Maternity Quality & Safety Programme

Annual Report
Bay of Plenty District Health Board

1 July 2013 – 30 June 2014

Bay of Plenty District Health Board – Women, Child and Family

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The Governance group would also like to acknowledge the women and families/whanau that have provided valuable feedback on our maternity services. Through this feedback we are able to work towards improving quality and safety of our maternity services in Bay of Plenty District Health Board.
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Section 1

Our Vision

Healthy, thriving communities
Kia Momoho Te Hapori Oranga

Our Mission

Enabling communities to achieve good health and independence and ensure access to high-quality services.

Our Values

| Compassion | • We will treat everyone with empathy and compassion  
|            | • We will respect everyone.  
|            | • We will recognise the suffering of others and take action to help.  
|            | • We will preserve people’s dignity.  |
| Attitude   | • We will work constructively with people.  
|            | • We will lead by example.  
|            | • We will promote positive attitudes to healthy living.  
|            | • We will support patients to make choices that will improve their health.  |
| Responsiveness | • We will respond to people’s needs in a timely and appropriate way.  
|               | • We will recognise and respect individual needs and requirements.  
|               | • We will interact in ways which are culturally sensitive, and responsive, to our communities  |
| Excellence  | • We will strive to do the right thing in the right way, each and every time.  
|            | • We will do the best we can, with the resources we have, at the time.  
|            | • We will encourage and support all to participate in educational opportunities and to up-skill.  
|            | • We will recognise and celebrate when people deliver on excellence.  
|            | • We recognise that excellence is a dynamic concept, and will continuously strive for improvement.  |
Maternity Quality and Safety Programme

The purpose of establishing the Maternity Quality and Safety Programme is to find effective ways to deliver appropriate maternity services with maternity providers and consumers working 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

This Annual Report covers the implementation and outcomes of BOP DHB’s Maternity Quality & Safety Programme in 2013/2014, as required under section 2.2c of the Maternity Quality & Safety Programme Crown Funding Agreement (CFA) Variation (Schedule B42):

This Annual Report:

- Demonstrates BOP DHB’s delivery of the expected outputs as set out in Section 2 of the Maternity Quality and Safety Programme CFA Variation
- Outlines progress towards BOP DHB’s MQSP Strategic Plan deliverables in 2013/14
- Showcase BOP DHB’s priorities, deliverables and planned actions for 2014/2015 and arrangements undertaken/planned to enable smooth transition of Maternity quality and safety programme to business as usual from July 2015

The vision and mission statements of the Bay of Plenty District Health Board align with the purpose and establishment of the Maternity Quality and Safety programme.
Background

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

<table>
<thead>
<tr>
<th>Expectations of the New Zealand Maternity Standards:</th>
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<tr>
<td><strong>Standard One:</strong> Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies</td>
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<tr>
<td>8.2 Report on implementation of findings and recommendations from multidisciplinary meetings</td>
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<td>8.4 Produce an annual maternity report</td>
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<td>8.5 Demonstrate that consumer representatives are involved in the audit of maternity services at Bay of Plenty DHB</td>
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<td>9.1 Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Bay of Plenty district</td>
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<td>9.2 Identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health needs</td>
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<td><strong>Standard Two:</strong> Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage.</td>
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<td>17.2 Demonstrate in the annual maternity report how Bay of Plenty DHB have responded to consumer feedback on whether services are culturally safe</td>
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<td>19.2 Report on the proportion of women accessing continuity of care from a Lead Maternity Carer for primary maternity care</td>
</tr>
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<td><strong>Standard Three:</strong> 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.</td>
</tr>
<tr>
<td>24.1 Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility</td>
</tr>
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Objectives: Bay of Plenty DHB’s MQSP for 2014/15

- Cultural Responsiveness of all MQSP initiatives
- Establish consumer feedback at all levels of maternity services
- Review and redesign the patient transfer services
- Increase the number of Smoke free pregnancies
- Promoting early booking with midwife
- Establish database for real-time reporting
- Reviewing the implementation of Referral guidelines
- Aligning the program with the priorities of national bodies
- Transition of MQSP initiatives to business as usual
Understanding district population is an important step towards understanding population specific needs. It does not only involve knowing about the numbers; it is learning about cultural sensitivities and their barriers.

The Bay of Plenty District Health Board has an estimated population of 210,000 people which ranks 5th in 16 regions across New Zealand and covers an area of nearly 10,000 square kilometres. (Statistics New Zealand, 2010).

Three quarters live in the Western Bay of Plenty with nearly half living in the main urban area of Tauranga City. One quarter of the population live in the Eastern Bay of Plenty.

For population aged over 15 years in Bay of Plenty region, the median income is $22,600 compared to $24,000 of New Zealand as whole. By ethnicity, Maori population in this district has a median income of $19,000.
Approximately one-quarter of the population are Maori with about half of the nearly 67000 Maori living in the Western Bay of Plenty and half in the Eastern Bay of Plenty.

The Median Age is 37.8 years for people in Bay of Plenty Region as compared to 35.7 years for the New Zealand as whole. 14.8% of population is over 65 years with only 4.8% of Maori falling into this age group.


**Uptake of Maternity Services**

**Introduction:**

In the 2012 Calendar year, in Bay of Plenty district:

- 2978 Labours were recorded
- Of the total recorded, 55 were handled in Tertiary (1.84 %); 2,655 in Secondary (89.15 %); 102 in Primary Facility (3.42 %) and 128 home births (4.29 %)

**Maternal Demographic Profile:**

In the 2012 calendar year, in Bay of Plenty district:

- Approximately half of women giving birth were European (50.63 %)
- 38.71% of all the women giving birth were Maori by ethnicity;
- Nearly one in every ten women giving birth were either an Asian or Pacific (6.61 % & 2.92 %)
- The most common age group for a woman giving birth was 25-29 years (26.19 %) followed by 30-34 years (24.51 %)
- Approximately, 9.8% of all women giving birth were teenagers (16-19 years)
- Maori women comprised 70% of all teenage pregnancies (16-19 years).
- 27.6 % of all women giving birth lived in the most socioeconomically deprived areas (quintile 5) of which nearly 70% were Maori by ethnicity.

**Maternity Facilities**

In the 2012 calendar year, in Bay of Plenty district:

- Majority of Women (89.15 %) gave birth at Secondary Facility (Tauranga and Whakatane Hospital) in contrast to 1.84 % at Tertiary (Waikato) and 3.42 % at Primary Facility.
- 4.29% of women were reported to have homebirth of which European and Maori women contributed one half to it.
- Women living in the most deprived areas were the most likely to give birth at a primary facility (68.62 % of quintile 5 women) or a Homebirth (33.59 % of quintile 5 women).
One of the prominent issues identified by the BOPDHB on analysing maternity clinical indicators provided by Ministry of Health is the significant variation in some indicators between its two facilities; Tauranga and Whakatane. One possible reason for such variation could be the result of difference in the needs of the population or the consistent use of overseas locum in Whakatane Facility. These findings needed further investigation.

Registration with midwife within first trimester is yet another challenge for BOP DHB maternity services. BOP DHB has witnessed only slight improvement in the number of women who register with a midwife within first trimester.

Another long standing challenge is the disparity in the health status of Maori population when compared with Non-Maori population. Some of the areas where figures show significant variation are:

- Pregnancy complications;
- Conditions around the time of birth;
- Mental health.
- Smoking in pregnancy
- Timing of Midwife Registration
- Immunization
- Engagement with well child providers

Multidisciplinary meetings like perinatal case reviews have brought another challenge into focus. Significant number of issues have been identified with the patient transfer process from Secondary (Tauranga) facilities to Tertiary Facility and vice versa in terms of sharing patient information and appropriate point of contact at both ends.
Steps Taken So Far

- To counter variations across sites and to address the MOH recommendation of national consistency both facilities are holding video linked monthly case reviews which give them an opportunity to understand each other and to learn from other experiences.

- Planning is underway to record these case reviews without any specific patient details and then posting on Bay Navigator as audio/video podcasts which can be accessed by Community and Hospital based maternity practitioners.

- Workforce challenge has been addressed effectively by employing long term Locum obstetricians rather than offering short term contracts. (Minimum 12 months). Whakatane has now appointed permanent obstetricians.

- To address the long standing issue of health disparity, Maternity and Quality Governance group has invited Director of Maori Health Services to the Group (in addition to Iwi Representatives) which will help the group to better understand the specific needs of the group and will further help to device Quality improvement measures tailored to their needs.

- Robust Patient Transfer plan has been designed at Regional level. Feedbacks are being sought from each DHB involved which will be followed by the implementation phase.
Maternity Service Configuration

- All primary care is provided by the Lead Maternity Carer (LMC) which is Midwives with only one General Practitioner holding an Access Agreement with the Bay of Plenty DHB, there are no LMC Obstetricians.

- The Maternity service has two secondary care maternity facilities at the Whakatane and Tauranga Hospitals, with primary birthing units at Murupara and Opotiki.

- The two secondary care units are staffed with midwives and a small number of registered nurses.

- Obstetricians are available in both the secondary care facilities with Registrars and House Surgeons on the Tauranga site.

- Whakatane and Tauranga both have level two Neonatal Services - Special Care Baby Units.

- Waikato Hospital is the Tertiary Centre provider for the Bay of Plenty District.

- There are a very small number of women that do not register with an LMC. Unless their delivery is imminent the women are given a list of Lead Maternity Carers and offered assistance in engaging one.

- If the woman is delivered by the Maternity Unit staff midwife, then a midwife is found to provide the postnatal care. If they are an out of town visitor their LMC will be contacted and updated.

- The LMC is supported by the secondary service which consists of Obstetricians, Paediatricians, Midwives, Neonatal Nurses, and Lactation consultants.
- Antenatal education is provided by external providers who have a contract with Planning & Funding to provide the education. In addition to this, Bay Of Plenty District Health Board have three Kaupapa Maori antenatal education providers.

- Currently there are 65 access holders in the Western Bay and 13 in the Eastern Bay.

- The access holders do have varying caseloads; however there is an opportunity for all women to have a Lead Maternity Carer.

- Bay of Plenty District Health Board has achieved and maintained Baby Friendly Hospital Initiative (BFHI) status in the Tauranga, Whakatane and Opotiki facilities. Murupara was exempt from this process.
Bay of Plenty DHB has worked both regionally and on local level on this priority work stream in compliance with NMMG and other national body’s recommendations. Analysis of the data provided by the Ministry of Health and the National Maternity Monitoring Group has the following key points:

- Bay of Plenty has one of the greatest proportions of women who are registered with LMC at any point of time of pregnancy (99.4% - BOP; 99.7% - Otago as per Maternity Annual Report 2010).

- BOPDHB through its effective and efficient Maternity Service Configuration is above the national average of number of women registered with LMC within first Trimester.

- As per the data provided by Ministry of Health for the year 2012, 68.08 % of all women were registered with within the first trimester of pregnancy against the national average of 64%
By the second Trimester, approximately 95% of women were registered with LMC against the national average of 83.7%.

By ethnicity, Maori and Pacific women are less likely to get registered with LMCs within first trimester of Pregnancy (51.1% and 42.52% respectively).

Rates of Registration with LMC increases with the increasing age group. Only 59.29% of pregnant teenage women were registered with LMC within first trimester compared to 75.47% for age group 30-34 years and 72.3% for group 25-29 years of age.

Through the data analysis, we have been able to identify at-risk population groups in terms of ethnicity and age group which has enabled us to design interventions targeting specific group of population. For this purpose, we have established strong working relationship with community providers of maternity services through MQSP Governance Group to enable integration of services to support this priority.

With the help of consumer and Maori health services representatives on the governance group, we have been able to identify some common barriers for early registration. Consumer representatives interviewed mothers in the parenting groups and survey in the Tauranga and Whakatane maternity units has concluded that public awareness and ease of access are the areas where improvements can be made. During interviews, even the large proportion of mothers who understood the importance of early registration with midwife stated they were not sure of the appropriate channels through which they could book a midwife.

For both the years 2011/2012 there are specific vulnerable ethnic groups which has significantly higher number of women who register late with the LMC compared to other ethnic groups. In the year 2012, only 51% of Maori women register within the first trimester against the BOP average of 68%. For this reason, MQSP
governance group with the help of Iwi Reps has used “Health equity assessment tool” to identify cultural barriers and health equity issues.

Following these findings, Governance group discussed about devising strategies to promote awareness not just about the importance of early booking but also about the available channels through which women can book a midwife. Initially “Finding Health Professional” section was introduced on the public website to help people finding nearest G.P. or midwife. In addition to this, dedicated Maternity resource webpage “Planning or Having a Baby” within BOPDHB public website was introduced which gives a clear overview of the Maternity services and emphasizes the benefits of early registration with LMC.

It was further realised that there is a need to promote these developments and messages around importance of early booking with midwife. WCF worked with communications team at BOPDHB to design a communication plan for the promotional campaign. This was also put on table with the Governance group and outcomes were incorporated into the plan. Communication team picked up NHS programme “ASAP- As Soon As You’re Pregnant” as an example and worked closely with NHS London to share ideas and resources. With this, we now have long term promotional campaign plan ready and campaign will be launched in April 2014. This campaign also promotes “Find Your Midwife” website for easy access to list of midwives. Some key points of the campaign:

- In addition to Social and print media, posters and flyers will be used at GPs, PHOs, Maternity/Midwife Centres, Family Planning, Pharmacies, Parent Centres, Plunket offices, Health NGO’s including Maori/Pacific providers, Hospital campuses (ED, maternity, paediatrics), Social workers, School nurses/counsellors, Work and Income offices, Iwi (marae, kapa haka groups), Multicultural and ethnic-based agencies, Local businesses and Schools/kindergartens/kohanga reo.

- Posters in holder at back of the toilets in supermarkets, bars, cafes, cinemas.
• Information wallet cards or leaflets added to the pregnancy test kits available at pharmacies.

• Print Media : Press releases, Health Matters articles (Weekend Sun, Bay Weekend), Health Promoting Schools newsletter, WorkWell e-newsletter

• Message Badges for GP and Pharmacy staff.

In addition to this, Lead Maternity Carers are offered to participate in Cultural safety education programme which enable them to understand the cultural needs of our district. This education programme is compulsory for all DHB maternity provider staff.

BOPDHB has reviewed non-LMC claims data provided by Ministry of Health. It was realised that these numbers are significant and needs attention as there is a high tendency for a missed screening in these women. Feedback was sought from GP representatives on the group who with discussion with other GPs reported that most GPs are not very sure of scans and screenings that needs to be done. To address this, Governance group decided to send out the updated service specification to all GPs. Also, work is underway to upload it to the Bay Navigator which can be accessed by the non-hospital staff and will be available as a reference for GPs even after the completion of MQSP programme.
BOP DHB supports the MoH approach to Immunisation as “is one of the most effective and cost-effective medical interventions to prevent disease”. The New Zealand government therefore offers a series of free childhood immunisations to babies, children and adults known as the National Immunisation Schedule.

It is generally agreed that to reach the national targets there are a number of proven actions that needs to be implemented are:

- All children should be enrolled with a general practice as soon as possible after birth.
- Parents should be contacted before each immunisation is due.
- Immunisation appointments should be made at a time that suits the parents.

MQSP Governance group has joined hands with Well Child / Tamariki Ora Quality Improvement team to work collaboratively to improve safety and quality experience for the child and family/whānau. With this linkage, it was established that quality and safety of services can be measured, to some degree, by the uptake of and continued engagement with services, as families will be more likely to access and remain involved with acceptable, high-quality services that address barriers to access for families.
Meeting the Ministry of Health’s immunisation target of 85% of eight-month-olds to have their primary course of immunisation at six weeks, three months and five months on time by July 2013, BOPDHB has worked on various fronts to witness significant improvement in the immunization rates to surpass the national target. In the year 2013, BOPDHB was able to achieve national target in all the quarters. Planning is underway to design strategies to increase rates to meet the increased national target of 90% by July 2014 and 95% by December 2014.

The Bay of Plenty District Health Board funds the Primary Health Organizations in the district to immunise children and there are some GP practices that have struggled to achieve the Government’s targets, while others Te Kaha and Waitangi practices have achieved 100%. We are working more closely with the PHOs, GPs and practice nurses resulting in increasing numbers of our children immunised. Our actions have included emphasizing the need for GPs practice systems to be up-to-date and compatible with and staff using the NIR.
In 2013, BOPDHB has again achieved BFHI accreditation which is a joint UNICEF and WHO project and aims to increase breastfeeding rates and encourage global breastfeeding standards for maternity services. BOP DHB encourages practices that fully protect, promote and support exclusive breastfeeding from birth.

BOP DHB produces monthly reports on breastfeeding on defined Key Performance Indicators which helps to identify service gaps and areas of improvement. The figure below shows the Exclusive breastfeed KPI results for all the facilities.

As documented in 2012/13 BOPDHB work plan, options have been explored for use of IT applications to improve access to information for Māori and disadvantaged mothers.

As per BFHI requirement, the breastfeeding resource book is now being translated into other languages even where the maternity population of specific language is less than 5% so that information can be easily understood.
Maternal smoking is the largest modifiable risk factor affecting foetal and infant health in the developed world. The significant number of women smoking during pregnancy is a major health concern. To reduce the health impact of smoking on the community the Bay of Plenty District health board has staff working in Smoke free Health promotion, enforcement of the smoke free Environments act and assisting people to quit smoking.

**Steps Taken So Far**

Studies have proved that women who smoke are more likely to stop during pregnancy than any other time in their lives. Considering this valuable opportunity, two new roles of smoke free co-ordinators (0.6 FTE) has been added to the existing role, as the smoke free coordinators are also safe sleep champions and pepi-pod distributors.

With the introduction of these two new roles, a variety of initiatives have been taken to provide better support with the interventions for promoting smoking cessation in pregnancy. Issues were identified in all the areas of DHB around the
documentation of “ABC” screening where patients are often screened but not reflected in the documented. Steps now have been taken in maternity with the help of smoke free coordinators to improve the documentation of the screening. Some initiatives include:

- Daily Auditing of all admissions to check if screening is documented which is evidenced by the use of green stickers.
- Strong working relationship between primary health workers and DHB staff through Smoke free coalition group. This engagement enables effective communication between service providers, collaboration of strategies, updates of national initiatives and support and education.
- Smoke free coordinators are facilitating NZ Heart Foundation online smoking cessation training for all the maternity care providers, which allow them to become quitcard providers. Staff who have already done this course in the past have been asked to take this course as a refresher. This training is also available for all LMCs.
- Smoke free coordinators are in process of developing a “smoking and pregnancy” booklet for the pregnant women who are identified as smoker. This booklet is designed in a way to work as a personalised diary and as a companion on their journey to quit smoking keeping them motivated.

Planning is underway to issue this booklet to all LMCs so that they can then give it to pregnant women who smoke at the time of booking along with “Quit Pack” which contains all written resources in zip lock bag.
Every year of the total two hundred and fifty infant deaths, about sixty die from Sudden Unexpected Death in Infancy (SUDI) which makes SUDI the leading cause of preventable post-neonatal deaths in New Zealand. SUDI rates for BOPDHB is just under the national average, quite low regionally but relatively high when compared with some other DHBs in the country.

Steps Taken So Far

Considering significantly high SUDI rates in the region, BOPDHB stood in support of this issue in regional meetings. BOPDHB has worked closely with other DHBs in the Midland region to develop a region wide Safe Sleep policy.

Aligning with other DHBs, Bay of Plenty District Health Board is also a member of the Pepi-Pod programme which was developed as a public health intervention for tailoring protection directly to more vulnerable babies. Under this programme, Pepi-pods are being offered to families of more vulnerable babies, to help reduce sudden infant deaths, and are making a positive difference, especially for Māori. Quality distribution process and safe sleep awareness are the key performance indicators of the programme.
The 2013 Pepi-pod programme report released by Change for our children has acknowledged and appreciated the efforts of safe sleep champions and all other maternity care providers at BOPDHB for achieving an average diffusion of awareness rate of 9.1 others per person followed compared to 5.0 for the all the DHB group as whole.

**Pepi-Pod Programme Report 2013**
The Bay of Plenty DHB maternity quality and safety programme is governed by a multidisciplinary team. The Governance Group includes professional, consumer, administration and management representations along with representatives for the population to ensure that the cultural needs are met and are safe and appropriate.

The Table below shows the structure of the Governance Group:

<table>
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<tr>
<th>Role</th>
<th>Number</th>
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<tbody>
<tr>
<td>Lead Maternity Carers</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Midwife Manager</td>
<td>2</td>
</tr>
<tr>
<td>Midwifery Leader</td>
<td>1</td>
</tr>
<tr>
<td>Project Manager MQSP</td>
<td>1</td>
</tr>
<tr>
<td>Midwifery Educator</td>
<td>1</td>
</tr>
<tr>
<td>Consumer Reps from Tauranga and Whakatane</td>
<td>2</td>
</tr>
<tr>
<td>GP Liaison</td>
<td>2</td>
</tr>
<tr>
<td>Iwi Reps</td>
<td>2</td>
</tr>
<tr>
<td>Quality and Patient Safety Representative</td>
<td>1</td>
</tr>
<tr>
<td>Obstetricians</td>
<td>2</td>
</tr>
<tr>
<td>Paediatricians</td>
<td>2</td>
</tr>
<tr>
<td>Anaesthetist</td>
<td>2</td>
</tr>
<tr>
<td>Radiologist</td>
<td>2</td>
</tr>
<tr>
<td>Mater Mental Health Representatives</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
The clinical leadership positions utilize the existing clinical governance structure that has been in existence and working effectively for a number of years. The Obstetrics and Gynaecology HOD and the Midwife Leader are supported in their roles by the Project Manager in the operations of this project.

Their work is endorsed and supported by the Medical Leader and the Business Leader for the WC&F Service. This structure reports through to both the Chief Operating Officer and Planning and Funding General Manager and then to the Chief Executive Officer, who will then report to the Bay of Plenty District Health Board.

### Responsibilities & Operations

- Oversee the production of an annual report on maternity services and outcomes
- Oversee the implementation of maternity quality and safety activities
- Ensure consistency across the quality activities
- Support the implementation of recommendations from national bodies such as the Perinatal and Maternal Mortality Review Committee (PMMRC) and the National Maternity Group
- Contribute to discussions and decisions about maternity care at DHB level, including making recommendations to other decision makers
- Take decisions about quality improvement activities

The frequency of the Governance Group meetings have been increased to every two months unless indicated before for up to two hours each meeting to oversee and guide the implementation of the programme.
Bay of Plenty DHB recognizes consumer involvement as a key strategy for any Quality improvement process. To have consumer Representative on-board for the Governance Group, Bay of Plenty DHB has contacted the people that have made themselves available through the Maternity Quality and Safety workshops, with the Maori Health Services and consumers via the NZ College of Midwives Midwifery Standards Review.

The aim was to have a right candidate who can advocate for the improvement of the maternity services to better meet the needs of people and their family/whanau including using personal experiences, or those of others to illustrate service gaps or opportunities for improvement. For this purpose, BOPDHB targeted “hard to reach population” as recommended by Ministry of Health who help us to design the Quality Improvement initiatives which addresses population specific issues like access to health services, Cultural issues etc.

Governance Group has two consumer Representatives for each end (Tauranga and Whakatane). Both the representatives are very proactive and have experienced maternity services recently in the region. Their valuable feedback on many occasions has enabled the group to look at the initiatives from consumer perspective and making appropriate changes.

As a part of Maternity Quality and Safety Programme, it was agreed by all to open new channels for consumer feedback which provides a basis for reviewing and upgrading existing systems and practice. Within the maternity webpage, consumers now have the opportunity to leave a feedback of the services. Numbers of
responses received are increasing evidencing that this is a preferred channel of communication. The WCF will continue to engage with its community and be responsive to feedback.

Some issues that have been identified following consumer feedback are as follows:

- Facilities not catering for partners to stay overnight has been raised as an issue by vast majority of patients.
- Breastfeeding resources during pregnancy did not prepare women for the reality of the hard work and difficulty it took to establish this.
- Mental stress associated with unsuccessful breastfeeding.
- Lack of appropriate referral for specialist input during the first weeks after the birth resulted in undue stress
- Social pressure/expectation to deliver naturally and to have things go as per birthing plan which set unrealistic expectations for the event of birth which more often than not does not go to plan and they felt as they had failed at something.

**Steps Taken So Far**

Feedbacks were discussed regionally and with lactation consultants in Tauranga hospital. Following the discussions, it was concluded to review current and introduce new and user friendly resources for consumers which is easy to follow and is supportive for women. Recently, it was further extended to include other areas of maternity. Bay Of Plenty District Health Board is working with midland regional DHB’s to introduce maternity application for mobile devices. It was discussed to implement in two phases. In the first phase, all the resources will be published on the regional consumer website. Feedback will be sought from the consumers following which resources will be launched as a mobile application.
BOPDHB recognizes that significant proportion of maternity care is provided by community based practitioners, so it is important to have community practitioner’s perspective while framing Quality Improvement activities. BOPDHB has increased number of community practitioner representation roles from three to four positions - GP Liaison and LMC Liaison (x2 - one from each site) who helps us to identify issues and challenges from the community practitioner’s perspective.

Community Practitioners Feedback

Community practitioners have contributed valuable feedback to the Governance group on various issues. In addition to this, some new issues has been put forth by the Representatives on the group.

**Lead Maternity Carer**

- More informative Caesarean section reviews. Should try to review all cases and not just emergency Caesarean cases.
- Policies and procedures should be reviewed to be more supportive of vaginal birth
- More information for women about the increase in risk of c/section for induction of labour
- Communication between Obstetrician and women should be more positive about normal vaginal birth.
- More channels of communication between midwives for second opinion to avoid consultation when not needed

**GP Representative**

During the discussions around early registration with midwife and the non-LMC claims data provided by Ministry of Health, GP representatives noted that there is no guidelines available to follow when pregnant women comes for consultation. It
was suggested to publish these guidelines which can be accessed by the non-hospital staff.
To this, BOPDHB has provided a copy of service specification to publish in “Health Matters” and will be sent to the PHOs for distribution to all GPs.

Maori Representation on MQSP

BOPDHB strongly believes that we all have a role to play in reducing inequalities in health in New Zealand, regardless of how we measure health. We acknowledge that Maori population are consistently disadvantaged in health and eventually these disparities affect us all. Some of the areas where figures show significant variation are:

- Timing of Registration with Midwife
- Pregnancy complications;
- Conditions around the time of birth;
- Mental health.
- Smoking in pregnancy

BOPDHB maternity Quality and Safety Governance group has Iwi affiliated members to assist with these issues. Considering the Maori population in the Bay of Plenty Region (One Quarter) and the significant gap in some indicators, as set out in the work plan, group decided to use the Health Equity Assessment Tool to assess the impact of initiative on health equity.

Maori health representative on the group has provided valuable feedback about spreading messages around importance of early booking with midwife.
The Clinical Governance Structure that is in place in the Bay of Plenty District Health Board Provider Arm lends itself to provide the governance and leadership to the maternity providers and services.

As stated in the 2012/13 report, to set up, administer and manage the systems and infrastructure for the Quality and Safety programme; WC&F initially appointed 0.8 FTE experienced Programme Manager funded by this programme. The programme manager also assists with the data analysis (including Clinical indicators) in addition to the production of MQSPF Annual maternity Report. However, due to increased workload WCF decided to make it full 1 FTE.

The WC&F Service also has a Quality and Risk Coordinator for its service that assists with the Quality processes including customer concerns, formal and informal complaints, risk register management, review of cases, certification and audits.

0.6 FTE has been allocated for Smoke free Coordinator roles to the existing Pepi Pod /Safe Sleeping coordinator (One at each end). These roles promote and support DHB initiatives for smoke free pregnancy.

The current Midwifery Leader role already includes liaising with the lead maternity carer providers. There are regular forums in place for the LMCs to meet with the Midwifery Leader and the Clinical Midwife Managers to discuss and address issues, concerns, matters of interests and any changes within the facilities.

The Midwifery Leader has an established relationship with the LMCs and manages the Access Agreements and is available at all times to the LMCs.
BOPDHB has analysed the Clinical indicators provided by MOH to drive Quality Improvement Initiatives. The aim was not just to identify the areas of improvement but to identify area of strengths as well so that strengths can be further strengthened. A Document “Maternity Clinical Indicators-Where We stand?” summarising the BOP DHB’s performance on these indicators with areas of improvement and strengths is being circulated to all maternity care providers in the region which will help them to set up priorities as per local needs.

**Spontaneous Vaginal Birth**

**Strength:** According to 2011 data released by Ministry; BOP DHB is just above the national average of spontaneous birth with 71.5% (Average 70%)

**Areas of further investigation:** But notable fact is that figures sink down by 2% (to 72.5%) in the year 2010 and further to 71.5 in 2011 when the national average increased to 70.1% in 2010 and remain almost constant at 70% in 2011.

**Instrumental Vaginal birth**

**Strength:** BOP DHB is just below the National average of instrumental vaginal birth with 13.8% (Average 13.9%)

**Areas of further Investigation:** In contrast to the year 2009; in 2010, there was a significant rise in the figures by 2.4% when the national average came down by 0.4%.

**Caesarean Section Among Primiparae**

**Strength:** Since 2009 figures for Caesarean section among primiparae were well under the national average. Numbers sunk down further in 2010 by 0.7% when national average rose by 0.1%
Areas of further Investigation: In 2011, numbers shot up by 1.1% as compared to last year whereas national average was almost stable at 15.5%.

**Induction of Labour Among Primiparae**

**Strength:** Figures were well under National average for years 2009, 2010 and 2011.

**Intact Lower Genital Tract – Vaginal Birth**

**Strength:** In the year 2009, figures were very favourable with 41% against the average of 35.6%. Also, in the year 2011, when the national average dropped by 1.7%, BOP DHB experienced 1% increase in the figures.

Areas of further Investigation: In the year 2010, BOP DHB witnessed notable drop in the figures by 6.2% (34.8%) when the national average dropped by merely 0.8%

**Episiotomy & No 3rd or 4th Degree Tear**

**Strength:** In 2010, Figures for Episiotomy with no 3rd or 4th Degree Tear further sunk down as compared to 2009 and were well within national average for both years.

**3rd or 4th Degree Tear & No Episiotomy**

This is one of the clinical indicators which have been prioritised for this programme. The numbers were high in the year 2009 where BOP DHB stood at 3.6% against the average of 2.9%. Though the figures improved next year and was below the national average but it was decided that this area needs further investigation.

Following these findings, new case reviews have been set up across the facilities to achieve consistency throughout the DHB. A separate group is studying the 3rd and 4th degree cases and working on designing clinical practice changes that can help reduce these figures.
Consistent with other populations nationally and in other parts of the developed world, Bay of Plenty region is witnessing more women and their families affected by perinatal and infant mental health disorders and addiction. Māori women generally experienced higher rates of mental illness and were therefore at increased risk of illness during the perinatal period. The specific needs of Māori younger child bearing women who have a history of mental illness has been identified as the area of concern.

**Steps Taken So Far**

BOPDHB is working regionally on Perinatal and Infant Mental Health and Addiction Project. This project has been established to increase knowledge and understanding of the region’s perinatal and infant mental health, and addiction service needs. A stock take was undertaken which confirmed that mental health and addiction services across region had referral processes in place to support women with perinatal mental health disorders. This was specific to accessing secondary level assessment and intervention.

A workshop attended by the region stakeholders considered stock take information and evidence from the literature and discussed & debated opportunities for future service delivery. The specific needs of Māori younger child bearing women who have a history of mental illness were raised as an area of concern. Workshop discussion also included perspectives about inpatient mother and baby units’ requirements, location and accessibility.

A second workshop was held to increase understanding of infant mental health service provision and whānau ora approaches to improve perinatal and infant mental health.
BOPDHB is working with other regional partners to draw best model of care for perinatal and Infant mental health services using *Healthy Beginnings guidelines* (Ministry of Health, 2012) and stock take of services.

**Strategies in Consideration**

Several strategies are into consideration with the recent publication of Healthy Beginnings (Ministry of Health, 2012) guidelines on how best to improve the mental wellbeing of mothers and infants.

**Established Pathways**

Development of a maternal or perinatal mental health pathway which articulates the steps of care and support available to mothers from the antenatal period to the first months of an infant’s life (Department of Health2011; Ministry of Health, 2012).

**Early identification**

Given the significant predictors of perinatal and infant mental disorders, health care professionals should screen for predictors when a woman comes in contact with the service at both the antenatal and postnatal periods (National Institute for Health and Clinical Excellence, 2007).

**Early intervention**

Where intervention is required this should be undertaken seamlessly with health professionals and agencies sharing information and working collaboratively.
This analysis is based on data released up to 2011. Further analysis will be done when 2012 data is available.

With the release of clinical indicators, some members of the governance group expressed concern about the timing of the release of clinical indicators. As every release is two years behind the running year, it was suggested to establish a database/tool which reports on clinical indicator in real-time which enables the group to monitor and track any changes in the data with the implementation of any initiative.

After extensive consultation with coders, all the included and excluded conditions in each indicator were studied and coded using Maternity Clinical indicator technical notes which were then handed to decision support analysts and IT team to develop a tool. Newly developed tool/database was cross checked with ministry data for year 2009, 2010 and 2011 to confirm its reliability. This tool now can report on monthly basis and can further split clinical indicator data by several other factors like ethnicity, deprivation index etc. which enable analysts to identify vulnerable population for each indicator.
Spontaneous Vaginal Birth

Instrumental Vaginal Birth

Caesarean Section among Primiparae

Induction of Labour Among Primiparae
Intact lower Genital Tract - Vaginal Birth

Episiotomy & No 3rd or 4th Degree Tear Birth

3rd or 4th Degree Tear & No Episiotomy

Episiotomy & 3rd or 4th Degree Tear Tear
There are several Quality and Clinical effectiveness meetings occurring throughout WC&F. Current practice in the Bay of Plenty DHB is an open invitation for all maternity providers to attend any of the meetings, as per Section 88 Maternity Services of the New Zealand Public Health and Disability Act 2000.

Both facilities; Tauranga and Whakatane are holding Perinatal Mortality Meetings every three months. Cases are presented without identifying the clinical people or the women, the meetings are open to and attended by Midwives, Obstetricians, Paediatricians and invited guests where appropriate eg radiology, laboratory. Any recommendations that come out of these meetings for future pregnancies will then be documented in the woman’s notes; any practice changes will then be considered and implemented following consultation.

Audits are regularly carried out in the facilities relating to clinical practice and the findings/outcomes along with current research on best practice are then presented to the Maternity Providers. The House officers are expected to undertake an audit of a clinical practice of choice during their period of time in the Maternity Service.

LSCS reviews are done monthly in Whakatane only. These meetings collect data, look at what changes could be made and the processes around the implementation of the recommendations.

Joint training projects like PROMPT (Practical Obstetric Multi Professional Training) between Tauranga and Whakatane. This involves Obstetricians, Paediatricians, Anaesthetists, midwives and nurses.

Other reviews and Training/teaching projects includes NLS (New born life support), NZRC (New Zealand Resuscitation Council) Meetings and STABLE (Post resuscitation stabilisation of the neonate prior to transfer)

Education based on best practice is provided and extended to all maternity providers by the Midwifery Educator.
In addition to these strengths, BOPDHB through its Quality and Safety Programme has undertaken some key actions that were set out in the last Maternity Quality and Safety Programme Strategy Report.

LSCS reviews have been introduced in Tauranga facility (already in place in Whakatane) twice a month to review the Caesarean cases with an aim to evaluate whether Caesarean sections were performed on the right women at the right place and at the right time and any learning outcomes are identified and documented with further teaching organized.

Considering the significant variation in the indicators across the facilities in BOPDHB and the MOH recommendation to extend the focus from serious and sentinel events to less serious events, both facilities are holding interesting case reviews which is video linked. Specific cases are preferred which has shown variation during analysis of clinical indicators (3\textsuperscript{rd} & 4\textsuperscript{th} degree tears, Instrumental vaginal birth). It is a great opportunity for both facilities to understand the population needs of each other and to learn from them which facilitates the consistency of the data across the DHB.
Bay of Plenty DHB is currently using the existing email networking to communicate with MQSP Governance Group, External Stakeholders and Consumer Groups.

As documented in BOP DHB’s last Annual report, Bay Navigator which is BOP DHB’s shared communication platform between hospital and non-hospital staff is being widely used. BOP DHB is working regionally for joint educational training/session using Moodle learning.

New Communication Network has been established using existing technology across the two facilities. Midwifery case reviews and the Perinatal Mortality Meetings are now being done across sites using Video conference tool which gives an opportunity to share information and experience to support evidence based best practice and to achieve consistency in the maternity outcomes at the DHB level.
**Patient Notes Recording**

Patient notes recording has been reviewed and restructured so that less serious or unexpected events are highlighted and can be easily identified for further multidisciplinary discussions.

**K2 CTG Training**

K2 is a broad and deep foetal monitoring training which covers CTG interpretation and maternity crisis management. K2 Foetal Monitoring Training System, the Perinatal Training Programme is an interactive computer based training system covering a comprehensive spectrum of learning that can be accessed over the internet, anywhere, anytime, from within hospital or from home. It is a cost effective option compared to the high cost and inconvenience associated with traditional 'lecture based' training courses. This Training is available free for all maternity medical staff, staff midwives and LMCs. It is mandatory for the staff midwives to undergo this training.

**PROMPT (PRactical Obstetric MultiProfessional Training)**

PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome, clinical skills and team working.

These Multidisciplinary Joint training programmes across facilities are provided free of any cost and all maternity providers are encouraged to attend. In Bay of Plenty District Health board we have designed PROMPT as a joint training programme across the site with the aim to make a better learning experience for all.

**Personalised Growth Charts**

It was found that the use of standard growth charts is limited for clinical assessment considering the heterogeneous maternity population in the region. These findings were reviewed in the multidisciplinary reviews and all the midwives were encouraged to use the customised growth charts.
Effective Communication (SBARR)

BOP DHB recognises prompt and appropriate communication as an important key to reduce error in patient care. BOP DHB has adopted internationally recognised “SBARR” technique that provides a framework to structure communication in a constant and reliable way. It promotes patient safety because it helps practitioners communicate with each other with a shared set of expectations.

Neonatal Life Support Training

This evidence and case based full day training makes the staff competent in the evaluation and management of a new-born at birth. Learning is facilitated by extensive hands-on practice, with each candidate getting several opportunities to participate in simulated clinical scenarios, guided by positive and constructive feedback. BOP DHB actively encourages all the maternity and paediatric staff to undergo this training. To encourage more participation, this training is available free of any cost for all the maternity and paediatric staff including LMC. It is a mandatory training for the staff midwives.

Maternal Obstetric Early Warning Chart (Modified Early Warning Scorer)

To prevent delay in the specialist intervention and transfer of critically ill patient, MOEW scoring system has been introduced in the Women, child and Family BOPDHB. It is used as the track-trigger system where high score escalates the response from the medical team.

The systematic use of ‘MOEWS’ (Maternal Obstetric Early Warning Scores) and their trigger responses for pregnant women helps identify women in whom more detailed observations and examinations are required. Once the problem has been recognised the escalation of level of care proceeds according to the specific nature of the pathology involved and will usually include not only senior involvement but also the involvement of other specialists.
This identified issue is on the BOPDHB risk register. Tests are being ordered by the midwives but have not been accepting their results which then meant they have been sitting in the system as unaccepted results.

Steps Taken So Far

The LMC Midwives were all given remote access and training in using the system so they could receive, review and accept their results using their Laptops or Home PCs. There are now only a small number of midwives that do not want to use this system. They are now going to be approached as there is a move towards a paperless system.

Meetings and further training with midwives are being set up to inform and include in the decision around the paperless system. Education around the difference between the forms used to request tests. The internal form used in the DHB and the form used by the LMC Midwives.

Laboratory tests that have been ordered are reviewed and actioned appropriately.
Review Implementation of Referral Guidelines

This important component of the Maternity Quality and Safety Programme was brought into the focus since the early establishing stage of the programme. Through the implementation of the revised guidelines, it was aimed to enhance communication, collaboration and documentation between clinical providers. Revised referral guidelines were circulated to all the hospital and community based maternity care providers. Copy of the guidelines was uploaded to the Bay Navigator for an easy access. It was widely disseminated and discussed at all the appropriate levels. Copy of the referral maps were provided to the maternity units for reference. Also, chart depicting conditions and type of referral needed has been provided to maternity units for reference.

In recent Governance group meetings, it was agreed to audit the implementation of referral guidelines. Timing of referral, three way communication & collaboration with proper documentation were selected criteria for the audit. Audit tool was proposed to the group and finalised with some suggested changes. Initially, audit forms will be placed in the antenatal clinics and the maternity units. At this stage, we are in process of recording and collection of data.

With the implementation of these initiatives, areas of further improvement have been identified. In addition to maternity care providers, it is equally important to communicate revised guidelines to maternity consumers as well which gives confidence to women, their families/whānau, and other practitioners if a primary care or specialist consultation or a transfer of clinical responsibility is required. Furthermore, there is a need to strengthen ties with other stakeholders involved in transfer of care like ambulance services which will help us improve emergency transfers.

Bay of Plenty District Health board has worked regionally to develop a regionally standardised robust Maternity Patient Transfer Plan for improved patient care. Feedback is being sought from maternity care providers. After feedback, appropriate amendments will be made to the policy before implementation across the region.
After the release of national consensus guideline for treatment of post-partum haemorrhage by Ministry of Health in 2013, this was brought into the focus of the Maternity Quality and Safety Governance Group. As agreed, it was well circulated to all the maternity care providers. Guidelines were uploaded on the Bay Navigator (with Referral guidelines) which can be accessed by both hospital and non-hospital staff. With the introduction of the guidelines, education session was arranged during the joint perinatal meeting between Tauranga and Whakatane facilities. For ease of access, poster summarizing the guideline was made available to both sites to use as a reference. Guidelines were also discussed during the LMC and midwives meetings in Tauranga and Whakatane hospital.

Recently, decision was reached during MQSP Governance group meeting to review/audit the implementation of the guidelines. Midwives were asked to fill out separate audit form in every case of PPH and return for analysis. This audit has been accepted as a plenary session for Midwifery Conference 2014. 76% of response rate has been recorded so far since February, 2014. Analysis of the data hasn’t been done as we are still in process of recording and collecting data. Further course of action will be discussed taking audit results into consideration.
It has been and will be a key focus area for Governance group to sustain the quality improvement initiatives undertaken beyond July 2015 after the completion of Maternity Quality and Safety programme. Since the start of the programme, Governance group has worked closely with the quality teams working within wider DHB networks with an aim to embed this programme and initiatives into the business as usual of BOP DHB quality teams. Some of the steps include:

**Timely Registration with midwife**

- While developing a strategy to promote early booking with midwife, governance group agreed to have a long term and sustainable. With the proposal of ASAP campaign, the agreed funding approach supported the decision and is now aimed at long term and will go beyond the completion of MQSP program.

- Campaign resources will be available for maternity units and in community with the help of communication team. Governance Group hasn’t assigned roles yet, who will keep monitoring the campaign after July, 2015.

- Service specifications for GPs assisting women in first trimester are available on bay navigator for access.

- Messages around the importance of early booking on the public website will continue to exist.
Referral Guidelines Implementation

- Referral guidelines are available on Bay navigator for all hospital and community maternity care providers to access.

- Copies of the referral maps are available in maternity units.

- Audit tool for reviewing Referral guidelines will be handed to internal audit team who will audit the implementation at agreed interval of time.

- Education sessions will be set up with midwife educators for midwives.

Smokefree Pregnancies

These initiatives will continue to work even after the completion of MQSP program and will continue and maintain the work done so far:

- New roles have been established

- Maternity care providers are undergoing NZ Heart Foundation online training

- Personalised resources are being developed to encourage smokers to quit smoking

- DHB staff and community providers will continue to work through Smokefree coalition group.
Safe Sleep

- Safe Sleep champions at both sites have already successfully finished their training and will continue to work in this role after the completion of this programme.

- Funding has been secured for the ongoing Pepi-pod programme.

- Safe-Sleep messages through posters and pamphlets are available in maternity units and will be ongoing.

National Clinical Indicator Data Tool

At this stage, maternity care providers don’t have a direct access to the tool as it requires technical knowledge to handle any data request. However, work is underway to integrate this newly developed tool to the central DHB database which will allow maternity care providers (with access to central database) to access the clinical indicator reports directly.
## List of Priorities, Deliverables and Planned actions for 2013/14

### Governance

<table>
<thead>
<tr>
<th>Priority area</th>
<th>Planned local actions to deliver quality improvement</th>
<th>Expected outcomes</th>
<th>Measured by</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure cultural responsiveness of all MQSP related activities</td>
<td>Ethnicity data in each initiative/programme of work will be captured</td>
<td>Improved responsiveness to vulnerable population</td>
<td>See measures below table.</td>
<td>Completed and Ongoing. HEAT tool is being used for all activities</td>
</tr>
<tr>
<td>Consumers are already in the Governance Group, however it is to be ensured that consumer input is established at all levels of Maternity services</td>
<td>An agreed regional framework exists relating to consumer involvement, (inclusive of payment, job descriptions, contracts)</td>
<td>Decisions made inclusive of consumer view</td>
<td>See measures below table.</td>
<td>Completed and Ongoing. New channels of feedback are open. New opportunities will be explored.</td>
</tr>
</tbody>
</table>

### Quality & Safety

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</thead>
<tbody>
<tr>
<td>LMC Registration BOPDHB Figures are well above the national average but further improvement in these figures has been put on priority.</td>
<td>DHB data regarding number of women who register by 12 weeks with an LMC is available and monitored regionally Print and Digital Media options will be explored Networking with Parenting Groups will be strengthened</td>
<td>Improved access to care</td>
<td>See measures below table.</td>
<td>Completed and Ongoing. ASAP – As Soon as you’re Pregnant Campaign. This is a long term campaign.</td>
</tr>
</tbody>
</table>
Develop and Implement Regionally standardised Robust Maternity Patient Transfer Plan for improved patient care

Regional maternity patient flow policy with sign off by COOs.
Quality indicators for maternity transfers developed, standards for midwifery coordination developed
Expeditious transfers to place of definitive care
Improved communication between midwifery coordinators

Quality & Safety

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| Shared Educational events to strengthen consistency of practices and maximise collaboration between regional midwifery educators | E-learning modules are developed in collaboration with GMs HR and e-learning facilitator
Regional education plan is developed and activities are prioritised annually | Consistent and supported maternity education delivered across region | See measures below table. | Regional education plan is developed and activities are prioritised annually |
| Reduce the smoking and SUDI rates – Support to the women smoking in their pregnancy | All maternity providers have access to education around smokefree pregnancy
Progress towards 90% of all pregnant women entering into LMC/obstetric care are assessed using the MoH ABC programme
All providers of maternity services are trained in promoting safe sleeping messages | Increased focus on smoking cessation and SUDI prevention with decreased morbidity of infants
Increased numbers of pregnant women accessing quit smoking programmes | See measures below table. | Completed and Ongoing. New Smoke free coordinators roles in maternity. Daily audits of screening. Smoke free personalised booklet being developed. Average diffusion of awareness rate of 9.1 against group average of 5. |
### Research and Evaluation

<table>
<thead>
<tr>
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<th>Planned Local Actions to Deliver Quality improvement</th>
<th>Expected outcomes</th>
<th>Measured by</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive data collection systems and real-time reporting</td>
<td>Dashboard for maternity clinical indicators is developed which will identify issues, trends and helps framing initiatives for specific needs</td>
<td>Current regional data is available to shape direction of care and action</td>
<td>See measures below table.</td>
<td>Regional dashboard for maternity clinical indicators is developed and updated</td>
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<td></td>
<td>Local Database tool for real-time clinical indicator reporting has been developed</td>
</tr>
<tr>
<td>Improving breastfeeding rates through networking and sharing of resources</td>
<td>Identify breastfeeding rates in our region using BFHI data. Explore the options using Existing technology to improve access to information for Expecting or new Mothers</td>
<td>Improved access to consistent breastfeeding information</td>
<td>See measures below table.</td>
<td>Options have been explored for use of IT applications to improve access to information for Māori and disadvantaged mothers. Regional breastfeeding rates using BFHI data is being identified</td>
</tr>
</tbody>
</table>

### Enablers / Support

<table>
<thead>
<tr>
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<th>Planned Local Actions to Deliver Quality improvement</th>
<th>Expected outcomes</th>
<th>Measured by</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Develop and Implement Workforce Intelligence - plan for a sustainable maternity workforce which a special focus on rural areas</td>
<td>Capturing the exact number of current service population against the workforce needed for future birthing trends Areas of shortage are identified</td>
<td>Understanding of current state and future state needs to achieve sustainability</td>
<td>See measures below table.</td>
<td>This area has been added to 2014/15 Action Plan</td>
</tr>
</tbody>
</table>
**Priority area** | **Planned local actions to deliver quality improvement** | **Expected outcomes** | **Measured by** | **Timeframe (Completed by)**
--- | --- | --- | --- | ---
LMC Registration  
BOPDHB has witnessed slight increase in the number of women booking within first trimester. BOPDHB numbers are above the national average.  
BOPDHB will be launching “ASAP” Campaign in April 2014. This is a long term campaign. Monitoring and reviewing the program is the next phase of this area | Improved access to care | Improve LMC registration within first trimester to 75% in BOP region | August 2014
Strong working relation with both hospital and community practitioners  
Workshop to be organised with GPs around the primary maternity service specifications. | Improved referral and care of women. | Improved referral and care of women. | August 2014
Establishing consumer involvement at all levels  
Consumers are already in the Governance Group in addition to feedback through online form. Maternity consumer survey tool will be reviewed to gather better insight of the experience. | Decisions made inclusive of consumer view | Consumer feedback is used to shape maternity services, with support for consumer representation | September 2014
Improve rates of New-born screening indicators  
BOPDHB has lowest proportion of samples taken with recommended timeframe. Education session will be planned for LMC’s and Midwives.  
Initiatives will be taken regarding sample taking and dispatching accountability after discussions with LMC representatives on group.  
Letter will be sent out to all LMC’s to share DHB rates and new proposed initiatives | Samples will be taken within recommended timeframe | Improved timely screening rates reflected in the next National screening unit report. | September 2014
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<tr>
<td>Implementation of Referral guidelines</td>
<td>BOPDHB will be auditing the implementation of referral guidelines. Timing, communication and documentation are the key areas of audit. 3 month audit starting from July.</td>
<td>Improved safety and quality of maternity care and women are referred by their LMC to the most appropriate level of care.</td>
<td>October 2014</td>
</tr>
<tr>
<td>Develop and Implement Regionally standardised Robust Maternity Patient Transfer Plan for improved patient care</td>
<td>Regional maternity patient flow policy with sign off by COOs. Quality indicators for maternity transfers developed, standards for midwifery coordination developed</td>
<td>Expedient transfers to place of definitive care</td>
<td>Improved consistency of practices and systems through development of regional wide standards, procedures and processes</td>
</tr>
<tr>
<td>Post-Partum haemorrhage Guidelines Implementation</td>
<td>Auditing and reviewing the implementation. Audit is in process</td>
<td>To standardise the treatment of postpartum haemorrhage</td>
<td>October 2014</td>
</tr>
<tr>
<td>Improving breastfeeding rates through networking and sharing of resources</td>
<td>BOPDHB is working closely with regional DHB’s to develop IT applications to improve access to information for all parents, particularly Māori and disadvantaged mothers. Use of the regional website as a central repository for breastfeeding information which can be linked to from each of the DHBs</td>
<td>Improved access to consistent breastfeeding information</td>
<td>An improvement in accessible consistent breastfeeding information</td>
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<td>Progress towards a 5% increase of infants fully and exclusively breastfed, particularly amongst Māori, for babies at 6 weeks and 3 months.</td>
</tr>
<tr>
<td>National clinical indicators</td>
<td>Governance group has already reviewed national maternity Clinical indicators available till 2011. Strengths and weaknesses have been identified. Areas of improvement will be brought into focus and relevant initiatives will be introduced.</td>
<td>Improved safety and quality of maternity care</td>
<td>Improvement in the national clinical indicator data.</td>
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<tr>
<td>Develop and Implement Workforce Intelligence - plan for a sustainable maternity workforce which a special focus on rural areas</td>
<td>Identify maternity service workforce across primary, secondary and tertiary sectors Identify current workforce shortages and areas where maternity services are vulnerable</td>
<td>Understanding of current state and future state needs to achieve sustainability</td>
<td>Accessible resources, information and web links</td>
</tr>
</tbody>
</table>