HUTTmaternity

Hutt Valley Maternity Care

Maternity Services Annual Clinical Report 2012

www.huttmaternity.org.nz

HUTT VALLEY DHB

We would like to acknowledge the contribution of:

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- HVDHB Community Midwives Team
- HVDHB Lactation Consultant
- Maternity Clinical Governance Group
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Published by Hutt Valley DHB June 2013

Message from the Executive Officer, Hutt Valley and Wairarapa DHBs

Maternity services are a significant part of the healthcare services we and our partners provide. The staff involved are committed to delivering high quality services, both now and into the future. This annual report, and future reports, will be helpful tools in delivering on that commitment.

The reality and pressure of day to day healthcare means that it is not always easy to look to the future, or to engage in service planning. Having good data and trend analysis easily to hand will make it easier to do so.

The development of a strategic plan in 2012, now being measured against, is also a significant step forward. Having a pathway to guide service development and improvement increases confidence in making changes, and in keeping a clear focus on the future.

I thank those who have been involved in preparing this report, and I encourage them to share the key themes, successes, and opportunities with all staff involved in maternity services. The goal of any report such as this is not simply preparing a report, but for the main points of that report to be shared - so that it can inform and influence the future of services in the Hutt Valley.

Don't keep this report in the bottom drawer. Use it to help us improve services, and to contribute in a concrete way to achieving our vision of healthy people, healthy families, healthy communities.

Richard Schmidt
Executive Officer, Wairarapa and Hutt Valley DHBs

Message from the Chair, Maternity Clinical Governance Group (MCGG)

Welcome to Hutt Maternity’s inaugural annual clinical report. Throughout the year the Hutt Maternity team has worked together to provide the best care for our community’s mothers and babies. An annual clinical report gives us the opportunity to reflect our core business, it is an opportunity to examine trends, to look at the work we have done well and to see what we can do better. It is a showcase for our innovations.

Maternity is multifaceted with many people working together and increasingly not only are we working across professions but across the sub-region, region and nationally. An annual clinical report is an opportunity to show that ’the whole is more than the sum of its parts’.

Jo McMullan
Clinical Midwifery Manager

Hutt Valley DHB Vision, Mission and Values

Whanau Ora ki te Awakairangi

Vision Healthy People, Healthy Families, Healthy Communities

Whanau Ora ki te Awakairangi

Mission Working together for health and wellbeing

Values 'Can do' – leading, innovating and acting courageously

Working together with passion, energy and commitment

Trust through openness, honesty, respect and integrity

Striving for excellence

Contents

Executive Summary

The resourced focus on quality improvement, through the Maternity Quality and Safety Programme (MQSP) has afforded us the opportunity to publish our first annual maternity clinical report. The ability to pull together existing and new data has assisted in identifying not only our areas of development but also our areas of strength. This report is part of Ministry of Health requirements under the Maternity Quality and Safety Programme introduced in the 2012 calendar year. The Maternity Quality and Safety Programme aims to improve maternity care in New Zealand for women and their babies.

Our report, in the first section, sets the context of our service by describing our DHB's demographic which is slightly more Maori, younger and urban than the national average; with Maori and Pacific people over-represented in the most deprived areas.

The second section describes our service and how we work. In our district we care for approximately 2000 births per year. Although the birth numbers have decreased over the last five years the complexity of the health of our women has increased, leading to the re-location of our antenatal services and introduction of an early pregnancy assessment clinic and combined obstetric/diabetic clinic.

The New Zealand Maternity Clinical Indicators are reviewed in section three. The indicators provide clinically based information and analysis on Hutt Maternity services for the twelve national Key Performance Indicators. There is a small increase in vaginal births above the national average and, although it is not statistically significant, may be the beginning of a trend in conjunction with the decrease in caesarean section and induction of labour rates. The increase in blood transfusions after caesarean section has led us to look more closely at our postpartum haemorrhage management through a comprehensive audit due to commence late 2013.

Section four concentrates on quality and safety: how we engage nationally, regionally and internally with quality processes. The establishment of the Maternity Clinical Governance Group is envisioned to facilitate recommendations, govern implementation and accountability through the specific work streams: data, dashboard and documentation; sector and consumer engagement, and strategic planning.

The last section of the report indicates our response to the data collected 2009-2011, recommendations from the Perinatal Maternal Mortality Review Committee (PMMRC), Ministry of Health imperatives and the needs of our community. Our intention is to focus on innovations in the areas of maternal mental health, reduction in smoking, early registration with a maternity carer, maternal and child nutrition, and seamless linkages between obstetrics and medicine.

We envisage that subsequent reports will evolve in time and the opportunity to concentrate on refining our data to reflect accurately what we do is an area that needs further work. The

key driver of quality and safety will be the Maternity Clinical Governance Group (MCGG), working alongside the DHB maternity stakeholders, to drive our commitment to improve care for the women, babies and whanau of our community.

Section One: Hutt Valley Population and Health Profile Demographics

Hutt Valley Population

Hutt Valley DHB is home to 3 percent of the national population. Geographically it is an urban DHB, covering two territorial authorities: Hutt City and Upper Hutt City. Our neighbouring DHBs are Capital & Coast DHB, and Wairarapa DHB.

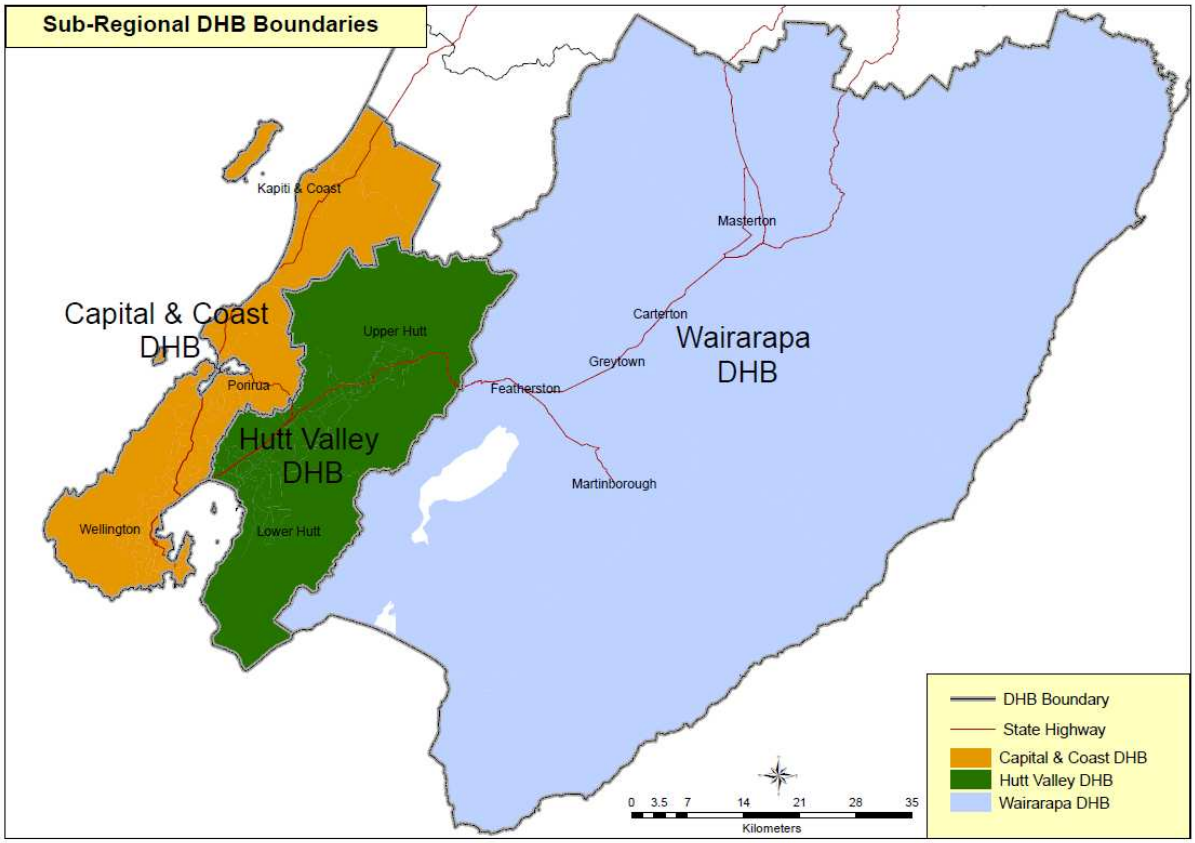
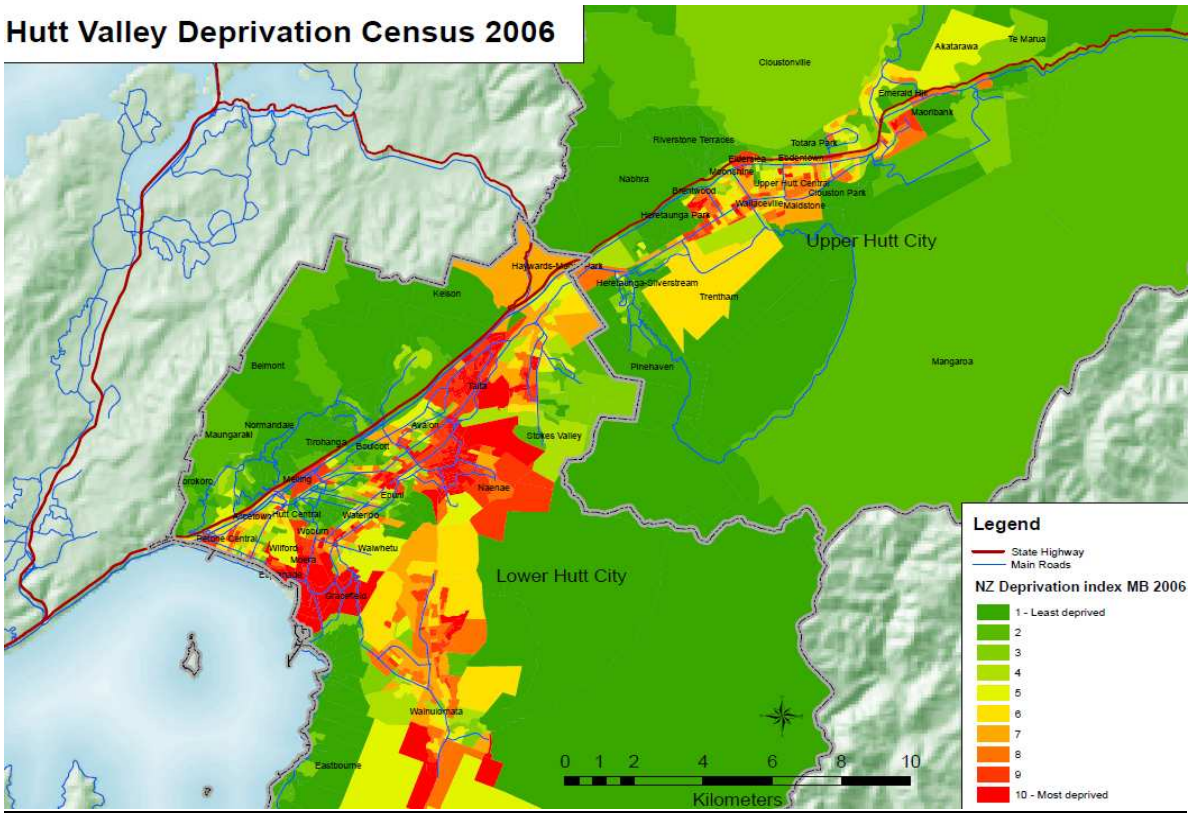


Table 1. Estimated Hutt Valley Population in 2012

Age Band	Maori		Pacific		Asian		Other		Total
< 15 yrs	8,620	28%	3,620	12%	2,760	9%	16,030	52%	31,030
15-19	2,440	23%	1,070	10%	790	8%	6,110	59%	10,410
20-24	2,260	22%	1,020	10%	870	9%	6,040	59%	10,190
25-29	1,660	19%	900	10%	1,070	12%	5,230	59%	8,860
30-34	1,610	18%	870	10%	980	11%	5,280	60%	8,740
35-39	1,680	18%	880	9%	880	9%	6,020	64%	9,460
40+	6,980	11%	3,620	5%	4,860	7%	50,590	77%	66,050
Total	**25,250**		**11,980**		**12,210**		**95,300**		**144,740**

Table 2. Estimated Hutt Valley Female Population of Child Bearing age in 2012

Age Band	Maori		Pacific		Asian		Other		Total
15-19	1,200	24%	510	10%	380	7%	2,970	59%	5,060
21-24	1,100	23%	500	10%	430	9%	2,840	58%	4,870
25-29	890	20%	450	10%	510	11%	2,640	59%	4,490
30-34	830	18%	450	10%	490	11%	2,750	61%	4,520
35-39	900	18%	420	8%	480	10%	3,140	64%	4,940
40-44	880	16%	370	7%	440	8%	3,770	69%	5,460
Total	**5,800**		**2,700**		**2,730**		**18,110**		**29,340**



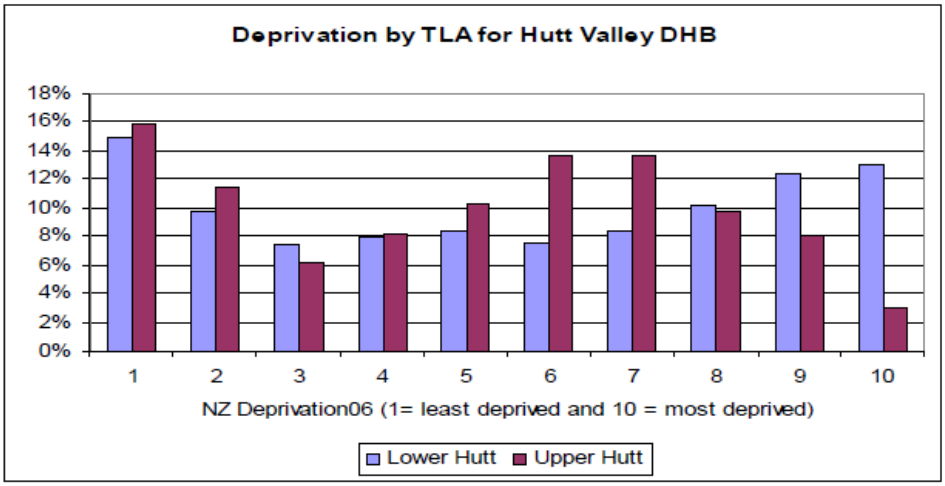
Key features of our population:

Our population is currently approximately 144,740[1], projected to increase to around 146,805 by 2026

- Population distribution (age, gender, ethnicity) is similar to the New Zealand population, but with a slightly higher proportion of Maori (17.6%) and Pacific people (8%), when compared to the national average
- Our population is currently slightly younger than the national average
- 70% of the population reside in Lower Hutt

[1] 2012 NZ Stats Population Projections

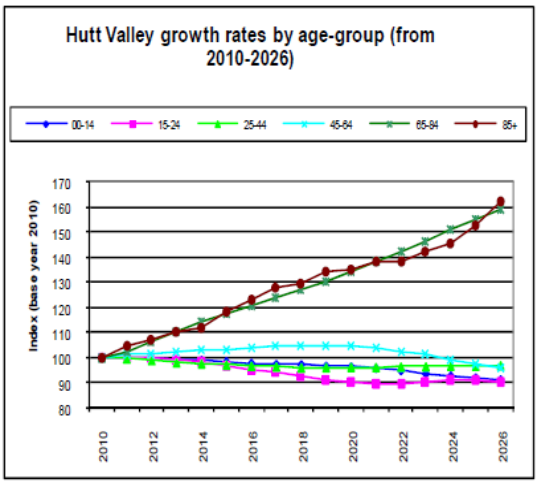
- The proportion of people residing in urban areas (98.1%) is higher than the national rate (86%).
- There is variation in the level of deprivation across the Hutt Valley, with 25% of Lower Hutt within Quintile 5, compared with 11% within Upper Hutt (compared to an average of 20%). This is shown in the graph below.

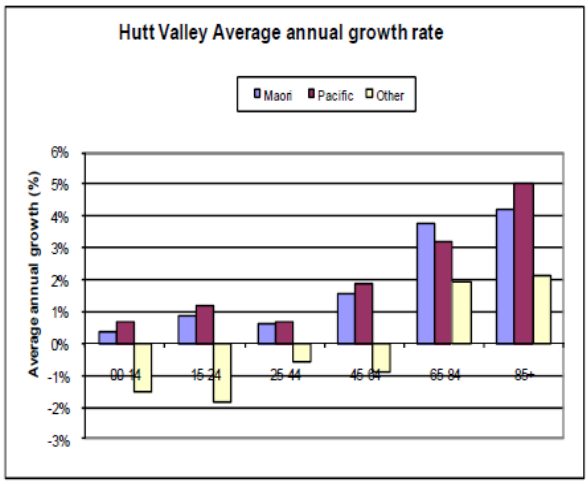


- Maori and Pacific people are over represented in the most deprived areas.
- Information available from Census data indicates that an estimated 27,000 (17%) Hutt Valley residents have some form of disability and around 16,000 of those people are younger than 65 years. Most disabled people live in the community, with only 13% of older disabled people in residential care and less than 1% of disabled people under the age of 65 in residential care.

Our population demographic is projected to change over time. On current projections, by 2026:

- We will have more Maori (20%) and Pacific people (10%).
- We will have more people who are older (19% of our population will be 65 years+.





Our Health Profile

The Hutt Valley DHB's health profile is gained through a comprehensive Health Needs Assessment (HNA)[2] that describes our population and their health status. A clear understanding of our population's health status and the conditions and illnesses prevalent in our district helps us focus on the right priorities to meet the needs of our population. The following information is drawn from the 2008 HNA and is being revised during 2012. Key features include:

Health behaviours and risk factors

Our population's rates for health risk factors are broadly similar to the national rates, i.e. for smoking prevalence, physical activity, hazardous drinking, obesity, high cholesterol, and high blood pressure. Worse or significantly worse rates, when compared with national figures, occur for:

- Consumption of fruit and vegetables.
- Breastfeeding.

Health status

When compared with national figures, our population experiences:

- Higher population rates of chronic conditions; diabetes prevalence, asthma prevalence, chronic obstructive pulmonary disease prevalence, and chronic mental health disorder prevalence
- Similar leading causes of mortality, with the addition of stroke.

Health service utilisation

When compared with national figures, our population has:

- Similar leading causes of hospitalisation, with the exception that asthma is a leading cause of hospitalisation for Maori, Pacific and Asian children aged 0 to 4 years, and diabetes is a leading cause of hospitalisation for Maori and Pacific people 65 years and over
- Significantly higher rates of avoidable hospitalisation, in particular for diabetes, cardiovascular disease – especially ischaemic heart disease, and asthma
- Significantly higher rates for prescriptions in the last 12 months
- Significantly higher rates for emergency department attendances
- Lower number of GPs per 10,000 population.

[2] Ministry of Health Public Health Intelligence, September 2008 and Central Technical Advisory Services, June 2008 as published on our website www.huttvalleydhb.org.nz

Maori Health

Our current Maori population is around 25,585 people, which makes up 17.6% of the population in the Hutt Valley. Our Maori population is generally younger than the rest of the population, and experiences higher levels of deprivation than non•Maori. If Maori are to achieve the same level of health as other New Zealanders their health status should be understood in the context of the broader determinants of health, particularly social and economic status.

Strategies to improve Maori health should be effective at improving access to quality health care services for Maori. The Hutt Valley DHB HNA identifies a range of factors where significant disparities exist for Maori.

Health behaviours and risk factors:

When compared with non•Maori in the district, Maori experience:

- Higher prevalence of smoking
- Lower consumption of vegetables and fruit
- Lower rates of breastfeeding
- Higher rates of hazardous drinking
- Higher prevalence of obesity.

Health status

When compared with non•Maori in the region, Maori experience:

- Higher rates of death from cancer (especially lung), cardiovascular disease, stroke, and suicide
- Higher prevalence of asthma, diabetes, and depression
- Poorer oral health.

Health service utilisation

When compared with non•Maori in the region, Maori experience:

- Higher rates of avoidable hospital admissions
- Higher rates of hospitalisation of children for dental conditions and asthma
- Greater unmet need for a GP.

Pacific Health

Hutt Valley has a relatively high Pacific population, and is one of seven District Health Boards (DHBs) with specific responsibility for addressing Pacific Health inequalities. The current Hutt Valley Pacific population is around 12,085 people, or 8.3 percent of total population. By 2031 the Hutt Valley Pacific population is projected to grow to around 14,750, or around 10 percent of the total Hutt Valley population.

The Pacific population in the Hutt Valley is generally younger than the rest of the population and experience higher levels of deprivation than both Maori and non•Maori. Around 60% of the Pacific population in Hutt Valley is Samoan, with the next

biggest island groupings being Cook Island Maori and Tokelauan.

Pacific people experience significantly poorer health than other New Zealanders, excluding Maori. In particular, they experience high rates of chronic diseases such as diabetes, and higher rates of avoidable hospitalisations.

Health behaviours and risk factors:

When compared with non Pacific/non Maori people in the region, Pacific people experience:

- Lower consumption of vegetables and fruit
- Higher prevalence of obesity.
- Lower rates of breastfeeding

Health status:

When compared with non Pacific/non Maori people in the region, Pacific people experience:

- Higher rates of death from cardiovascular disease, stroke, cancer,
- Higher prevalence of diabetes, stroke, depression, and TB
- Poorer oral health.

Health service utilisation

When compared with non Pacific/non Maori people in the region, Pacific people experience:

- Higher rates of avoidable hospital admissions
- Higher rates of hospitalisation of children for dental conditions and asthma
- Poorer access to oral health checks, diabetes checks, breast and cervical cancer screening

Implications

These factors indicate that our existing activities in the following areas need to continue and increase in emphasis:

- Working closely with primary care to address long term conditions and avoidable hospitalisation, and to reinforce education and prevention, particularly amongst Maori and Pacific and people with higher needs.
- Continuing our positive engagement with our community providers, including through the cluster of Whanau Ora providers, with a focus on education, prevention and outreach services particularly amongst Maori and Pacific people
- Continuing our emphasis on undertaking actions to better link our hospital with our primary care providers; and
- Positioning ourselves to meet the changed demand for services which will result from an aging population.

We would like to acknowledge the above information has been sourced from the Hutt Valley DHB, 2012/2013 Annual Plan, with Statement of Intent 2012-15.

Section Two: Maternity Service Configuration and Facilities

Maternity Services

The Hutt Valley DHB is a mid sized service providing both primary and secondary facilities. Hutt Valley DHB maternity service supports 2000 - 2,200 births annually from an urban population of 144,740. Of the almost 30,000 women of child-bearing age: 20% are Maori, 9% Pacific Island, 9% Asian and 62% are NZ European or belong to other ethnic groups.

The Hutt maternity unit is the only birthing facility in the DHB. The number of homebirths per 100 births is 2.0-3.9 (Maternity Fact sheet 2001-2010, Ministry of Health).

Table 3. Births in NZ and Hutt

	2008	2009	2010	2011	2012
Births in NZ (NZ Statistics)	64,850	62,927	64,315	61,923	Not avail
Births at Hutt Valley DHB	2,198	2,205	2,161	1,969	1,982
% of all NZ births in Hutt	3.3%	3.5%	3.3%	3.1%	Not avail

Primary maternity care is provided by LMCs (midwives and obstetricians), who have an access agreement to use the facility.

In the Hutt Valley there are two choices of primary maternity care for women:

- *LMC Midwife*: The DHB has on average 40 community-based case loading midwives with primary access agreements providing lead maternity care for approximately 68% of women in the district (based on 09/10 financial year).
- *LMC Private Obstetrician*: There are 3 LMC Obstetricians (2 are also employed by the DHB). Midwifery care for women in who have a private obstetric LMC is subcontracted either by the hospital and/or community based midwives.

There are no GPs practicing obstetrics in the Hutt Valley.

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

Women who are unable to engage with a Lead Maternity Carer are able to be cared for by the HVDHB community midwives.

Workforce

The majority of the midwives have worked within the DHB for many years and fluidity between core and community based practice is supported. This long term relationship and our willingness to be flexible assists us with the challenge of integrating community based LMCs into hospital based clinical reviews and other quality processes.

The maternity service includes the following clinical staff:

- Director of Operations, Surgical, Women's and Children's
- Clinical Head of Department (CHOD) Obstetrics and Gynaecology
- Clinical Midwifery Manager (CMM)
- Associate Clinical Midwifery Manager (ACMM) – Birthing Unit
- Associate Clinical Midwifery Manager (ACMM) – Postnatal
- Midwifery Educator
- Lactation Consultants x 2
- 4 Obstetrics and Gynaecology consultants, Registrars (one ITP training post), House Surgeons, trainee interns on rotation, and medical students
- We have a core DHB employed team of approximately 50 midwives, registered nurse, enrolled nurses, and healthcare assistants
- Midwifery students on rotation

The DHB is currently developing an Operations Centre and will be introducing Trend Care to the organisation. These tools will provide better utilisation of workforce and bed management across the DHB.

Maternity Ward and Birthing Suite

Birthing Suite

The Birthing suite consists of 8 birthing rooms and an acute assessment room. Each birthing room is fully equipped for labour and birth, including a neonatal resuscitation station and private bathroom facilities. The rooms have a large deep corner bath for water births. A portable inflatable birthing pool is also available.

The Birthing suite is staffed by core midwives, providing midwifery care for DHB primary and secondary care women, as well as those women under a private LMC obstetrician. The midwives provide emergency care 24 hours a day, 7 days a week, and support LMC midwives as required.

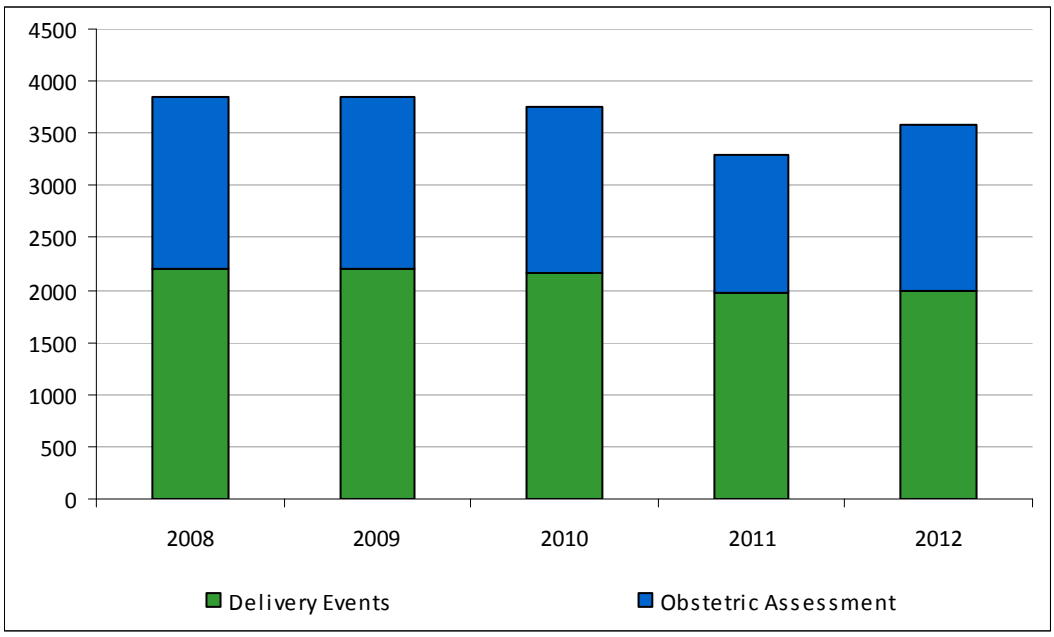
Medical staff are rostered to cover an on call system 24 hours a day. This consists of a Consultant Obstetrician, Senior Registrar or Senior House Officer.

Maternity Ward

The maternity ward is made up of 13 single rooms, 2 double rooms and the facility for an extra 5 bed spaces within the unit. The maternity ward caters for both antenatal and post natal inpatients, and also if required, provides rooms for women ‘rooming in’ with babies in the Special Care Baby Unit (SCBU). The ward is staffed by Midwives with assistance from Nurses and Health Care Assistants (HCAs).

The below graph indicates all **inpatient** birth events, non birth admissions and urgent obstetric assessments undertaken in the Maternity Unit on level 2. HVDHB has a Maternity Assessment Unit (MAU) as describe below with a separate table outlining the events/activity of MAU (see Figure 2).

Figure 1: Maternity Ward and Birthing Suite events/activity

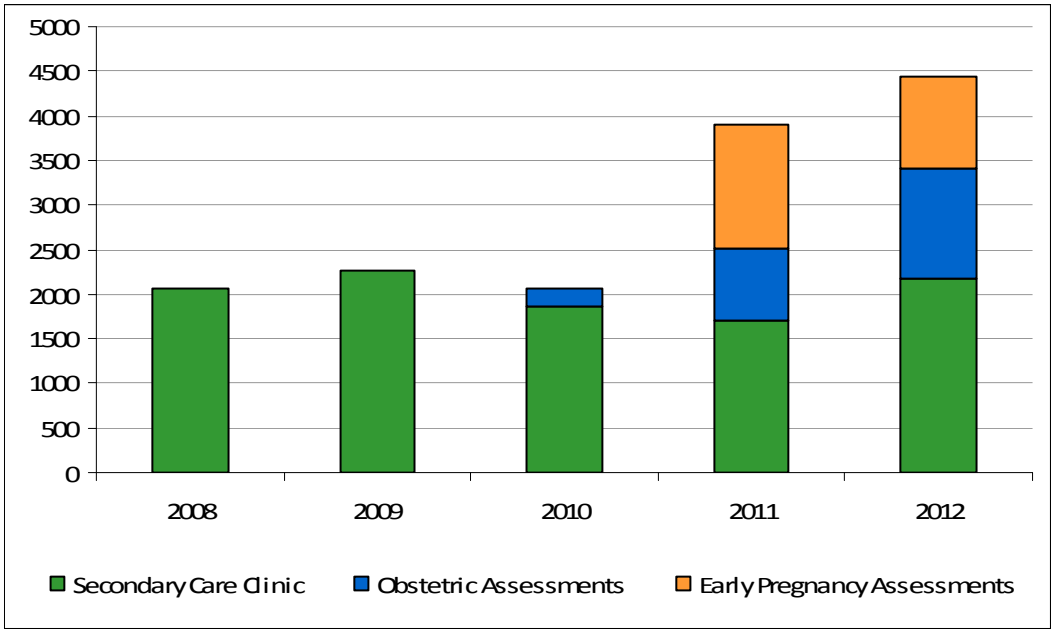

4500
4000
3500
3000
2500
2000
1500
1000
500
0
2008
2009
2010
2011
2012
Delivery Events
Obstetric Assessment

Maternity Assessment Unit

As a response to the increase in births up to 2008, and associated activity, there was a need to move non urgent assessments and day cases to free up birthing rooms. The development of our Maternity Assessment Unit commenced in 2009 and opened on the 4th of October 2010. MAU is a Monday to Friday acute assessment area, and works as an outpatient facility. The facility is utilised by both community based LMC and women under DHB maternity care. Women requiring inpatient care are transferred to the birthing suite or ward.

The unit expanded further to incorporate the Secondary Care Clinics in late 2010 and an early pregnancy assessment service at the beginning of 2011.

Figure 2: Maternity Assessment Unit Total Patient Events



There are now three main work streams in MAU:

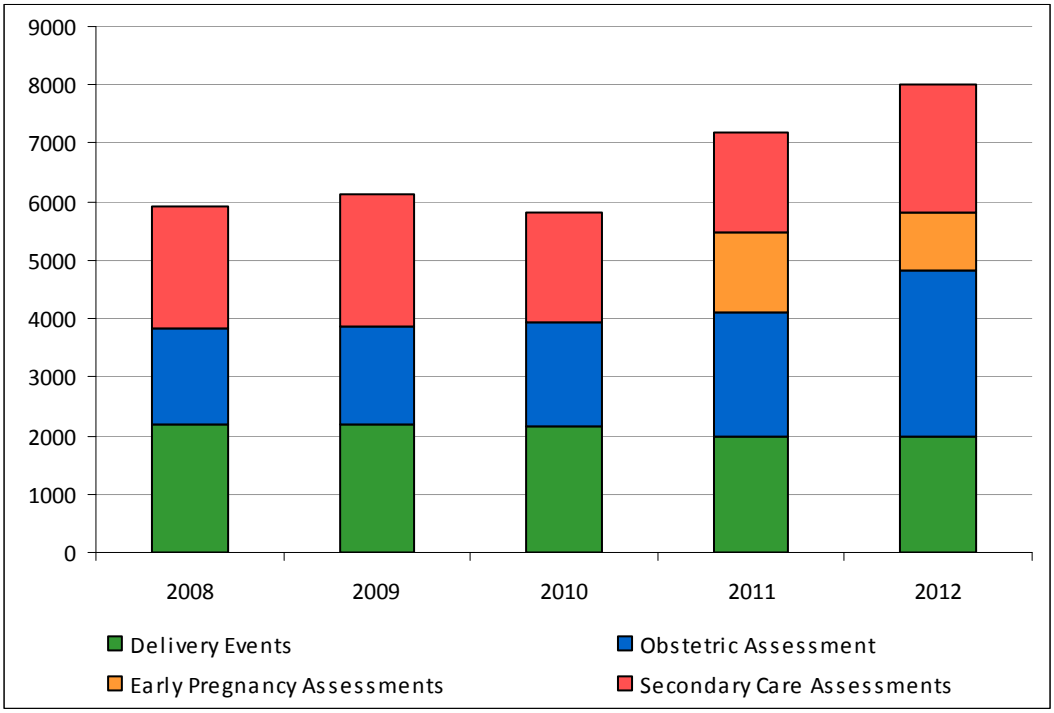
Secondary Care Clinic episodes refer to women seen by an Obstetrician at the Secondary Care Obstetric Clinic in MAU. These women have been referred to the Secondary Care Obstetric Clinic under the Guidelines for Referral and Consultation (2012) for an obstetric opinion.

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

Early Pregnancy Assessments include women experiencing pain and/or bleeding in early pregnancy who are seen for assessment

and management. Prior to 2011, these women were managed by Emergency Department.

Overall Workload



Comment:

Although the total birth numbers at Hutt Maternity has decreased, the workload of the service has shown marked increase since 2011. Our service opened a Maternity Assessment Unit (MAU) late in 2010 as a response to increasing pressure on the maternity unit beds

MAU introduced an early pregnancy assessment service early in 2011 to provide women with better access and timeliness of care when experiencing early pregnancy difficulties, rather than being managed through the Emergency Department.

There has also been a significant demand for non-delivery obstetric assessments relating to the increased co-morbidities in the general population.

HVDHB Community Midwives Team

Historically we have had a small team of community midwives providing purely postnatal care for Secondary and for women who have a private obstetrician LMC. However in response to a fluctuating population and workforce needs in the community, our midwives team has evolved to include primary care of women who have been unable to engage LMC care.

We initially commenced the primary service with antenatal clinics based in the community. Over the 2012 year we have altered the focus of this service to home based visits, offering more responsive women-centred care.

Lactation Consultants/BFHI Coordinators

HVDHB employs two Lactation Consultants (1.1 fte) covering Monday to Friday. They are based in the Maternity Ward.

The Lactation Consultants provide specialist assistance with breastfeeding for inpatients throughout the hospital and for outpatients up to six weeks postnatally.

A significant part of their role is the ongoing education of DHB staff and external stakeholders to maintain BFHI accreditation and midwifery recertification, and continuous quality improvements e.g. audits and policies to maintain standard of care.

Other Links

Social Worker

We have a dedicated women's health social worker available Monday to Friday. Women can be referred by a health practitioner or they can self refer.

CYF Liaison

A CYF Liaison Social Worker is on site and provides support for Maternity Services to address the needs of our vulnerable women and babies.

Operating Theatre

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

SCBU

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

Acupuncture Clinic

Hutt Maternity provides a free acupuncture service in conjunction with The NZ School of Acupuncture and Traditional Chinese Medicine.

Stretch Class and Physiotherapy Services

Stretch classes are run once a week by our Women's Health Physiotherapist. She is also available to women for consultation on issues in pregnancy eg carpel tunnel, back pain on referral from their LMC or self referral. She visits the postnatal ward Monday – Friday.

Ionazone Treatment

Our Women's Health Physiotherapist provides this free service.

Antenatal Education

DHB funded Antenatal Education is subcontract to an external agency. There is also one private provide in the district.

Maternity Providers

Maternity provider at time of registration data is not currently collected by the DHB. We are investigating ways that this may be collated; this will require a review period for robustness. MOH have provided data from HealthPac for the 2011 year. This table depicts the facility where women birthed, and at what point in the pregnancy their registrations document by HealthPac.

Table 4. Timing of registration and birth facility type

Birth facility type/location

Trimester of Registration	Tertiary	Secondary	Primary	homebirth	unknown	Grand Total
1	68	889	1	45	4	1007
2	35	727	1	15	11	789
3	1	41		1		43
Postnatal		1				1
Unknown	41	180				221
Grand Total	**145**	**1838**	**2**	**61**	**15**	**2061**

National maternity Collection, Ministry of Health, 2011

Comment:

Hutt Valley DHB LMC registration in the first trimester sits at 55% for the 2011 year, as provided by the National Maternity Monitoring Group.

Some of the issues that may attribute to this low percentage may include:

- LMCs not registering at first visit
- Accuracy of claim forms
- The exclusion of 221 women with unknown timing of registration includes the women which come under Hutt Primary Maternity care. This relates to the constraints that MOH have in criteria/allocation of women with no LMC under Section 88.
- The 15 women of unknown birth location may include BBA, unclaimed births fee especially homebirth, data entry error

The Maternity Clinical Governance Group (MCGG) is aware this is a national priority and is currently investigating ways to encourage early engagement with maternity care and subsequently early registration with an LMC. The national rate was 63% in 2011.

Births Events in Hutt Valley Facilities

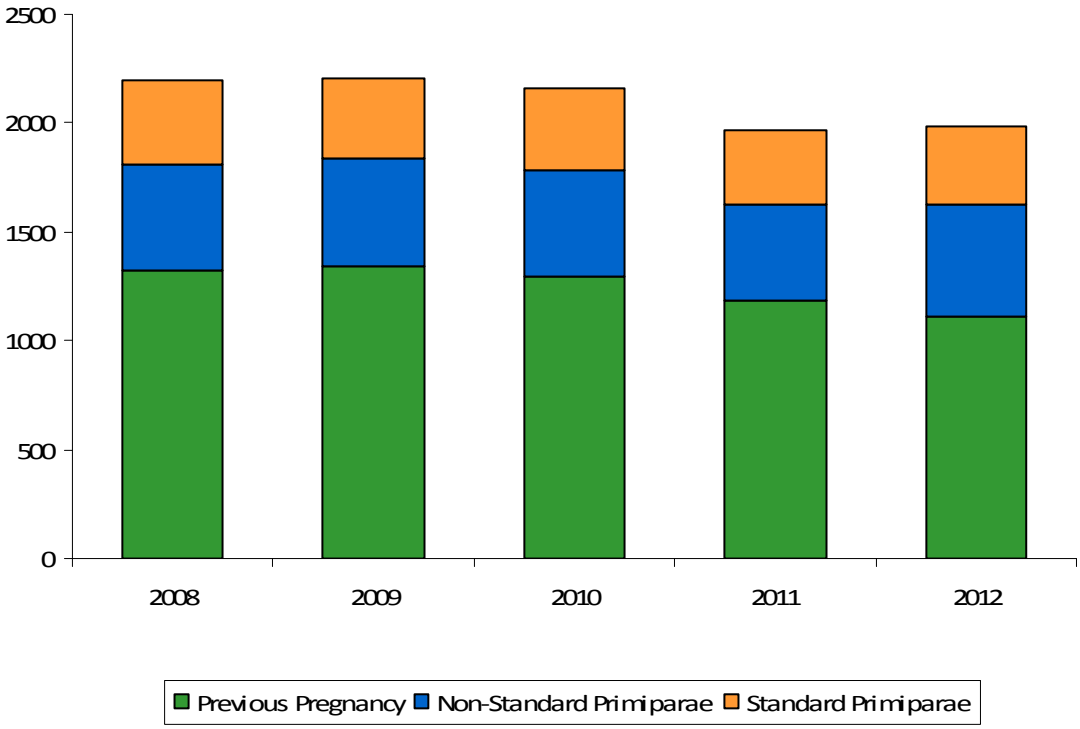


Table 5. Women giving birth in Hutt Hospital 2008 to 2012

ParityType	2008	2009	2010	2011	2012
Previous Pregnancy	1326	1345	1299	1187	1109
Non-Standard Primiparae	482	489	481	436	519
Standard Primiparae	390	371	381	345	354
Grand Total	**2198**	**2205**	**2161**	**1968**	**1982**

Table 6. Age and Ethnicity of women giving birth in Hutt 2012

Ethnicity & Age	Under 16 Years	16 to 19 Years	20 to 24 Years	25 to 29 Years	30 to 34 Years	35 to 39 Years	40 plus Years	Grand Total
Maori	1	60	143	88	71	32	10	405
Pacific	1	15	42	54	37	32	8	189
Asian		1	8	55	63	32	13	172
Indian			5	28	31	6		70
European	1	34	166	256	371	214	57	1099
Other			6	6	13	7		32
Not Stated		2	3		5	4	1	15
Grand Total	**3**	**112**	**373**	**487**	**591**	**327**	**89**	**1982**

The raw data suggests that the number of women giving birth peaks at different ages for different ethnicities. For example for Maori women this is 20-29, compared with European at 30-34. Further statistical analysis needs to be undertaken when there is more data is available.

Table 7. Parity of birthing cohort by Age 2012

Parity Type & Age	Under 16 Years	16 to 19 Years	20 to 24 Years	25 to 29 Years	30 to 34 Years	35 to 39 Years	40 plus Years	Grand Total
Standard Primiparae			117	130	107			354
Non-Standard Primiparae	3	88	90	106	117	88	27	519
Previous Pregnancy		24	166	251	367	239	62	1109
Grand Total	**3**	**112**	**373**	**487**	**591**	**327**	**89**	**1982**

Table 8. Parity by Ethnicity 2012

Parity & Ethnicity	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Standard Primiparae	54	26	43	16	203	10	2	354
Non-Standard Primiparae	89	40	47	25	306	6	6	519
Previous Pregnancy	262	123	82	29	590	16	7	1109
Grand Total	**405**	**189**	**172**	**70**	**1099**	**32**	**15**	**1982**

Body Mass Index for Births in 2012

Table 9. Body Mass Index by Age Group

BMI	Number	Percentage
< 35	1717	86.63%
35 - 49	237	11.96%
>= 50	14	0.71%
Not Stated	14	0.71%
Grand Total	**1982**	**100.00%**

The rate of overweight women (BMI>25) at booking taken from the National Maternity Collection from 2008 - 2010 was 50%. The rate of obesity (BMI>30) in the same years was 21-22%. The criteria differ across data collections so it is difficult to compare data. The link between obesity and poor pregnancy outcomes has been shown to be directly co-related. It will be important as a region to develop strategies to ensure our community is given correct advice in regards to healthy eating and activity in pregnancy.

Comment:

HVDHB Data collection for BMI be standardised with PMMRC criteria.

Smoking rates in pregnancy for 2012 (at birth)

Table 10. Number of patients identified as smokers at time of birth

Number of Smokers	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Under 16	1							1
16 to 19	23	1			10			34
20 to 24	70	12	1		35		1	119
25 to 29	40	3			22			65
30 to 34	27	2	1		17			47
35 to 39	9				11			20
40 plus	1	1			3			5
Smokers	**171**	**19**	**2**	**0**	**98**	**0**	**1**	**291**

Table 11. Smoking Rate

Smoking Rate	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Under 16	100%	0%	0%	0%	0%	0%	0%	33%
16 to 19	38%	7%	0%	0%	29%	0%	0%	30%
20 to 24	49%	29%	13%	0%	21%	0%	33%	32%
25 to 29	45%	6%	0%	0%	9%	0%	0%	13%
30 to 34	38%	5%	2%	0%	5%	0%	0%	8%
35 to 39	28%	0%	0%	0%	5%	0%	0%	6%
40 plus	10%	13%	0%	0%	5%	0%	0%	6%
Total	**42%**	**10%**	**1%**	**0%**	**9%**	**0%**	**7%**	**15%**

Comment:

Under the umbrella of the Maternity Quality and Safety programme, the MCGG is awaiting further information and communication from Sector Capability and Implementation/Tobacco Control about the ‘Better help for smokers to quit’ health target to plan strategies moving forward.

Home Births in Hutt

Hutt Valley DHB does not currently collect data on Homebirths. The Ministry of Health has provided the data for the 2011 calendar year from the National Maternity Collection. The number of homebirths for the 2011 year is 61 for this DHB region.

Comment:

This data is difficult to comment on, and further data over an extended time frame would be of more use to examine trends.

Breastfeeding rates at discharge from Hutt Facility 2012 year

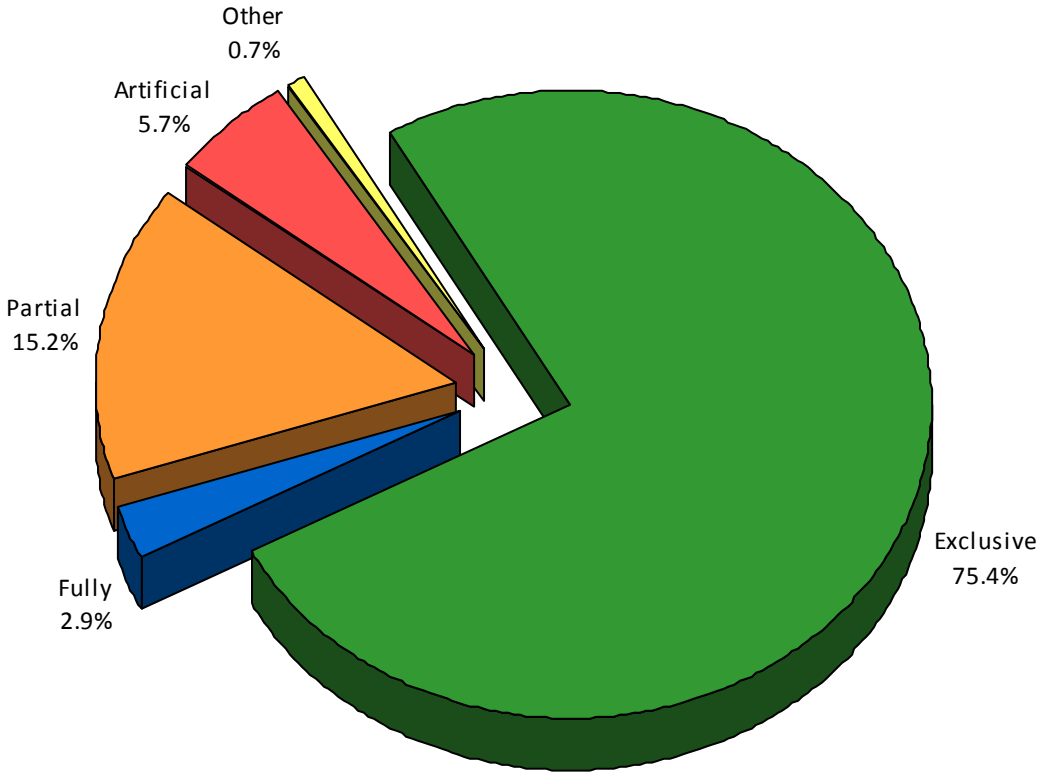


Table 12. Feeding Type by Ethnicity

Feeding Type	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Exclusive	295	131	98	40	791	25	11	1391
Fully	5	4	9	5	29	1		53
Partial	47	24	51	18	131	6	4	281
Artificial	29	11	5		61			106
Other	2	1	1	1	8			13
Total *	**378**	**171**	**164**	**64**	**1020**	**32**	**15**	**1844**

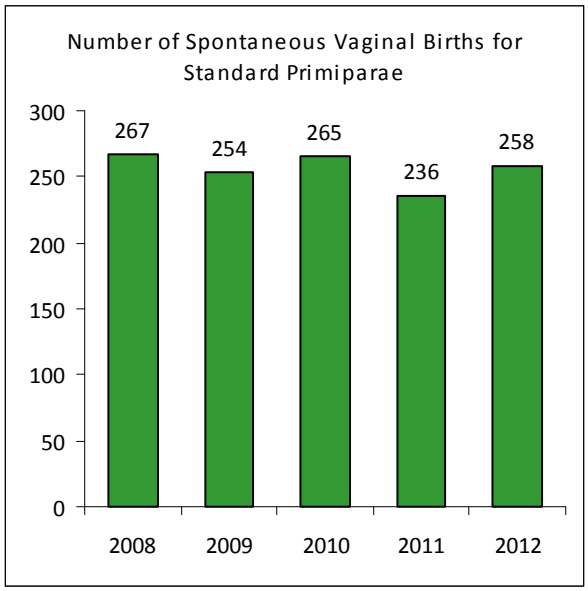
Table 13. Percentage of Feeding Type by Ethnicity

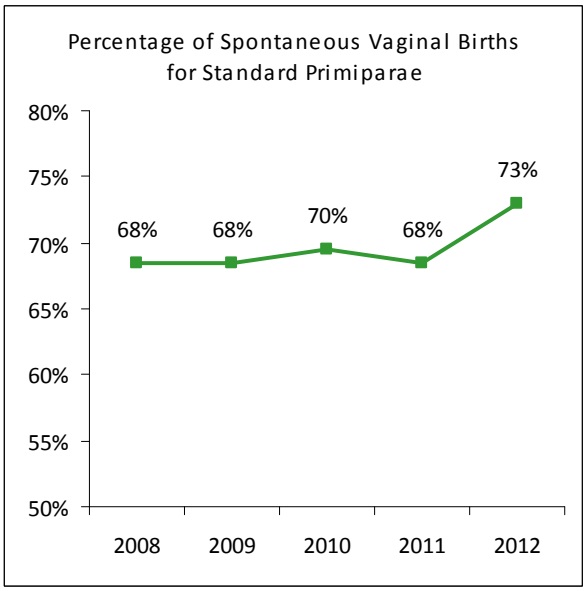
Feeding Type (%)	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Exclusive	78.04	76.61	59.76	62.50	77.55	78.13	73.33	75.43
Fully	1.32	2.34	5.49	7.81	2.84	3.13	0.00	2.87
Partial	12.43	14.04	31.10	28.13	12.84	18.75	26.67	15.24
Artificial	7.67	6.43	3.05	0.00	5.98	0.00	0.00	5.75
Other	**0.53**	**0.58**	**0.61**	**1.56**	**0.78**	**0.00**	**0.00**	**0.70**

*** Excludes patients where feeding type is "Unknown" (13) and SCBU Transfers (125)**

Section Three: Maternity Services Clinical Outcomes 2012

Indicator One: Standard primiparae[3] who have a Spontaneous vaginal birth





Numerator: Total number of standard primiparae who had a spontaneous vaginal birth

Denominator: Total number of standard primiparae who give birth

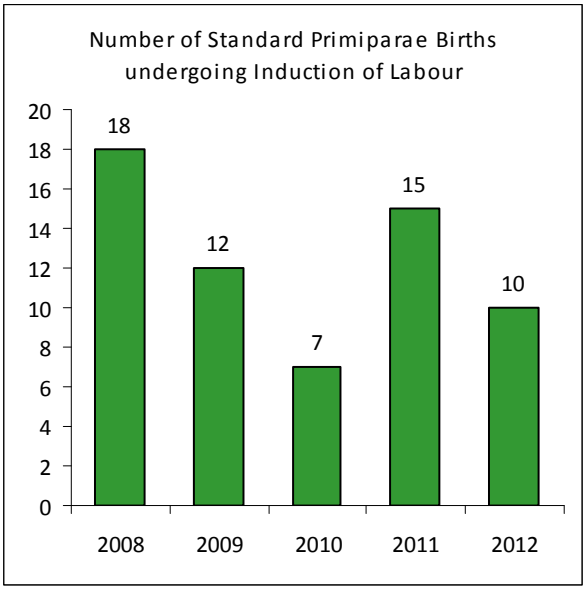
Comment:

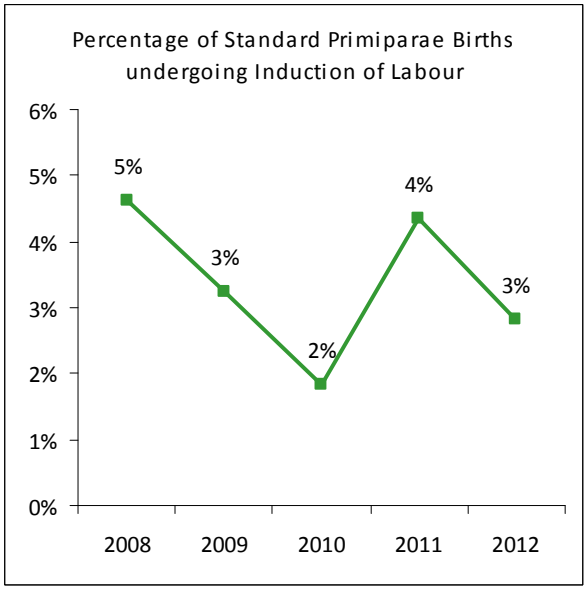
Our standard primiparae birth rate is comparable to the national rate for 2009 at 64.8%, 2010 at 65.5%, and 2011 at 65.6%[4]. The vaginal birth in standard primiparae has shown an increase in 2012. This is encouraging; however it is not statistically significant (P=0.17).

[3] The definition of a Standard Primiparae must meet all the following criteria: no previous pregnancy of 20+ weeks; maternal age 20-34; cephalic presentation; singleton; term gestation; and without specified medical complications

[4] All national rates are from NZ Maternity Clinical Indicators 2009, 2010 & 2011

Indicator Two: Standard primiparae who undergo induction of labour





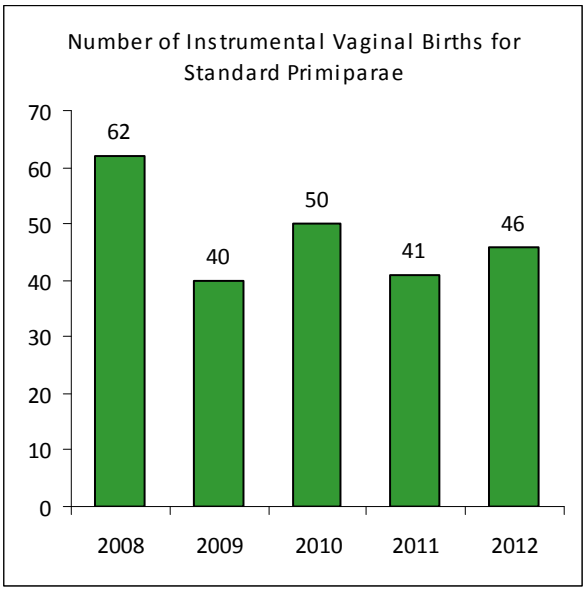
Numerator: Total number of standard primiparae who undergo induction of labour

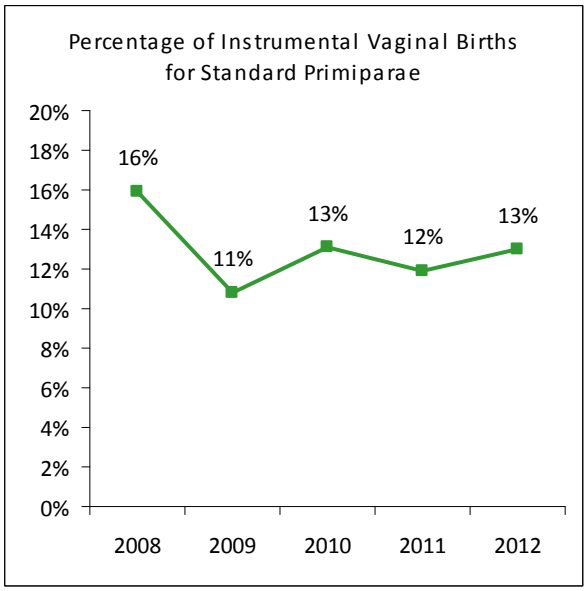
Denominator: Total number of standard primiparae who give birth

Comment:

Our IOL rate is comparable to the national rate for 2009 at 4.9%, and below the 2010 national rate of 4.4%. Nationally the percent for 2011 was 4.8%; our rate of induction of labour for standard primiparae continues to be below national average. One of the factors of a low induction rate is appropriate management of timing of birth. The unit's policy on induction for dates is to book the induction as closely to 42 weeks gestation as possible (as clinically indicated).

Indicator Three: Standard primiparae who undergo an instrumental vaginal birth





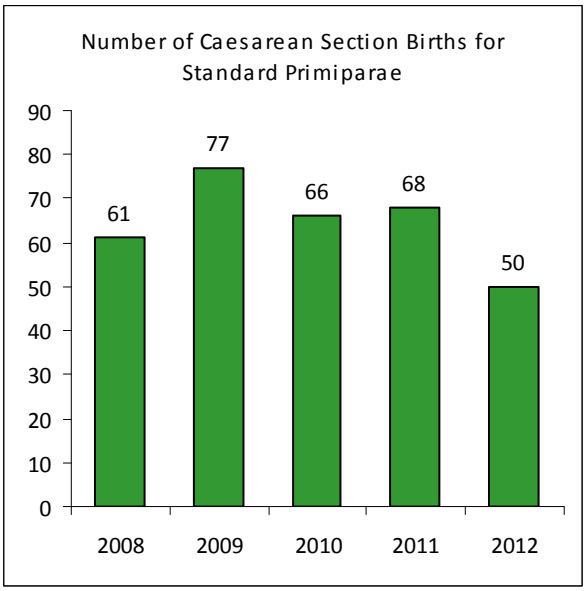
Numerator: Total number of standard primiparae who undergo an instrumental vaginal birth

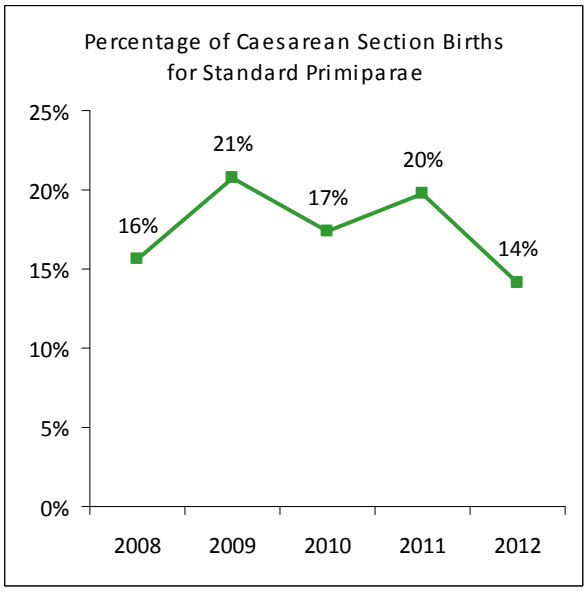
Denominator: Total number of standard primiparae who give birth

Comment:

Our rates for 2009 and 2010 are lower than national rates for 2009 16.3%, 2010 15.8% and 2011 at 16%. Our figures demonstrate we are below the national average. This may influence indicator 3. When the unit has junior registrars they are more likely to perform caesarean sections if not confident at performing forceps or ventouse deliveries. The consultant obstetricians' are committed to supporting the registrars to gain competence and confidence in performing instrumental births.

Indicator Four: Standard primiparae undergoing caesarean section



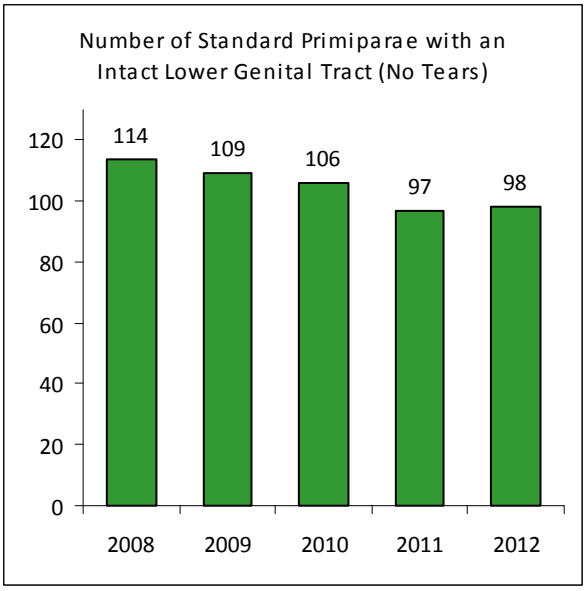


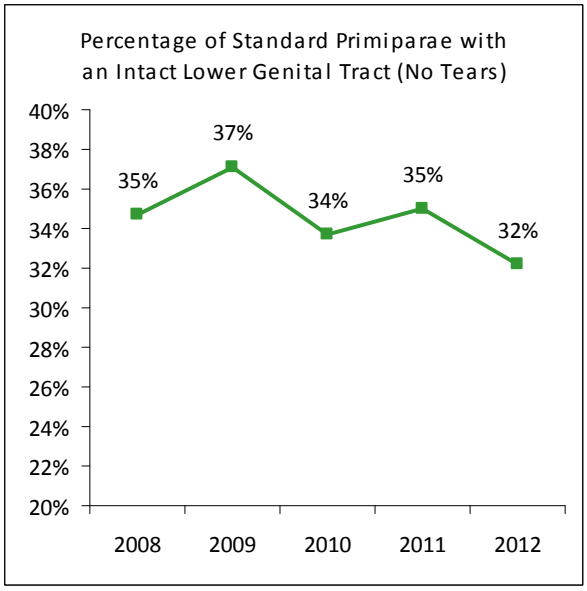
Numerator: Total number of standard primiparae undergoing caesarean section
Denominator: Total number of standard primiparae who give birth

Comment:

Hutt Valley DHB hovers around the national averages of 19.9% for 2009, 17.9% for 2010 and 17.9% for 2011. This maybe related to an increase in Spontaneous Vaginal Births and a slight percentage increase in Vaginal Instrumental births. It will be interesting to see 2013 data to see if this trend continues.

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





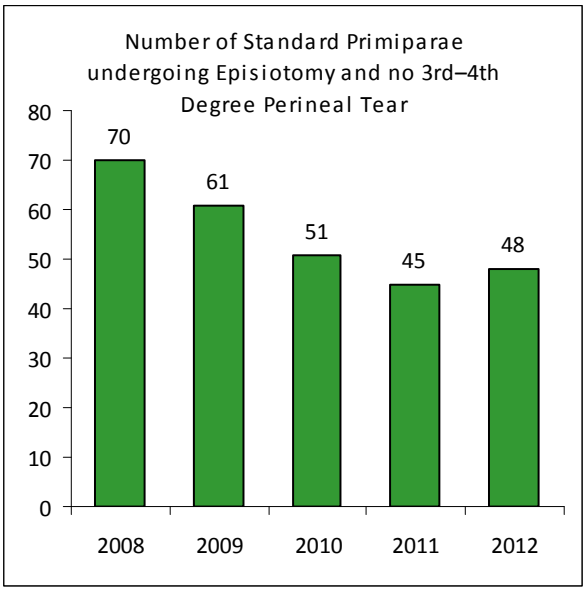
Numerator: Total number of standard primiparae with an intact lower genital tract

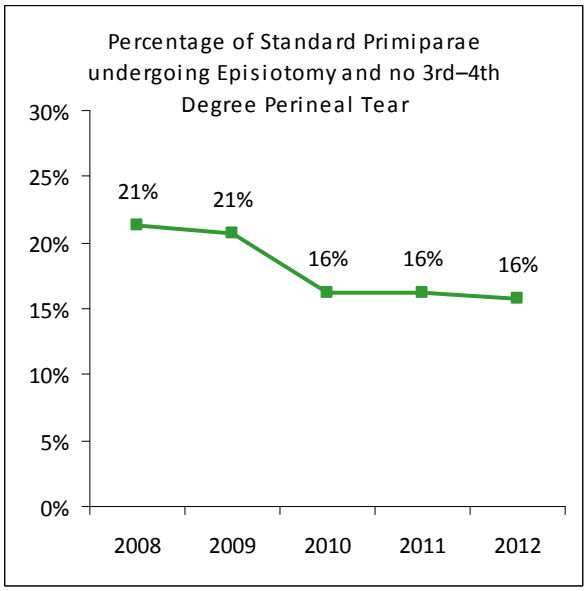
Denominator: Total number of standard primiparae who gave birth vaginally

Comment:

Hutt Valley DHB is consistently above the national averages for intact lower genital tract comparing data from 2009 to 2011. (National averages: 2009 year 28.8%, 2010 year 28.4%, and 2011 year 27.3%).

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





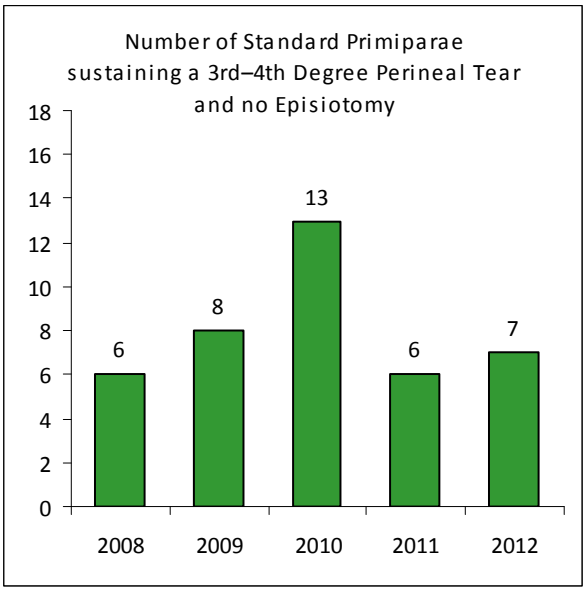
Numerator: Total number of standard primiparae undergoing episiotomy and no 3rd-4th degree perineal tear while giving birth vaginally

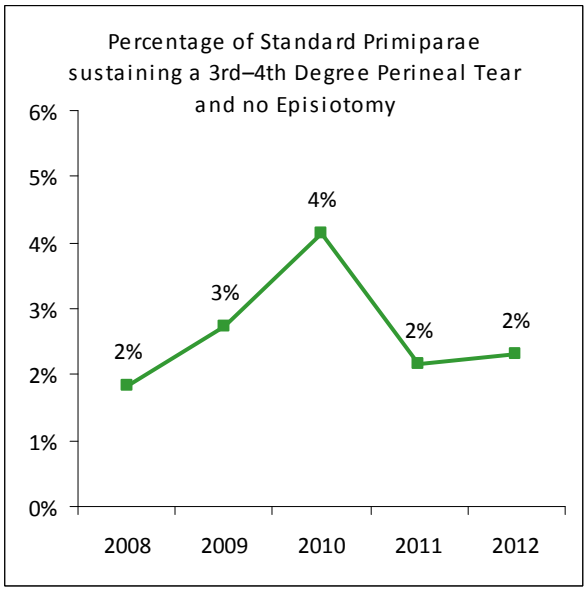
Denominator: Total number of standard primiparae who gave birth vaginally

Comment:

Even though national average remained between 19.2% for 2010 and 22.1% for 2011, Hutt Valley DHB episiotomy no 3rd/4th degree perineal tear rate was well below the national average and static at 16%.

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





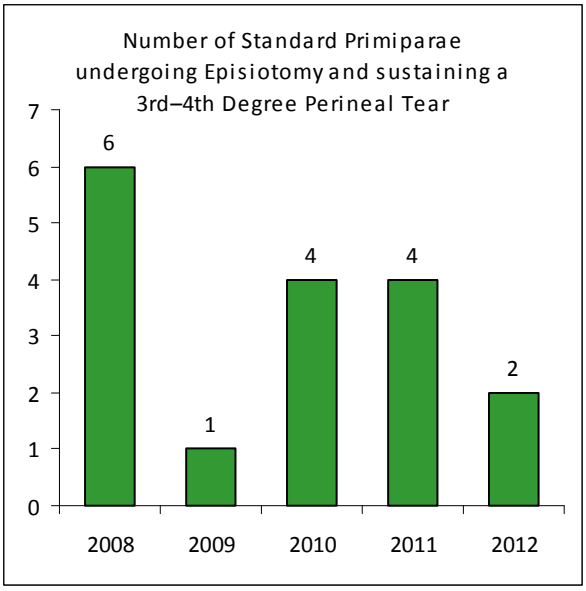
Numerator: Total number of standard primiparae sustaining a 3rd-4th degree perineal tear and no episiotomy

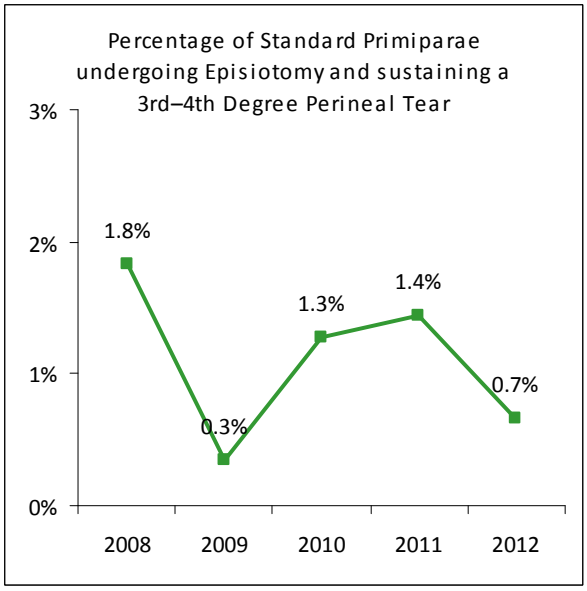
Denominator: Total number of standard primiparae delivering vaginally

Comment:

This is below national averages 2009 to 2011, and indicates good practice managing the integrity of the perineum.

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





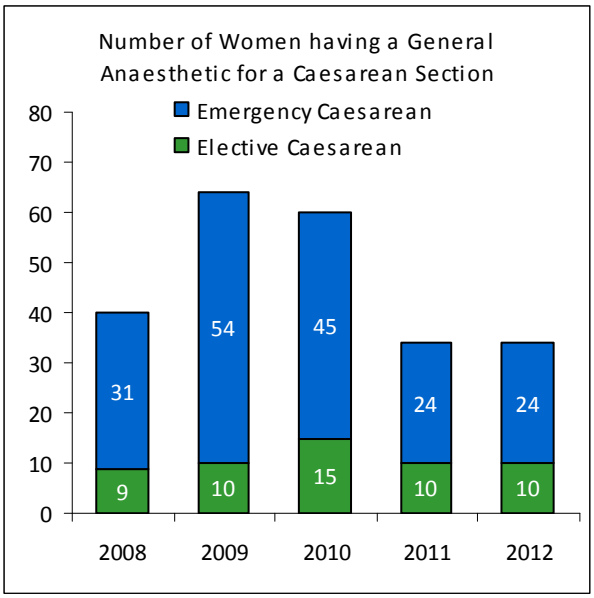
Numerator: Total number of standard primiparae undergoing episiotomy and sustaining a 3rd-4th degree tear while giving birth vaginally

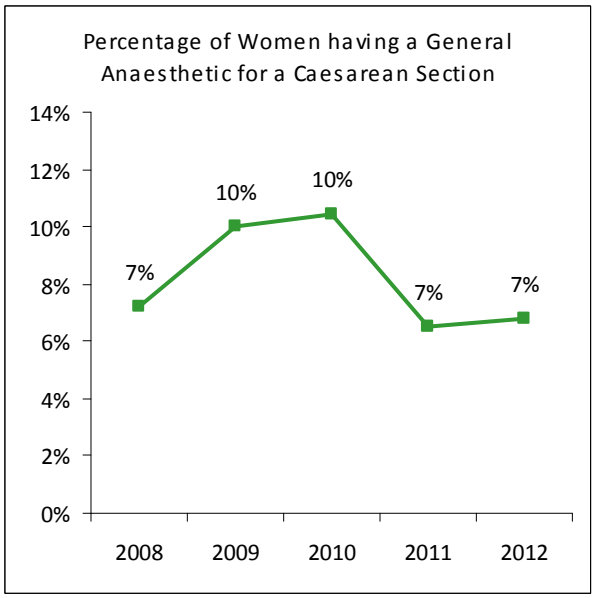
Denominator: Total number of standard primiparae delivering vaginally

Comment:

Consistent with national averages 2009 1.4%, 2010 1.1%, and 2011 1.3%. It is difficult to make further comments from such small numbers.

Indicator Nine: General anaesthesia for all caesarean sections





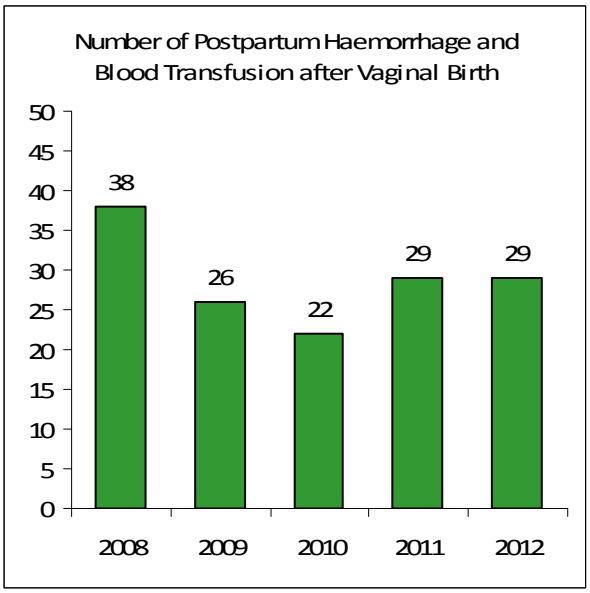
Numerator: Total number of women having a general anaesthetic for a caesarean section

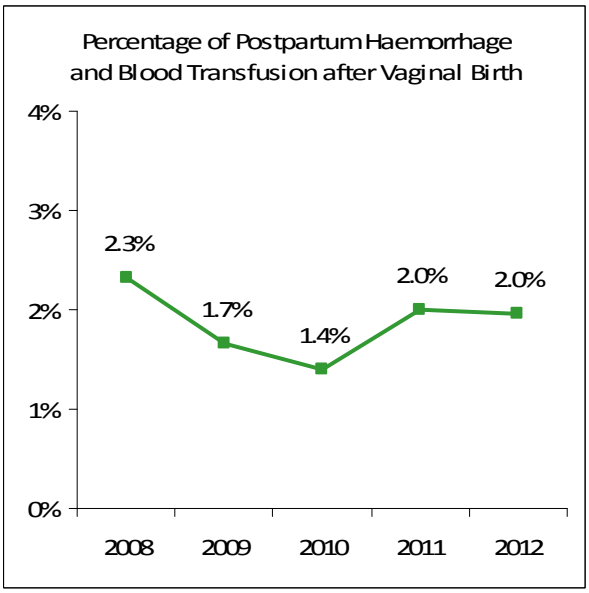
Denominator: Total number of women having a caesarean section

Comment:

National averages for 2009 9.0%, 2010 9.1%, and in 2011 8.3%. Our rates are comparable to this. In 2011 there is a decrease in both the national rate and Hutt Valley DHB rate.

Indicator Ten: Postpartum haemorrhage and blood transfusion after vaginal birth



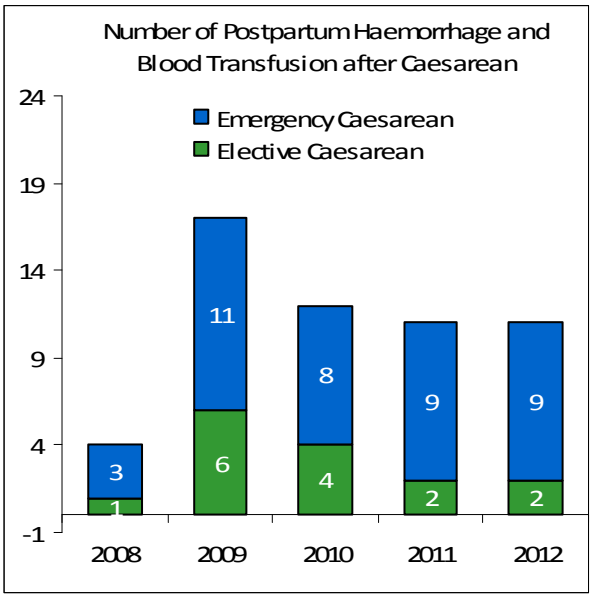


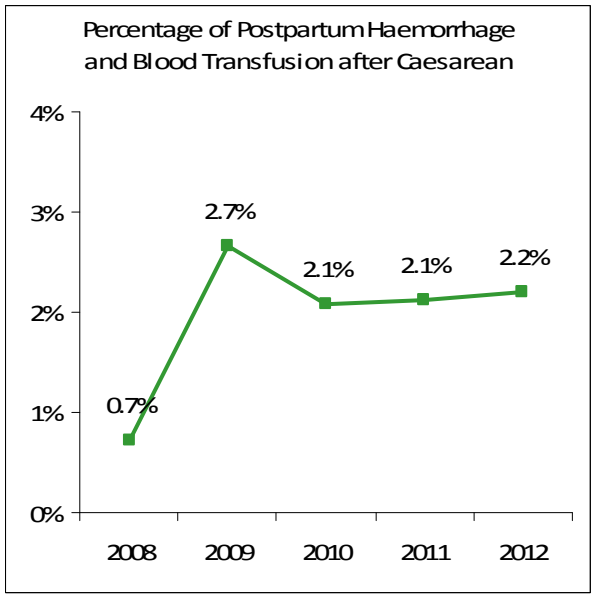
Numerator: Total number of women giving birth vaginally with a Postpartum haemorrhage who required a blood transfusion during the same admission
Denominator: Total number of women who give birth vaginally

Comments:

We note there is an increase in the postpartum haemorrhage rate with blood transfusion after vaginal birth between 2010 and 2012. This trend is a concern and may indicate practice issues and/or the pre-birth physical health of women. We have initiated a post-partum haemorrhage audit to investigate this problem.

Indicator Eleven: Postpartum haemorrhage and blood transfusion after caesarean section





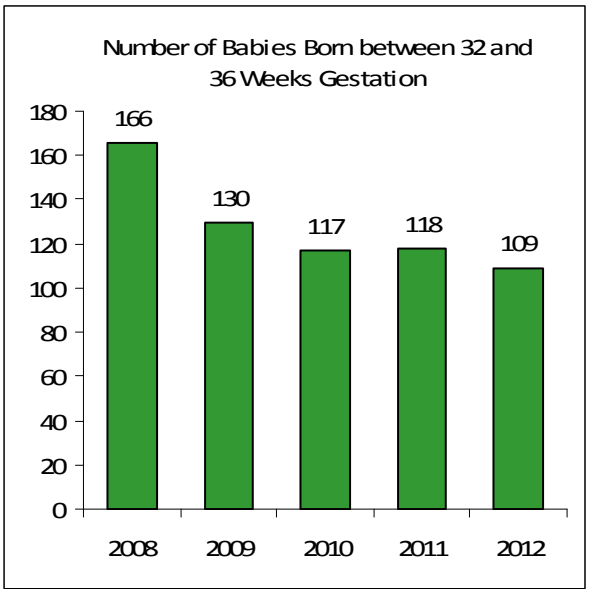
Numerator: Total number of women undergoing caesarean section with a Postpartum haemorrhage who required a blood transfusion during the same admission

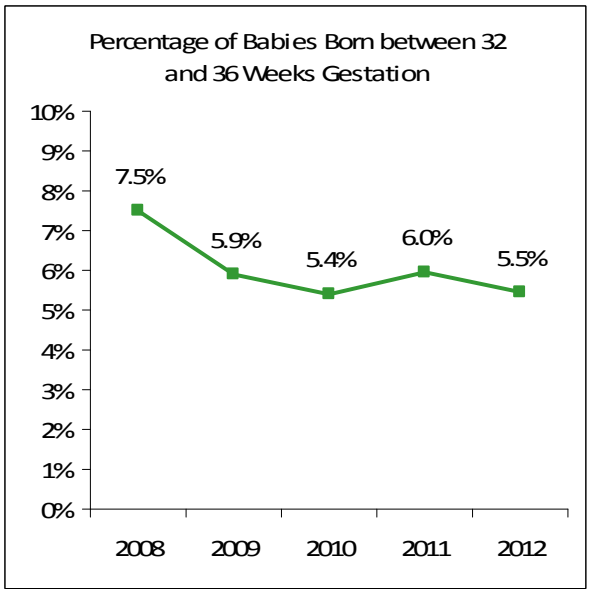
Denominator: Total number of women who give undergo caesarean section

Comment:

As noted in Indicator 10 there is an increase in the postpartum haemorrhage rate with blood transfusion after vaginal birth between 2010 and 2012, there has been a concurrent increase for postpartum haemorrhage and blood transfusion after caesarean section from 2011 to 2012. This will also be address in the post-partum haemorrhage audit.

Indicator Twelve: Premature births (between 32 and 36 weeks gestation)





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

Denominator: Total number of hospital births

Comment:

We remain below the national averages from 2009 to 2011, and continue with a decrease in 2012.

Section Four: Quality & Safety

Maternity Quality and Safety Programme

Hutt Valley District Health Board was selected as a Demonstration Site for the Ministry of Health Maternity Quality and Safety Programme. Work has been reviewed, implemented and embedded at Hutt Valley DHB in the following areas as a result of that work. The final report was presented to MOH June 2011. The team focused on 4 main work streams as summarised below:

Practical Obstetric Multi-Professional Training (PROMPT)

- Imbedded as regular training course
- Obstetric emergency skills and drills practised onsite at our DHB
- Focuses on teamwork and effective communication
- Maintained at no cost to participants

Dashboard

- Visible way of displaying clinical indicators, trends etc
- Reviewed monthly by Maternity Quality Committee
- Lots of work done on data collection, parameters, definitions
- Work being done on aligning data with MOH and Heath Round Table

Quality Forums

- Getting right people, right time, right place
- Creating linkages
- Well established
- Good participation
- See Strategic Plan below for outline of HVDHB Quality forums

Community

Website development undertaken. Currently awaiting Communications team due to change in staffing and IT system within DHB, aim to have live in 2013 year.

Maternity Clinical Governance Group (MCGG)

Work undertaken by all the selected Demonstration Sites and MOH was then incorporated into the current National Maternity Quality and Safety programme, rolled out in 2012.

Initial meetings were held with the Clinical Midwifery Manager, the Obstetric Team Leader and the Quality Facilitator, to plan the next phase, including establishing the MCGG and drafting the Strategic Plan for 2012/2013 year.

HVDHB established our Maternity Clinical Governance Group (MCGG) to oversee this programme and other maternity forums, and links to the DBH governance structure.

The recruitment process for MCGG members commenced in July 2012 with a variety of methods to reach a wide group of stakeholders. Adverts were run in the local community newspapers (Hutt News, Upper Hutt Leader and Wainuiomata Times).

The membership of this group includes clinicians, primary health representatives and consumers, who reflect our diverse ethnic community.

Maternity Clinical Governance Group Members	
Anne Mitchell, Paediatrician	Margaret Hope, Core Midwife Rep
Helen MacGregor, LMC Rep	Meera Sood, Obstetrician
Joan Burns, DHB Quality Advisor	Mere Te Paki, Primary Health Rep
Jo McMullan, Clinical Midwifery Manager (Chair)	Nicola Giblett, Quality Facilitator
Karla Gunby, NZE Consumer Rep	Regan Carroll, Maori Consumer Rep
Lyn Taylor, Funding and Planning	Sarah Boyes, Director of Operations
Mata Taafua, Pacific Island Consumer Rep	

The MCGG and Maternity Quality and Safety Programme is coordinated by the Quality Facilitator, Surgical Women’s and Children’s Directorate.

The first complete MCGG meeting was held on 22/8/2012 and time was spent outlining and discussing all of the background and relevant documentation.

Terms of Reference were developed and signed off by the MCGG members. These are attached as an appendix.

Central Region Midwifery Leaders Group (CRMLG)

The Chair of the MCGG also belongs to the CRMLG. This group is working on standardisation of documentation and processes across the region. They also provide a coordinated response for midwifery in settings such as the Regional Training Hub and Regional Clinical Leaders Board. The CRMLG have supported the Central Region Midwifery Educators to work together to develop the epidural passport and Midwifery Technical Skills curriculum.

National Level

At a national level Hutt Maternity is also involved with many groups and committees:

Perinatal and Maternal Mortality Review Committee (PMMRC)

The PMMRC is a national body that reviews the deaths of mothers and babies in New Zealand. Each year PMMRC provides a series of recommendations applicable to maternity services and practice. Each DHB has a local coordinator.

The Coordinator at HVDHB completes data collection, and the dissemination of the recommendations from the reviews to the Maternity Quality Team for consideration. The Coordinator also facilitates the in-house Perinatal Mortality Meetings 3-4 times a year.

The Australasian Maternity Outcomes Surveillance System (AMOSS)

AMOSS is an Australasian group collecting data on rare conditions affecting women in pregnancy, birth and postnatally. The aim of AMOSS is to improve the safety and quality of maternity care in Australia and New Zealand by collating the information gathered and interpreting into reliable evidence-based practice.

Data is collected via the PMMRC local Coordinator.

Our local Coordinator was recently interviewed by AMOSS for their 15th international newsletter, talking about their experience as a coordinator and the impact of AMOSS.

Health Round Table (HRT)

HVDHB has been a member of Health Round Table for several years. HRT is a non-profit collaborative that collects, analyses and publishes health statistical information. HRT offers comparisons amongst similar organisations and identifying ways to improve operational practices.

Midwifery Leaders Forum

The Clinical Midwifery Manager (CMM) is a member (and the secretary) of the national Midwifery Leaders Forum. The purpose of the forum is to enable maternity issues to be addressed in a systematic and proactive manner. It provides an opportunity to lead on midwifery issues within the context of DHB employed midwives. The group is a key stakeholder in matters which may impact on the midwifery workforce and the direction, development and delivery of services.

Strategic Plan July 2012 to June 2013

Our first Maternity Strategic Plan was published in June 2012. Using the MOH Guide, "Implementing the Maternity Quality and Safety Programme in Your DHB" as our basis, we incorporated the 7 elements.

The following tables outline our aims and objectives of the MCGG and Maternity and Quality Safety Programme.

Clinical Governance/Leadership

Date	Objective		Strategy	Expected Outcome	Outcome	Status
June 2012	1	Recruitment of a Sub-Regional Director of Midwifery	Regional discussion by DONs/CMM re role Presentation of proposal at Sub-Regional CEO Meeting Role Scope outlined Recruitment process	Employment of a DOM for the Region	Action Proposal submitted to CEO November 2012. Comment Sub regional/regional 3D restructure in progress.	Awaiting response.
June 2012	2	Establish a Clinical Governance Group and framework for Maternity Services at HVDHB	Recruit and form group, considering skill/knowledge mix and representation. Define TOR MCGG to establish priorities and direction of the MQSP.	Maternity Clinical Governance Group (MCGG) is formed. Strategic Plan is implemented for Maternity Quality and Safety Programme (MQSP)	Action First MCGG Meeting held 22 August 2012.	Completed
June 2012	3	Align Maternity Clinical Governance Group with HVDHB governance framework and structure	Liaise with HVDHB Quality and Executive Teams.	HVDHB over-arching Governance aligned.	Action Liaison with DHB Quality Manager Comment sub regional/regional 3D restructure in progress	Awaiting Response

Co-ordination and administration

Date	Objective		Strategy	Expected Outcome	Outcome	Status
June 2012	4	Establish a Maternity Quality Facilitator role	Recruit and explore avenues to have a Quality Facilitator Role Scope role/JD Use Project Coordinator until this established	Maternity Quality Facilitator Role established and recruited	<u>Action</u> Job description and advertising <u>Comment</u> Awaiting signing of contract. Midwife in role at present.	Complete
June 2012	5	Investigate the facility for an Admin Support Role Maternity Quality and Safety	Outline proposed role and JD, including FTEs and possibilities of working within current staffing structures. Discuss role with Director of Operations, Surgical Women's and Children's Directorate (SWCD)	Admin Support Role agreed on and recruitment considered	<u>Action</u> Job description completed Administration restructure in process.	Awaiting Director of Operations
June 2012	6	Establish allocated FTEs for lead clinicians for Maternity Clinical Governance and Quality and Safety Programme	Discuss with Director of Operations (SWCD)	FTEs allocated for lead Clinical staff	<u>Action</u> Negotiated with Director of Operations	Complete

Consumer engagement

Date	Objective		Strategy	Expected Outcome	Outcome	Status
June 2012	7	To engage consumer participation on the MCGG	Outline role Advertise role	Consumer participation on the MCGG	Action Recruitment	Complete
June 2012	8	Establish website as forum for information sharing and engaging consumers	Draft website Go live Review website	Web site is live and used	Action Design and draft content Comment With Web Design company. Go Live end of March 2013	Complete
June 2012	9	Investigate Consumer interface methods	Utilise current feedback in conjunction with HVDHB Quality Team, Maori Health Unit, current MOH reports. Establish community based forums to garner best methods for consumer feedback with special attention to vulnerable groups Review the previous Community Consultation documents and feedback comments	Feedback is utilised as guidance to engage with consumers	Action Develop methods of engagement Comment Utilising a 3D approach HVDHB Consumers are currently liaising with CCDHB Consumers to discuss methods of engagement	On agenda for MCGG in 2013

Sector engagement

Date	Objective		Strategy	Expected Outcome	Outcome	Status
June 2012	10	Increase our profile among external stakeholders	Website Meet and Greet Forums Newsletters	Web site is live and used	Action Website development as above	In progress for 2013
June 2012	11	Investigate ways to encourage sector engagement	Use a variety of techniques ie survey and face to face meetings about how stakeholders wish to engage with the service Meet and Greet Forums Newsletters Review the previous Community Consultation documents and feedback comments	Participation in MCGG Participation in wider range of Maternity Meetings	Action Plan strategy for stakeholder engagement	On agenda for MCGG in 2013
June 2012	12	Ongoing promotion of PROMPT and increased participation by wider range of sector stakeholders	Increase access to booking of PROMPT. Advertise on website	Increased participants	Action Embedded	Ongoing
June 2012	13	Continue to foster relations with LMCs at LMC interface monthly meeting	Ongoing monthly meetings. Regular attendance by Clinical DHB Leadership, and Maternity Quality Facilitator	Open meetings Good attendance Productive outcomes from meetings are actioned	Action Embedded	Ongoing

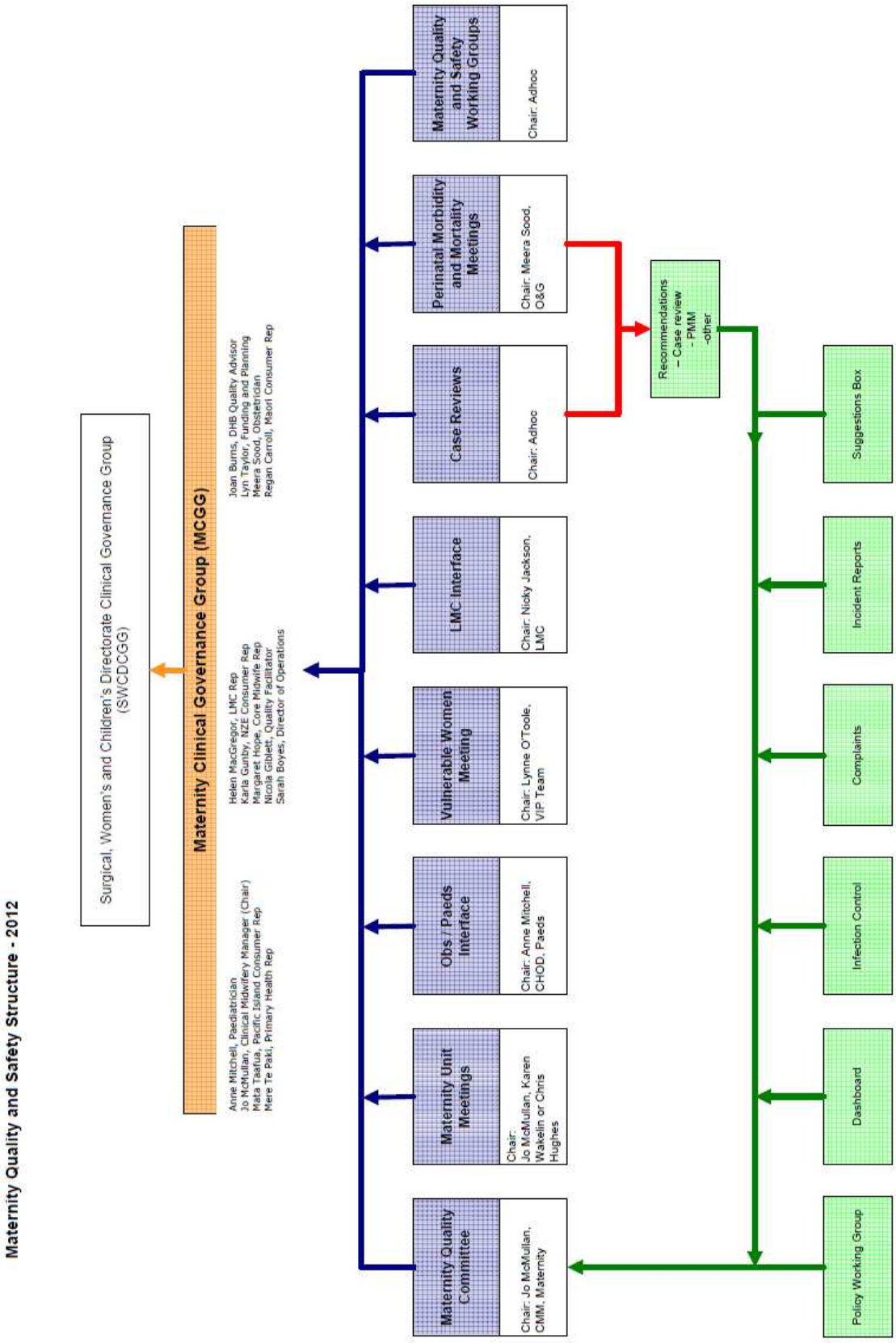
Data monitoring

Date	Objective		Strategy	Expected Outcome	Outcome	Status
June 2012	14	Ongoing monitoring of KPIs	Monthly Dashboard Monthly MCGG review Audits on 'red' or 'orange' indicators	Dashboard remains up to date and visible to stakeholders Action is taken on 'alarm' issues	Action Work done on National KPIs as priority for Annual Report. Once Annual Report submitted work to be done in 2013 on aligning our Dashboard with National KPIs	Ongoing
June 2012	15	Align HVDHB KPIs with MOH and HRT	Sub group including members of IS department	Data, parameters and definitions are consistent amongst HVDHB, MOH and HRT data sets	Action As above	Ongoing
June 2012	16	Data is presented in the Maternity Annual Report	The Maternity Quality Facilitator to work with IS and Business Analyst to produce an Annual Report	First report will be completed for 2012 calendar year	Action Draft report to be submitted by 31st March	completed

Information and communication systems

Date	Objective		Strategy	Expected Outcome	Outcome	Status
June 2012	17	Develop a framework for communications and information sharing with the wider maternity community	Website and updates Communications book Meeting agendas, notes and actions points accessible to all Local newspaper updates Annual Grand Round Annual Report Staff emails LMC emails	Improved visibility of the maternity Service. Better communications across internal and external stakeholders		On hold pending Website and work on Annual Report
June 2012	19	Develop a seamless robust process for maternity documentation requirements	Review whole documentation system –gap analysis Standardise processes and unit documentation Identify unnecessary duplication	Required maternity information is available, accessible and standardised as necessary.	Action Further work required Comment With development of Annual Report, documentation/data issues highlighted. Consumers tasked with reviewing current patient information used in maternity services.	Ongoing

Quality Improvement



Quality Framework Structure

As part of the demonstration site we looked at our quality forums. We outlined a structure for our meetings. Our ongoing work has been to formalise this structure. There is now a clear framework with reporting structures in place.

CTG Meeting/Audit

The maternity team meets weekly to review all the previous week's emergency caesarean sections and instrumental births with attention given to the CTG recordings. The management of each labour and birth are critiqued and issues or policy changes are forwarded to the maternity quality committee.

Policy work

In early 2012 a standardized pathway for policy review on a rotational basis was established and is overseen by dedicated "Owner". All policies are reviewed and signed off by the Maternity Quality Committee. The finalised policies are then available both hard copy in the unit and electronically on the HVDHB Intranet. Our longer term goal is to have these on our HuttMaternity Website.

Compliments

We have had 50 praises registered with the DHB Quality Team for 2012. The themes across these compliments surround care and staff professionalism.

"I was also encouraged to stay an additional night as I was struggling to breastfeed and it was the best advice given"

"The midwives are very encouraging and supportive, they were great at listening to me as a mother as I experienced new skills and gave great advice, being careful not to tell me what to do but rather suggest ideas – allowing me to make decisions for myself empowering me and my partner as the parents. Nothing was ever too much trouble and they were always positive and cheerful in their approach"

Reportable Events, Serious Events and Complaints

HVHDB had no adverse serious (SAC2) or sentinel (SAC1) events in the 2012 year.

For our internal event reporting there were 30 events. All events are reviewed by the Clinical Midwifery Manager and line managers as appropriate.

These can be summarized into 3 main categories

- Ward Administration issues: such as incorrect controlled drug counts, staffing levels, and equipment.

- Care service coordination issues: primarily surround inter-service communications eg appropriate timing of calling Paediatric team for a delivery.
- Drug and Fluid errors: eg Medications given but not charted, medications not been given as charted.

Complaints

In the 2012 year there was 18 complaints registered with the DHB Quality Team. These can be summarized into 2 main categories

Person event: While some complaints directly reflected the care given, others focused on poor communication. One complaint focused on the lack of facility for partners to stay and our guideline on this is currently being reviewed.

Environment event: These reflect the physical environment such as poorly labelled access to the unit, shower design, and noise in the ward.

Our compliments, complaints and recommendations from all sources are reviewed by the Maternity Quality Committee. Appropriate actions are planned, documentation altered as needed and decisions communicated to relevant parties. Feedback from the Maternity Quality Committee is a standard item on our MCGG agenda.

All compliments and complaints are currently administrated through the DHB Quality Team. There is a suggestions box at the Maternity Unit reception.

Perinatal Mortality Cases

MCGG Recommendation: small community, detailed info. Not to list

In 2012 there were 8 stillbirths (0.4%) and 2 neonatal deaths. The age range of the mothers was 20 -39 years with representation across Maori, Pacifica, New Zealand European and Other ethnicities. There was an even split between primiparas and multiparas, and between smokers and non-smokers. One mother would be classed as morbidly obese and 3 overweight.

Almost half the babies (3) had a congenital abnormality as the primary cause of death, followed by chorioamnionitis as the second most common cause of death (2). Eight out of the ten cases had a post-mortem. The small numbers do not allow for any statistically significant analysis, however, we are aware of the PMMRC recommendations that we endeavour to incorporate into practice.

Sub Regional

There is a national intent towards regionalisation and neighbouring DHBs having closer working relationships and collaboration across services. This is in response to increasing fiscal constrains, clinically vulnerable services,

inequalities in access to health services and increased expectations of healthcare services.

In 2012 there was an overall vision for a 3D (three District Heath Boards) sub-regional approach amongst Hutt Valley DHB, Wairarapa DHB, and Capital and Coast DHB of greater collaboration.

Hutt began working closely with Wairarapa DHB to strategize the progression of the alliance and subsequent direction with CCDHB.

Baby Friendly Hospital Initiative (BFHI)

Monthly quality audits are undertaken to ensure robust data input into our breastfeeding statistics. This is lead by our Lactation Consultations and midwifery staff.

WellChild/Tamariki Ora (WC/TO), General Practitioner (GP), Oral Health Enrolment

Our breastfeeding rates remain below the national average, which is of continuing concern. We know that the future health of the infant is enhanced if breastfeeding is practiced, but this does require timely communication between providers so that every service is able to support the family and that the infant's care pathway is optimised.

We have agreed strategies to improve a timely connection between key stakeholders following the hospital discharge of mother and baby to better support breastfeeding, receipt of scheduled WCTO visits, early access to oral health care and commencement of timely vaccination.

Nationally, fewer than half of newborns were enrolled with a GP at 12 weeks; this has been addressed nationally (October 2012 commencement) through early enrolment of the newborn with a GP. This process enables newborn babies to receive timely immunisation and other health checks. This process requires GP notification at hospital discharge, which is already embedded through our hospital discharge processes.

We estimate from our National Immunisation Register (NIR), that at least 10% of newborns have not been identified as having nominated a WC/TO at hospital discharge. However, approximately 20% of infants do not receive their first WC/TO visit. This is due to a combination of system failures, i.e. timeliness of the maternity discharge notification to the chosen WCTO provider and the associated planning and management of the first WC/TO visit.

To overcome these gaps, consultation with our key stakeholders has resulted in a recommendation that the hospital discharge is communicated to the nominated WC/TO provider. This requires an IT system update to involve the parent in that notification at hospital discharge, as is current for the GP notification. We also require an IT system change for enrolment of the infant at hospital discharge to our oral health services. This will allow infants to be scheduled for a first visit at age two years and any infants who are

identified as vulnerable will be targeted for scheduled visits from six months of age.

New Zealand Maternity Standards

Along side the New Zealand Clinical Indicators and the 7 elements for the Maternity Quality and Safety Programme MOH have outline 3 high level standards. These clearly outline audit criteria and measurements for the provision of equitable, safe and high-quality maternity services nationally. Hutt Valley DHB meet a portion of these criteria, those that we do not currently meet are items for investigation within our strategic planning.

Standard One:

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

Audit Criteria	**Measurement**	
8. All DHBs have a system of ongoing multidisciplinary clinical quality review and audit of their maternity services, involving consumer representatives and all Practitioners linked to maternity care.	8.1 Multidisciplinary meetings convene at least every three months.	Yes
	8.2 DHBs report on implementation of findings And recommendations from multidisciplinary meetings.	Yes
	8.3 DHBs invite all practitioners linked to maternity care, including holders of Access Agreements, to participate in the multidisciplinary meetings, and report on proportion of practitioners who attend.	All invited, don't report on proportion of practitioners who attend.
	8.4 All DHBs produce an annual maternity report.	Underway for 2012, will be completed June 2013
	8.5 DHBs can demonstrate that consumer representatives are involved in their audit of maternity services.	Yes
9. All DHBs work with professional organisations And consumer groups to identify the needs of their population and provide appropriate services accordingly.	9.1 All DHBs plan, provide and report on appropriate and accessible maternity services to meet the needs of their population.	In Strategic Planning and Annual Report
	9.2 All DHBs 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.	In Strategic Planning and Annual Report
	9.3 All DHBs plan and provide appropriate services For the groups of women within their population who are accessing maternity services and who have identified additional health and social needs.	In Strategic Planning and Annual Report

Audit Criteria	Measurement	
	9.4 The proportion of women with additional health and social needs who receive continuity of midwifery care is measured and increases over time.	Data collection to be devised and collated
10. Communication between maternity providers is open and effective.	10.1 Local multidisciplinary clinical audit demonstrates effective communication among maternity providers.	Audit across LMCs
	10.2 The number of sentinel and serious events in which poor communication is identified as a risk decreases over time.	Review of past sentinel events for communication issues
11. A national set of evidence-informed clinical guidelines is implemented within each DHB funded Maternity service.	11.1 The number of national evidence-informed clinical guidelines implemented in each DHB funded maternity service increases over time.	
12. National maternity service specifications are implemented within each DHB-funded maternity service.	12.1 100% maternity service specifications are implemented in each DHB-funded maternity service.	Yes

Audit criteria Measurement

Standard Two:

Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage.

Audit Criteria	**Measurement**	
16. All women have access to pregnancy, childbirth and parenting information and education services.	16.1 All DHBs provide access to pregnancy, childbirth and parenting information and education services.	Yes
17. All DHBs obtain and respond to regular consumer feedback on maternity services.	17.1 All DHBs apply the national tool for feedback on maternity services at least once every five years.	yes
	17.2 All DHBs demonstrate in their annual maternity report how they have responded to consumer feedback on maternity services.	Yes
18. Maternity services are culturally safe and appropriate.	18.1 Consumer feedback demonstrates that consumers consider the services to be culturally safe and appropriate.	
	18.2 All DHBs demonstrate in their annual maternity reports how they have responded to consumer Feedback on whether services are culturally safe and appropriate.	
19. Women can access continuity of care from A Lead Maternity Carer for primary maternity care.	19.1 All DHBs have a mechanism to provide Information about local maternity facilities and services and facilitate women’s contact with Lead Maternity Carers and primary care.	Yes
	19.2 The proportion of women accessing continuity of care from a Lead Maternity Carer for primary maternity care is reported in each DHB’s annual maternity report.	Yes

Audit criteria Measurement

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.

A

Audit Criteria	**Measurement**	
22. All DHBs plan locally and regionally to provide the nationally agreed levels of primary, secondary and tertiary maternity facilities and services for their population.	22.1 Local services are consistent with the national and regional plans and are accessible and appropriate for the local population.	
23. Women and their babies have access to the levels of maternity and newborn services, including mental health, that are clinically indicated.	23.1 Local multidisciplinary clinical audit demonstrates women and babies have access to levels of care that are clinically indicated.	Data collection to be devised and collated
24. Primary, secondary and tertiary services are effectively linked with seamless transfer of Clinical responsibility between levels of maternity care, and between maternity and other health services.	24.1 All DHBs report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility.	Next annual report
	24.2 Local multidisciplinary clinical audit demonstrates effective linkages between services.	Data collection to be devised and collated
25. All DHBs plan locally and regionally for effective clinical and organisational pathways to respond to maternity and neonatal emergencies.	25.1 All DHBs have local and regional maternity and neonatal emergency response plans agreed by key stakeholders including emergency response services.	Yes
	25.2 All maternity providers can demonstrate knowledge of local and regional maternity and neonatal emergency response plans.	Yes
	25.3 Local multidisciplinary clinical audit demonstrates effective communication among maternity providers in cases of clinical emergency.	Data collection to be devised and collated
26. Women whose care is provided by a secondary Or tertiary service receives continuity of midwifery and obstetric care.	26.1 All DHBs provide, or accommodate, a model Of continuity of midwifery and obstetric care when secondary or tertiary services are responsible for the woman’s care.	Under development
	26.2 Consumer feedback demonstrates that an increasing proportion of women requiring secondary or tertiary level care are satisfied with the continuity of midwifery and obstetric care they received.	Under development

Section Five: Forward Planning

In the 2012 year the MCGG have identified 3 ongoing work streams to continue to establish the elements of the Maternity Quality and Safety Programme. As a result of this they have established 3 working groups to focus on these areas:

- Data/Dashboard/Documentation
- Sector & Consumer Engagement
- Strategic Planning

These working groups sit along side the rest of the work the MCGG is undertaking from the 2012-2013 strategic plan and upcoming items as raised.

As we were ambitious with our first strategic plan for the July 2012 - June 2013 timeframe, there are several items as outlined earlier that are ongoing. We will continue to work on these for the latter half of 2013, and commence our next strategic plan for the 2014 calendar year.

Maternal Mental Health

The PMMRC 2010 recommended a strengthening of maternal mental health provision. In 2012 a multidisciplinary meeting was held and a referral pathway drafted to navigate amongst the disparate mental health providers within the DHB.

The vision of the maternity service is to provide a multidisciplinary approach to women with mental health concerns, to provide a seamless wrap-around service. Discussions with Regional Maternal Mental Health have provided potential areas of collaboration that will be cemented in 2013.

Maternal mental health was invited to be a member of the Vulnerable Women’s Group.

From March 2013, Hutt Maternity is starting a monthly combined clinic with Maternal Mental Health Services. This is run by a dedicated Obstetrician and Midwife, alongside a specialist nurse from Regional Maternal Mental Health, supported by a Psychiatrist.

Increasing targets to reduce smoking

As mentioned early the MCGG are awaiting further communications/information from Sector Capability and Implementation/Tobacco Control about the ‘Better help for smokers to quit’ health target to plan strategies moving forward.

Maternal and Child Nutrition and Physical Activity Services

HEHA change to RFP for Maternal and Child Nutrition and Physical Activity Services – late 2012 Regional Public Health, HVDHB, CCDHB, and WDHB collaborated in an EOI to the Ministry of Health for a sub-regional approach to maternal and child nutrition, awaiting MOH response.

Obstetric Cardiology

Hutt Maternity has been negotiating improved access to Cardiology for pregnant women. The DHB has a Cardiologist with special interest in Obstetrics. The aim is to have an ongoing closer consultative process for pregnant women needing cardiologist input.

Appendix One: Data Information

Data Sources

Data for birth numbers and clinical indicators was sourced from hospital events stored in the Hutt Patient Management System (IBA) and the Hutt Maternity Database (Concerto).

Data from the Hutt PMS is reported to the National Minimum Dataset (NMDS) and coded using ICD-10-AM-v6 clinical codes. Therefore the coding rules followed for extracting patients to meet the specifications of this report were obtained from the Ministry of Health's Analytical Services team.

Data captured in the Maternity Database is sourced from online forms completed by Maternity staff during the patient admission and the clinical summary completed by the consultant after patient discharge. This data was used to determine the parity of the patient and provide detailed Breast Feeding reporting as this information is not available using clinical codes.

For this report, all women discharged following a publicly funded hospital birth in 2012 and all babies live-born in hospital in 2012 were selected based on the rules listed below. Specific conditions and procedures (including birth type) were identified using ICD-10-AM-v6 clinical codes.

Coding extract rules for Mothers

All records (including privately funded) where any of the following codes are present, and where Delivery date (DPD, if null then ESD) is between 01/01/2012 and 31/12/2012:

- Z370 to Z379 (ICD-10-AM-v6, outcome of delivery)
- O80 to O82 (ICD-10-AM-v6, delivery diagnosis code)
- 9046700, 9046800, 9046801, 9046802, 9046803, 9046804, 9046805, 9046900, 9046901, 9047000, 9047001, 9047002, 9047003, 9047004, 1652000, 1652001, 1652002, 1652003 (Blocks 1336 to 1340) (ICD-10-AM-v6, delivery procedure code)

Coding extract rules for Babies

Please extract all records (including privately funded) where Event start date is between 01/01/2010 and 31/12/2010 and at least one of the following criteria is met:

- any diagnosis code is equal to Z380 to Z388 (ICD-10-AM-v6, Live born infant)
- Event type = BT

Standard Primiparae

Must meet all the following criteria:

- No previous pregnancy of 20+ weeks, and
- Maternal age 20-34, and
- Cephalic presentation, and

- Singleton, and
- Term gestation, and
- Without specified medical complications

New Zealand Maternity Clinical Indicators

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

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

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

Appendix Two: Terms of Reference MCGG

Hutt Valley District Health Board Maternity Clinical Governance Group (MCGG)

Background

The Ministry of Health (MOH) have provided a national quality and safety programme in order to improve quality of maternity care and outcomes across New Zealand.
The programme is based upon: the Maternity Standards 2011; Referral Guidelines 2011; Primary Maternity Services Notice 2007 (Section 88); DHB Maternity Service Specifications; New Zealand Maternity Clinical Indicators; and New Zealand Maternity Clinical Guidelines.
Hutt Valley DHB, chosen as an original quality demonstration site in 2010, developed a clinical governance structure to oversee and ensure coherence of all maternity quality and safety activities. The continuance of the project with an enhanced governance structure will augment existing activities and inform future direction.

The establishment of the Maternity Clinical Governance Group (MCGG) provides a mechanism whereby clinicians and community representatives can provide advice to form the strategic direction of maternity services as it pertains to the health and wellbeing of women using maternity services across the Hutt Valley District Health Board.

Scope

Maternity quality and safety activities incorporating internal and external stakeholders, across both hospital and community.

Purpose

- To oversee and ensure coherence of maternity quality and safety activities
- To provide visible leadership and expert advice throughout the DHB and community regarding quality and safety activities
- To provide a focus for multidisciplinary maternity stakeholders to work collaboratively
- To provide a conduit for information exchange between the maternity service and the community
- To support the implementation of recommendations from local quality initiatives eg clinical reviews, and national bodies such as Perinatal Maternal Mortality Review Committee and the National Maternity Group
- To make decisions about quality improvement activates
- To ensure strategic alignment with DHB, regional and national quality and safety policies
- To oversee the production of the annual maternity report on maternity services and outcomes
- To report issues and risks to the Strategic Clinical and Corporate Governance Group (SCCG).

Meeting Frequency

The group will plan to meet initially monthly, and then frequency of meetings to be determined by the group, but a minimum of four times a year. *NB: Additional meetings can take place at the discretion of the Chairperson and with the approval of the clinical director to address any pertinent quality or safety issues.*

Chairperson

The MCGG group will nominate a chair person and deputy chairperson at the first meeting. Ideally the chair will sit on the directorate strategic governance group.

Quorum

A quorum will consist of a minimum of 6 group members (including the Chair/Deputy Chair) plus one.
NB: In the event of the planned absence of one of the elected clinical representatives, a proxy can be nominated and attend in their place. Group members should notify the Chair, in advance of the meeting, of their proxy nomination.

Reporting requirements

The MCGG will report as required to the SCCG as appropriate.
The SCCG, CEO or Board can request specific reports from the MCGG.
The MCGG will provide input and sign-off of the annual maternity report as required by the MOH.

Membership/representation

Individuals will be appointed to the MCGG on the basis of their experience and expertise in maternal health.
Each appointment will be for a specified term of 1 year with the option of reappointment

Membership of the group shall be a combination of the following:

- Director of Operations, SWCD
- Clinical Head of Department (or delegate)
- Clinical Midwifery Manager (or delegate)
- 1 HVDHB Quality Team Representative
- 1 SWCD Quality Facilitator
- Paediatric Representative
- Core Midwife Representative
- Lead Maternity Carers’ Representative
- 1-2 Consumer Representative(s)
- 1 Primary Health Representative
- Planning and Funding Representative
- Maori Health Representative
- Pacific Health Representative

Other experts can be co-opted to the group for short periods to advise/ assist with particular work undertaken by the group.

Dual representation is acceptable as long as it does not create a conflict of interest. Conflicts of interest need to be declared and minuted.

Duties and responsibilities of members of the MCGG

- active participation in meetings and work groups as needed
- 100% attendance at meetings, or in the event of not being able to attend, notifies the MCGG Chair and arranges a proxy.
- recommend improvements to processes and systems
- Active involvement in actioning recommendations and monitoring the results.

Financial acknowledgement for non DHB members of the MCGG

A payment to cover costs of attending meetings will be available for non HVDHB members, as set in the role description reviewable by MCGG annually

General:

- This is not a forum to discuss individual competence. Where competence issues are apparent the chair (or professional leader) should consider referring the matter to the appropriate professional leads or bodies.
- Consideration should be given to the need to inform the relevant senior clinical/management leaders or the SCGG of events known or potential medico-legal or reputational risk for individual clinicians or the DHB, eg involving coroner, HDC, ACC or likely to generate a significant complaint.
- TOR will be reviewed annually by the group
- The MCGG is registered as a PQAA

Confidentiality:

Individual’s comments and conversations are to remain within the setting of the meeting.