# MATERNITY QUALITY & SAFETY PROGRAMME

## Annual Report

## July 2018 – June 2019

WAIRARAPA maternity
Wairarapa Maternity Care

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

# EXECUTIVE SUMMARY

It is a pleasure to present the Wairarapa DHB MQSP 2018/19 Annual report with my colleagues, it has been another great year of collaborative work within the region providing quality care to the women and babies of the region.

Work streams have remained unchanged over the year as we continue to strive for completion of projects before starting on others. The Executive Leadership Team continue to provide support in order to maintain a service that requires fluidity in staffing dependant on acuity and primary care services provided to women that are unable to access an LMC. The exemplary websites for Wairarapa Maternity and Pēpē Ora have been another example of quality work making information accessible to women and noticed by other DHB's that are wanting to produce similar work.

Our consumer voices continue to be integral in the day to day operations and work planning of the maternity service and I would like to take this opportunity to thank them for their input and time to ensure we continue to meet the needs of women and babies.

I appreciate the efforts made by the Maternity Clinical Governance Group and the team of the maternity service across DHB and community in striving to provide quality care and recognise the outstanding contribution from the Director of Midwifery and her team of midwifery staff. I would like to acknowledge those that have supported the collation of this document by providing information and data and also to those that feature in the photos.

Kieran McCann
Executive Leader Operations

# Contents

# Wairarapa DHB

**Our Vision:**

Well Wairarapa - Better health for all

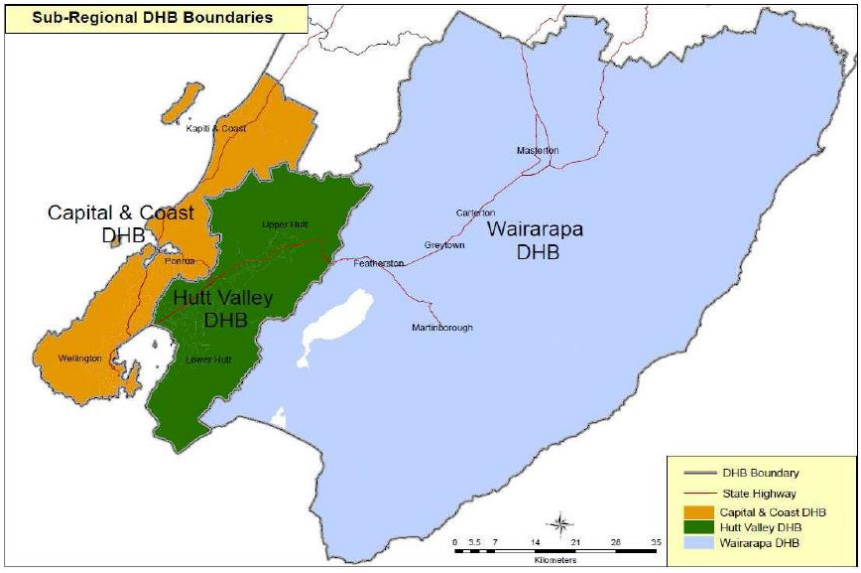
**Our Mission:**

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

**Our Values:**

**Respect – Whakamana Tangata**
According respect, courtesy and support to all.
**Integrity – Mana Tū**
Being inclusive, open, honest and ethical.
**Self Determination – Rangatiratanga**
Determining and taking responsibility for ones actions.
**Cooperation – Whakawhānaungatanga**
Working collaboratively with other individuals and organisations.
**Excellence – Taumatatanga**
Striving for the highest standards in all that we do.

The Wairarapa region is located in close proximity to three other larger DHBs – Hutt Valley, Capital and Coast, and MidCentral DHBs who all provide additional secondary and tertiary services to Wairarapa residents. With the 3 DHB merger happening the majority of the time transfer to CCDHB and Hutt would be the preference. Our small population is spread over a large geographic area extending from the Remutaka Hill and Ocean Beach in the south to Mount Bruce in the north. It extends from the Remutaka Hill in the west to Ocean Beach in the south and Mount Bruce in the north, a total of 8423 square kilometres, this is described as rural and remote rural.



# 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 (WrDHB) Maternity Quality & Safety Programme in 2018/2019, as required under section 2.2c of the Maternity Quality & Safety Programme Crown Funding Agreement (CFA) Variation (Schedule B42):

This is the seventh maternity services annual clinical report from 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 2018 to the 31st May 2019. 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 2017 annual year, maternity data is 2018 annual year and MCGG project work covers the 2018/19 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 2018/19
- 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 2018-2019.

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: Goal

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

## 1.2: Aims

The aim of the Wairarapa Maternity Quality and Safety Programme (MQSP) is to guide and facilitate the implementation of 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.

## 1.3: 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 2018/19 year the following objectives will be further explored throughout the Annual Report:

- Workforce sustainability and service provision
- Monitoring of Caesarean section, Induction of Labour and Vaginal Birth after Caesarean (VBAC)
- Ensure Maternity specific procedures and guidelines are updated and document controlled
- Annual Pēpē Ora Expo
- Hypnobirthing classes
- Providing antenatal education for Māori / Pasifika population.

## 1.4: Quality Commitment

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 women 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.

# Section 2: Wairarapa DHB Maternity Service

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 421 births in 2018, a decrease of 16% from the 2017 year. The maternity services are based at WrDHB in Masterton; this is the only birthing facility in the region though a most LMC's support home birthing and the number of homebirths for the district was 34 (8%) of births for the year 2018, well above the national average.

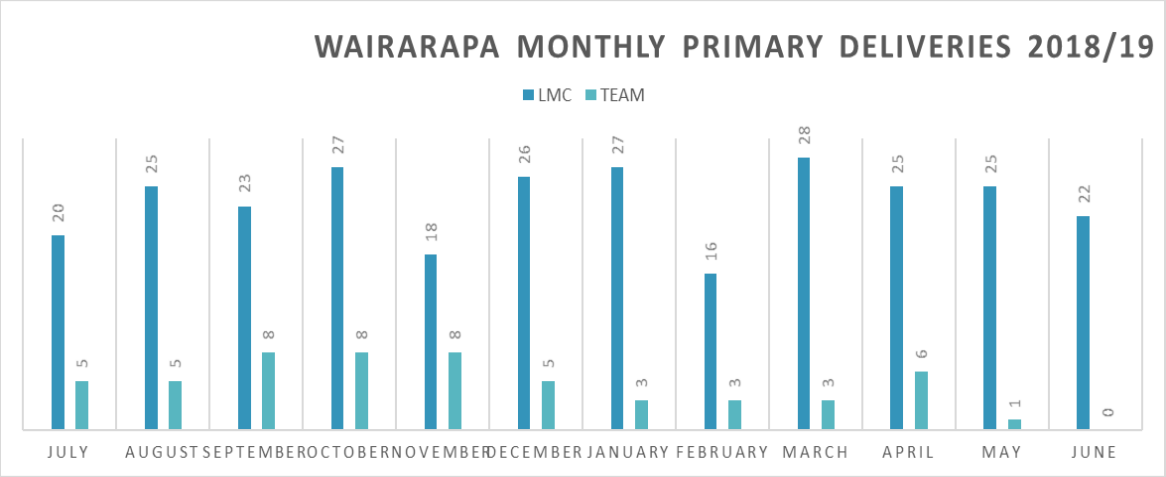
## WORKFORCE PLANNING

***Midwifery***

The support from the Executive Leadership Team and CEO with regard to workforce recruitment and succession planning following a rapid decline in LMC's and core staff in 2017 made for a challenging but very successful 2018. We now have an Antenatal Midwife 1.0 FTE to facilitate obstetric and midwifery clinics, provide care for ladies unable to secure an LMC and flex up or down clinically as a core midwife as acuity demands. We also for the first time have a dedicated HCA currently working 0.6 FTE with the scope to flex up her hours as acuity demands.

There are now 11 active LMC's in the Wairarapa region including 4 new graduates and most of the LMCs are providing care to small caseloads of 3/month with a couple holding a fulltime caseload of 5-6/month. Currently the DHB continues to provide antenatal and intrapartum care to those women that find it difficult to find an LMC and capturing this data allows the flexibility for acuity and planning.

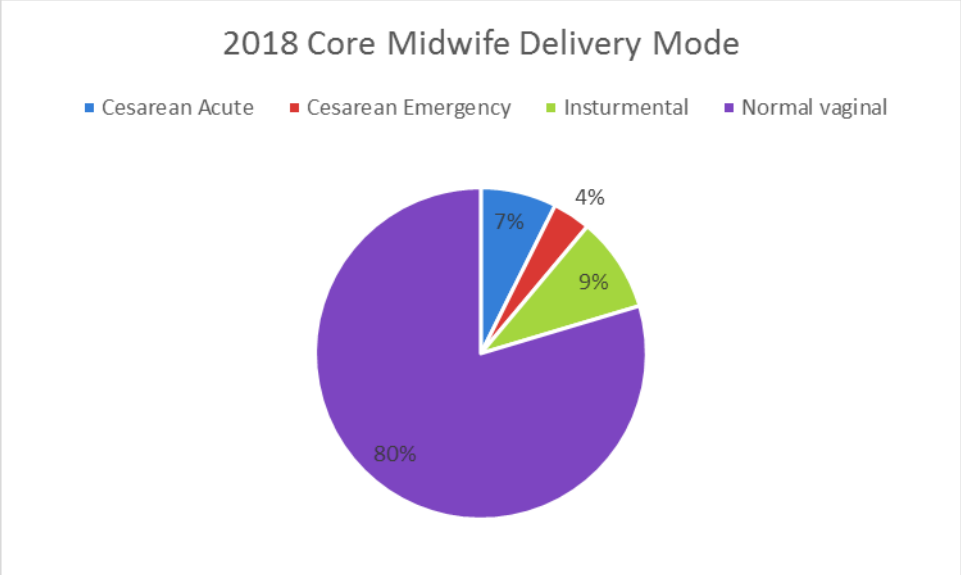
**Graph 1.1: Registered number of women**




Graph 1.2 below shows the mode of birth for the women that received their care from the core midwives and an 80% vaginal birth rate is somewhat pleasing and supported by excellent feedback from women expressing that they feel well looked after, safe and prepared for labour and birth. 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 in the 2018 year.**




The total of births in graph 1.2 is 54 and there are a further 19 women that were unaccounted for as they may have experienced a miscarriage this pregnancy or had a LMC pick up their labour and birth care claiming independently.

### *Maternity Unit*

So now in 2019 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 has now extended to include the triage and initial contact with women experiencing early miscarriage via referral from primary health care providers.

The maternity unit now has an HCA that takes care of stores / ordering / cleaning / beds and linen, answering the door and assisting families, facilitating breast pump and birthing pool hire and has completed Breastfeeding peer support training to further support our new families.

We have 3 obstetricians working a roster which will enable a better coverage of on call by local obstetricians therefore a reduction in locum use aside from leave cover. This also means there is 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:

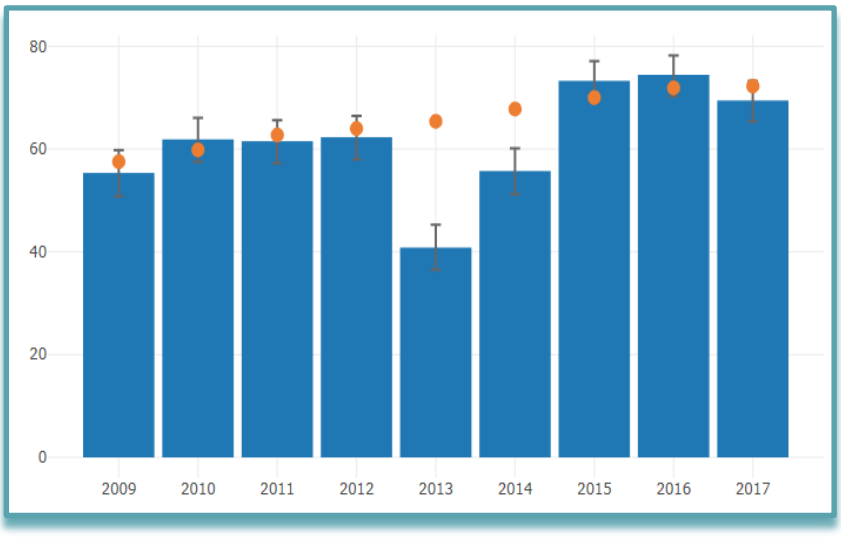
- Midwifery Director
- Executive Leader Integration, Allied & Community
- 3 part-time Obstetric Consultants
- Charge Midwife Manager
- Midwife Educator and Maternity Quality & Safety Programme Co-ordinator
- Antenatal clinic midwife
- 17 Core midwives
- Lactation Consultant
- Newborn Hearing screener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

# 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***

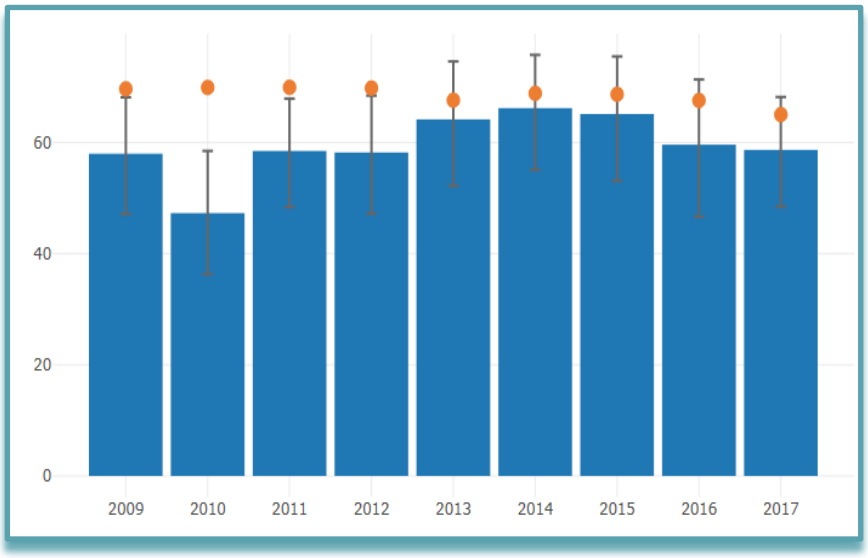
*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*




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 meant that women experienced some delay in finding an LMC midwife then would access the DHB services therefore the drop in 2017 data. The DHB anticipates that the early 2018 year will also have an impact on this clinical indicator as full complement of LMC workforce did not take place until early 2019.

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

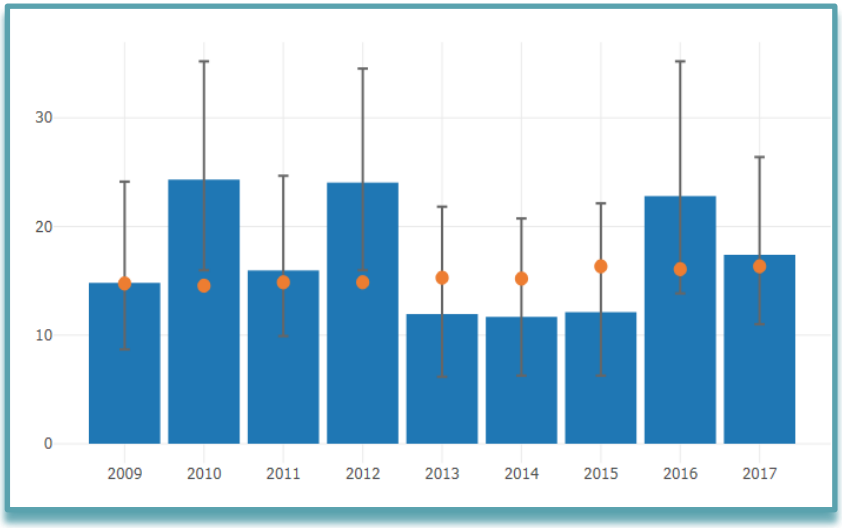
*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*




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. 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*

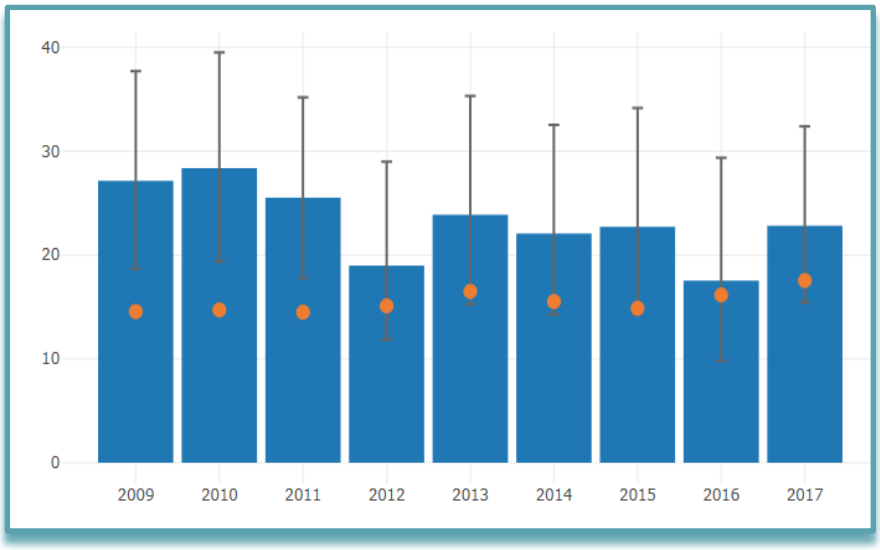
*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*




A significant reduction in the instrumental birth rate may be a reflection of increased use of locum obstetricians. WrDHB is committed to promoting active labour and vaginal birthing.

### *Clinical Indicator 04: Standard Primiparae who undergo a cesarean section*

*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*

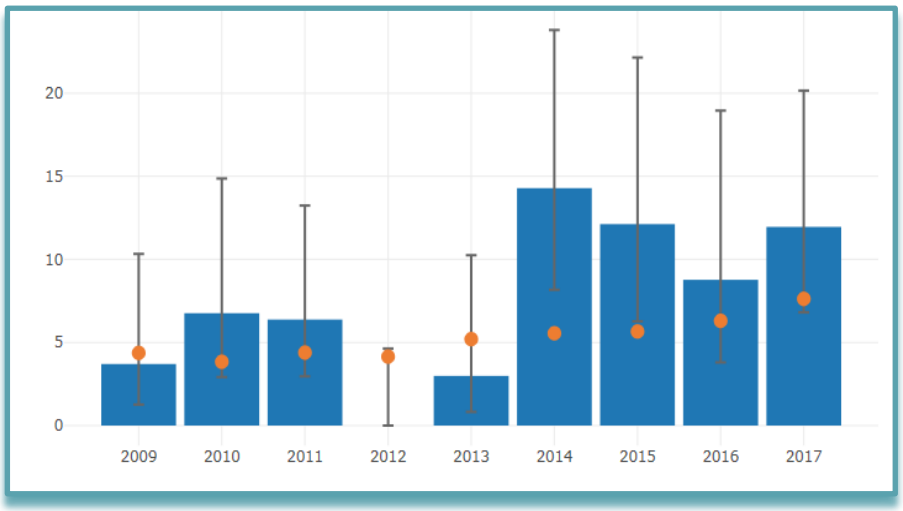



Surprisingly with all the work surrounding reducing the cesarean section rate, 2017 showed a reflective year of an increase. Local raw data kept on the maternity clinical indicators shows an expected reduction for the 2018 year.

The obstetricians and midwives strive to achieve positive birth experiences for the women and their whānau. The continued team work of reviewing all cesarean sections continues and 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*

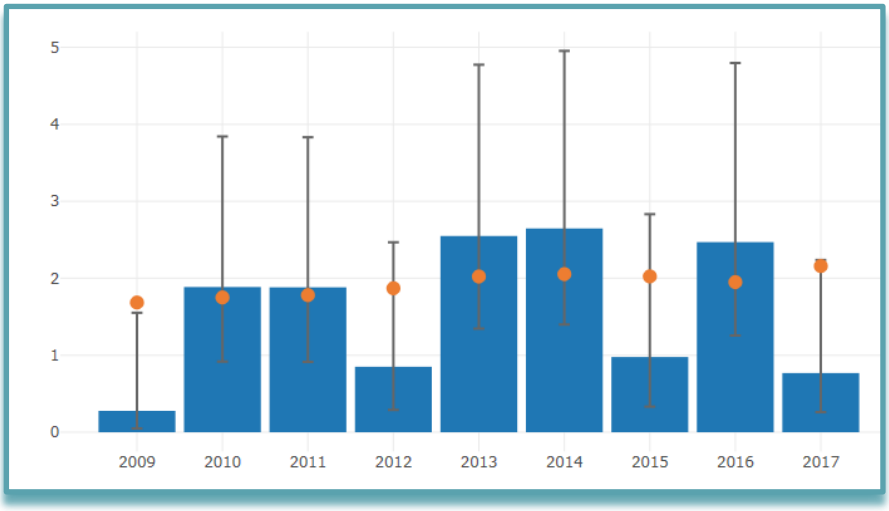
*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*




As the induction of labour has increased for the 2017 it has identified the need to investigate why this has occurred. Following discussions with clinical coders it was identified that there is often confusion regarding induction or acceleration of labour. Documentation was reviewed and small amendments were made to give clarity to coders. Further audits are also being undertaken to collate data regarding indications for induction.

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

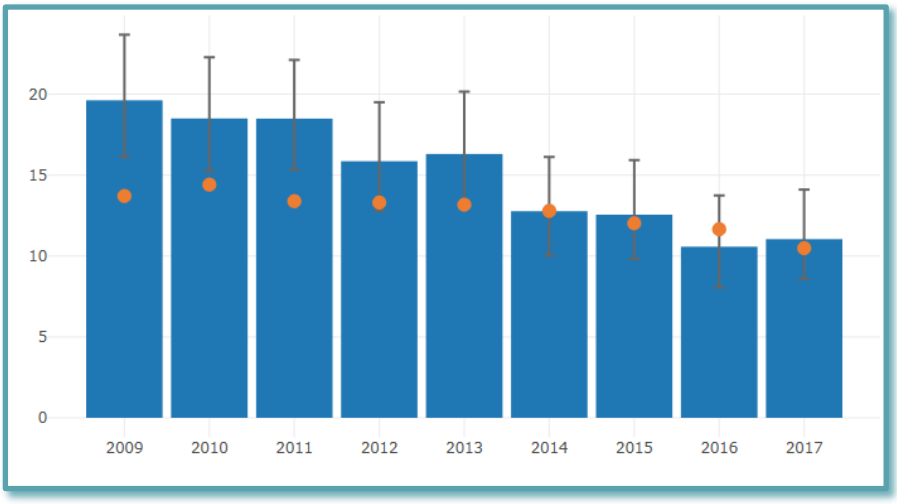
*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*




It is pleasing to see a reduction in the number of women requiring a blood transfusion following vaginal birth. The implementation of iron infusions antenatally if oral treatment is not sufficient has meant that women are hemodynamically stable in preparation for labour and birth.

### *Clinical Indicator 16: Maternal tobacco use during postnatal period*

*Rate (%) of women giving birth (all ethnic groups), residing in the WrDHB area, 2009–2017*

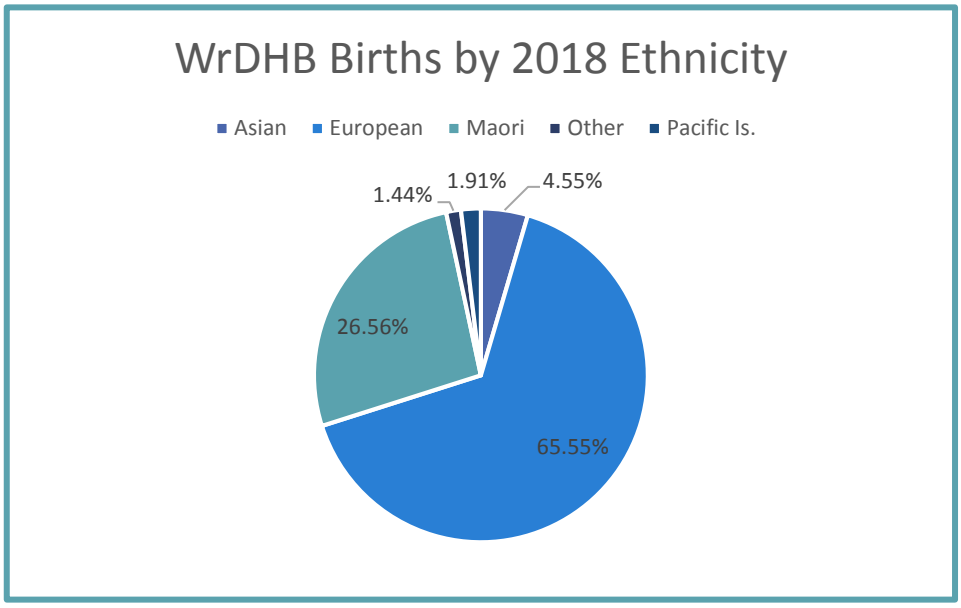



Overall there has been a slight increase in maternal tobacco use in the postnatal period, and Māori continue to have higher smoking rates overall. Further in the report we have included the ongoing work that is undertaken within both the DHB and community to reduce the smoking rates in Hapū Māmā and whānau.

# MATERNITY DATA 2018

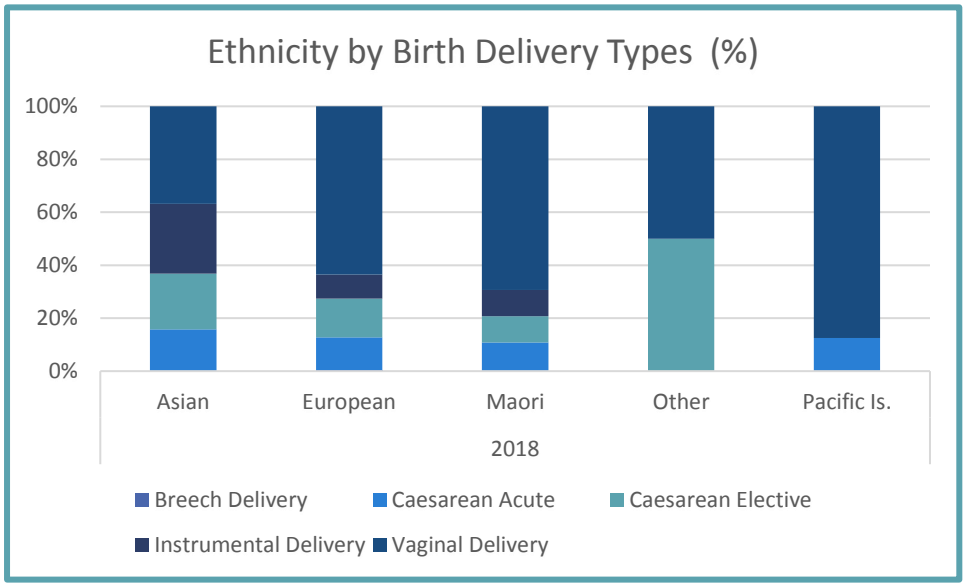
As shown in graph 3.1 below the diversity of ethnic groups residing in the Wairarapa is smaller than that of larger urban areas. It remains relatively unchanged from previous years and we aim to achieve a cultural component of care provided to the birthing population is precise and of a high standard. 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 shows that Māori and Pasifika women have the best normal birth rate with an overall reduction of caesarean sections across all ethnicities in keeping with the lower caesarean section rate. The caesarean section rate for the Asian population remains static but has had a swap between the numbers of elective and acute.

***Graph: 3.2***

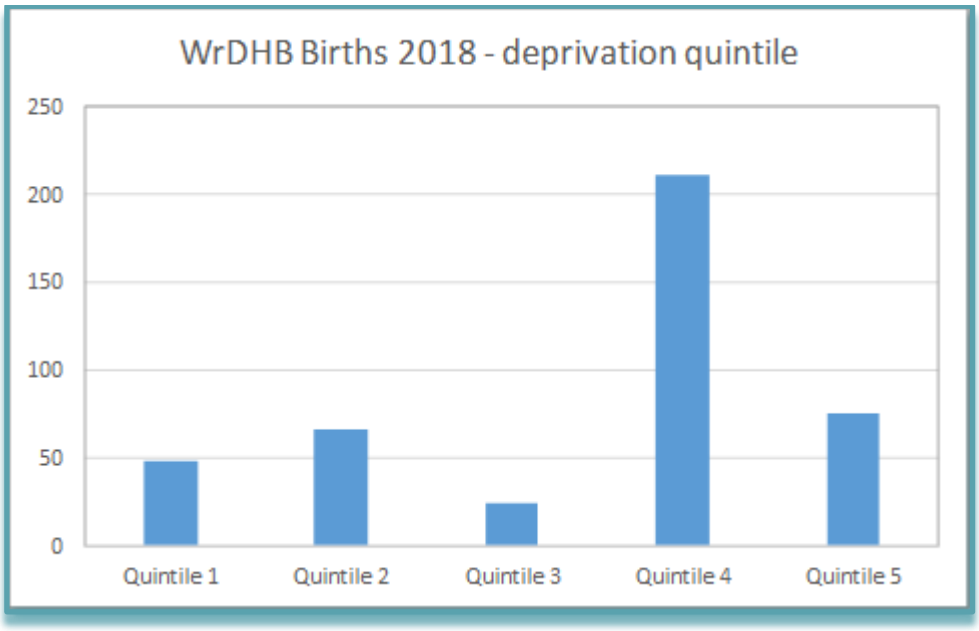


Wairarapa has a high proportion of women and whānau in the more deprived section of the population when compared to the national average; this is evident in graph 3.3 below. Evidence shows that social deprivation has a direct impact on birth outcomes as the health of this group is more likely to have complexities of health as a result of lifestyle choices/situations. The sub-regional programme Maternal Green Prescription (MGRx) continues to be a free programme available to hapū māmā and whānau promoting health and well-being 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***

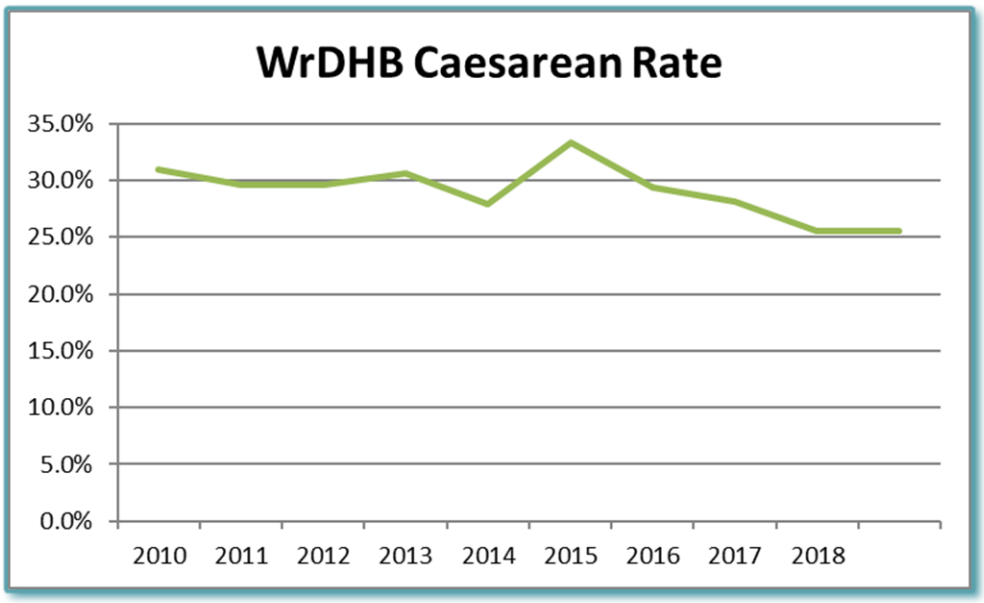


# PRIMARY BIRTHING

As WrDHB continues to provide a space for primary birthing within the secondary facility we advocate active labour and birthing. Some funds this year have been allocated to the purchase of 2 big pieces of birthing equipment supporting women to be active in labour and birth. Focusing on the promotion of normal birthing within a secondary facility does have its challenges but is an empowering experience for women.

Below shows the overall cesarean section rate for all birth in the facility and there has been a reduction from 28.1% in 2017 to 25.8% in 2018. Overall this is reassuring however still well above WHO and MOH recommendations so work continues in this area.

***Graph: 3.4***




# PMMRC

WrDHB continues to hold PMMRC meetings x 2 per year and submits data via the online process through Otago. Classification occurs as part of the PMMRC meetings and acknowledges the impact that barriers, staff, environment and systems may have in relation to the outcomes for mums and babies. The success of a pathologist present for the meetings has encouraged good attendance and generate excellent discussion for the multidisciplinary team. Morbidity reviews continue to be undertaken through the monthly audit education sessions as a multidisciplinary team and where appropriate on a smaller review scale if necessary. Outcomes and findings are shared and improvements implemented where necessary.

**Table 3.5**

| Stillbirths by Gestation | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| 20 – 30 weeks | 1 | 1 | 2 | 3 | 2 |
| 30 + 1 – 35 weeks | | | | | |
| 35 + 1 – 40 weeks | | 2 | 2 | | |
| 40 +weeks | 1 | | | 1 | |

While the numbers of IUD / Stillbirths has been less in the 2018 year statistically we have an overall high incidence on perinatal loss. As per recommendations from PMMRC 2017/18 we have

Strategies to reduce preterm birth

An early registration campaign initiated 2 years ago still retains high visibility through primary health care provider's community wide. The Pregnancy information packs that GP's distribute to pregnant women, guide early registration and direct contacts with LMC's and is aligned to content developed for the recent launch of the Wairarapa Maternity Website.

All women that experience a preterm birth are referred into the specialist obstetrician for input as early as possible in their pregnancy, with planning and monitoring undertaken with a shared care approach throughout the pregnancy.

Birth outcome information

WrDHB has access to information from CCDHB for women and whānau prior to transfer to the tertiary facility for birth outcomes prior to 25 weeks gestation. This facilitates continuity and consistency for mothers and whānau in the region and facilitates transition in situations where active care is pursued through the tertiary provider.

Antenatal corticosteroids administration

Introduction of Fetal Fibronectin Testing was introduced in 2016 as part of the clinical assessment. The current Management of Pre-term labour Guideline includes the administration of corticosteroids and consultation with consultants at CCDHB regarding management / transfer of women at a gestation of 22-35 weeks gestation.

Through the MQSP programme there are intentions for WrDHB to be involved in a project auditing the use of corticosteroid administration and repeat doses. This sub-regional approach is required as with most premature births there may be an initial dose administered in the Wairarapa and repeat dose in Wellington, which, in the absence of a single, integrated, electronic record system carries some latent risk for clear identification by either provider. Wairarapa is only just embarking on implementing an electronic record for maternity. The development of an electronic record locally may provide some opportunities to improve this situation

Staffing ratios and acuity tools

With the introduction of the MOH consensus statement Observation of the mother and baby in the immediate postnatal period, WrDHB has made available education to all midwives providing immediate postnatal care and midwives are encouraged to risk assess all women/situations. The practicality of a core midwife role at WrDHB is such that midwives are often in and out of the room supporting post-natal care and emergencies. We have included educating women and their whānau especially where there may be any risk ie, smoking, medications, tiredness so that babies are encouraged to be in their own safe sleep space

WrDHB does not have an acuity tool for staffing. From a critical mass consideration there are 2 midwives on per shift for a 6 bed P/N and A/N and 3 bed birthing unit. LMC's are the main carer 2 hours post birth, in the instance of transfer of clinical responsibility the core midwife becomes the main carer.

Better forecasting of workloads by using LMC advanced booking information has provided opportunities to plan for periods of increased activity and we have the flexibility to increase staffing on a shift by shift basis. We have also recently trialled using a Health Care Assistant to supplement the midwife role to ensure that the observation of the mother and baby in the immediate post-natal period by the midwife is facilitated by delegating less critical tasks to alternate roles.

Access to safe sleep space

WrDHB's aim is that every baby will have a safe sleep device from the DHB as funding and co-ordination has been supported through funding from MOH. We are actively and effectively working with the Māori Health Directorate and local iwi communities, with the aim to establish Hapū Wānanga and weaving of wahakura for whānau in the region.

Data collection and numbers of pēpi pods distributed is being collated and shared with the MOH as appropriate.

PROMPT

WrDHB will prioritise the training of the midwifery educator, an obstetrician and anesthetist in order to be able to run the training at WrDHB. There was discussion over the past year of being supported by a neighbouring DHB but resources are stretched for both facilities so to provide it locally will be much more beneficial for the multidisciplinary team.

Neonatal Encephalopathy

There has been one baby identified with neonatal encephalopathy that was born at WrDHB and was transferred to CCDHB. The appropriate reporting was initiated by CCDHB and the local LMC provided additional information as required, local review provided background to the management of the case and identified learnings and recommendations.

# SMOKING RATES IN PREGNANCY

The Fresh Air Project was launched in Wairarapa November 2018, it is about promoting smokefree public spaces and with 11 cafes and one bar on board in the region, Wairarapa health professionals have their fingers crossed that smokefree areas will be the norm soon.

WrDHB Smokefree co-ordinator Linda Spence said the Fresh Air Project was a national initiative led by the Cancer Society, the Wairarapa Cancer Society has come on board and is leading the project.

“We are going around different cafes asking if they wanted to join the project which means they have to put out signs every day for the month of November,” Linda said.

The Fresh Air project is a partnered initiative between Tū Ora Compass Health, Regional Public Health, WrDHB, the Cancer Society and Wairarapa midwives.


*From left, Antenatal clinic midwife with the DHB Lisa Wood, lead maternity carer Donna Thompson, Village Grinder owner Sue-Anne Shannahan, Wairarapa DHB Smokefree co-ordinator Linda Spence, and Whaiora quit smoking coaches Jaqs Lumsden and Helen Ropiha-Waiwai. PHOTO/EMILY IRELAND*

**Table 3.6**

| CalendarYear | Data<br>Hospitalised Smokers | Smokers Offered Advice | Inpatient Discharges Over 15 | Rate of Smokers Offered Advice | Rate of Smokers to Inpatient Discharges |
|---|---|---|---|---|---|
| 2015 | 31 | 24 | 270 | 77.4% | 11.5% |
| 2016 | 62 | 49 | 498 | 79.0% | 12.4% |
| 2017 | 93 | 85 | 595 | 91.4% | 15.6% |
| 2018 | 84 | 80 | 501 | 95.2% | 16.8% |

**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. WrDHB provides the funding and the RSSS delivers the programme with the Smoke Free Coordinator leading reviews planned for each quarter. Hapū Māmā has been operating for two years with slow but steady results. The Lead Maternity Carers (LMCs) and Hospital Midwives have increased their referral rates to the programme significantly over the past two years and are now the key referrer to the programme. Engagement onto the programme has been low and in response to this:

- A survey has been designed and emailed out to 60 past hapū māmā to determine any barriers to the programme.
- Three Pico baby smoke analyzers have been purchased by the WrDHB to help LMCs and hospital midwives engage with pregnant women who smoke.
- A half day training was organized with the NTS to teach the midwives and LMCs how to use the monitors correctly and also on vaping in pregnancy. The Smoke Free Coordinator will follow up to see how useful the monitors have been.

**Table 3.7**

**Hapū Māmā Programme Numbers 2018**

| **Referrals** | **83** |
|---|---|
| Hapū Māmā | 62 |
| Support person | 9 |
| Post | 12 |
| | |

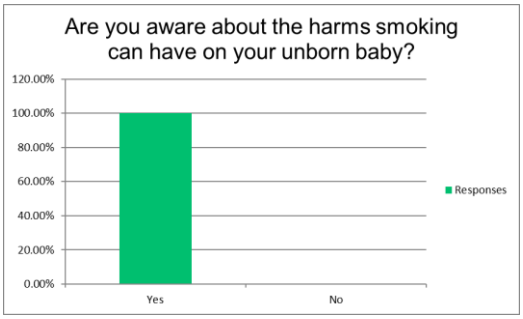
| **Referred by** | |
|---|---|
| Midwives | 47 |
| Family Start | 10 |
| Self-Referral | 12 |
| Tamariki Ora | 4 |

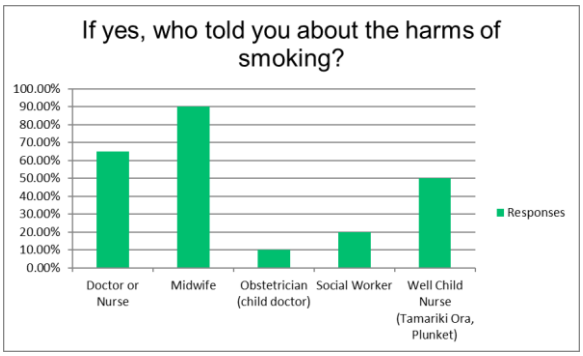
| **Outcome** | |
|---|---|
| Declined – Hapū Māmā | 12 |
| Did Not Engage | 17 |
| Joined but Did Not Complete | 21 |
| Completed Hapū Māmā | 12 |
| Completed Post Natal | 2 |
| Completed – Support person | 7 |

Below are the new Hapū Māmā postcards that are now widely distributed throughout the community and also on the website and education channel. Feedback from a recent survey identified the lack of advertising of the Hapū Māmā programme and so this will be a focus for us moving forward.


A total of 21 women participated in the online survey undertaken in early 2019 and key features are demonstrated below:

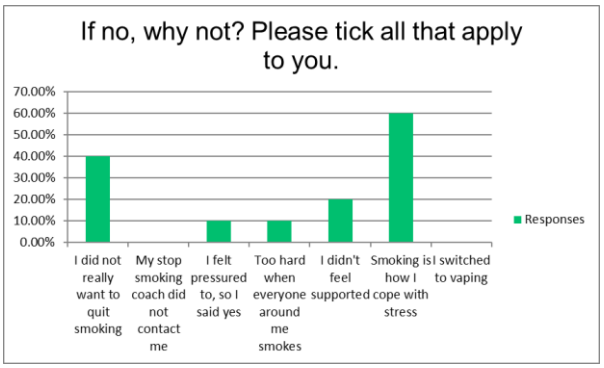
All girls knew the harms of smoking




The LMC referral rate is good the graph shows that all health professionals are appropriately discussing the harms of smoking.

Women were asked why they didn't give up smoking and results show that the relationship between smoking and stress is the predominant reason to not give up smoking.




The survey did highlight that there were 2 South Wairarapa women that did not know about the programme and this was a result of their care being provided by an LMC out of the region and choosing to birth in a neighbouring DHB.

It also identified 3 women that didn't require smoking support as they successfully stopped smoking as soon as they knew they were pregnant.

**Hapū Māmā Celebration**

The RSSS and the Smoke Free Coordinator planned a celebration of those girls who had successfully completed the programme in the past two years. The girls were treated to a pamper session with the students on the beauty course at UCOL, professional photos were taken of māmā and pēpē, a morning tea and a smokefree gift to thank them for coming. The photos will be used for future hapū māmā promotions.

Following on from Dr Lynne Russell's presentation and engagement in early 2018 the Smokefree Coordinator facilitated a health promotion campaign called "I quit smoking for my mokopuna". This focused on a number of nannies in our community that wanted to be an example for their whānau. The nannies shared their experiences of what drove them to quit smoking, below is Cindy's experience:

On World Smokefree Day 2017, Cindy Gillies-Adams smoked the last of the smokes she had on her and quit. She has been smokefree for a year now.

Cindy was nine years old when she started smoking -- influenced by '*….the older girls at the pool'.*

At the most, Cindy was smoking '*….about 20 rollies a day. My partner and I started to give up about 12 years ago -- he's been smokefree that whole time, but I've had the odd puff here and there and then I'd be back smoking. It's taken 12 years to finally kick it*.'

Cindy said the push for her to quit smoking was because she didn't want her grandkids thinking she smoked. On May 31 last year, Cindy smoked the rest of her smokes and *'….that was it".*

*"I know it was World Smokefree Day, however, that was my way of dealing with it - it was my last day ever. Boom."*

She said support from her friends had helped keep her smokefree.

*'Just keep at it. If you fall off the waka, so be it. Just pick yourself up and get back on it again.'*

# PREGNANCY & PARENTING EDUCATION

**Hospital Classes**

These classes have been offered free of charge to all birthing clients in Wairarapa. Currently classes run for a series of 6 evenings, lasting 2 – 2 ½ hours each evening. Based on site at the DHB in the CSSB building but including a visit to the Maternity department. Class sizes have been relatively stable with an average of 8 attendees plus support person per series.

In 2019 an online booking system has been launched through the Wairarapa Maternity website to capture registrations. Whilst manual collection is still available via detail collection at MSW reception, the digital collection is a more simple and efficient process for the Educator to contact the client and invite to a series suitable for her gestation.

Classes in 2019 have not been advertised with 'set dates'. This flexibility has allowed the educator to build classes at dates that suits client's gestation, preferably 28 weeks-33 weeks. This also ensures class sizes are suitable for the environment space size, manageable for the educator, personal and tailored for the class and allow interaction within small group scenarios.

**Qualitative Participant Feedback**

A simple handout/feedback questionnaire was being used by the DHB when I took over the classes in a permanent role in 2019. The questionnaire provides very little valuable data or information that would contribute to improving the quality of programme. I receive an enormous amount of positive verbal feedback from local LMCs and from the attendees but would like to develop a feedback tool that could assist in service improvement. Potentially an online feedback opportunity or a modified DHB feedback form. This opportunity will be explored with Midwifery Management and Maternity Quality Co-ordinator.

**Ethnicity data DHB classes**

| Ethnicity | | Ethnicity Participants | Number of Attendees not completing 75% of programme |
|---|---|---|---|
| NZ European | 43 | 57% | 2 |
| Maori | 18 | 24% | 1 |
| Indian *<br>- Sri Lanka | 6 | 8% | 1 |
| SE Asian *<br>- Filipino<br>- Vietnamese<br>- Cambodian | | | |
| Pacific Island | 1 | 1% | |
| Chinese | 1 | 1% | |
| Other Euro<br>- French | 5 | 7% | |
| South African | 1 | 1% | |
| **TOTAL 75 clients** | | | |

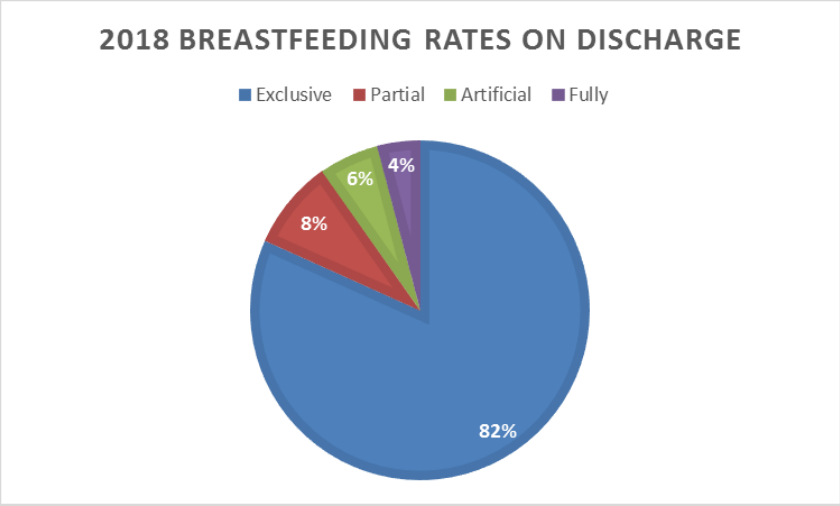
**Teen Parenting Unit**

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

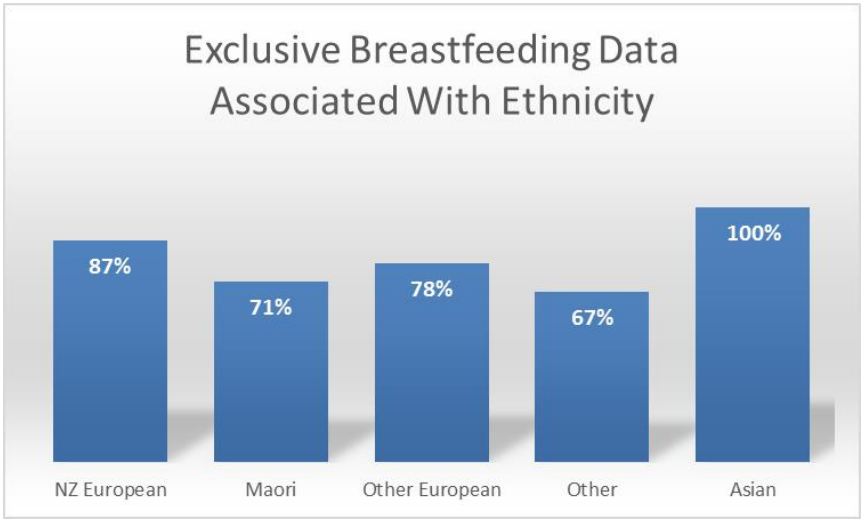
The 2018 saw another increase in the number of babies exclusively breastfed on discharge from 78 % in 2017 to 82% in 2018. . The presence of the lactation consultant / BFHI coordinator within the maternity and SCBU setting has ensured the ongoing high quality education is available to staff involved with breastfeeding women. She has also been instrumental in the development and continued weekly Little Latch on support sessions in the maternity unit. The DHB met the standards and achieved BFHI accreditation until 2022.

***Graph: 3.8***




In the table below there has also been a positive increase in the Asian population with 100% exclusively breastfeeding on discharge, Māori have increased to 71% from 67%, NZ European have increased to 87% from 80% while there was a reduction in remaining other populations.

***Graph: 3.9***




Little Latch on Sessions started at the maternity unit for mums that are inpatients and those in the first 6 weeks postnatal, they had low attendance initially. 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 2019**

The Big Latch On 2019 had many wāhine attending from hapū, breastfeeding, bottle feeding inclusive, through to toddlers, dads and nannies. We had 90 mums register, 77 latching, and 4 bottle feeding. The event showcased support services available locally from Wairarapa Maternity, Well Child Tamariki Ora, Plunket, Parents Centre, Breastfeeding Wairarapa, La Lache League, Smokefree, SPACE and the Māori Women's Welfare League. Wonderful Activities from the Carterton Littlies Childcare Centre and Playcentre Association for the toddlers, beautiful morning tea provided by Carterton New World and served by the Carterton Lionesses. A true community event and further sponsored goodies to give away to mums and babies, don't forget the dads, by local businesses.

# Section 3: MQSP Governance (MCGG)

## 3.1: Maternity Clinical Governance

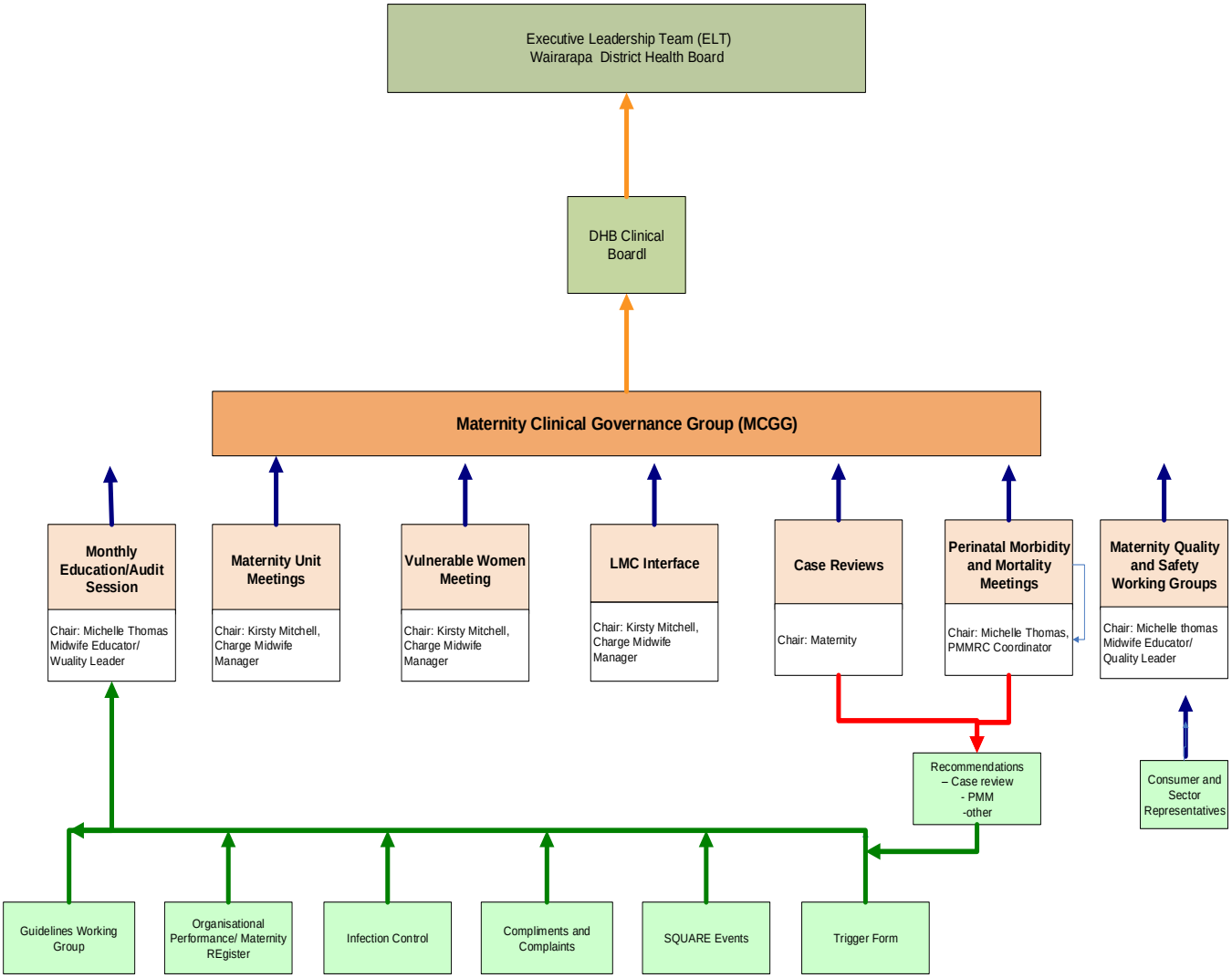
WrDHB established the Maternity Clinical Governance Group to oversee the Maternity Quality & Safety Programme. The group has had a very successful year of driving aims and objectives as set out for the 2013/2014 plan. The consumers have participated hugely in not only local issues but connecting also 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 2018/19

| Objective | Action | Progress | Completion |
|---|---|---|---|
| Introduce GROW/GAP into the Wairarapa maternity service meeting PMMRC recommendations. | ○ Involve IT services in setting it up within WrDHB<br>○ Support training requirements for all clinicians to be able to use it<br>○ Implementation of the Growth Assessment Programme and follow data collection and audit. | GROW app is available on the midwifery workspace.<br>The GAP training has been delivered to obstetricians and midwives in the region. WrDHB had decided to await the data collection and auditing supporting the GAP programme while negotiations continue for funding through ACC. |  |
| Providing safe sleep devices for Māori /Pacifika population | ○ Provide pēpi pod devices to all that require them. This programme does not have a criteria at WrDHB but be available for all babies that are at risk or whom may be in a bed with a parent.<br>○ For wahakura to be available for Māori / Pacifika | The Māori Health Directorate has worked hard to source a provider of wahakura for WrDHB.<br>Wānanga will be held for health professionals prior to the implementation of the programme and distribution of wahakura. |  |
| Develop an educational channel available to women while having their inpatient stay at WrDHB | ○ Quotes for tvs have been authorised<br>○ Agreement from the producer to develop the channel<br>○ Posters to be designed advertising the education channel | The education channel has been developed and is now available on the tvs in each postnatal room along with being available on the Wairarapa maternity website for when women go home. |  |
| Implement a hapū wānanga programme. | ○ Following re-evaluation and consultation with Māori Health Directorate wānanga will be held for weaving of wahakura<br>○ Progress to wānanga for hapū māmā and whānau These wānanga will offer opportunities to receive positive hauora messages such as smokefree environments, breastfeeding and health and nutrition. | Initital wahakura wānanga held with local weavers.<br><br>Progression to a hapū wānanga programme is still under consultation. |  |

# 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, 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. The maternity unit continues to capture feedback in the form of a written survey and are moving toward using an electronic survey with Ipads by 2020. 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.

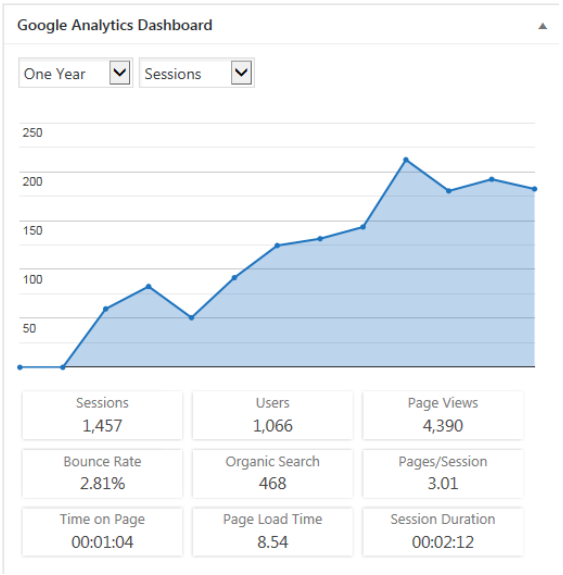
# MATERNITY WEBSITE

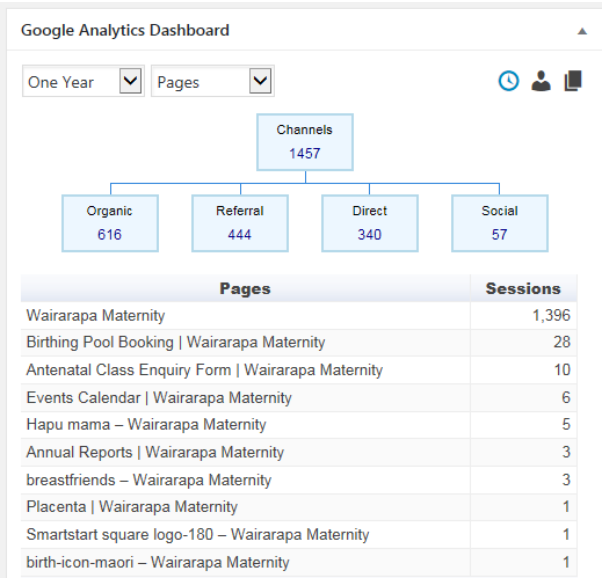

Wairarapa maternity has a new website that has required an initial outlay of set up costs but will continue with a small administration fee over the year at a significant reduction from the previous hosting. While the website does not sit on the WrDHB platform the decision to have an alternative platform was that we want it to be easy to navigate and interactive with the community and in time may have the potential to have live streaming of antenatal or breastfeeding sessions. The layout of the website means that it is easy to follow on PC or android device. The design of the website had the input of a web designer, midwife and 2 consumers it was also important to ensure that the design was able to be followed through to the pēpē ora website. The website displays information for pregnant women and whānau in relation to pregnancy, birth and postnatal, and links with support groups and many other services accessible for women both locally and nationally.


Registering for antenatal classes is now completed online and the booking of the birth pool for women choosing to homebirth is provided in the calendar.

We have also put the education channel on the website so it is accessible for women and whānau at home if they wish to view parts of it again or if they did not get the opportunity to see it all in hospital. It has also been viewed by expectant mums in other regions of New Zealand and we have received very positive feedback regarding its content and presentation.

Data collected of views and use of the website will be an advantage to continue with the updating and maintenance of the website and observing where women's interests are online.




| Pages | Sessions |
|---|---|
| Wairarapa Maternity | 1,396 |
| Birthing Pool Booking \| Wairarapa Maternity | 28 |
| Antenatal Class Enquiry Form \| Wairarapa Maternity | 10 |
| Events Calendar \| Wairarapa Maternity | 6 |
| Hapu mama – Wairarapa Maternity | 5 |
| Annual Reports \| Wairarapa Maternity | 3 |
| breastfriends – Wairarapa Maternity | 3 |
| Placenta \| Wairarapa Maternity | 1 |
| Smartstart square logo-180 – Wairarapa Maternity | 1 |
| birth-icon-maori – Wairarapa Maternity | 1 |

The launch of the website was celebrated with the purchase of fridge magnets that have been distributed with LMC midwives and are given to women at first registration encouraging them to utilize the website in informing their research and education of their pregnancy, labour, birth and preparation for parenting.


## MATERNAL MENTAL HEALTH

Maternal Mental Health services continue to meet the needs of women in the community through the Consultation – Liaison nurse whom provides 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 for women with pre-existing mental health conditions.

The pathway for access to the clinical liaison nurse and acute mental health services works efficiently and there are no barriers to accessibility. 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.

Over the previous year there have been women that have required admission and specialling in maternity, while plans were made for appropriate care. The multi-disciplinary approach to the women's care ensured her safety and wellbeing was paramount.

2018 data shows that there has been a 3 % increase in the number of women accessing and receiving consultation/liaison from the Maternal Mental Health Clinician with 53 women being seen equating to 12% of women pregnant and birthing in our region.

Referrals into the service were via the following:

- 27 from primary health (includes FP, Family Start, Primary mental health nurses)
- 19 from LMC midwives
- 7 from adult mental health service.

33 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 continues to be a multi-disciplinary team whom 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. Support plans are now accessible on concerto so anyone involved in the woman's care within the DHB setting and GP's can be fully informed of the care plan. 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: 3.1***

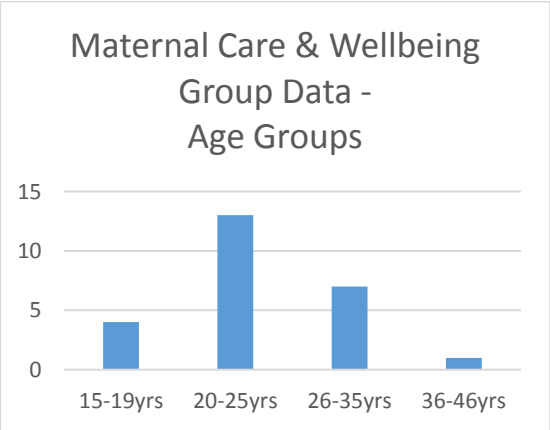
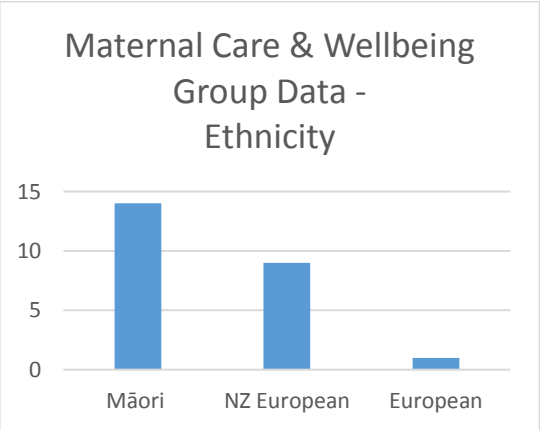



***Table: 3.2***




The tables above show an increase in the 20-25 yr olds and an increase for Māori on the group in comparison to the 2017 year.

***Table: 3.3***

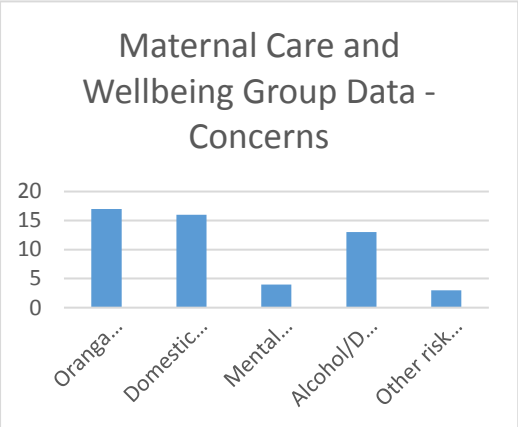
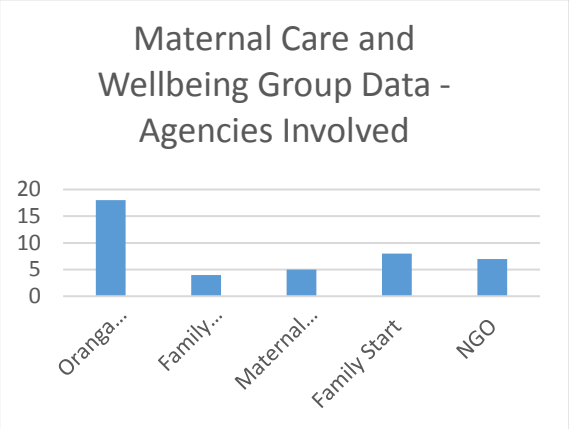



***Table: 3.4***




Concerns and reasons for the women being referred to the group varied and most had multiple reasons for complexities supporting the referral being made.

# Section 4: Quality Improvement

## EARLY PREGNANCY MANAGEMENT

Early pregnancy loss became a focus for the MCGG when consumer feedback entered the Quality & Risk Department in the form of complaints following the care or lack thereof experienced by women that attended WrDHB Emergency Department experiencing a miscarriage. The complaints were of such a nature they prompted a response with the maternity unit leading an Early Bleeding Disorders in Pregnancy project. Feedback from medical, nursing and midwifery professions has highlighted the frustration that they have in both the primary and secondary settings with accessing and providing a seamless approach to women and their whānau experiencing early pregnancy loss.

A team was developed with representation from Obstetrics / Gynaecology, maternity, emergency department and a consumer, a project charter was developed to keep the project focused. The team met regularly initially to identify what the problem was, what issues there were in the system, interfacing between primary and secondary.

With the emergency department not being the appropriate place for women to receive treatment unless acutely unwell and access to a scheduled gynae clinic potentially causing up to a week delay, the best way forward for women to receive efficient and appropriate treatment was to have direct access to the antenatal clinic midwife. Utilising this new role LMC's and GP's could refer to the clinic midwife and she could triage and prioritise next steps in management and / or treatment. A guideline was developed for referral into the antenatal clinic midwife for triage, the obstetrician for urgent guidance or emergency department for immediate care. The electronic Healthcare Pathway was updated for primary care clinicians and a roadshow completed to inform primary care of the change. An information leaflet was designed and included national miscarriage websites so women were able to consider their choices with regard to management if the pregnancy loss was confirmed. It seemed that historically due to time delays in getting access following a complicated referral process women were often weeks down the track and often best advised for surgical management as the opportunity for medical had passed.

Follow-up care and communication is crucial in this situation it was clearly identified early in the project that this was something that women were not experiencing. Since introducing the new referral pathway women have expressed appreciation at having the antenatal clinic midwife phone them to follow up on how they are doing, arrange follow-up bloods and scans dependant on outcomes of phone consults, co-ordinate medical/surgical process if required.

## HAPŪ WĀNANGA

During early 2018 there was the intention to move forward with wahakura wānanga providing whānau the opportunity to make their own wahakura, however due to external constraints these wānanga did not progress any further. The intention behind the project was to ensure opportunities were offered to receive positive hauora messages such as smokefree environments, breastfeeding and health and nutrition. The engagement with weavers remains something that we would like to pursue and further opportunity for this

may arise in the not too distant future. In the meantime we have been fortunate to contract Jenny Firmin of Whanganui, and a long time established weaver of wahakura to weave 30 wahakura and provide wahakura knowledge and training to LMCs, midwives and possibly other appropriate staff commencing 2020.

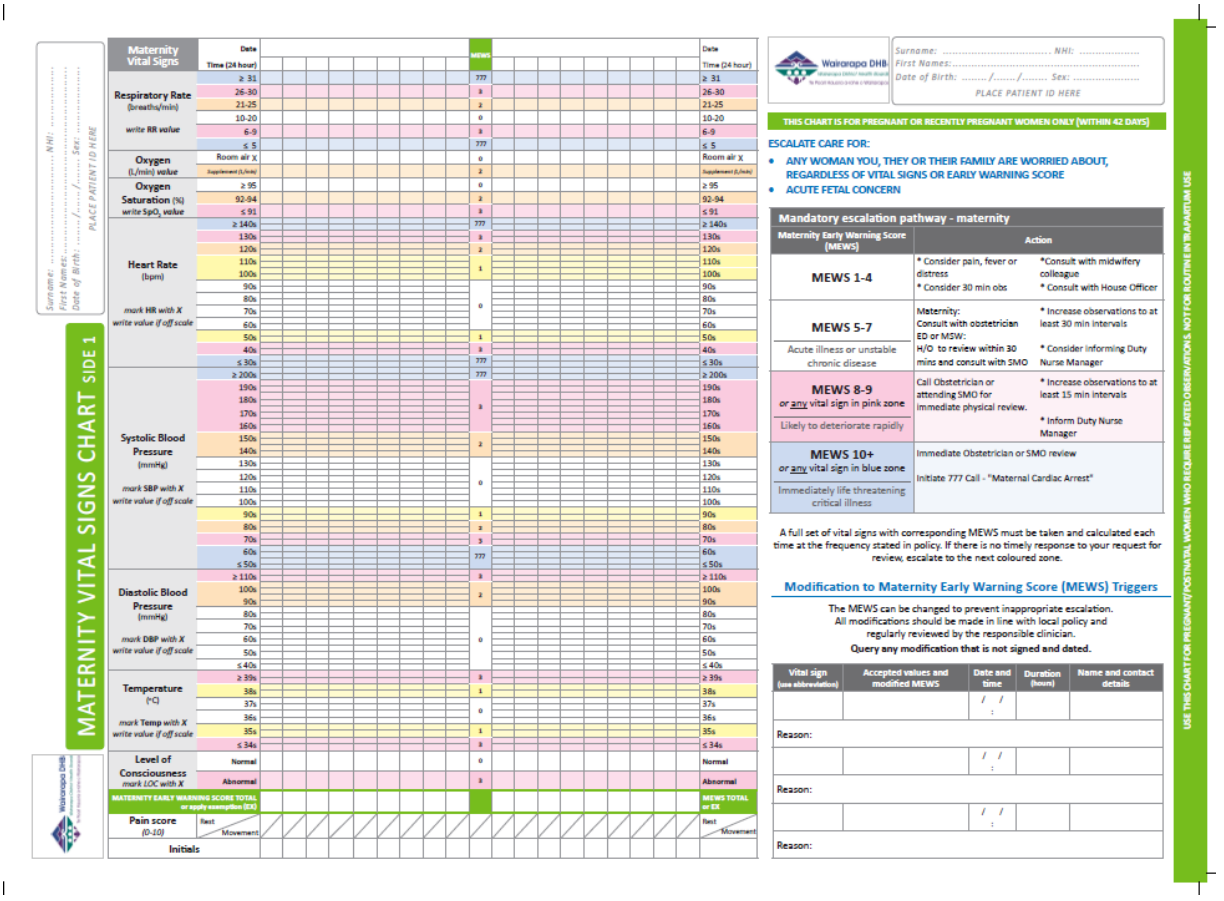
While the priority for hapū wānanga has been in the MQSP Project Plan for several years and advancing it has been challenging the 2018/19 year has seen several discussions regarding resources and progressing Hapū Wānanga. While there is much deliberation and no firm agreement on how this is to be moved forward the anticipation of a new CEO and DHB Board we hope will provide the leverage to prioritise this with some funding and resource embedding it as business as usual. Meanwhile discussions with the Māori Health Directorate and providers from other areas willing to share their programmes for the Wairarapa to localise have been encouraging. We are fortunate to have Māori midwives in our community now that will be an amazing source of knowledge and expertise to support and guide alongside local Iwi to build a programme that will be motivational, inspirational and meeting the needs of Māori.

## MATERNITY EARLY WARNING SCORE CHART

WrDHB was invited to participate in the first cohort of implementing the national Maternity Early Warning Score chart (MEWS). March 2019 saw the first workshop with HQSC with a team of an obstetrician, midwife educator and core midwife attending and receiving the resources and guidance to return to WrDHB to commence implementing the programme.

The initial months were spent creating a project charter, collaborating with colleagues regarding the escalation pathway and meeting an agreed pathway. Education was provided throughout the hospital as the decision was made to do a whole hospital roll out due to the small size of the hospital. Engagement was excellent and the interest and uptake was positive, we were fortunate enough to have Dr Matt Drane from Auckland DHB visit SMO's and share his experience of the piloting of MEWS in Auckland.

July 1st is the planned roll out of the MEWS chart, monitoring and auditing of the chart will be undertaken over the next year and feedback provided in the 2020 MQSP Annual Report.




# 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.

Below is the experience of a consumer whom has attended hypnobirthing and felt it important to share the impact of her experience:

*"I cannot speak highly enough of Hypnobirthing.*

*My husband and I both practiced hypnobirthing for both Labours.*

*We have two children as I write this. Our Son is 20 months old and our daughter is 6 weeks.*

*Our son was 2 weeks overdue (sleeping in) and I was scheduled to go in to be induced. The night before, we met with Carole to do some relaxation techniques in hopes that in the morning, the hypnobirthing information was fresh in our minds and I walked into the hospital with a 'healing room' mindset. We left the maternity unit at 9pm.*

*That same night at 10.30pm, my waters broke at home.*

*Yay - I had never been so excited! Strange as I entered this journey with the greatest amount of fear.*

*I went to the hospital to meet with my midwife. I think this is where I things slowed down as due to demand for beds, I was admitted so that could stay to be induced as I was not dilating. Surges had already begun and I was practising the surge breathing.*

*Once I was induced in the morning to assist with dilation, I started to feel my mind shift from the healing room to the emergency room and it was a real battle to focus of fear release. More people we getting involved and I felt like decisions were being removed from me.*

*My husband and my mother helped take hold of this so that I felt amongst all that was happening that I was given clear information and was able to ask them "do we have to have these particular interventions or is my baby ok an can we wait"?*

*My main focus during the journey of my son entering the world was to keep as much of what was going on in my control. I knew each surge I was getting closer to meeting him and this was not a permanent state that we were in. I chose not to have any pain relief and solely relied on the hypnobirthing techniques to get through.*

*During the first 12 hours in hospital, we discovered that my son was posterior and was having difficulty engaging. We tried to assist in moving him and allowing him to do some of the work. Surges were a consistant 3 minutes apart from the get-go. I had no idea or concept of time, apart from when it became dark at night. Over the night, my mum took over from my husband and we practiced the inverted thermometer when surges were stronger than others. Having the ability to try and focus on something else created the 'challenge' I needed at that time. It is what I held on to, and taking myself to my happy place and visualising a space as indepth as I could. I didn't realise that through some of these, although I could still feel what was going on, I was actually able to sleep.*

*The next morning, as I still was not dilating enough, I was put on a Syntocinon IV. my son's heart rate had started to drop at this point and he was then monitored by a fetal scalp monitor. This meant the water birth I wanted was not able to happen.*

*At this point I did honestly feel somewhat upset because all that I had put in my birth preference was being crossed off, however, I kept holding on to the hypnobirthing techniques. The syntocinon IV was in for 4 hours and after that point I was in active labour. After 35 hours I was pretty tired to say the least. My pushing was not as strong as it probably should have been, but with the end in sight and some words from my midwife (let's do this before the Obstetrician arrives), my son was born after 40 hours of labouring him into this world.*

*The experience was long in hindsight although at the time, it didn't factor, but it was amazing.*

*Even though he took his time arriving, even though my preferences went out the window. There were still the most important things that were achieved;*

- *No pain relief (allowed me to stay in control of my body and mind)*
- *I didn't scream or yell, I managed to breathe and stay calm*
- *My son was born healthy and without escalating to a surgical intervention*
- *My husband was an active part of the experience. (And my mum, who I leant to book to read)*
- *I was able to make informed decisions and have the voice I feared losing through the process.*

*I simply wouldn't have achieved this without practicing hypnobirthing. I even used the techniques to overcome my fear of needles through the pregnancy process in preparation for birth.*

*I remember the next day lying in hospital with my son next to me saying "I could do this again".*

*9 months later….*

*I found out I was pregnant with our daughter. This time we signed up for Spinning Babies as well as Hypnobirthing so that we could make the experience better than the first.*

*Knowing that our son was overdue and mainly because of positioning, the spinning babies complimented the hypnobirthing practice.*

*Our daughter up until 39 weeks was not positioned properly, we were able to use the spinning babies tools to aid her into finding her way.*

*41 weeks and I started to feel a little 'strange'. Surges started at 10.30pm and although I did not recognise them as such, I couldn't sleep or stay still. I said to my husband that he should probably get some sleep as it was just him and I this time, and it was likely (in my mind) that this would day another couple of days.*

*I kept moving, doing lunges in the lounge and remember the surge breathing whilst watching home and garden TV. At 2.15am, I was not able to walk, sit down, stand but in my mind I was playing this down and telling myself that it would be longer and stronger soon and to stay at home for as long as possible. I rang my midwife to give her a courtesy call to put her on notice. In my mind, I was still a long way away from birthing our daughter. She reassured me to stay at home for as long as I felt safe to.*

*3.am - I arrived in hospital. I was 3cm dilated (this was huge for me as I spent 30+ hours at 2cm). My surges were 2 mins apart. I decided to get into the birthing pool (only thinking I would be there to loosen things up and get out). Surges escalated,*

*within half an hour. It was just my husband and I in the room with my midwife (lifeguard) in the background. All of a sudden during one of my strongest surges yet, my waters broke. I remember feeling the need to bear down and begin to push, but was confused and not sure if this was 'time' to do so. It was indeed time and in what felt like 5 minutes (an hour) I had J breathed my daughter calmly into the water. She looked up at me without crying and we just stared at each other. This was at 4.36am.*

*I was amazed. We had the 'perfect' birth that was total opposite to previously.*

- *A beautiful calm baby*
- *Delayed cord clamping*
- *Physiological birthing of the placenta*
- *No interventions*
- *In an 8th of the time!*

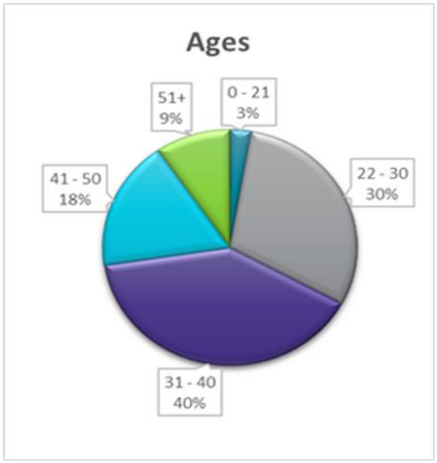
*I am in ore of the process. Each delivery was totally different. The second did feel stronger in my opinion but was over faster. Either way I was in control of my body and listened to my baby.*

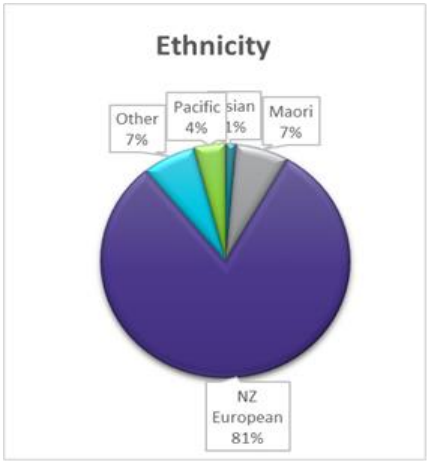
*Thank you Carole from the bottom of our hearts for the knowledge you have given us and all the support you provide to our community. We are so lucky to have you here and I am sure you are going to be very busy as I share this information far and wide as I think every family expecting should have this knowledge. It has so much to do with how we could not only birth and welcoming loved ones into this world, but pass on how we treat others and experiences on this earth."*

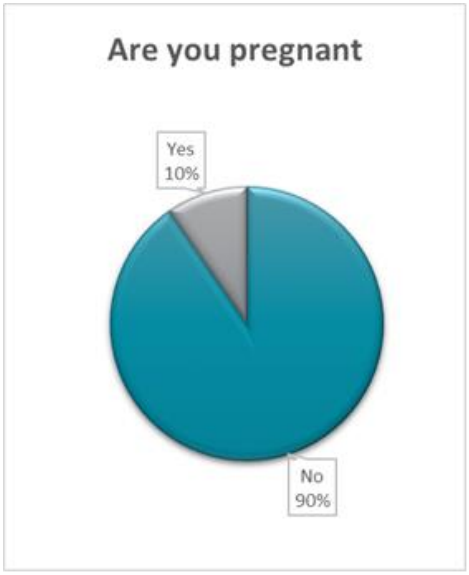

# PĒPĒ ORA


This year the Pēpē Ora Expo was held in Featherston, South Wairarapa in March and saw over 200 patrons attending. On evaluation of the event the host group Wairarapa Breastfeeding Committee will look to hold this again in 2020. The success of the day was the stall holders that were able to come along sharing the wonderful things they are doing in the community from fruit and vegetable growers, dental hygiene, baby wearing, play centres, well child services, hypnobirthing and safe sleep. The variety of stalls offered the opportunity to educate and share information along with free samples, gifts and goody bags. While parents and whānau took this opportunity children were occupied with Zappo the magician, balloon making and a visit from Chase from Paw Patrol.

Below is the data captured of those that attended:

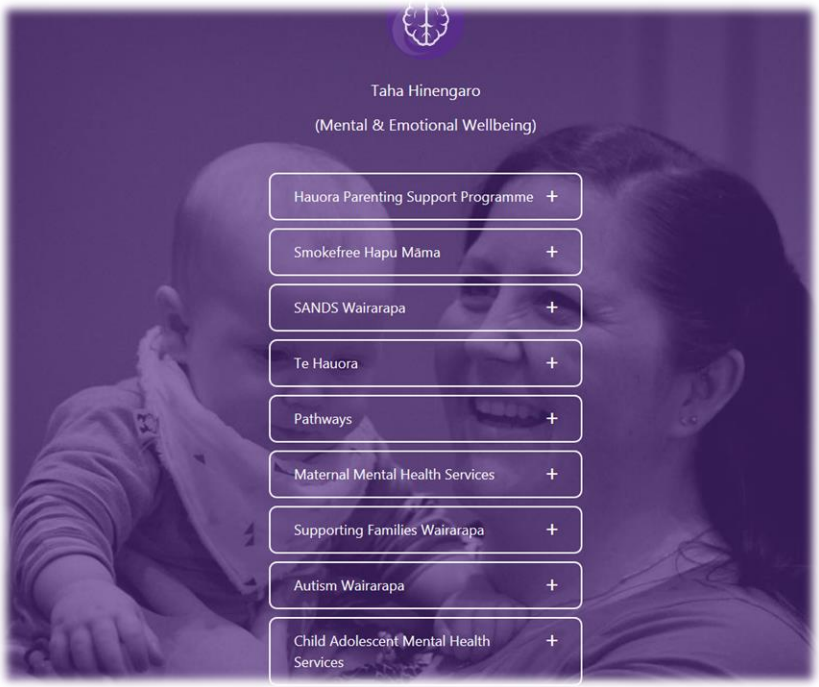



This year we have seen the launch of the Pēpe Ora Website which began at the Wairarapa Big Latch On 2019 community event. Much of the focus is on Action Planning as we are looking to strategise how the work can be progressed and recommendations from within the Pēpe Ora survey. The website was developed to mirror the Wairarapa Maternity website thus providing a cohesive approach to the wellbeing of mama and tamariki.

"Pēpē Ora is our communities supporting the wellbeing of our Wairarapa babies and mums, dads, caregivers and whānau. Pēpē Ora hopes to enable our babies to get the best start in life through access to information and multiple support services for prenatal and postnatal care, through to school age". Go to [www.pēpeora.nz](http://www.pēpeora.nz)




The website hosts information, local community supports and links to national websites. It comprises Taha Tinana, Taha Hinengaro, Taha Wairua and Taha Whānau and emergency contacts. The vision is for the website to be a platform that will be interactive and have the potential to live stream breastfeeding support / discussions and components of parenting education.

# Maternity Quality & Safety Programme

## Programme Plan

2019 – 2020

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**

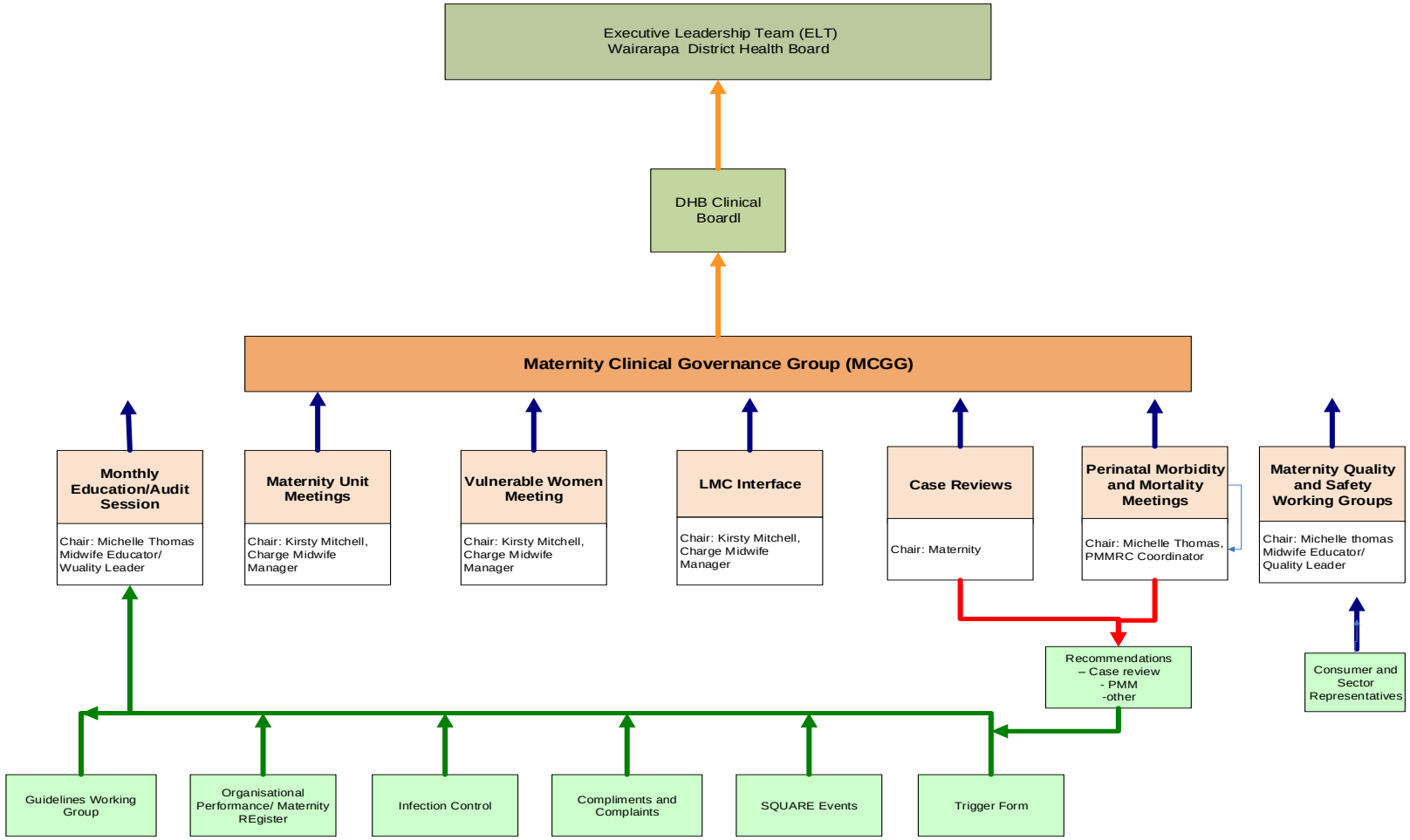
**To ensure consumer engagement and participation**

**That we put the woman 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.<br>Ensure consistent approach to data collection and reporting.<br><br>Improved information sharing between maternity service and GP services when women and babies are discharged. | ○ Engagement with MOH regarding implementation of the MCIS has occurred as a 3DHB approach due to IT services including CCDHB, HVDHB and WrDHB. Driving this will be complex as the 3 DHB's have differing platforms but WrDHB is willing to be the first to implement, funding processes allowing.<br><br>○ Discharge summaries will be available to midwives for completion and | An electronic system that is robust will be fully functioning and accessible in the maternity service.<br><br>Mechanisms in place to evaluate information/reporting | MQSP Coordinator and IT Services. | As soon as possible |

| | | | | | |
|---|---|---|---|---|---|
| | | sharing with LMC's and GP's in Jan 2020. | | | |
| 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<br>○ Grow our own Māori midwives and ring fence FTE for new graduate positions<br>○ 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<br>○ Antenatal clinic midwife role becomes a permanent FTE structure. | Maternity Clinical Governance Group | Start date:<br>August 2018<br>Due date:<br>May 2019 |
| Implement a safe sleep devices programme for pēpē | To ensure all pēpē born in the Wairarapa are offered a safe sleep device.<br>At risk pēpē are a priority and education with whānau is paramount. | ○ Increase capability to purchase pēpi pods and wahakura<br>○ Encourage and enable midwives to confidently discuss safe sleep education<br>○ Establish local wahakura weaving groups that can work with hapū māmā and whānau. These wānanga will offer opportunities to receive positive hauora messages such as | ○ Data collection and analysis of pēpi pods and wahakura distributed with education to whānau<br>○ Wānanga attended by hapū māmā and whānau | Maternity<br>Māori Health Directorate<br>Smoke cessation services<br>Funding and Planning<br>TAS | Start Date:<br>July 2018<br>Finish Date:<br>Ongoing |

| | | | | | |
|---|---|---|---|---|---|
| | | smokefree environments, breastfeeding and health and nutrition.<br>○ Hold a training day with inspiration speakers on the key topics of: Safe sleep, smoke cessation, breastfeeding, shaken baby prevention.<br>○ 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<br>○ Involve IT Services in setting it up | ○ Consumers participating in the survey<br>○ Data available | MQSP Coordinator & IT Services | Dec 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 wellbeing will offer | ○ 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 2019 |

| | | | | | |
|---|---|---|---|---|---|
| | opportunity for labour to continue working toward a vaginal birth. | | | | |
| Providing antenatal education for Māori /Pasifika population - hapū wānanga | ○ To provide an antenatal programme specifically for Māori /Pasifika women and whānau.<br>○ 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.<br>○ Set time line from outcomes of meeting held<br>○ Support local Māori new graduate midwives in their chosen LMC or DHB role. | ○ Hapū wānanga programme in the Wairarapa community. | Maternity Clinical Governance Group, Māori Health Directorate. | Ongoing |

# 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 WrDHB |
| **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 WrDHB 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**

WrDHB 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 WrDHB 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. 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. 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 DOM, Charge Midwife Manager, RM, Obstetrician.
- Planning & Performance
- Māori Health Directorate
- A LMC representative
- Tū Ora Compass Health
- Regional Public 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 Operations |
| Charge Midwife Manager |
| Core Midwife |
| LMC Representative |
| Maternity Quality and Safety Coordinator |
| Māori Health Coordinator |
| Planning & Performance |
| Tū Ora 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