū Māmā Programme Numbers

Calendar Year	Referred but did not engage	Completed Programme	Currently on Programme
2017	16	3	0
2018	5	6	9

The Hapū Māmā postcards are currently being re-designed and when the graphics are recieved the Wairarapa Smokefree Network will distribute it widely through the community and Facebook as a New Year promotion. The postcard below is what is currently being used.

While smoking remains prevalent in the Māori community WrDHB's smoke free coordinator with the support of Regional Public Health and Well Child Services invited Dr Lynne Russell to present her findings "What wāhine Māori think about smoking and trying to quit", held at Whaiora on October 25th 2017.

An open invitation was sent to all Kaupapa Māori and addiction services, primary and secondary care and to all our community links. Fifty people attended the two sessions. The Wairarapa Smokefree Network will build on the ideas that Dr Russell presented – in particular the Mokopuna Influence. This will be an initiative for 2018 and it will support the Hapū Māmā programme. The feedback was very positive with a number of people commenting that they wished she had spoken for longer. The Ministry of Health's "Exploring why young Māori smoke" supports Dr Russell's research.

Ka Tipu Auahi Kore Ngā Mokopuna - Smokefree Mokopuna

Following on from Dr Lynne Russell's research "What wāhine Māori think about smoking and trying to quit" the Smoke Free Coordinator wrote a pilot project plan to highlight "the mokopuna effect" This project was funded by Regional Public Health and Compass Health. It involved finding nine Wairarapa wāhine who had quit smoking for their moko, taking professional photographs of them with their moko, writing their quit journey stories, having posters of all sizes printed for display and launching the exhibition at Aratoi – Wairarapa Museum of Arts and History on May 31 World Smokefree Day. This was a community wide project involving the Masterton District Council, Wairarapa Times Age, Te Kura Kaupapa Māori o Wairarapa, medical practises, Aratoi Museum and the RSSS. After the launch on May 31st the Wairarapa Times Age published one of the photos and associated story each day for nine days at no cost. The A1 portraits are being exhibited at different locations in the Wairarapa during the next six months and they are also available to the community for display. Accompanying the display is a five minute video clip explaining the purpose of the exhibition, the photos and a brief answer to the question "what advice would you give to someone who wants to quit smoking". This was posted on social media by Whaiora and has had 382 clicks and 133 reactions, comments and shares. The matching posters have been popular and they have been distributed throughout the community.
The aim of this pilot project is to encourage grandparents to quit smoking for their grandchildren by offering an incentive of $200 over six weeks. There are 12 places available in the Wairarapa for any grandparent who wants to quit smoking. Currently there are two grandfathers enrolled on the programme.

PREGNANCY & PARENTING EDUCATION

WrDHB currently offer the following facilitate by the Antenatal & Parenting Educator:

Hospital Classes
The course is 6 weeks entailing 15 hours facilitated by a midwife. Ideally starting at around 30 weeks pregnancy. Women are able to come with support people or by themselves, all support people actively welcomed and included. The classes are open to anyone but predominantly, but not exclusively, attended by first time parents. Women have been aged between 18 and 40 years.

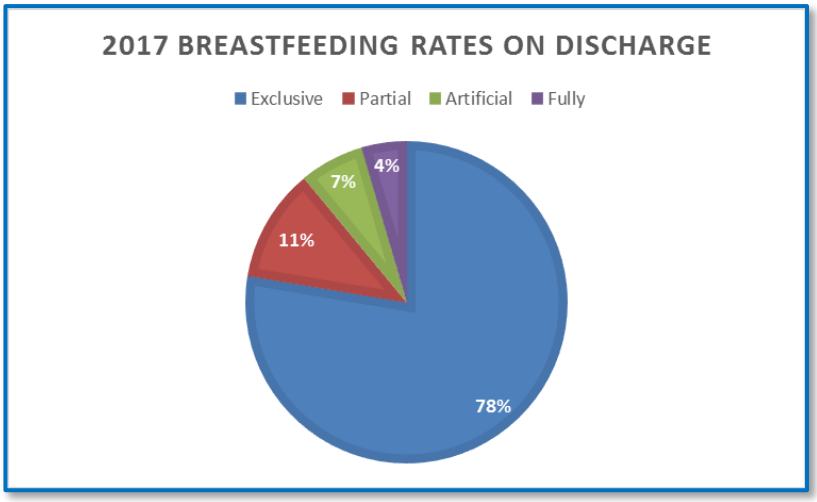
Teen Parenting Unit
Drop in session continue at TPU with a very dedicated and passionate LMC midwife holding these, they are run on Thursday 1.30-3.00 for women 19 and under- do not need to be in school, partners can attend but until now have mainly chosen not to. Attendance continues to be unpredictable so content is rolling and women led addressing their concerns. Each week we cover a subject such as normal labour or SUDI as well

as exercise and healthy pregnancy. Some sessions such as contraception and infant CPR are attended by mothers from the school. The majority of mothers are Māori at present so these classes have a tikanga Māori focus. Incorporating the creation myth, importance of history, traditional birthing practices, wahakura, oriori, respect for the whenua- participants decorate an ipu whenua in class.

BREASTFEEDING

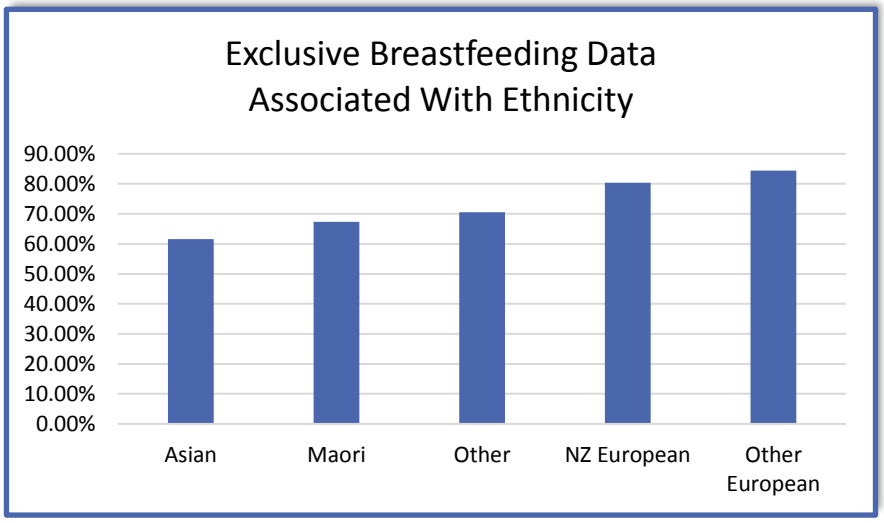
The 2017 exclusive breastfeeding rates on discharge from maternity services have had a slight increase from 74% in 2016 to 78% in 2017. The recruitment of a lactation consultant / BFHI coordinator has ensured that a quality education/updating is available to staff involved with breastfeeding women. NZBA now have a robust data collection source that will provide continual reporting over the calendar year and thus enable rigorous auditing if themes present themselves. To this point it has always been very retrospective.

Graph: 3.8



In the table below there has also been a reduction in the Asian population by 20%, Māori have remained static with NZ European increasing to 80%.

Graph: 3.9



In 2015 the "Breastfeeding Wairarapa" committee was formed and the 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.

The recent report from Breastfeeding Wairarapa Breastfeeding included an update on where the group is at and what lies ahead.

Wairarapa Research Project: He Rangāhau, Tuatahi "Nāumai e Pēpe"; This piece of work was undertaken by all three of the Māori Women's Welfare League roopu based within the Wairarapa; Te Peka O Ruamahanga, Te Peka O Wairarapa, Te Peka O Wairarapa Ki Te Tonga. Letter of Agreement for services has been completed and signed off to begin 1st of March, with report and recommendations to be completed by the 30th of June. A questionnaire was developed to look at the barriers for Breastfeeding Māori mothers within the Wairarapa around accessibility to local services offered, development of current services, attendance at current antenatal programmes, a local kaupapa Māori breastfeeding service. This research aims to reach 30+ Māori women living within the Wairarapa; this number has been estimated based on a three month birthing rate of Māori woman for the Wairarapa.

Funding for a Professionals Peer Counsellor programme has been approved, supported by the Māori Health Directorate Wairarapa DHB, the aim being to hold 3 sets of the programme from 1 run in June 2017 a further one at the end of 2017 and 2018. Following some consultation with services the course has been condensed into a two day programme. Our aim is to ensure we have continued breastfeeding support available within the communities and by furthering the development of a Professionals cohort, who have access to mothers, can assist us with our sustainability, through on going education and development. Services we will target but are not limited to will be all Kohanga Reo, ECE of interest, South Wairarapa Services and those working with young mums.

Mitigation / issues arising:

Breastfriends Drop in Centre: After some consultation with Breastfeeding Wairarapa Committee members and the Peer Counsellor volunteers running the Breastfriends Drop in Centre we decided to temporarily close the Drop in Centre pending a review of the service. Over the past six months the Drop in Centre, in particular Featherston has had minimal to no visits. The Featherston Drop in Centre relies solely on volunteers to run this service and with (1) a smaller pool of those willing to participate, (2) lack of attendance and (3) their skill set not being utilised, we have decided to look at better use of our time and resources. Breastfriends has continued to have the on-call component available to mothers requiring

support for over the phone or text support, with the option to be peered with a Peer Counsellor for a meet and greet at their discretion. The Facebook Page is also readily available for private messaging with referral or information support. Further discussion with other smaller local volunteer community groups found that they too have faced similar issues. After holding a group meeting the decision made is to collaborate and take a collective impact model trialling monthly mother support groups, across the three TLA's, as a baby/mother one stop shop idea. Breastfriends hopes to finalise details and have this initiative off the ground running by June 2017.

There is also the potential to introduce Little Latch on Sessions at the maternity unit for mums that are inpatients and those in the first 6 weeks postnatal as a starting point. The aim will be to include Peer Support Counsellors thus engaging women with another support service that is available in their community.

The Big Latch On 2017

Another amazing event that was well supported by the community from providing morning tea, spot prizes, stalls, and resources. The Carterton Events Centre continues to be an excellent venue that hosts a large group of people and is central within the region making it accessible for all. The local bus company also ran buses to the event this year for those that had transport difficulties.

140 women and whānau attended the event with 109 babies latching on at 10am. A local photographer was there to capture the memories for mums and whānau.

Section 4: MQSP Governance (MCGG)

4.1: Maternity Clinical Governance

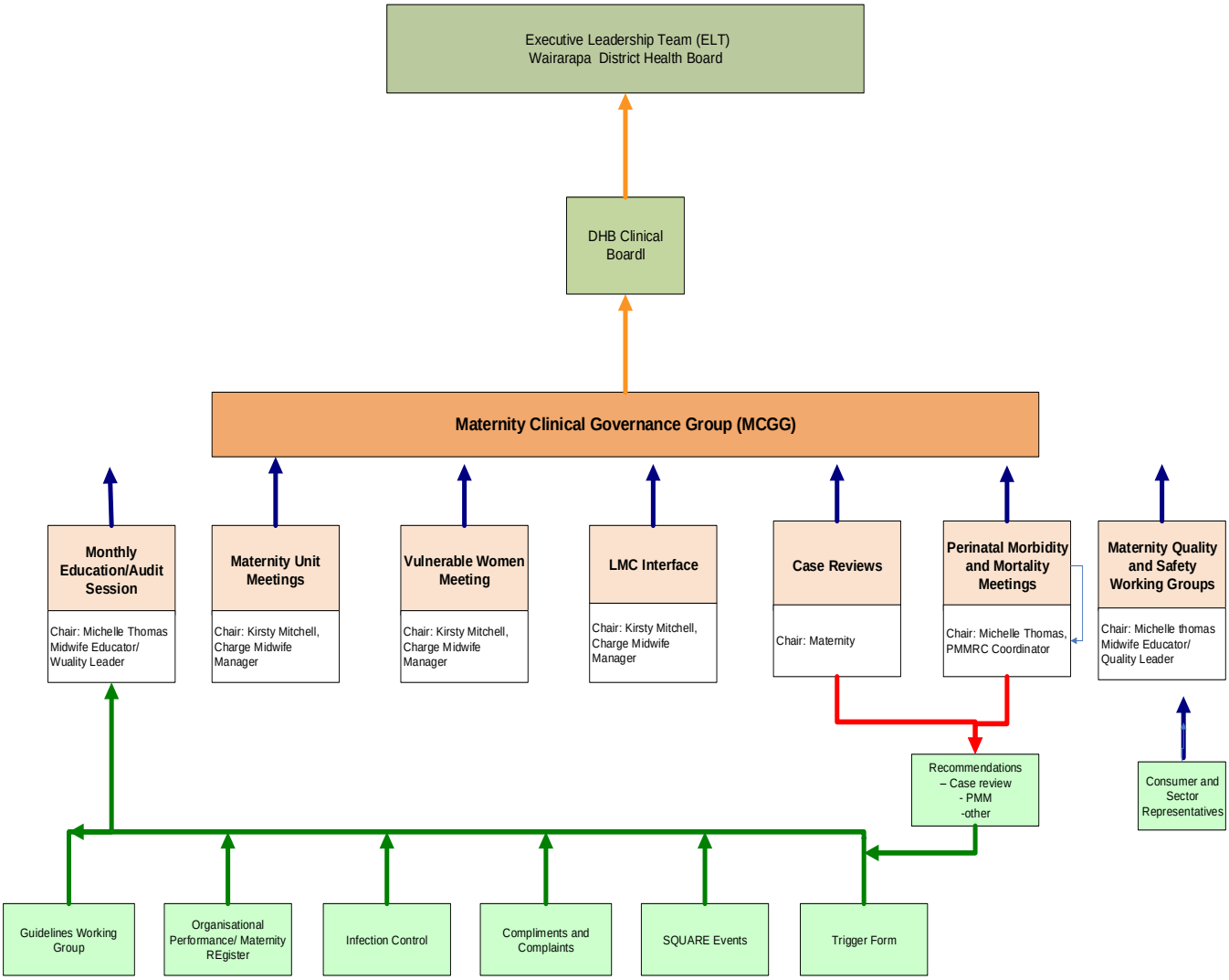
Wairarapa DHB established the Maternity Clinical Governance Group to oversee the Maternity Quality & Safety Programme. The group has had a very successful year of driving aims and objectives as set out for the 2013/2014 plan. The consumers have participated hugely in not only local issues but connecting 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 whānau.

Māori representation continues to be strong on the group with a member from the DHB's Māori 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 whānau.

MATERNITY CLINICAL GOVERNANCE GROUP MEMBERS	
David Cook, Obstetrician	Kirsty Mitchell, Charge Midwife Manager
Kieran McCann, Executive Leader Operations	Janeen Cross, Māori Health Directorate
Chris Stewart, Executive Leader Quality, Risk & Innovation	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	Lisa Burch, Planning & Performance
Liz Stockley, Primary Health Rep	Aleisha Badco, Whaiora
Vicki Perris, Plunket	Sarah Taylor-Waitere, Public Health Advisor

GOVERNANCE STRUCTURE

Maternity Quality and Safety Structure – 2017/2018



PRIORITIES & DELIVERABLES 2017/18

Objective	Action	Progress	Completion
Introduce GROW/GAP into the Wairarapa maternity service meeting PMMRC recommendations.	○ Involve IT services in setting it up within WrDHB ○ Support training requirements for all clinicians to be able to use it ○ Implementation of the Growth Assessment Programme and follow data collection and audit.	GROW app is available on the midwifery workspace. The GAP training has been delivered to obstetricians and midwives in the region. A team has been identified to work on the implementation of the programme within the unit.	
Improve primary/secondary consultation and transfer of care processes.	○ Identify project team and develop an aim and project charter ○ Produce driver diagram, ideas, measurements and tools ○ Test tools, measure and compare ○ Implement change.	The project has been a success in encouraging improved 3-way conversations, documentation.	
Develop an educational channel available to women while having their inpatient stay at WrDHB	○ Quotes for tv's have been authorised ○ Agreement from the producer to develop the channel ○ Posters to be designed advertising the education channel	Information has been gathered for the 2hr programme and it is now being produced. TV's have been purchase and are awaiting being installed in maternity postnatal rooms.	
Providing safe sleep devices for Māori /Pacifika population with integration of some aspects of antenatal education.	○ Following re-evaluation and consultation with Māori Health Directorate wānanga will be held for weaving of wahakura ○ Progress to wānanga for hapū māmā and whānau To These wānanga will offer opportunities to receive positive hauora messages such as smokefree environments, breastfeeding and health and nutrition.	Agreement with weaver to provide 30 wahakura to WrDHB. The first wānanga has been held for the weavers and it was a successful in that 5 attended though bigger numbers were expected.	

CONSUMER ENGAGEMENT

Consumers continue to be an integral component of the voice within the maternity service. There are representatives sitting on the Clinical Governance Group, the Miscarriage project group, participating in local surveys and have the opportunity to provide feedback on the maternity service. Compliments and complaints are appropriately dealt with through the Quality and Risk Directorate with the support and clinical expertise of senior leadership in maternity. As we move forward in the world of IT the clinical governance group agreed to purchase Ipads so that the consumer feedback survey can soon be undertaken through Survey Monkey. Feedback provided by consumers is always considered and where possible improvements are made, an example of this is the work completed with the quality of food provided to women on maternity and additional supper supplies along with the introduction of a support person staying overnight with women if they request.

MATERNITY WEBSITE

The maternity website has been live since Dec 2013 and while we are working towards the maternity quality & safely programme becoming business as usual the website is a significant monthly cost that we can do without. While investigating the best options we could either change to be under the umbrella of the DHB

or redesign the website with a new provider significantly cheaper. The clinical governance group decided that in view of the website needing to be easy to navigate, interactive and educational we would invest in a redesign and do it in collaboration with the pēpē ora website. The website will display information for pregnant women and whānau in relation to pregnancy, birth and postnatal, with a vision to live streaming educational/question & answer sessions. It will link with support groups and many other services accessible to women, all LMC midwives will be found on the website and will be linked to the NZCOM 'Find your midwife' website. The website design is being undertaken by the film editor that completed our virtual tour and educational channel.

MATERNAL MENTAL HEALTH PATHWAY

In 2015 a working group was developed to work on the services (or lack thereof at the time) for maternal mental health. Generated from this working group was a pathway and the FTE allocated to a regional Consultation – Liaison service provided by the Specialist Maternal Mental Health Service at CCDHB.

The aim; to support women, their infants and whānau
who require additional mental health support
during the perinatal period.

The role is to provide support and advice to Primary Care and Community Mental Health Services in the Wairarapa. Co-assessment, co-work and brief intervention may be offered and liaising with the adult mental health services directly if psychiatric assessment is required with pre-existing mental health conditions.

NMMG 2017 recommend that DHB's ensure the pathway works efficiently and there are no barriers to accessibility and WrDHB can confirm that there is a multi-disciplinary approach to the pathway, LMC's work well with referring and sharing of information to inform care planning is approached in a collaborative way with the woman at the centre of the care.

2017 data shoes that there has been a significant increase in the number of women accessing and receiving consultation/liaison from the Maternal Mental Health Clinician with 44 women being seen. There was an even split with 22 being pregnancy and 22 being postnatal.

Referrals were as follows:

- 22 from primary health (includes FP, Family Start, Primary mental health nurses)
- 5 from hospital (paediatrics and social work)
- 9 from LMC midwives
- 8 from adult mental health service.

23 face to face initial assessments followed on from the consultation/liaison work. These were usually completed in their own homes and were completed over 1-2 sessions. Women were then either referred to their GP, CMHT, Family start, counselling or no further referral was required.

MATERNAL CARE WELLBEING AND CHILD PROTECTION GROUP

The Maternal Care Wellbeing and Child Protection group has been functioning very well over the past year with improved support of administration through the Violence Intervention Team, pathway, referrals and discharge documents are been reviewed. The function of the group continues to be a multi-disciplinary approach with aim to ensure the wellbeing of mother and baby is paramount. The group ensures that there is a wraparound service to women and her whānau that enables her to have the appropriate individualized support plan in place facilitating and fostering healthy parenting. In improving access to the care plans for health professionals administrators within the group have worked with the IT department in loading the support plan. This is in its final stages and the sharing of this information will improve interfacing between primary and secondary care services and thus the outcome for the woman and baby.

Tables below demonstrate consumers that are referred to the group and services involved in their care and safety planning.

Table: 4.1

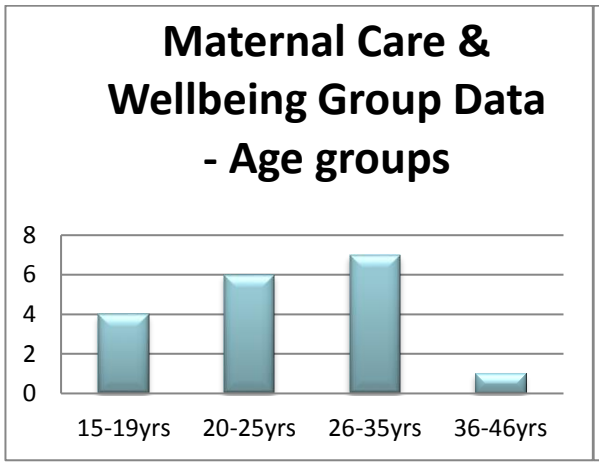


Table: 4.2

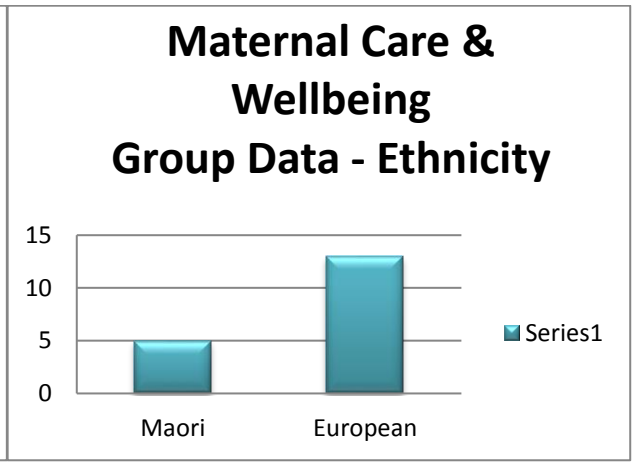


Table: 4.3

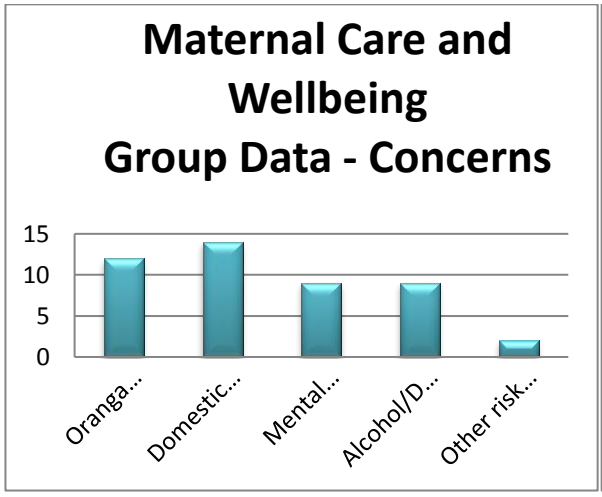
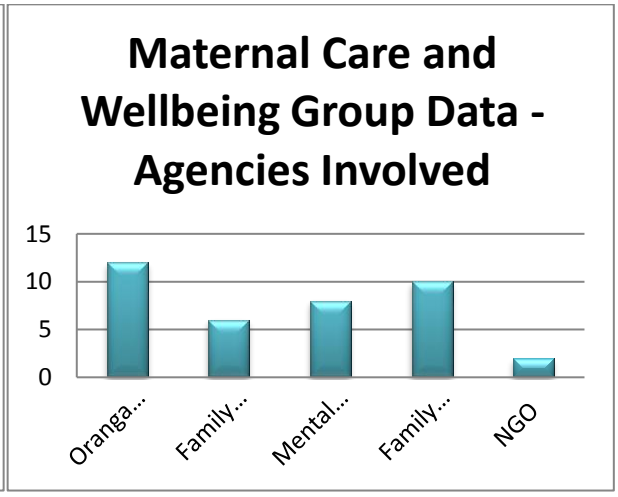


Table: 4.4



EDUCATIONAL CHANNEL

Information sharing with women and whānau is crucial in the informed decision making process that they are exposed to throughout their pregnancy, labour and birth. A collection of brochures and information resources was undertaken and we found that there is 4kg of resources a woman collects during this time. With this in mind consumers on the Maternity Clinical Governance Group suggested making an education channel that women and whānau can view in maternity prior to discharge, sharing with them information on key topics. The channel has been designed to be informative and directs individuals to support networks in the community where necessary. The theme from the Wairarapa Maternity Unit virtual tour has been continued throughout the channel and all resources have been chosen specifically to be orientated to New Zealand and culturally centred. Where there may be language barriers utilising translators and sitting through the programme with whānau will aid better understanding of important messages.

WATCH OUR POSTNATAL EDUCATION CHANNEL

1. LOOK AT YOU, AROHA ATU, AROHA MAI
Starts at 00m00s Duration - 24m46s

2. FOLLOW ME MUM
(THE KEY TO SUCCESSFUL BREASTFEEDING)
Starts at 25m04s Duration - 19m08s

3. HAND EXPRESSING MILK
Starts at 44m45s Duration - 5m50s

4. STORING BREASTMILK
Starts at 50m37s Duration - 2m47s

5. SAFE SLEEP
Starts at 53m26s Duration - 4m35s

6. SAFE HANDS
Starts at 58m04s Duration - 2m00s

7. NEVER SHAKE A BABY
Starts at 1h00m06s Duration - 10m25s
****WARNING*** Some of the content in this video may be upsetting, it is advisable to watch with caution.*

8. HOW TO PERFORM CPR ON A BABY
Starts at 1h10m33s Duration - 6m39s

9. BRONCHIOLITIS
Starts at 1h17m14s Duration - 1m05s

10. SMOKING CESSATION
Starts at 1h18m21s Duration - 48s

11. CORE & PELVICE EXCERCISES
Starts at 1h19m10s Duration - 2m21s

12. IMMUNISE YOUR CHILD
Starts at 1h21m32s Duration - 10m42s

13. WHY DOES MY CHILD NEED A CAR SEAT?
Starts at 1h32m16s Duration - 3m38s

14. HOW TO SWADDLE YOUR BABY
Starts at 1h35m56s Duration - 1m02s

15. MAMA'S MATTER
Starts at 1h37m00s Duration - 30s

Instructions: Press SOURCE on TV Remote select MEDIA PLAYER, then select 'C', then select WDHB_Maternity_Education-V2.0_FINAL.mp4. Press green button at bottom of remote to load and play movie. When finished press SOURCE again and select Antenna to return to normal TV viewing.

WAIRARAPA maternity

Section 5: Quality Improvement

IMPLEMENTATION OF GROW / GAP

It is recognised that growth restriction is associated with stillbirth, neonatal death and perinatal morbidity and that better identification of growth restriction should enable strategies to reduce these issues. Evidence shows that antenatal detection of fetal growth restriction is improved by standardised assessment on risk, serial assessment of growth and plotting on customised charts and has been recommended by PMMRC (2015).

With the role out of the GAP programme being supported by ACC WrDHB Midwife Educator considered it an optimum time to introduce clinicians to GAP and formalise the implementation to meet the gold standard of care for women of the region. A day of workshop training for obstetricians and midwives was held in the region by the Perinatal Institute, it was divided into 2 workshops to ensure good attendance, 2 obstetricians and 18 midwives and 2 sonographers. A team was developed to then continue the roll out of the programme and quality assurance, guidelines are being developed and expectations raised for women to have completed growth charts on referral to secondary care services and on intrapartum admission for completion of the birth centile.

During the training it was identified by some LMC's the difficulties they have with using differing electronic maternity programmes. The voice of 2 LMC's querying why growth charts differ in their programmes led the trainer on the day to take this back to providers and then successfully followed up with the confirmation that 1 specific provider was changing their charts to the GROW charts. Inadvertently we have successfully implemented change through discussion and collaboration with external resources, great work Wairarapa!!

Wairarapa Maternity Service GAP Team.

From left: Michelle Thomas, Kirsty Mitchell, Marilyn Smethurst, David Cook, Alex Williamson

PREGNANCY & PARENTING CLASSES FOR MĀORI

The Wairarapa District Health Board Maternity and Māori Health Directorate 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.

To date

While the priority for this deliverable was put into the 2017/18 year meeting a specific antenatal programme has not been achieved, however there have been small steps in the introduction of a programme though specific in the creation of wahakura it will also include tikanga around birthing practise. The Māori Health Directorate identified an amazing woman Justina Webster and her son Sharn who have developed a method of teaching wahakura weaving to weavers and non-weavers, particularly whānau who are expecting a pēpē. The ability of whānau to make their own wahakura will empower them to create pathways of mauri and whānau ora or wellbeing. Justina and Sharn both learnt the waikawa style of weaving wahakura from Jenny Firmin of Whanganui and have developed their aroha for this kaupapa to empower whānau.

It is an aspiration to hold Wānanga for hapū māmā and their whānau, weavers, tamariki ora and other health professionals. In addition to providing understanding around the tikanga (cultural practices) associated with harakeke; weaving and wahakura have many similarities with antenatal, birthing, postnatal care and child rearing. For example, Hineteiwaiwa is the goddess of both weaving and childbirth. The harakeke plant depicts a whānau. The rito (pepi) is the centre shoot, surrounded by ngā mātua (parental leaves) and then rau kaumātua (grandparent leaves). The rito and mātua rau are always nurtured and never harvested until new rito shoots are birthed as they ensure the future survival and wellbeing of the harakeke plant.

Consistent high rates of SIDS and SUDI deaths in largely Māori communities highlight the continued significance of other SUDI risk factors, such as smoking in pregnancy, unsafe bed sharing practices and social deprivation. These wānanga will offer opportunities to receive positive hauora messages such as smokefree environments, breastfeeding and health and nutrition.

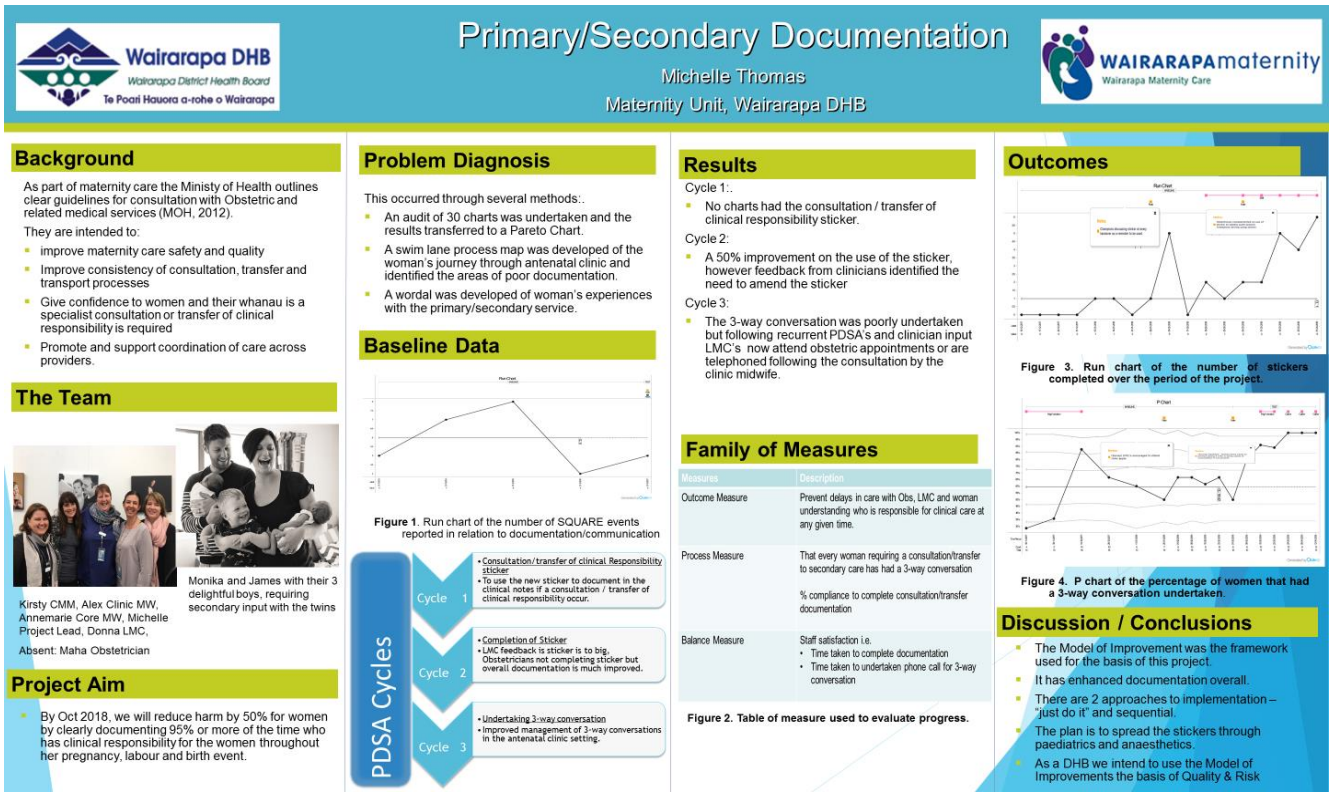
The first wānanga held was quiet a success and feedback from wāhine participating in the days was positive and we look forward to the next wānanga for hapū māmā and their whānau where the original local weavers can be involved and inspired to continue these wānanga in the future with support from the Māori Health Directorate and Maternity.

The Wairarapa region is excited to be growing our own amazing Māori student midwives that will be graduating in 2019 and intending to remain in the region once qualified and so will be fabulous midwives that will be able to meet the needs of some of the birthing Māori population.

PRIMARY / SECONDARY INTERFACE

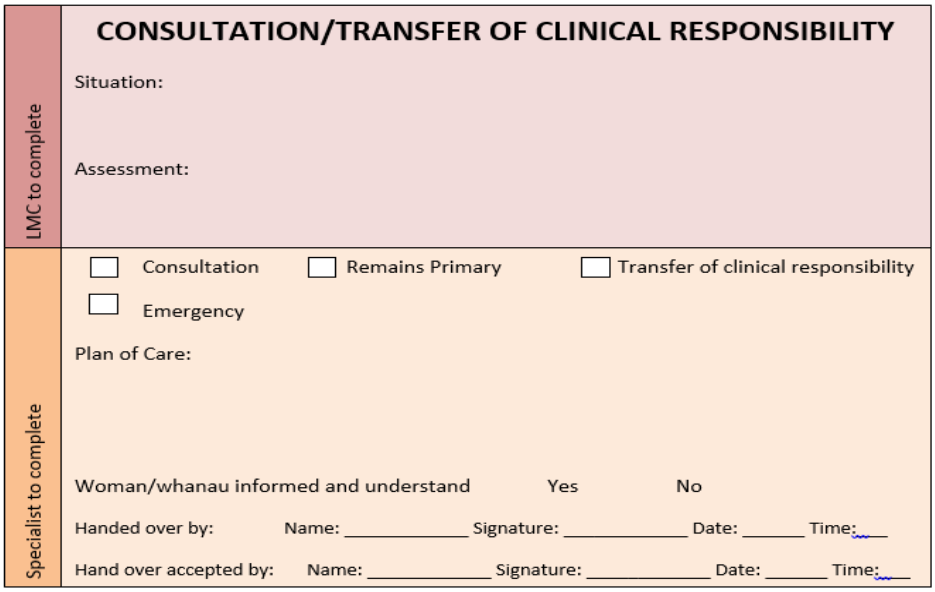
September 2017 presented the opportunity for the MQSP Coordinator to accept a scholarship offered by HQSC to take a place on an Improvement Advisor Course. Discussion within the team of the maternity service identified several areas of care that would benefit from the attention of the Improvement Advisor course. The one that was chosen would have an impact on the interface between primary/secondary and documentation. Some background is that a couple of years ago a transfer of care sticker was implemented and not widely used (nor evaluated) which caused confusion in practice and could have contributed to the outcomes of 2 SAC 2 events and this prompted a clinical review of process. Discussions were held at a monthly education session and it highlighted that there are many different views on the application of the Referral guidelines and transfer of care, further training was provided and clinical reflection for midwives on their clinical practice and philosophy on care they individually provide. Over the period of the course a team was developed, an aim developed, a selection of tools and methodologies used to identify problems and solutions. Measurements were undertaken to display the success of changes and what worked well with PDSA cycles.

Below is the story board of the project that was presented to all participants of the Improvement Advisor Course. It clearly displays the content of the project and progress that has been made.



The improvements made have encouraged consistent 3-way conversations, well informed women and clearly documented clinical responsibility.

This example of the sticker now being used was redesigned by the project team and has taken a period of time to be accepted by clinicians but is now well utilised.



CONSULTATION/TRANSFER OF CLINICAL RESPONSIBILITY

LMC to complete

Situation:

Assessment:

Specialist to complete

☐ Consultation ☐ Remains Primary ☐ Transfer of clinical responsibility

☐ Emergency

Plan of Care:

Woman/whanau informed and understand Yes No

Handed over by: Name: _____ Signature: _____ Date: _____ Time:___

Hand over accepted by: Name: _____ Signature: _____ Date: _____ Time:___

HYPNOBIRTHING COURSES

Hypnobirthing courses commenced In July 2015 as a free service to women and their whānau, MQSP funds the hours and resources of a local midwife (who is a qualified hypnobirth facilitator) to provide HypnoBirthing Classes at the DHB. The aim is to enable women to birth without fear while continuing to aid the reduction of repeat CS rates and increase the VBAC rate using a structured programme of education and support. The courses have extended to first time parents, parents suffering from a previous traumatic birth experience, women with anxiety or fear of the next labour and birth. 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 to the women, whānau and service.

In 2017 there were 5 classes held with 51 couples taught and 49 completing the course (1 couple transferred to CCDHB and birth prematurely).

Of 25 births 3 had elective caesarean sections, 6 emergency c/s, 4 women attempted VBAC but required emergency c/s and 12 women birth vaginally.

Feedback from women is always positive about the experience of learning the physiology and art of hypnobirthing and below are some beautiful examples of women's reflections of their experience.

"Hypnobirthing techniques used even in c section was so amazing to keep me calm, grounded and connected to my baby."

"I can't even put into words how useful your class was. My birth couldn't have gone better and I feel healed from my first traumatic birth."

PĒPĒ ORA

Pēpe Ora was born out of a local Nurturing Baby Event called 'Healthy Māmā, Healthy Pēpe'. This event was the brain child of a local Midwife who felt our community needed to hold a baby expo to inform and share in local maternal care for mothers, babies and whānau. In evaluating this event it was decided to ensure hitting our local target groups a greater focus on the needs of the baby, rather than the mother, may encourage more participation by wāhine to future events. This name change would signify the overall health for baby and so became Pēpē Ora. Our collective vision is to create a safe sharing space for hapū wāhine, breastfeeding mothers, parents/caregivers/whānau and children. It is our goal to ensure all whānau, tamariki and pēpē will be well supported to get the best start in life through access to information and support services in their communities. Pēpē Ora is working towards a 'one stop shop' model where by Wairarapa communities work collectively together, identifying community need and seeking community solutions.

What we know is when people are better informed about what supports are available to them they will choose to make better health decisions for themselves and their whānau, improving health outcomes. Building health literacy is an important part of this project and as recognised a health-literate health system reduces demands on people and builds health literacy skills of its workforce, and the individuals and whānau who use its services. It provides high-quality services that are easy to access and navigate and gives clear and relevant health messages. The Ministry of Health have developed a framework to enable all New Zealanders to live well and keep well and this framework outlines expectations for health organisations and for the health workforce to take action [1]. Building confidence in individuals to know where and how to seek the support they need through improved systems of information sharing is where Pēpē Ora hopes to create its four pillars for maternal health. The four pillars for maternal health are based on the Te Whare Tapa Whā model of practice as an all-encompassing holistic approach to wellbeing with the Pēpē and Māmā at the centre of the wharenui.

Work will continue in developing an identity for Pēpē Ora of its own logo and website sitting alongside Wairarapa Maternity.

The annual Pēpē Ora event will be held at different locations throughout the Wairarapa ensuring that it is accessible to all, holding the event in 2018 alongside Children's Day meant that many attended the event to make it a success. The collaboration between providers was fabulous and positive feedback will ensure the makings to another successful event in 2019.

3DHB 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 worked on the 2017 campaign "Mamas Matter" with the key messages being for women to ensure they feel safe, supported and emotionally well in pregnancy and postnatal. The group came up with the idea following a brainstorm of "what was on top" for consumers, there was a strong focus on positive birthing and maternal mental wellbeing. The Hutt Valley led the campaign this year and with many adaptations designed 2 beautiful posters in English and Te Reo that share the key messages in a beautiful way.

The campaign will be marketed through different means of media advertising and in coordination with Mother's Day and International Day of the Midwife. 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, Kohanga Reo, childcare centers, libraries and Plunket.

TATOU WAHINE TO TATOU TAONGA

Our Women Our Treasure

Let someone know if you are feeling down.

Talk to someone you trust: Whānau, Marae, Midwife, Well Child provider, GP or Ph: HealthLine on 0800 611 116.

"Ehara taku toa I te toa takitahi, engari, he toa takitini"
"My strength is not the strength of one,
it is the strength of many"

For more pregnancy or postnatal information visit: www.huttmaternity.org.nz

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

Maternity Quality & Safety Programme

Programme Plan

2018 – 2019

WAIRARAPA maternity
Wairarapa Maternity Care

Our vision is to deliver - **Better Health for All**

Our mission is to achieve - **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**

Our Maternity Service priorities are:

Community, Environment & Whānau
Choice, Equity and Access
A sustainable workforce
Quality & Safety
Service Continuity

Our goal is to:

Provide an integrated Maternity Service that enables best possible care and support for the women on the Wairarapa.

Our Quality Commitment is:

That as individuals, and as a maternity service we continually improve the safety and quality of healthcare for women and babies

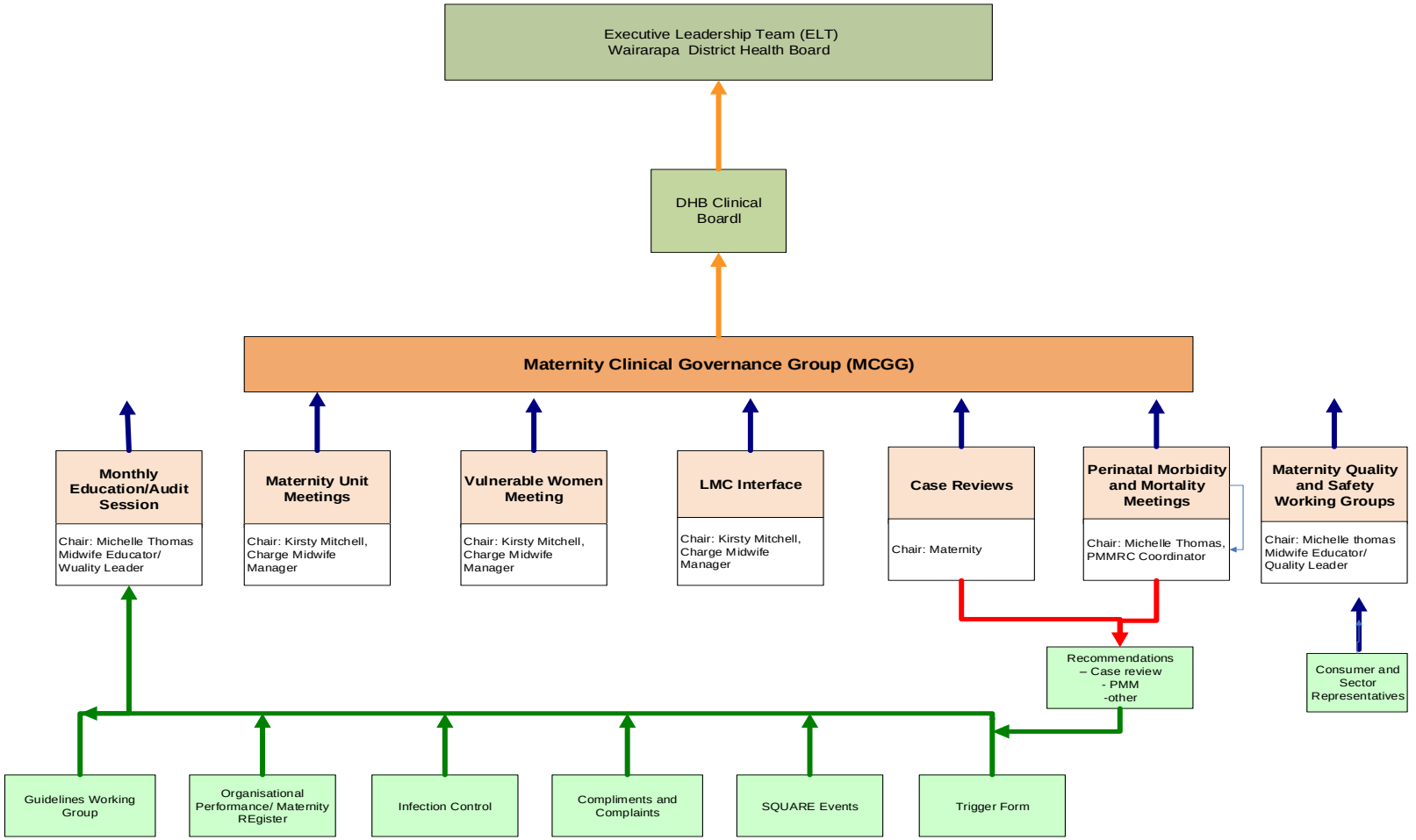
To ensure consumer engagement and participation

That we put the patient at the centre of everything we do and focus on continuous improvement

That we ensure all of community and DHB clinicians are well supported and have the skills to deliver high quality and safe patient care, every time

GOVERNANCE STRUCTURE OF
MATERNITY CLINICAL GOVERNANCE GROUP

Maternity Quality and Safety Structure – 2017/2018



WrDHB Maternity Clinical Governance Group is committed to working toward the Maternity Quality & Safety Programmes Quality Improvement projects as set by the Ministry of Health 2018. The group recognises the importance to prioritise 2 key projects from this work programme and 2 projects that will be specific for local needs.

The Maternity Clinical Governance Group has representation from Executive Leader Operations & Executive Director Quality & Risk whom ensure that the quarterly Programme Progress Summaries are reported on in the HAC reports, the Midwifery Director's involvement in the group offers the opportunity for her to feed into the COO and provide professional support to senior leading midwives. Annually the Midwifery Director, MQSP Coordinator and Charge Midwife Manager present to the Board the programme's achievements over the year and the focus for the year ahead. This enables support and guidance in the implementation/embedding of changes in processes and practice to achieve a high standard of care for those women and babies we provide care for.

PROJECTS					
CONCEPT	**RATIONALE**	**MAIN PHASES OF WORK**	**DELIVERABLE**	**PERSON/GROUP RESPONSIBLE**	**INDICATIVE DATES**
Introduce an electronic system in maternity.	Implement the national maternity information system to aid admission to discharge planning, consistent and aligned data collection systems. Ensure consistent approach to data collection and reporting. Improved information sharing between maternity service and GP services when women and babies are discharged.	Collection of consistent and comprehensive maternity data occurs, regardless of the provider of primary maternity care Data/information used to prioritise quality improvement activities. Processes to audit and improve the quality of maternity data collection, storage and reporting are in place	An electronic system that is robust will be fully functioning and accessible in the maternity service. Mechanisms in place to evaluate information/reporting	MQSP Coordinator and IT Services.	As soon as possible

Build a sustainable workforce committed to actively working with women and whānau to achieve a positive pregnancy, birth and postnatal experience. Succession planning will enable a fluid workforce between core/LMC roles.	To provide a fully staffed maternity service and appropriate number of community LMC's ensuring women get a choice of LMC.	○ Provide micro-teaching sessions frequently exposing staff to scenarios supporting their confidence in the 2ndry setting ○ Grow our own Māori midwives and ring fence FTE for new graduate positions ○ Establishing a new graduate programme across 2-DHB to enhance clinical experience in MFYP ○ Enhance the Antenatal clinic midwife role by specialising in diabetic care and miscarriage liaison improving services for women.	○ Support 1-2 graduate midwives per year through the MFYP programme ○ Antenatal clinic midwife role becomes a permanent FTE structure.	Maternity Clinical Governance Group	Start date: August 2018 Due date: May 2019
Implement a safe sleep devices programme for pēpē	To ensure all pēpē born in the Wairarapa are offered a safe sleep device. At risk pēpē are a priority and education with whānau is paramount.	○ Increase capability to purchase pēpē pods and wahakura ○ Encourage and enable midwives to confidently discuss safe sleep education ○ Establish local wahakura weaving groups that can work with hapū māmā and whānau. These wānanga will offer opportunities to receive positive hauora	○ Data collection and analysis of pēpē pods and wahakura distributed with education to whānau ○ Wānanga attended by hapū māmā and whānau	Maternity Māori Health Directorate Smoke cessation services Funding and Planning TAS	Start Date: July 2018 Finish Date: June 2019

		messages such as smokefree environments, breastfeeding and health and nutrition. ○ Hold a training day with inspiration speakers on the key topics of: Safe sleep, smoke cessation, breastfeeding, shaken baby prevention. ○ Integrated with primary care i.e. LMC's, GP practices, Well Child Providers and Regional Public Health on key messages			
Transfer the consumer feedback form to an electronic system captured on Ipads available to women for completion on maternity.	○ Ease of ability to engage women in completing the survey and data analysis collection will be easily collected	○ Purchase Ipads x 2 ○ Involve IT Services in setting it up	○ Consumers participating in the survey ○ Data available	MQSP Coordinator & IT Services	March 2019
Implement a lactate machine in aiding the move to decrease the caesarean section rate.	○ Data from 2016/17 shows fetal distress as the outstanding theme for emergency c/s. At present fetal distress is identified by CTG interpretation. Utilising the lactate machine as another tool for assessment of fetal	○ Discussion needs to occur with how the service can sustain using the lactate with workload pressures of obs & gynae and oncall.	○ Ideal would be to have a lactate machine within the maternity service to aid the reduction of c/s rate and improved outcomes for women and babies.	Executive Leader Medical Services, Obstetricians, Midwifery Director, Charge Midwife Manager and MQSP Coordinator	Nov 2018

	wellbeing will offer opportunity for labour to continue working toward a vaginal birth.				
Providing antenatal education for Māori /Pasifika population.	○ To provide an antenatal programme specifically aimed at the Māori /Pasifika women and whānau. ○ To collaborate with Māori Health Directorate and local Iwi.	○ Meeting has been had with Māori Health Directorate, Wairarapa REAP representative Midwifery Director, Charge Midwife Manager, Quality Leader and Antenatal Educators. ○ Set time line from outcomes of meeting held ○ Support local Māori student midwives through their training and location of work once qualified.		Maternity Clinical Governance Group, Māori Health Directorate.	Jan 2019

APPENDIX 1

Expectations of 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

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 centered 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 whānau.

RESPONSIBILITIES OF THE GROUP

The MCGG will:

1. Encourage collaboration and good working relationships between DHB staff including maternity staff, obstetricians and the Māori Health Directorate, 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. Advice 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. Provide a governance structure and quality assurance to ensure the UNHSEIP services are delivered consistently and to a high standard of care.
7. 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.
8. 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
- Māori 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)	Liz Lelievre
Chairperson	Michelle Thomas
Data provision	All participating organizations as agreed

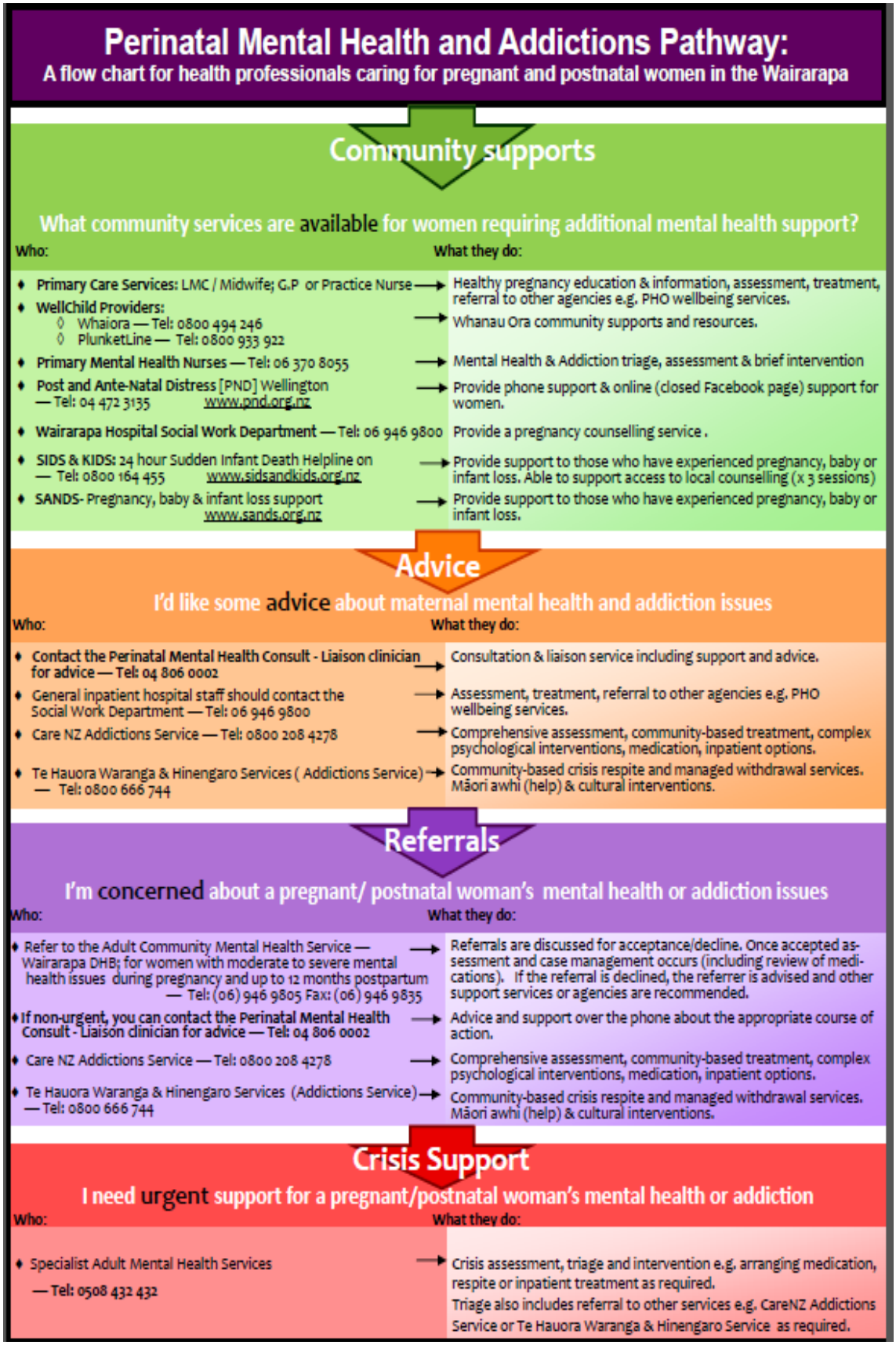
MEMBERSHIP

Role
Midwifery Director
Obstetrician
Executive Leader Integration, Allied & Community
Charge Midwife Manager
Core Midwife
LMC Representative
Maternity Quality and Safety Coordinator
Māori Health Representative
Planning & Performance
Compass Health (PHO)
Tamariki Ora Nurse
Consumer Representatives
Clinical Leader, Plunket
Executive Director, Quality & Risk
Regional Public Health

SCHEDULE OF MEETINGS

- Meetings will be held three monthly

APPENDIX 3


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.