MATERNITY QUALITY AND SAFETY PROGRAMME

Canterbury and West Coast District Health Board

Annual Report

2015 -16

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Acknowledgements

The following people are acknowledged for their participation in compiling this report:

Sam Burke – Maternity Quality and Safety Programme Coordinator, CDHB

Vicki Piner - Maternity Quality and Safety Programme Coordinator, WCDHB

Karyn Bousfield - Director of Nursing and Midwifery, West Coast DHB

Chair, CDHB & WCDHB Maternity Clinical Governance Committee

Ian Chen – Information Analyst, CDHB

Sarah Pullinger - Project Specialist, Planning and Funding, CDHB/WCDHB

Jessica Wise - Accountability Coordinator, Planning and Funding, CDHB

Mary Olliver – Clinical Director, O&G, CDHB

Christine Dwyer – Midwife Coordinator - Quality, CDHB

Martine Ribotton - Graphic Designer, Medical Illustration, CDHB

Kate Aldred - Medical Photographer, Medical Illustration, CDHB

Emily Keefe - Medical Photographer, Medical Illustration, CDHB

Di Leishman – Midwife Coordinator - PMMRC

Monique Botha – Administrator, CDHB

Bronwyn Torrance - Charge Midwife Manager, Burwood and Lincoln, CDHB

Vanessa Oswell – Lead Maternity Carer, Canterbury

Jo Gullam – O&G Consultant, CDHB

Ruth Hughes – Medical Specialist, CDHB

Marnie Erkkila – Maternity Consumer representative, CDHB

Jen Coster - Maternity Consumer representative, CDHB

Helen Wells - Maternity Consumer representative, CDHB

Sandra Pugh - Health Information Manager, CDHB

Lisa McKechie - Quality Manager, Women's & Children's Health, CDHB

Jenni Stephenson - Project Manager, Planning and Funding, WCDHB

Ravi Vemuapalli - HoD, Obstetrics & Gynaecology, WCDHB

Chris Davey - Clinical Midwife Manager, WCDHB

Linda Monk - Midwifery Educator, WCDHB

Silvie Saskova - PA to Director of Nursing & Midwifery, WCDHB

Lee Harris - Senior Communications Advisor, WCDHB

Canterbury DHB & West Coast DHB Maternity Clinical Governance Committee members

A big thank you to the families, staff and LMC's that so kindly gave their time and permission to take photographs to illustrate our Annual Report.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Disclaimer

While every effort is made to ensure the accuracy of the information contained in this report, Canterbury District Health Board and West Coast District Health Board cannot guarantee the accuracy of the information or data supplied.

Foreword

The Canterbury and West Coast District Health Boards are pleased to present the Maternity Quality and Safety Programme Annual Report for 2015/16.

Canterbury and the West Coast work collaboratively under a transalpine arrangement to provide health care services to a large portion of the South Island. This way of working across the Southern Alps ensures a partnership approach and supports seamless service delivery, continuity and excellence in care.

The combined Canterbury and West Coast Maternity Quality and Safety Programme, structure and governance has provided a platform for our respective and combined maternity services to develop robust quality processes and improved outcomes for our mothers and babies. Shared policies and procedures have created consistency in standards as clinicians move between the two DHBs, and the development of maternity webpages for both DHBs has created a valuable source of information for mothers and whānau.

The Maternity Quality and Safety Programme continues to add significant value to our maternity systems, and planning is underway for progression of the DHBs to the excelling tier of the national programme.

Karyn Bousfield

Director of Nursing and Midwifery, West Coast DHB

Chair, CDHB & WCDHB Maternity Clinical Governance Committee

Overview

Background

This is the fourth Canterbury DHB and West Coast DHB Maternity Quality and Safety Annual Report since the establishment of the Ministry of Health (MoH) Maternity Quality and Safety Programme (MQSP) in 2011. The National Maternity Monitoring Group (NMMG) came into operation in 2012, as part of this programme, to oversee the maternity system in general and the implementation of the New Zealand Maternity Standards.

The high-level strategic statements of the New Zealand Maternity Standards (MoH, 2011) are:

- Provide safe, high-quality maternity services that are nationally consistent and achieve optimal health outcomes for mothers and babies;
- Ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage;
- 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.

Aims and Objectives

Both Canterbury DHB and West Coast DHB are committed to improving the quality and safety of maternity services for consumers.

The Canterbury DHB and West Coast DHB Maternity Services' aims and objectives are to:

- Provide woman-centred maternity care that meets the needs of the population;
- Continue to implement, review and establish as required, systems and processes to support the provision of quality and safe care;
- Take a whole of systems approach towards improving the health of women and children as guided by the Ministry of Health's goals and targets;
- Align the maternity workforce to meet the needs of the population;
- Align and strengthen regional links.

Purpose

The purpose of this report is to provide information about the DHBs':

- Improvements in relation to the overall aims and objectives
- Achievements against the quality improvement goals set for 2015/16
- Contribution towards addressing the priorities of the NMMG and Perinatal and Maternal Mortality Review Committee (PMMRC)
- Performance in relation to the Ministry of Health's New Zealand Maternity Clinical Indicators 2014 (MoH, 2016) ;
- Response to consumer feedback and ongoing consumer involvement
- Quality initiative goals for 2016/17

Canterbury and West Coast 'Transalpine' Relationship

Canterbury provides many services for the population of the West Coast DHB. The shared service and clinical partnership arrangements that have been developed are also part of the MQSP. This 'transalpine' approach to service provision has allowed better planning for the assistance and services Canterbury DHB provides to the West Coast DHB, so people can access services as close as possible to where they live.

As with previous years we have continued to submit a joint Annual Report to reflect the shared governance model and 'transalpine' relationship, whilst acknowledging the DHB's are at different stages of progress in terms of the Maternity Quality and Safety Programme national tiers.

The content in this report demonstrates the collaboration between professional disciplines, managers and consumers and it should therefore serve as a useful resource for a range of stakeholders including the NMMG, local clinicians, planners and funders as well as consumers.

Table of Contents

List of Figures

List of Tables

Glossary

Caesarean Section	An operative birth through an abdominal incision.
Episiotomy	An incision of the perineal tissue surrounding the vagina to facilitate or expedite birth.
Gravida	A pregnant woman.
Maternity Facilities	A maternity facility is a place that women attend, or are resident in, for the primary purpose of receiving maternity care, usually during labour and birth. It may be classed as primary, secondary or tertiary depending on the availability of specialist services (Ministry of Health 2012). This section describes women giving birth at a maternity facility.
Neonatal Death	Death of a baby within 28 days of life.
Parity	Number of previous births a woman has had.
Primiparous	A woman who has given birth once; multiparous is a woman who has given birth two or more times.
Primary Facility	Refers to a maternity unit that provides care for women expected to experience normal birth with care provision from midwives. It is usually community-based and specifically for women assessed as being at low risk of complications for labour and birth care. Access to specialist secondary maternity services and care will require transfer to a secondary/tertiary facility. Primary facilities do not provide epidural analgesia or operative birth services. Birthing units are considered to be primary facilities. Primary maternity facilities provide inpatient services for labour and birth and the immediate postnatal period.
Postpartum Haemorrhage	Excessive bleeding after birth that causes a woman to become unwell.
Primary Maternity Services	Primary maternity services are provided to women and their babies for an uncomplicated pregnancy, labour and birth, and postnatal period. They are based on continuity of care. The majority of these maternity services are provided by Lead Maternity Carers (LMCs).
Secondary Facility	Refers to a hospital that can provide care for normal births, complicated pregnancies and births including operative births and Caesarean Sections plus specialist adjunct services including anaesthetics and paediatrics. As a minimum, secondary facilities include an obstetrician rostered on site during working hours and on call after hours, with access to support from an anaesthetist, paediatrician, radiological, laboratory and neonatal services.
Standard Primiparae	A group of mothers considered to be clinically comparable and expected to require low levels of obstetric intervention. Standard primiparae are defined in this report as women recorded in the National Maternity Collection (MAT) who meet all of the following inclusions: • delivered at a maternity facility • are aged between 20 and 34 years (inclusive) at delivery • are pregnant with a single baby presenting in labour in cephalic position • have no known prior pregnancy of 20 weeks and over gestation • deliver a live or stillborn baby at term gestation: between 37 and 41 weeks inclusive • have no recorded obstetric complications in the present pregnancy that are indications for specific obstetric interventions. Intervention and complication rates for such women should be low and consistent across hospitals. Compiling data from only standard primiparae (rather than all women giving birth) controls for differences in case mix and increases the validity of inter-hospital comparisons of maternity care (adapted from Australian Council on Healthcare Standards 2008, p 29).
Stillbirth	The birth of an infant after 20 weeks gestation, which has died in the womb and weighed more than 400 grams.
Tertiary Facility	Refers to a hospital that can provide care for women with high-risk, complex pregnancies by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. Tertiary maternity care includes an on-site, level 3, neonatal service.
Weeks' Gestation	The term used to describe how far along the pregnancy is. It is measured from the first day of the woman's last menstrual cycle to the current date.

Abbreviations

CDHB	Canterbury District Health Board
DHB	District Health Board
GDM	Gestational Diabetes Mellitus
GP	General Practitioner
HDU	High Dependency Unit
ICU	Intensive Care Unit
IOL	Induction Of Labour
LMC	Lead Maternity Carer
MQSP	Maternity Quality and Safety Programme
NICU	Neonatal Intensive Care Unit
NMMG	National Maternity Monitoring Group
PMMRC	Perinatal and Maternal Mortality Review Committee
PPH	Postpartum Haemorrhage
RMO	Resident Medical Officer
SUDI	Sudden Unexpected Death in Infancy
SMO	Senior Medical Officer
VBAC	Vaginal birth after Caesarean
WCDHB	West Coast District Health Board
W&CH	Women's and Children's Health

Canterbury District Health Board

Annual Report

2015 -16

Our Mission Statement

To improve, promote and protect the health of the people in the community and foster the well-being and independence of people who experience disabilities and reduce disparities.

Our Vision - Tā Mātou Matakite

To improve, promote, and protect the health and well-being of the Canterbury community.
Ki te whakapakari, whakamanawa me te tiaki i te hauora mō te oranga pai o ngā tāngata o te rohe o Waitaha.

Our Values - Ā Mātou Uara

Care and respect for others. Manaaki me te whakaute i te tangata.
Integrity in all we do. Hāpai i ā mātou mahi katoa i runga i te pono.
Responsibility for outcomes. Te Takohanga i ngā hua.

Our Region

The Canterbury DHB is the second largest DHB in the country by both geographical area and population size - serving 510,000 people (12% of the New Zealand population) and covering 26,881 square kilometres.

There are three separate divisions within Canterbury DHB responsible for providing the maternity services; Women's and Children's Health (W&CH), Ashburton and Rural Health, which includes the Chatham Islands. The DHB also has a contract with St George's Hospital, Maternity Centre to provide maternity care.

The Canterbury DHB provides an extensive range of specialist services on a regional basis - to people referred from other DHBs where these services are not available. This includes neonatal services.

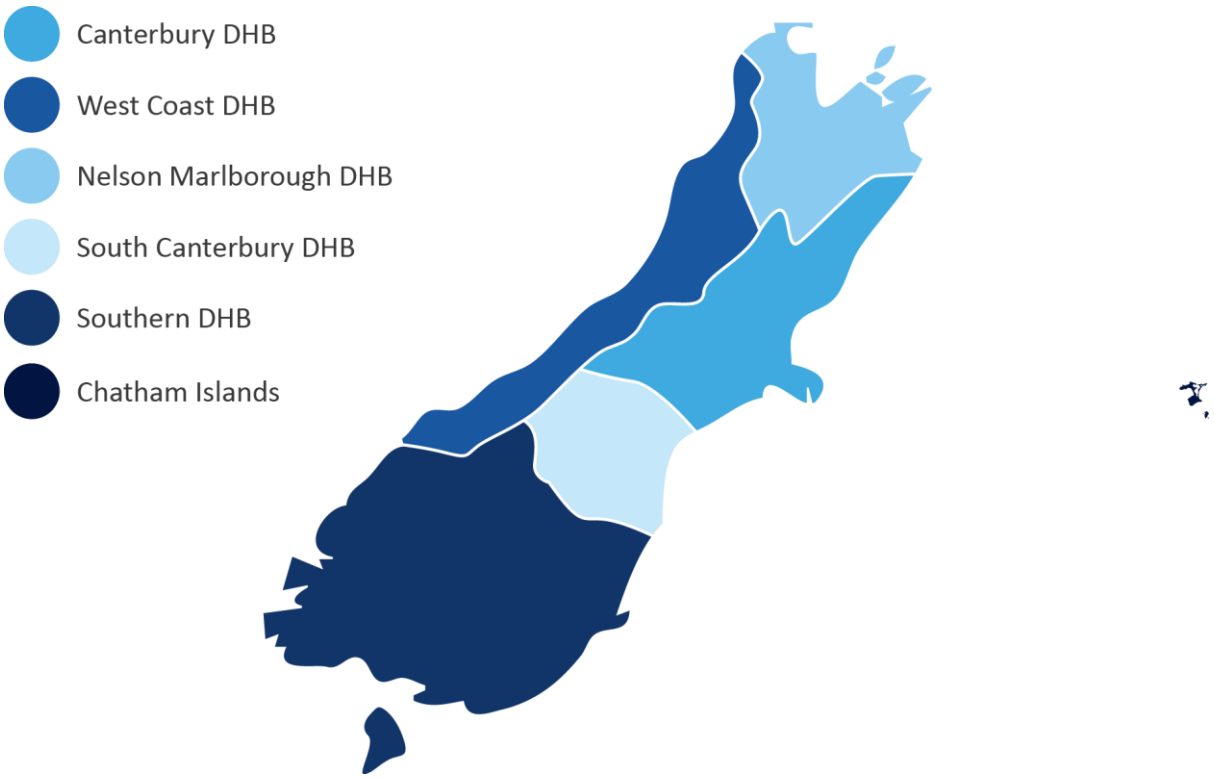


FIGURE 1 SOUTH ISLAND DHB BOUNDARIES

Our Community

Our community demographics are taken from the latest Report on Maternity 2014 (MoH, 2015), New Zealand Maternity Clinical Indicators 2014 (MoH, 2016), 2014 MAT data, (MoH, 2015) and our CDHB database.

Table 1 provides a visual picture of health statistics for women giving birth in Canterbury in 2014.

TABLE 1 CANTERBURY DHB SNAPSHOT FOR WOMEN GIVING BIRTH IN 2014

Category	Canterbury DHB
Birth rate 162 babies born every day in New Zealand	6055 births in 2014 That is an average of 16 babies born a day
Age	Highest percentage of CDHB mothers are in 30-34 years bracket
Maternal ethnicity	71% European descent 8.8% Maori 12.5% Asian 4.3% Pacific 3.4% Other
Primary Maternity Services Registration by Trimester	1st Trimester - 76.5% 2nd Trimester - 19.9% 3rd Trimester - 2.5%
Deprivation	8.2% CDHB women are in Deprivation Quintile 5 - most deprived
Birth by Facility Type	87.3% of CDHB at Christchurch Women's Hospital 8.7% in Primary Units 4% home
Parity	44% Primiparous 56% Multiparous
Body Mass Index	49.7% were a healthy weight 7.3% CDHB women had a BMI over 35 at time of registration for care
Smoking at first LMC Registration	87.8% were not smoking
Smoking 2 weeks postnatal	88.7% were not smoking

Our Maternity Services

There are a range of facilities available to women in Canterbury (Table 2). Christchurch Women's Hospital (CWH) is the only tertiary facility and accepts referrals from Canterbury and the West Coast regions.

All referrals for tertiary care from West Coast DHB primary and secondary units, Canterbury DHB primary units and homebirths go to Christchurch Women's Hospital.

TABLE 2 CANTERBURY MATERNITY FACILITIES

	Women's and Children's Health Division	Ashburton	Rural Health Services
Primary	○ Burwood Birthing Unit ○ Lincoln Maternity Hospital ○ Rangiora Hospital ○ St George's Maternity Centre (contract with CDHB)	○ Ashburton Hospital	○ Chatham Islands (since 2015) ○ Darfield Hospital ○ Kaikoura Hospital ○ Waikari Hospital (Postnatal care only)
Tertiary	Christchurch Women's Hospital		

TABLE 3 BIRTH NUMBERS AT OUR DHB MATERNITY FACILITIES AND HOME BIRTH RATE 2013 AND 2014

CDHB Maternity Facility	Number of Births 2013	2014
Ashburton Hospital	**114**	**117**
Burwood Birthing Unit	**185**	**147**
Christchurch Women's Hospital	**5215**	**5165**
Darfield Hospital	**5**	**6**
Kaikoura Hospital	**15**	**11**
Lincoln Hospital	**80**	**107**
Rangiora Hospital	**90**	**125**
St. George's	**0** (Not open for birthing due to earthquake damage)	**141** (from February 2014)
Home birth	**204**	**236**
Grand Total	**5908**	**6055**

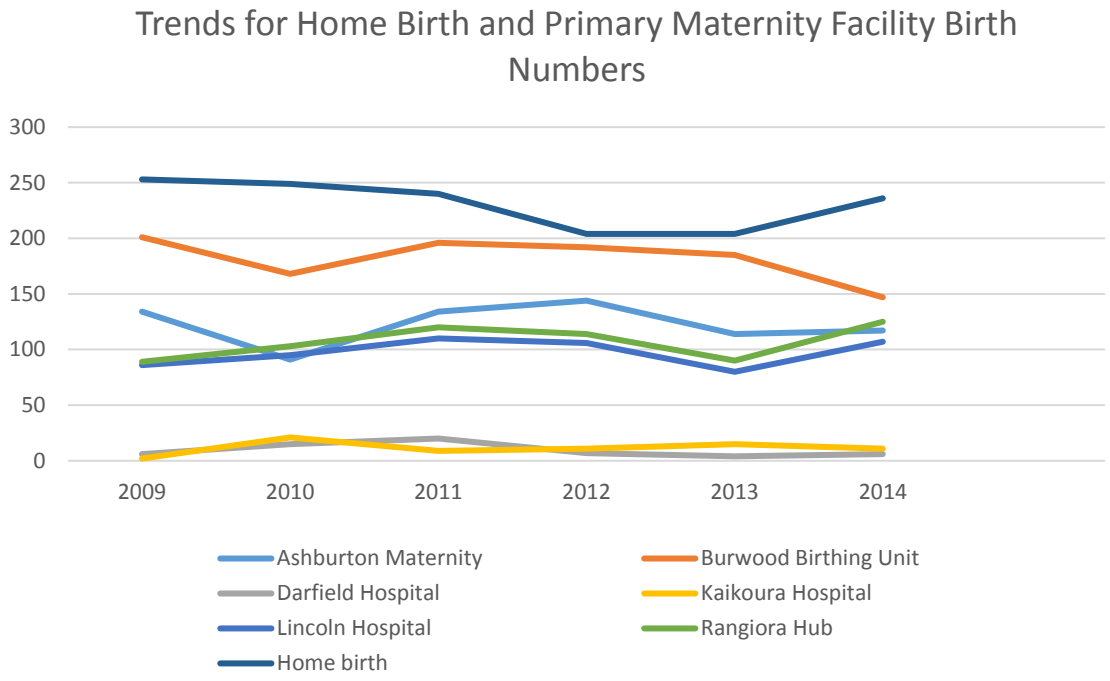


FIGURE 2 CDHB TRENDS FOR HOME BIRTH AND PRIMARY MATERNITY FACILITY BIRTH NUMBERS 2009-2014

Historically birth rates in our primary maternity units have been low and a high proportion of our birthing women have chosen Christchurch Women's Hospital as their place of birth. As Table 3 demonstrates.

Work began in 15 February 2011, just 7 days before the Christchurch earthquakes, to obtain the perspectives of women and family/whānau, maternity providers and other health professionals and key stakeholders regarding a vision for maternity services and what we needed to do to achieve that vision. Approximately 120 people attended this workshop. It was of no surprise that despite the evidence in support of birthing in a primary unit, the reasons not to were multifaceted.

Work to increase birthing in the primary units remains a high priority for our maternity services and this effort has continued in collaboration with our community, consumer representatives, Lead Maternity Carers, multidisciplinary team and planning and funders.

Two new facilities have been built in Kaikoura and Rangiora supporting the community with continued access to antenatal, intrapartum and birthing care.

All facilities are Baby Friendly Hospital Initiative accredited and offer a relaxed home like environment.

Processes and guidelines have been developed in collaboration with representation from our Regional New Zealand College of Midwives to ensure women are appropriate for labour and birth care at our facilities Admission to Primary Birthing Unit.

We have also considered the environment of our primary maternity units and made changes to improve our birthing and postnatal rooms, and developed an advertising campaign to showcase our maternity facilities, and continue to update our CDHB website to ensure up to date and relevant information for women.

CDHB Maternity Hospitals and Primary Maternity Units

Our Maternity facilities extend across Canterbury from Kaikoura to Ashburton. Despite our high birth rate at our main centre, Christchurch Women's Hospital, a high proportion of women will transfer for postnatal care to one of our outlying primary maternity units. The following information provides an overview of these facilities and their activity during 2014.

Christchurch Women's Hospital

Births **5165** Transfers for postnatal care **55**

Overview:

Tertiary Hospital

13 Rooms for labour and birth	**2** Pools for waterbirth	**2** Acute Observation Unit (AOU)
5 Assessment rooms	**2** Multi-purpose rooms	**45** bed antenatal / postnatal unit beds
2 Operating theatres	**16** Clinic rooms	
10 intensive care cots	**28** special care cots	
A Day assessment Unit	A Fetal Medicine Unit	

A garden room is available for women experiencing fetal loss in the latter half of pregnancy

Rangiora Hospital

Births **125** Transfers for postnatal care **206**

Overview:

Primary Maternity Unit. Distance **35km, 41mins from Christchurch**

2 Rooms for labour and birth **2** Pools for waterbirth **4** Assessment rooms
12 Postnatal rooms

Burwood Birthing Unit

Births **147** Transfers for postnatal care **503**

Overview:

Primary Maternity Unit. Distance **10.3km, 19mins from Christchurch Women's Hospital**

2 Rooms for labour and birth **1** Pool for waterbirth **3** Assessment rooms
6 Postnatal rooms

Lincoln Maternity Hospital

Births **107** Transfers for postnatal care **450**

Overview:

Primary Maternity Unit. Distance **19.7km, 30mins from Christchurch**

2 Room for labour and birth **1** Pool for waterbirth **6** Postnatal rooms
1 Assessment room

Ashburton Maternity

Births **117**	Transfers for postnatal care **134**	
Overview:		
Primary Maternity Unit.	Distance **87km, 1 hour 8mins from Christchurch**	
3 Room for labour and birth	**2** Pools for waterbirth	**5** Postnatal rooms

Darfield Hospital

Births **6**	Transfers for postnatal care **10**	
Overview:		
Primary Maternity Unit.	Distance **44km, 40mins from Christchurch**	
1 Room for labour and birth	**1** Pool for waterbirth	**2** Postnatal rooms

Kaikoura Hospital

Births **11**	Transfers for postnatal care **9**

Overview:

Primary Maternity Unit. **Distance 181km, 2 hours 10mins from Christchurch**

1 Room for labour and birth **2** Postnatal rooms

Waikari Hospital

Births **0** Transfers for postnatal care **5**

Overview:

Primary Maternity Unit. Distance **73km, 1hour from Christchurch**

2 Postnatal rooms

St. George's Hospital

Births **141 (from Feb 2014)** Transfers for postnatal care **1339**

Overview: Primary Maternity Unit. Distance **5.1km, 12min from Christchurch Women's Hospital**

2 Room for labour and birth **1** Pool for waterbirth **10** Postnatal rooms

CDHB Midwife and Lead Maternity Carer

Supporting Normal Birth

"As an LMC I am extremely passionate about supporting women and their families to birth in a primary birthing unit. I believe that the Primary Birthing Unit offers a non-medicalised, non-invasive yet safe and supportive space for women to labour and birth in. Primary Birthing Units give women empowerment and support the natural process of labour and birth. I use the primary birthing unit for all of my antenatal care and have found that this has given the women time to become familiar and relaxed with this unit. The location of the birthing unit is also a great reason to birth there, it is close to their homes and offers easy car parking without the hustle and bustle of negotiating the city traffic and long term parking fees. Following their birth, women are taken across the corridor to their room which is ready for them and there is no need to put baby in a car seat and transfer out in the middle of the night to another facility. My clients are aware that in the event of a transfer that we are prompt and have resources within close proximity should we require them. I always feel well supported by more core midwifery colleagues who work in the primary birthing unit. The core midwifery staff are always approachable and help facilitate and support the safe environment that has already been established between the LMC and her client. In turn it is this relaxed and comfortable atmosphere that supports, empowers and facilitates normal birth. In time I would love to see our Primary Birthing rates increase and normalise primary birth care into our communities for our future generations".

Vanessa, LMC

Our Workforce

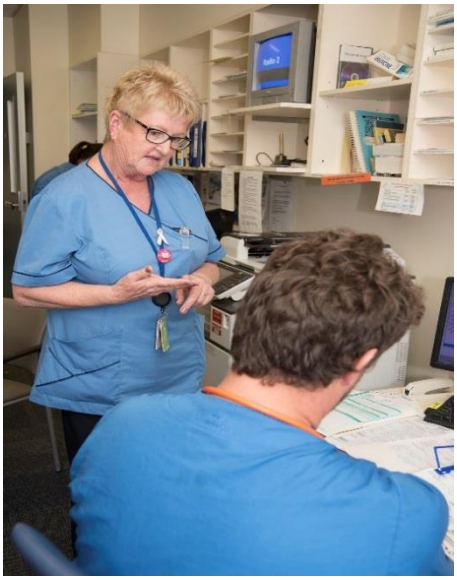
Canterbury's maternity service is provided by our multidisciplinary team of Midwives (Lead Maternity Carers and DHB employed Midwives), Obstetric staff, GP's, Physicians, Nurses, Lactation Consultants, Allied health and support staff.

Christchurch Women's Hospital provides antenatal clinic care, which includes specialised clinics for high risk pregnancies, diabetes, methadone in pregnancy and fetal medicine. The outpatient clinic also provides antenatal care for women unable secure an LMC.

A day assessment unit provides observational care for women under the care of the obstetric team, reducing the need for inpatient care.

A specialist obstetric clinic is provided at Ashburton Hospital every week.

Christchurch Women's Hospital provides a 24 hour service for consultation and acute care.



The medical team consists of:

- 21 Senior Medical Officers
- 16 Registrars (including 2 roster relievers and 2 night cover relievers)
- 8 Resident Medical Officers (including 1 roster reliever and 1 night cover reliever)

In 2014, 337 Midwives identified Canterbury DHB as the primary place of work as a midwife (SIWDH, 2016), and 204 as Midwives who had an access agreement with Maternity facilities across Canterbury, enabling them to practice as a Lead Maternity Carer. This equated to 11.3% of the National workforce.

The head count of Midwives employed by the Canterbury DHB fluctuates but is approximately 150. Noting that Kaikoura, Waikari and Darfield are staffed by Registered Nurses and supported by the woman's Lead Maternity Carer.

Our Maternity Quality Governance and Leadership

Who are we?

The Canterbury DHB part of Maternity Clinical Governance Committee comprises of members of the hospital multidisciplinary team as well as community and consumer representation.

The entire CDHB/WCDHB Governance group meet once a month via videoconferencing, this brings together Women's and Children's Health (CDHB), Ashburton and rural services (CDHB), St. George's (CDHB) and the West Coast Maternity group.

CDHB Maternity Clinical Governance Committee. From back left to right: Natalie King, Marnie Erkkila, Kelly Dorgan, Lisa McKechie, Violet Clapham, Sam Burke, Kathy Simmons, Helen Wells, Sarah Pullinger.

Not pictured: Andrea Robinson, Annette Norton, Gillian Halksworth-Smith, Mary Olliver, Adrienne Lynn.

Governance Structure

Canterbury DHB and West Coast DHB share governance for the Maternity Quality and Safety programme. Table 4 below illustrates the governance levels of the various groups.

TABLE 4 GOVERNANCE AND LEADERSHIP GROUPS CANTERBURY DHB AND WEST COAST DHB

Governance level	CDHB General Managers' Group	CDHB Clinical Board WCDHB Clinical Board	WCDHB Executive Management Team
	W&CH Clinical Governance Committee	CDHB & WCDHB Maternity Clinical Governance Committee	
Reporting level	W&CH Clinical Audit Committee	W&CH Maternity Operations Group	Ashburton and Rural Health Services Maternity Continuum Team
	St George's Obstetric Committee	WCDHB MQSP Group	WCDHB Clinical Quality Improvement team
Operational Level	Perinatal and Maternal Mortality Review Committee	Incident Review Groups	Maternity Clinical Guidelines Group

Quality Planning and Reporting

Each operational group develops a quality plan for their area which includes priorities directed by the Canterbury DHB & West Coast DHB Maternity Clinical Governance Committee. Quality plans and quarterly reports are submitted as outlined below in Table 5.

TABLE 5 REPORTING FLOW CANTERBURY DHB AND WEST COAST DHB

Women's & Children's Clinical Governance Committee	Canterbury DHB Clinical Board	West Coast DHB Clinical Board
Bi-annual Reports are submitted		
Canterbury DHB & West Coast DHB Maternity Clinical Governance Committee		
Annual Quality Plans and Quarterly Reports are submitted to ensure alignment of work across the services		
W&CH Maternity Operations Group	Ashburton and Rural Health Services Maternity Continuum Team	St George's Obstetric Committee	West Coast DHB Maternity Quality and Safety Group

Contracts relevant to maternity services between the DHB Planning and Funding Department and non-governmental organisations are also reported in a similar way.

Governance Committee Structure

The committee structure in Figure 3 below is complex due to the spread of maternity services and associated groups and committees both within and across the two DHB's.

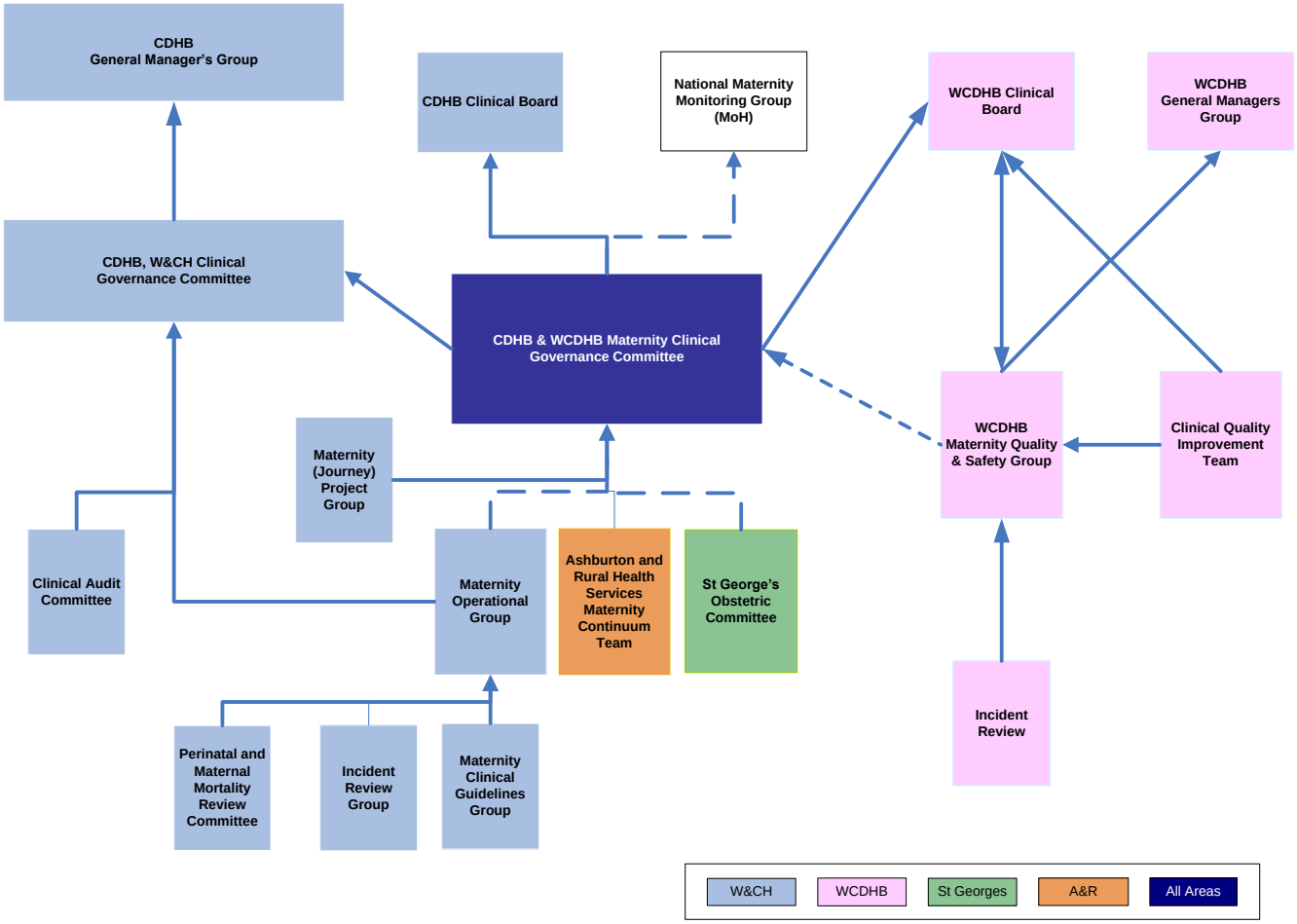


FIGURE 3 GOVERNANCE COMMITTEE STRUCTURE AND REPORTING LINES

Contract Funding for the MQSP Programme

In 2015 the MoH asked each DHB to self-audit and identify themselves within one of three tiers (Emerging, Established and Excelling). Meeting the requirements of each tier were based on the New Zealand Maternity Standards, (MoH, 2011) and the service specification for each tier as prescribed by the MoH.

Canterbury DHB have identified themselves as meeting the "Established" tier and have developed a two year plan to move to the Excelling tier.

This action plan has been included in our priorities for 2016/17. An MQSP Coordinator commenced in May 2016 to continue to progress the programme. The term of contract for the MQSP is two years. The implementation of the initial priority projects has required the input of additional staff resource, staff training and material resources. A significant amount has been specifically dedicated to the initial development of the Canterbury DHB Kiriata Māmā (Television for Mothers) project, as described further on page 31.

Consumers

As a part of implementing the Maternity Quality and Safety Programme in 2012 we were able to formally develop consumer representation roles for the Canterbury maternity service.

We currently have three actively engaged consumers that provide advice and opinion as a part of our quality activities. They are a valuable members of our CDHB/ WCDHB Maternity Clinical Governance Committee governance group and Canterbury DHB Maternity Operations Group.

As a part of our MQSP Priorities and Action Plan 2016/17 (page 46) we have included further project work to engage our higher needs consumers (young mothers, Maori, Pacific and women with mental health issues).

"Our role as consumer members is to give a consumer perspective to the various committees and groups within the Women's Health Division of the CDHB. Our backgrounds are quite diverse, but we all have strong connections to multiple community groups associated with parenting- Playcentre, Plunket, Homebirth, La Leche League, kindergartens, plus many more. Our aim is to take the consumer perspective, from the community, into the health sector to help give the policy makers a more holistic view to consider in their decision making".

Canterbury Maternity Consumer representatives: Jen Coster and Marnie Erkkila. Not pictured Helen Wells.

> ***"Congratulations on getting it right; a fantastic facility for our families to welcome their new babies. Excellent staff / facilities and care, wonderful experience. Thank you".***
>
> **Birthing Suite, Christchurch Women's Hospital**

Overview of MQSP Priorities 2015/16

This table summarises the quality improvement work undertaken by our Maternity Services in the 2015/16 years. The work is the result of interdisciplinary collaboration and the involvement of consumer representatives.

- Indicates that the work has been completed and / or in business as usual phase
- Indicates that the work is in progress / underway and nearing completion
- Indicates that there is still a significant amount to achieve before completion

TABLE 6 MQSP PRIORITIES AND ACTION PLAN FOR 2015/16

	Priority Area	Progress Report	Status
1	Introduce Newborn Early Warning Score (NEWS)	The Newborn Early Warning Score (NEWS) tool was implemented in February 2016. This is still a developing project and we will be reviewing the tool periodically over the next 12 months as part of the validation process. Education to core staff and LMC's has been rolled out.	
2	Promote Māori, Pacifica and younger women attending pregnancy and parenting support classes	Plunket became the new provider of Pregnancy & Parenting Education for Canterbury from March 1st 2016. Aligned to the Pregnancy and parenting information and education, Tier level two Service specification, 2014, the service has an emphasis on engaging Māori, Pacifica and younger women alongside other high needs groups i.e. Asian women and those living in remote rural areas.	
3	Implement standardised Safe Sleep Policy and education	The SI Safe Sleep Policy has been published as a DHB policy and is available for staff across the sector. Education is available online for all new staff and senior nursing staff have received education on safe sleep practices. In non-Maternity areas, for example, Medical and Surgical; where a baby may accompany a mother who is an inpatient, education packages have been developed and are available for staff to discuss safe sleep practices with parents/caregivers. Safe sleep is incorporated into our care pathways and discharge planning. A South Island audit tool has been developed and regular audits are scheduled for all Maternity units throughout the year. These are completed by our Safe sleep champions in the ward areas.	
4	Monitor gestation at birth and appropriate gestation for Induction of Labour (IOL) and CS (Caesarean Section)	An audit of elective Caesarean Sections was carried out in 2015 aimed to identify cases where Caesarean Section was potentially avoidable, identify methods to reduce the incidence of these cases, implement these changes and re-audit. The audit focused on: – Planned and actual delivery gestation – Indications (maternal and fetal) – Surgical risk factors – Rates of public and private cases Recommendations from the audit are being implemented. An audit of our induction of labours (IOL), post review of our guideline is currently underway.	

	Priority Area	Progress Report	Status
5	Implement measures to reduce CS, instrumental delivery and episiotomy rates	Several projects are underway to reduce Caesarean Section, instrumental delivery and episiotomy rates. – Fetal Surveillance Education Programme (FSEP) for all staff – Delay in labour guideline – Increased use of fetal blood sampling as a part of intrapartum decision making	
6	Improve guidelines, standards, policies and procedures	The Maternity Guidelines working group continues to meet each fortnight. The group consists of representatives from across the Maternity services, including the West Coast. All policies and guidelines are available on the CDHB internet for clinicians to access. 12 clinical Maternity Guidelines have been developed, published and implemented in the previous 12 months. Guidelines are developed as a result of change in clinical practice due to new evidence and research findings, incident review recommendations and quality improvements activities.	
7	Promote access to care in 1st trimester including early registration with an LMC	Canterbury internet page has been developed to promote early engagement of midwifery care. Pregnancy and childbirth information is also readily available via our webpage and Healthinfo webpage.	
8	Reduce smoking rates in pregnant women	This is being achieved. Canterbury DHB Quarter 3 results demonstrated that 95.4% of pregnant women were given brief advice and/or support to stop smoking.	
9	Review, restructure and evaluate effectiveness of lactation support services	This project is underway in collaboration with The Canterbury Initiative and encompasses priority number 11. Currently a six month audit is underway to ascertain our referrals, in particular referral for and management of tongue-tie release. This will enable us to better understand our business and changes to the service that need to occur.	
10	Increase use of primary birthing facilities	Promotion of our primary Maternity units continues. Updated information for the community is available on our CDHB internet page and an advertising campaign showcasing our primary units is ongoing. This remains a priority area for 2016/17.	
11	Promote and support breastfeeding	This remains a priority for Canterbury. The current strategic plan will be reviewed in 2016 and we intend to develop a governance structure which will encompass a whole of system approach to breastfeeding promotion and support. The existing Breastfeeding Steering group will continue to work closely with and be supported by the CDHB/WCDHB Maternity Clinical Governance Committee.	
12	Promote access to maternal mental health services	The Maternal Mental Health pathway has been implemented and is available for health professional via HealthPathways. Up to date and relevant information is also available via our Canterbury internet site and Healthinfo webpage. http://www.healthinfo.org.nz/	

	Priority Area	Progress Report	Status
13	Introduce new terminology for gestation over 37 weeks – e.g. early term, full term, post term	This topic is still in discussion across Transalpine services.	
14	Prepare for introduction of National Maternity Clinical Information System	National roll out of MCIS is on hold. In anticipation of implementing MCIS: – a project brief has been developed – a Maternity Clinical Reference Group has been developed with appropriate membership from across the Maternity sector – a stocktake of IT hardware across the Maternity facilities has been carried out	
15	Support Clinical Coding consistency to national standard and communication with maternity clinicians	We work closely with Clinical Coding to ensure we capture our activity accurately. We ensure our documentation is of a high quality to enable the coders to accurately report to the National Minimum Dataset (NMDS) which in turn results in the recording of quality NMDS data that are comparable at national and international levels.	
16	Analyse and review local performance in view of the NZ maternity clinical indicators	Clinical indicators are reviewed by the clinical leadership team and recommendations for quality improvement are incorporated into Maternity Quality and Safety Programme action plan.	
17	Continue to audit outcomes of care and service provided	"We Care About Your Care" maternity services feedback forms are reviewed and a report is disseminated every six months to the CDHB/WCDHB Maternity Clinical Governance Committee.	
18	Review evidence and indications for ultrasound scans	This priority is in progress. Feedback two way forms for LMC/Radiology have been developed. Antenatal ultrasound for obstetric indications: recommended scan frequency guideline developed published and available on our Canterbury internet page for health professionals.	
19	Evaluate effectiveness of information available to consumers	This priority has been identified for our 2016/17 action plan.	
20	Capture maternity consumer experiences / feedback	"We Care About Your Care" maternity services feedback forms are available as hard copy and online for all birthing mothers across the Canterbury DHB. Canterbury DHB compliment and complaint forms are also used to capture feedback from each of the Maternity areas. Feedback is collated by the Women's and Children's Quality team, and sent to each of the areas for review and to follow up on any areas for improvement.	
21	Link maternity consumer representatives with community	We have three actively engaged Maternity consumers who provide representation on the Maternity Operation Group and CDHB/WCDHB Maternity Clinical Governance group. Our consumers are also increasingly involved in various projects including audit.	
22	MQSP aligned with wider DHB quality agenda	The Maternity Quality Safety Programme is aligned with the Canterbury DHB Quality Plan and forms part of the annual Quality Accounts report. Priorities are aligned and there is collaboration with the wider health sector, for example the South Island Alliance.	

Our Quality Initiatives

Continued evaluation and improvement of our maternity services is vitally important to Canterbury DHB. It underpins our vision, values and goals for Women's and Children's Health, and is encouraged to be a part of everyday business for the team. We are actively involved in the implementation of the wider organisations quality initiatives, but also draw improvement projects from many sources, not limited to, but including:

- audit recommendations
- clinical case reviews
- incident investigation
- new evidence for clinical practice changes
- consumer feedback

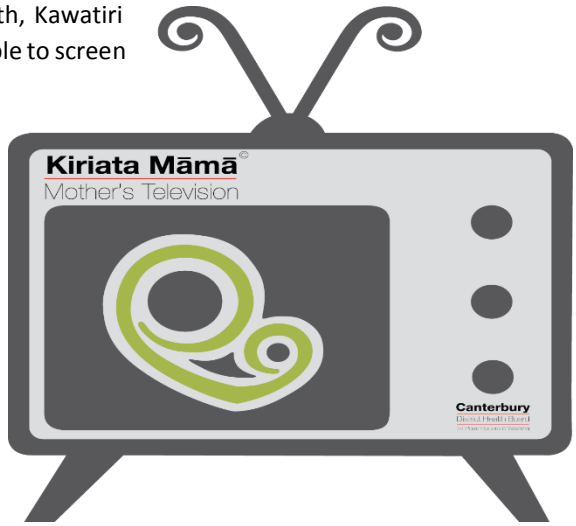
Our quality activities always strive to ensure the women's experience is optimal by reducing variation and being evidence based.

During 2015/16 our team worked on many quality improvement projects, and for the purposes of our MQSP Annual Report we have chosen a handful to showcase our efforts.

Kiriata Māmā TV

Empowering women is the philosophy behind the Kiriata Māmā TV programming that is screening across CDHB Maternity Services; a local quality initiative funded by the National Maternity Quality Safety Programme.

Kiriata Māmā provides 24 health-related parent-focused programmes, accessible to approximately 6000 women per annum. At Christchurch Women's Hospital, this is continuous on the dedicated channel (channel 100), of 55 televisions. In Primary Birthing Units from Kaikoura to Greymouth, Kawatiri (Buller), Ashburton, Lincoln, Rangiora, Waikari, and Darfield, it is able to screen via a flash drive enabling families to select programmes.



The health gains will be better informed, confident parents who will make choices that promote the health and wellbeing of themselves and their baby.

Content selected addresses priority topics identified by the Ministry, such as breastfeeding, smoke-free, family violence, and safe sleeping. There are also videos on how to respond to your baby's emotional and social needs, pelvic floor exercises, healthy eating and what it's like to be a father.

Kiriata Māmā is a strategic fit with the New Zealand Maternity Standards that state women need access to nationally consistent information on pre-pregnancy health, pregnancy, childbirth, maternity services, and care of newborn babies to inform their decisions. Twenty two of the twenty four programmes are New Zealand made.

To ensure the content remains contemporary and relevant to the women of Canterbury, QR codes linked to an evaluation survey are being developed for inclusion on the TV Guide. The Maternity Operations Group will review every six months to update content and ensure sustainability.

Safe Sleep Day

This quality project started as a Canterbury initiative for Safe Sleep Day 2015, led by Child and Youth Mortality Review Group, Canterbury District Health Board (Midwife Coordinator - PMMRC) and Change for our Children.

FIGURE 4 CDHB SAFE SLEEP DAY INFORMATION CARD 2015

The Key Message: Make every sleep a safe sleep - for every baby.

Secondary Key Messages:

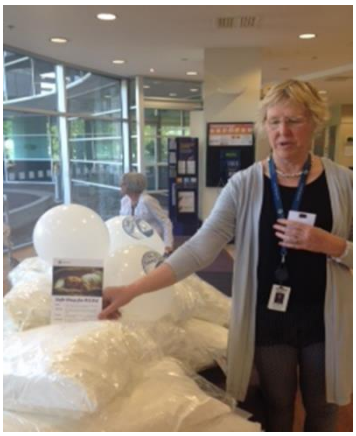
- Place baby in their own baby bed
- Eliminate smoking in pregnancy and protect baby with a smoke free environment
- Position baby flat on their back to sleep
- Encourage and support mum to Breastfeed

On Safe Sleep day there were static displays at Christchurch Women's Hospital and in the paediatric department at Christchurch Hospital.

Staff also talked to parents entering Christchurch Women's Hospital and handed out information.

All CDHB maternity units had resources (posters, fridge magnets and brochures) which was funded by MQSP monies to share with staff and new parents. Posters were displayed on all bedroom walls in the Maternity Unit and the discharge Coordinators in the Neonatal Intensive Care Unit (NICU) also reinforced the message and spoke to every family with a baby in NICU.

Elaine Mclardy, our previous Child and Youth Mortality Review Coordinator (CYMRC) presented three education sessions on her role as the Sudden Unexpected Death in Infancy (SUDI) researcher for the coroner, including information on safe sleeping. These were well attended by staff from Christchurch Public Hospital and Christchurch Women's Hospital.



Elaine Mclardy, previous Child and Youth Mortality Review Coordinator

Canterbury DHB Smoking Cessation for Pregnant Women

In our last Annual Report 2014/2015 we gave an update on our smoking cessation target for pregnant women who smoke. The CDHB and WCDHB Maternity Clinical Governance Committee endorsed the setting of the following goals for Canterbury and West Coast for reducing the numbers of women who smoke in pregnancy.

Smoking is the main preventable cause of problems in pregnancy. There is NO safe level of smoking while pregnant.
Our aim is to provide every woman high quality support to be smoke free during pregnancy and beyond.

Focus	Target	Goal (By 30 June 2015)
Booking	80%	Women have enrolled with an LMC midwife by 12 weeks.
Advice	90%	Pregnant women who identify as smokers are offered advice and support to quit at first registration visit.
Referral	50%	Pregnant women who smoke accept smoking cessation support during pregnancy.
Hospital	95%	Women who smoke will be given support to stop smoking while in hospital.
Home	86%	Mothers are smoke free at two weeks postnatal.
Education		LMCs, core midwives and nurses within CDHB maternity facilities complete a smoking cessation training programme.

FIGURE 5 CANTERBURY AND WEST COAST DHB GOALS FOR PREGNANT WOMEN WHO SMOKE

Progress towards the 'Goals for Pregnant Women Who Smoke' are outline below:

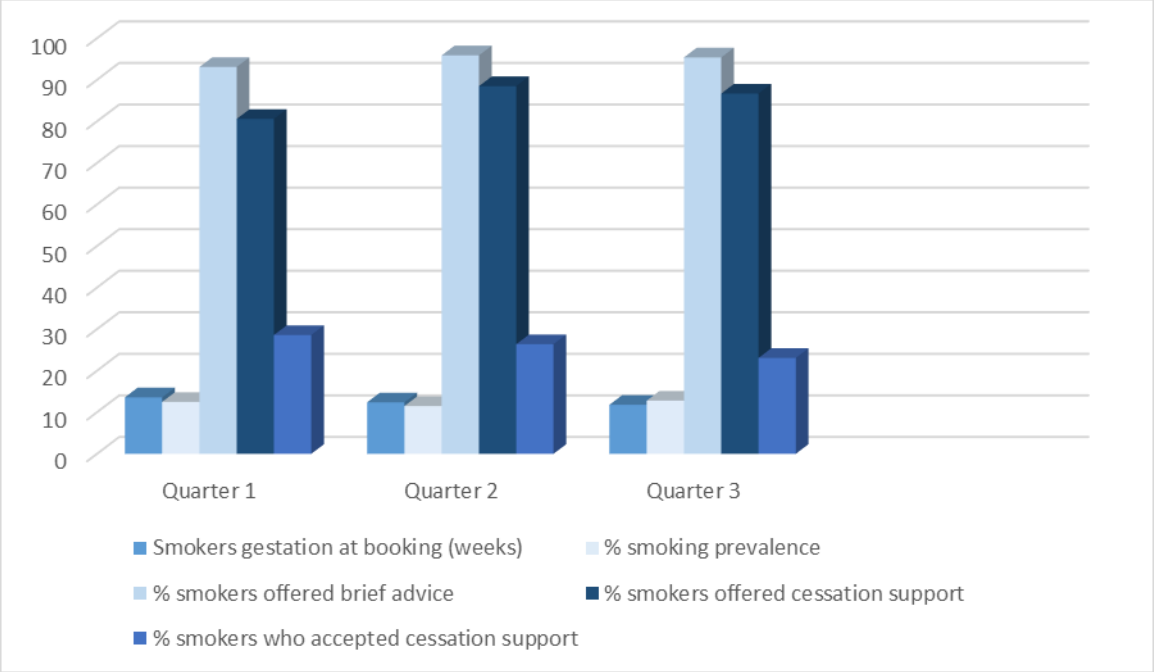


FIGURE 6 CDHB SMOKING CESSATION RATES FOR PREGNANT WOMEN 2015/16

Advertising Campaign for CDHB Primary Maternity Units

Promotion for primary birthing and normal birth has long been a priority for the CDHB. In 2015 a collaborative project to develop visual resources for the community were developed. The group included Charge Midwives, LMC representation, consumers, Maori representation and the communications team. Quick response codes (QR codes) were included on the resources to reflect the updated Canterbury website, and to give further information for women on choices for birthing.

The resources were distributed widely and are due for evaluation and possible review again in the next few months as per our 2016/17 Priorities and Action Plan.

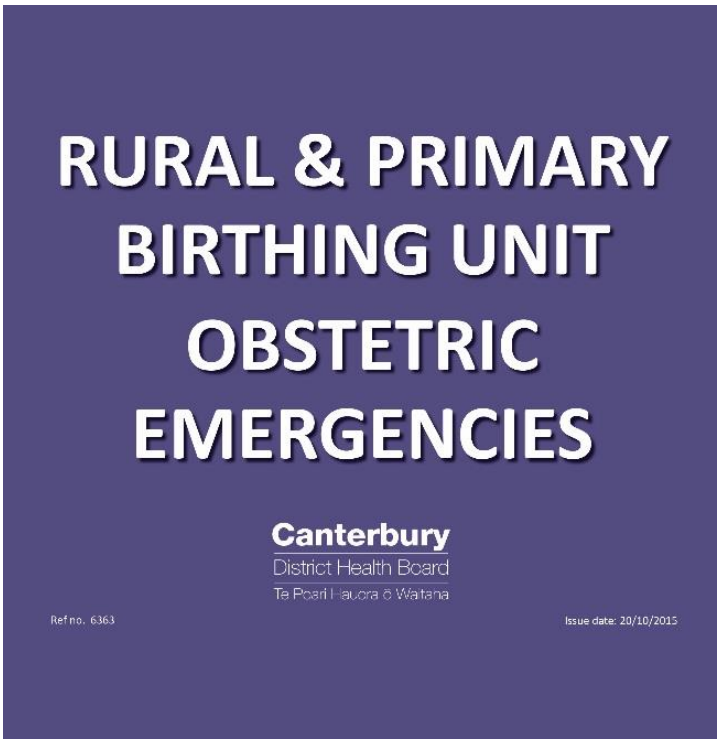
The posters and leaflets focused on the healthy women and primary maternity units being able to provide a safe, flexible and supportive environment for birth and postnatal care.

FIGURE 7 CDHB PRIMARY BIRTHING CAMPAIGN POSTER

FIGURE 8 CDHB ADVERTISING CAMPAIGN RESOURCES FOR PRIMARY BIRTHING

Rural and Primary Birthing Unit Flip Charts

This quality initiative was initiated to reduce variation in practice across our eight primary units, and provide a comprehensive and educational resource to deal with major obstetric emergencies, taking into consideration the nature of the rural and remote rural maternity environment.



The flip chart was developed in collaboration with the multidisciplinary team and is based predominantly on the current multidisciplinary evidence informed CDHB Maternity Guidelines.

It is aligned to the Midwifery Council NZ required CDHB Emergency Skills study day; and the CDHB Practical Obstetric Multi-Professional Training (PROMPT).

The flip charts were intended for use in the primary units where staffing is not exclusive to midwives, but also nurses and doctors, and is for use in consultation with the Christchurch Women's Hospital obstetric/neonatal teams.

Publication of the flip charts was funded through MQSP monies and these were distributed to each of the primary units for use.

Implementation of National Guideline – Diabetes

Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: A clinical practice guideline (MoH, 2014) has been implemented by CDHB.

HbA1c was routinely included with the first antenatal bloods in October 2015. We are now following the MoH guidelines management plan for women with elevated HbA1c levels. To increase capacity, outpatient clinics has moved to group education sessions for women with elevated HbA1c levels and / or obesity, and separate group education sessions for women with Gestational Diabetes Mellitus (GDM) and this is working well.

We are also developing new dietary information handouts that will be available in multiple languages as needed for women with elevated HbA1c levels at booking. The first draft of this handout is currently being modified after consumer and provider feedback in early May.

As per the MoH guideline, we are also trying to reduce the number of USS ordered for women with GDM and no complications, and standardise management/care plans aiming for fewer unnecessary early births.

A local GDM management flow diagram to standardise the local obstetric management of these women is also being developed.

Information and education has gone out to all Lead Maternity Carers and there is capacity for more women to be referred to the diabetes service as is recommended.

Our Outcomes

Clinical Indicator Analysis

The MoH data New Zealand Maternity Clinical Indicators 2014 (MoH, 2016) was published in May 2016. The publication shows key maternity outcomes for each DHB for 2014 and is the most recent data available for compilation of this Annual Report.

The analysis below shows Canterbury DHB's performance and position in relation to both the indicators and national averages. Percentage figures are from either the DHB of domicile or the facility of birth, as indicated, and are based on standard primiparae only.

The purpose of these indicators is to increase the visibility of quality and safety of maternity services and to highlight areas where quality improvement can potentially be made. There were originally twelve indicators however three were added for the 2012 indicator report. The 2014 indicator report is the third year to which those indicators apply.

A further six indicators were added to the 2013 report to review outcomes for babies and women experiencing severe morbidity. The methodology was expanded to count outcomes for women giving birth outside a maternity facility more accurately. The 2014 indicator report is the second year to which these indicators apply.

The data largely refers to "standard primiparae" (SP) who make up approximately 15% of all births nationally and 13.1% in Canterbury DHB. This group who are aged 20 – 34 years with uncomplicated singleton pregnancies birthing at full term with a head presentation represent the least complex situations for which intervention rates can be expected to be low and therefore enable valid comparisons between institutions.

TABLE 7 CANTERBURY DHB CLINICAL INDICATOR ANALYSIS 2014

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicator 1	Registration with a Lead Maternity Carer in the first trimester of pregnancy	75.2%	77.0%	▲ 1.8%	▲	67.7%
The PMMRC (2012), NMMG (2013) and the Health Committee Inquiry into improving child health outcomes (2013), all recommend early engagement with maternity care. The Canterbury rate has continued to increase each year and is reflective of the establishment of the Find Your Midwife website (www.findyourmidwife.co.nz) and the development of healthpathways and healthinfo that provide up to date information for health professionals and women and their families. The Canterbury internet page has also been developed to promote early engagement of midwifery care and providing up to date information on pregnancy and childbirth.						

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicators 2 -5 *These indicators are about the type of birth amongst SP. Their stated of purpose is to encourage Maternity service providers to review the appropriateness of interventions amongst low risk woman with the long term aim of supporting normal birth and reducing perinatal morbidity.*						
Indicator 2	Spontaneous vaginal birth	66.1%	71.0%	▲ 4.9%	▲	68.9%

This indicator shows our rate of spontaneous vaginal birth among our SP group in Canterbury is 71.0%, compared to the national average of 68.9%. This shows a consistent and continued improvement since 2009, which is due to a number of quality improvement activities including standardising practice and developing best evidence guidelines for CTG interpretation and fetal blood sampling. Projects to improve our clinical outcomes are ongoing and form part of our priorities and action plan for 16/17. Figure 9 demonstrates our trend for spontaneous vaginal birth from 2009-2014.

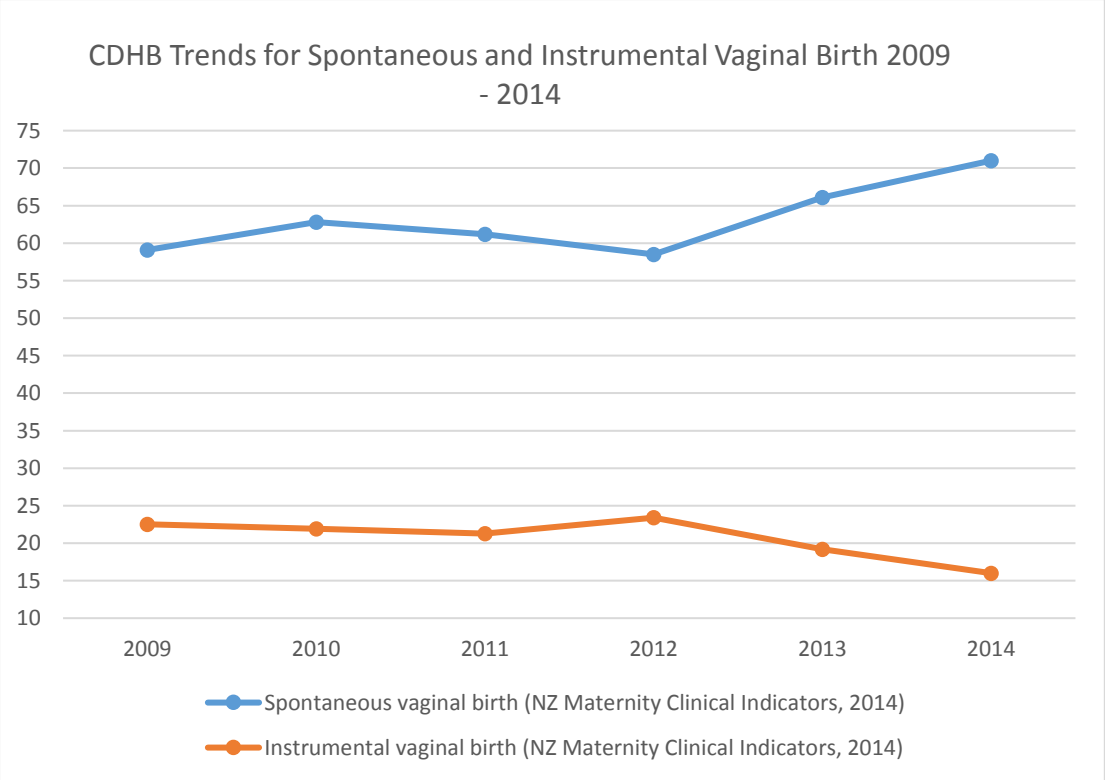


FIGURE 9 CDHB TRENDS FOR SPONTANEOUS AND INSTRUMENTAL VAGINAL BIRTH 2009-2014

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicator 3	Instrumental vaginal birth	19.2%	16.0%	▼ 3.2%	▲	15.2%
The rate of instrumental births shows that we have continued to reduce our instrumental birth rate in Canterbury overall (2009 = 26.9%, 2011 = 25.1%, 2012 = 23.4%, 2013 = 19.2%). This rate is still slightly higher than the national average by 0.8%, but demonstrates that year on year we have made significant changes to improve our outcomes. This continues to be a focus for our service and remains a priority for our quality improvement action plan for 2016/17.						
Indicator 4	Caesarean Section	13.7%	13.1%	▼ 0.6%	▼	15.6%
The rate of Caesarean Section for Canterbury overall was 13.1%, 2.5% below the national average. This clinical indicator rate has continued to fall each year (2009 = 21.7%, 2011 = 20.8%, 2012 = 18.0%, 2013 = 13.7%). We continue to monitor our intervention rates with regular audit and weekly case review of CTG and decision making for Caesarean Section. We also continue with mandatory fetal monitoring training for staff and have revised the CDHB 'Fetal heart monitoring' guideline to ensure robust documentation of CTG interpretation. We have also developed, published and implemented the 'external cephalic version' guideline in May 2016, this will further impact our rates favourably, as it provides an evidence base and consistency in practice for the medical team. We have further projects ongoing in this area over the next year including completion and implementation of the 'delay in labour' guideline. Figure 9 demonstrates our clinical indicator rates by year, 2009–2014.						
Indicator 5	Induction of labour	5.1%	4.1%	▼ 1.0%	▼	5.6%
The rate of induction of labour has remained fairly static since 2009, and is below the national average of 5.6%. The CDHB 'Induction of labour' guideline was reviewed and published in 2014, and it is expected that future data will demonstrate a further reduction in induction of labour rates.						
Indicators 6 - 9 *Degree of damage to the lower Genital Tract* *These indicators which are about the degree of damage to the lower genital tract of the mother demonstrate that this is not increased for the Canterbury population.*						
Indicator 6	Intact Lower Genital Tract	28.8%	30.8%	▲ 2.0%	▲	27.7%
The rate of intact lower genital tract for the SP group has remained static (2009 = 32.0%, 2011 = 33.3%, 2012 = 27.4%, 2013 = 28.8%). This rate is 3.1% higher than the national average of 27.7%. This rate compares favourably with other tertiary centres.						

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicators 7 and 9	Episiotomy <u>without</u> and <u>with</u> third and fourth degree tear	22.6% (without) 2.8% (with)	20.1% (without) 1.3% (with)	▼ 2.5% (without) ▼ 1.5% (with)	▲ ▼	22.7% (without) 1.5% (with)
The rate of episiotomy without third of fourth degree tear has remained relatively static each year (2009 = 27.6%, 2011 = 25.4%, 2012 = 27.0%, 2013 = 22.6%), with a 2.5 % reduction in 2014 to 20.1%, 2.6% below the national average. The rate of episiotomy with extending third and fourth degree tears has shown a reduction in 2014 to 1.3%, below the national average of 1.5%. It also shows a reduction from our 2013 rate of 2.8%. The CDHB 'Third and fourth degree tears' guideline was developed and published in May 2014, and it is expected that future data will demonstrate a further reduction in this rate.						
Indicator 8	Third or Fourth Degree Tear without episiotomy	3.9%	5.0%	▲ +1.1%	▲	4.5%
This indicator has shown a steady increase (2009 = 1.9%, 2011 = 2.7%, 2012 = 2.8%, 2013 = 3.9%) to 5.0% in 2014. This is above the national average of 4.5% and indicates an area for further analysis. Recent work in this area has included formulation of a 'Third and fourth degree tear' guideline and collaboration with the clinical coding team to ensure we are capturing this data accurately.						
Indicator 10	General Anaesthetic for Caesarean Section	4.8%	4.9%	▲ +0.1%	▼	8.4%
Canterbury rates for women having a General Anaesthetic (GA) for Caesarean Section within the SP group remains lower than the national average, (2009 = 6.1%, 2011 = 4.9%, 2012 = 4.7%, 2013 = 4.8%). A review of our local obstetric anaesthesia database shows an expected low rate of GA for elective Caesarean Section. This is likely to reflect 1/ the non-emergent nature of these births and 2/ that our elective Caesarean Section anaesthesia service is mostly consultant led. All Caesarean Sections are performed in a tertiary unit with a high quality obstetric anaesthetic team present 24/7. The application of regional anaesthesia at CWH is highly effective for caesareans. This reflects on the training of the front-line registrar anaesthetists, but also may be the result of other un-measured variables such as maternal BMI differences in other DHBs, obstetric doctor decision-making, patient education and acceptance of regional techniques, coupled with the introduction of our cord prolapse and fetal blood sampling guidelines that facilitate the use of regional anaesthesia over a general.						

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicators 11 and 12	Blood transfusion after Caesarean Section and Vaginal Birth	3.4% (Caesarean) 2.1% (vaginal)	3.0% (Caesarean) 2.1% (vaginal)	▼ 0.4% (Caesarean) Static (vaginal)	▼	3.2% (Caesarean) 2.1% (vaginal)
This indicator is used to as a measure of severe life threatening haemorrhage, and in Canterbury the 2014 rate following caesarean section is below the national average at 3.0%. This rate compares with previous years (2009 = 3.3%, 2011 = 2.6%, 2012 = 2.3%, 2013 = 3.4%). Similarly the rate of blood transfusions required after a vaginal birth remains static and consistent with the national average.						
Indicators 13 - 15 *Severe Maternal Morbidity* *This was introduced as a new indicator for the 2012 data and expanded further for this data set. Maternal mortality is a recognised indicator of maternity system safety and quality, but the number of maternal deaths in any given year is thankfully low and fewer still are potentially avoidable. The impact of severe morbidity is significant and of high personal and physical cost to the woman, her family and to the health system. The monitoring of severe morbidity allows wider view of cases that may provide a broader picture of the true impact of adverse outcomes in maternity in New Zealand and allow individual units to bench mark appropriately. It remains recommended that cases of severe maternal morbidity are subject to local multidisciplinary review for quality improvement purposes.*						
Indicator		**2013 CDHB (number of women)**	**2014 CDHB (number of women)**	**Change from 2013 (number of women)**		**National (number of women)**
Indicator 13	Diagnosis of eclampsia	(n = 2)	(n = 3)	▲ (n = 1)		(n = 18)
18 diagnosis of eclampsia were made in 2014 nationally, three of which were made in Canterbury. These were both subject to local multidisciplinary review as recommended above and were forwarded to the SAMM review panel for further analysis.						
Indicator 14	Postpartum Hysterectomy	(n=1)	(n = 0)	▼ (n=1)		(n = 37)
37 of these were carried out nationally, there were no cases in Canterbury for 2014.						
Indicator 15	Mechanical ventilation	(n=1)	(n = 1)	(n=0)		(n = 13)
This clinical indicator is used to measure the number of women admitted to ICU and requiring over 24 hours of mechanical ventilation, anytime during the pregnancy or postnatal period. In 2014 one case was recorded and subject to local multidisciplinary review.						

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicator 16	Tobacco use during the postnatal period	10.9%	11.3%	▲ 0. 4%	▼	13.5%
Our 2014 rates demonstrate we are below the national average of 13.5%. Smoking cessation for pregnant women has been a focus for our DHB and we continue to monitor these targets as reported to the CDHB & WCDHB Maternity Clinical Governance Committee each quarter.						
Indicator 17	Maternal Obesity	7.5%	7.3%	▼ 0.2%	▼	8.2%
This clinical indicator is based on women giving birth with a BMI over 35 at registration for maternity care. Our rate remains below the national average of 8.2%. Variation measurement and recording of BMI is still variable despite best efforts to encourage accurate measurement of height and weight. We are also aware that this is an issue nationally. All women referred for specialist consultation will have height and weight recorded to give an accurate BMI. Essential for formulating customised Gestation Related Optimal Weight (GROW) charts.						
Indicator 18	Pre-term births (under 37 week's gestation)	8.0%	7.9%	▼ 0.1%	▲	7.4%
The rate of pre-term births for women of Canterbury remains within appropriate confidence intervals nationally, this is consistent with being a tertiary unit and comparable to other similar units.						
Indicators 19 and 20 *Small for gestational age at term* *These indicators are designed to measure when intervention may have been appropriate and was not carried out. Timely detection of poor fetal growth may reduce the risk of stillbirth by presenting the opportunity for enhance surveillance and iatrogenic early birth.*						
Indicator 19	Small babies at term 37 – 42 weeks gestation	2.1%	2.6%	▲ 0.5%	▼	3.0%
The rate of small babies at term (37-42 weeks) is below the national average at 2.6%. This remains consistent with previous data.						
Indicator 20	Small babies at term Born at 40 – 42 weeks gestation	33.6%	40.4%	▲ 6.8%	▲	39.4%
The rate of small babies at term (40-42 weeks) is slightly higher than the national average at 40.4%. The numbers are small, with 59 recorded cases for the SP group. Projects to improve our clinical outcomes in this area are ongoing and form part of our priorities and action plan for 16/17, this includes developing an evidence based guideline encompassing The New Zealand Maternal Fetal Medicine 'Guideline for management of suspected small for gestational age, singleton pregnancies after 34 weeks gestation' (2014).						

Indicator	Title	2013 CDHB Rate	2014 CDHB Rate	Change from 2013	Higher or lower than national average	National Average
Indicator 21	Term babies requiring respiratory support	1.2%	1.8%	▲ 0.6%	▼	1.9%
All term babies unexpectedly admitted to NICU for respiratory support are subject to weekly multidisciplinary review. The CDHB rate of 1.8% remains slightly below the national average and consistent with comparable tertiary units.						

Conclusion

The indicators show the high level of safety for both mothers and babies in Canterbury continues to be above average for New Zealand. Data for almost all the indicators show continuing improvement compared to the previous 2013 figures. Most notable amongst these clinical indicators is the continued increase in spontaneous vaginal birth rate which is now above the national average, alongside a reducing instrumental birth rate and a caesarean section rate 2.5% below the national average.

These significant improvements are attributable to multidisciplinary, woman centred team working and we expect to see further improvements in subsequent reports.

There is a need to carry on our work to reduce the number of instrumental births and to continue with planned projects aimed to keep reducing our caesarean section rate. The 2014 clinical indicators have also uncovered an upward trend of third and fourth degree tears without episiotomy, which will need further audit and review.

Data Analysis

The data in this section is from local Canterbury DHB Maternity data sources and shows 2013 and 2014 in comparison, with percentage increase or decrease noted. Data here is counted either in terms of all 'deliveries' which is a count of mothers (as opposed to a count of exclusively standard primiparae) as used by the New Zealand Maternity Clinical Indicators 2014, (MoH, 2016) or in terms of 'births' which is a count of babies.

Key: *2013-2014 increase*  *2013-2014 decrease*  *No change* 

TABLE 8 GESTATION AT BIRTH 2013 AND 2014 CANTERBURY DHB

Gestation at Birth	Number of Births 2013		Number of Births 2014	
Extremely preterm (<28 weeks)	22	(0.4%)	25	(0.4%)
Very preterm (28-31 weeks)	48	(0.8%)	45	(0.8%)
Moderate preterm (32-33 weeks)	26	(0.5%)	23	(0.4%)
Late preterm (34-36 weeks)	391	(6.9%)	389	(6.9%)
Term (37-41 weeks)	5150	(90.3%)	5122	(90.2%)
Prolonged (>42 weeks)	67	(1.2%)	74	(1.3%)
Total	**5704**	**(100%)**	**5678**	**(100%)**

 The percentage of births in each gestational category has remained almost unchanged.

TABLE 9 TYPE OF LABOUR 2013 AND 2014 CANTERBURY DHB

Type of labour	Number of deliveries 2013		Number of deliveries 2014	
Spontaneous	3126	(55.5%)	3160	(56.3%)
Induced	961	(17.1%)	967	(17.2%)
Artificial rupture of membranes	344	(6.1%)	286	(5.1%)
Augmented	391	(6.9%)	365	(6.5%)
Did not labour	810	(14.4%)	832	(14.9%)
Total	**5632**	**(100%)**	**5610**	**(100%)**

 2014 data determines that there was a slight increase (0.8%) in spontaneous labour from 2013. Artificial rupture of membranes decreased by 1%, this may be due to introduction of CERVIDIL® (dinoprostone, 10 mg) for induction of labour. An audit of our revised induction of labour guideline is currently underway and may determine this further. Other data remains static.

TABLE 10 INDUCTION OF LABOUR 2013 AND 2014 CANTERBURY DHB

Induction of labour	Number of deliveries 2013		Number of deliveries 2014	
No	4303	(76.4%)	4277	(76.2%)
Yes	1329	(23.6%)	1333	(23.8%)
Total	**5632**	**(100%)**	**5610**	**(100%)**

 The proportion of women who had their labours induced remained unchanged.

Table 11 Method of Birth 2013 and 2014 Canterbury DHB

Method of Birth	Number of Births 2013		Number of Births 2014	
Vaginal	2849	(49.9%)	3115	(54.9%)
Vaginal Water Birth	272	(4.8%)	272	(4.8%)
Vacuum Extraction	355	(6.2%)	270	(4.8%)
Forceps	402	(7.0%)	356	(6.3%)
Caesarean Section	1826	(32.0%)	1665	(29.3%)
Total	**5704**	**(100%)**	**5678**	**(100%)**

There was a 5% increase in the rate of vaginal birth with a corresponding reduction in the rate of Caesarean Sections. There was also a 2.1% reduction in instrumental birth rate.

Table 12 Breech Births 2013 and 2014 Canterbury DHB

Breech Birth	Number of Births 2013		Number of Births 2014	
No	5456	(95.7%)	5447	(95.9%)
Yes	248	(4.3%)	231	(4.1%)
Total	**5704**	**(100%)**	**5678**	**(100%)**

There was very little change in the percentage of breech births between 2013 and 2014.

Table 13 Anaesthetic 2013 and 2014 Canterbury DHB

Anaesthetic	Number of deliveries 2013		Number of deliveries 2014	
None	1934	(34.3%)	2064	(36.8%)
Local	822	(14.6%)	836	(14.9%)
Pudendal Block	72	(1.3%)	59	(1.1%)
Epidural	1284	(22.8%)	1143	(20.4%)
Spinal/Epidural	114	(2.0%)	130	(2.3%)
Spinal	1291	(22.9%)	1275	(22.7%)
Sublimaze IV (fentanyl)			1	(0.0%)
Caudal	1	(0.02%)		
General	96	(1.7%)	81	(1.4%)
Mixed general/Epidural	6	(0.1%)	6	(0.1%)
Other	12	(0.2%)	15	(0.3%)
Total	**5632**	**(100%)**	**5610**	**(100%)**

There was no significant change in the method of anaesthetic used during labour or birth between 2013 and 2014.

Table 14 Perineal Tears 2013 and 2014 Canterbury DHB

Perineal Tears	Number of deliveries 2013		Number of deliveries 2014	
Intact	3027	(53.7%)	2871	(51.2%)
First Degree Tear	801	(14.2%)	758	(13.5%)
Second Degree Tear	958	(17.0%)	1113	(19.8%)
3a Degree Tear	64	(1.1%)	83	(1.5%)
3b Degree Tear	28	(0.5%)	43	(0.8%)
3c Degree Tear	14	(0.2%)	17	(0.3%)
4th Degree Tear	12	(0.2%)	8	(0.1%)
Episiotomy	728	(12.9%)	717	(12.8%)
Total	**5632**	**(100%)**	**5610**	**(100%)**

The data demonstrates very little change in outcomes for 2014 compared with the previous year.

Table 15 Blood Loss at Delivery 2013 and 2014 Canterbury DHB

Blood Loss at Delivery	Number of deliveries 2013		Number of deliveries 2014	
<1000mL	5255	(93.3%)	5196	(92.6%)
1000ml - 1500mL	275	(4.9%)	301	(5.4%)
>1500mL	102	(1.8%)	113	(2.0%)
Total	**5632**	**(100%)**	**5610**	**(100%)**

Overall there was no significant change in blood at delivery compared to 2013.

Table 16 Blood Transfusion Required 2013 and 2014 Canterbury DHB

Blood Transfusion Required	Number of deliveries 2013		Number of deliveries 2014	
No	5498	(97.6%)	5462	(97.4%)
Yes	134	(2.4%)	148	(2.6%)
Total	**5632**	**(100%)**	**5610**	**(100%)**

There was less than a 1% difference between the two years in regard to the percentage of women receiving blood transfusion.

Table 17 Admission to Neonatal Intensive Care 2013 and 2014 Canterbury DHB

Admission to Neonatal Intensive Care	Number of Babies 2013		Number of Babies 2014	
No	4956	(86.9%)	4827	(85.0%)
Yes	748	(13.1%)	851	(15.0%)
Total	**5704**	**(100%)**	**5678**	**(100%)**

There was a 1.9% reduction in the number of babies admitted to Neonatal Intensive Care in 2014.

Table 18 Neonatal Outcomes 2013 and 2014 Canterbury DHB

Neonatal Outcomes	Number of Babies 2013		Number of Babies 2014	
Well Neonates	5697	(99.9%)	5668	(99.8%)
Neonatal Death	7	(0.1%)	10	(0.2%)
Total	**5704**	**(100%)**	**5678**	**(100%)**

There were 3 more neonatal deaths in 2014 compared to 2013. Comparing this to 2012 data overall there is no change to neonatal outcomes.

Table 19 Small for Gestation Age 2013 and 2014 Canterbury DHB

Small for Gestational Age	Number of Babies 2013		Number of Babies 2014	
No	4995	(87.6%)	5003	(88.1%)
Yes	709	(12.4%)	675	(11.9%)
Total	**5704**	**(100%)**	**5678**	**(100%)**

Data for both 2103 and 2014 showed little change in babies born small for gestational age.

Table 20 Feeding Method 2013 and 2014 Canterbury DHB

Feeding Method	Number of Babies 2013		Number of Babies 2014	
Artificial	159	(2.8%)	165	(2.9%)
Exclusive	4293	(75.3%)	4258	(75.0%)
Fully	179	(3.1%)	48	(0.8%)
Nil	9	(0.2%)	16	(0.3%)
Partial	603	(10.6%)	727	(12.8%)
Not documented	461	(8.1%)	464	(8.2%)
Total	**5704**	**(100%)**	**5678**	(100%)

In 2014 there was a 2.3% reduction in the number of babies fully breastfed and a 2.2% increase in the number of babies partially breastfed.

MQSP Priorities and Action Plan 2016/17

Canterbury DHB have worked with West Coast DHB to identify some common objectives for 2016/17. We have taken into consideration the (NMMG) priorities for monitoring and investigation, in lieu of a final work plan from the group, as per the National Maternity Monitoring Group Annual Report (NMMG, 2015).

We have also considered and included the recommendations from the Ninth Annual Report of the Perinatal and Maternal Mortality Review Committee (PMMRC, 2015) and the priorities we had set out in our two year plan following our self-audit against the New Zealand Maternity Standards (MoH, 2011), to move from our Established to Excelling tier, as per the MQSP service specification and funding contract.

These Priorities were endorsed by the Canterbury DHB & West Coast DHB Maternity Clinical Governance Committee and any 2015/16 priorities still underway were also carried over to the 2016/17 plan.

These are included in Appendix 1.

In addition to our overarching CDHB and WCDHB quality plan we have further considered the differences between our two DHBs, and have developed key priority areas for further work over the next twelve months.

Consumer engagement and improving our information for women

Canterbury has a changing population and we are becoming more diverse. Noticeably we have a growing Maori and Asian population, and the aftermath of the Canterbury earthquakes has meant we now have a large migrant population due to the Canterbury rebuild.

Ensuring we have active consumer representation to mirror our changing population will be one of a key priorities this year.

We will also focus on our “at risk” women, for example, young mothers and women with mental health issues, which have historically not been well represented.

Our strategies will include use of community groups, social media and development of apps (applications) to make information more mobile friendly and therefore accessible, easier to download and view for women.

Our changing population means that we also need to review the information available to women that are not English speaking. Strategies will involve engaging with community groups and primary health, i.e. LMC’s and GP’s to further develop and enhance paper-based and on-line information.

We will look at smarter ways to gain feedback from consumers that will help to drive our quality improvements.

Improving our visibility

We will be focusing on ensuring the Maternity Quality and Safety Programme is more visible across the DHB and wider community.

Work has already commenced by linking in with various agencies, for example, planning and funding (Maori and Maternity portfolio holders), Well Child Tamariki Ora and the South Island Alliance Programme Office, to ensure that we are involved in the development of DHB strategic plans and reports, and that we are aligned and engaged with the wider health system in Canterbury, shared MoH targets and priorities.

West Coast District Health Board

Maternity Quality & Safety Programme

Annual Report

2015 / 16

WCDHB Maternity Management & Administration Team

		
Karyn Bousfield Director of Nursing & Midwifery	Chris Davey Clinical Midwife Manager	Correen Haslett Kawatiri Maternity Unit Manager
		
Alan Haslett Kawatiri Maternity Unit Manager	Dr Ravi Vemuapalli Obstetrician & Gynaecologist HoD, Obstetrics	Dr Sherif Mehrez Obstetrician & Gynaecologist
		
Dr Sam Henalla Obstetrician & Gynaecologist	Dr Vicki Robertson Obstetrician & Gynaecologist	Linda Monk Midwifery Educator
		
Kerri de Klerk Maternity Services Administrator	Vicki Piner MQSP Co-ordinator	Silvie Saskova PA to Director of Nursing & Midwifery

1. Maternity Service Delivery

1.1 Vision and Values

The West Coast DHB's Maternity Vision and Values in the delivery of maternity service:

Vision:

"Providing safe, high quality maternity care in partnership with West Coast women and their whānau"

Values:

- *Respect*
- *Protection / Care*
- *Education / Learning*
- *Efficient / Resourceful*
- *Accountable / Accountability*

1.2 Maternity Facilities

There are two facilities available to women living on the West Coast and most births are at the larger Grey Base Hospital. Christchurch Women's Hospital is the only tertiary facility and accepts referrals from both regions.

	WCDHB
Primary	Kawatiri Unit at Buller Hospital in Westport
Secondary	McBrearty Ward at Grey Base Hospital
Tertiary	**Christchurch Women's Hospital**

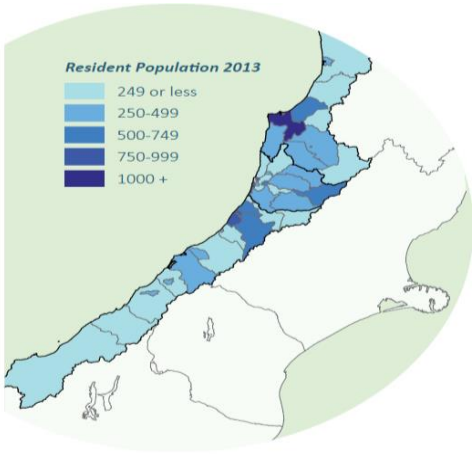
The number of total deliveries at the West Coast DHB for the 2014 year was 377. Just over 1% of the population identifies as Asian and less than 1% as Pacific. 10% of the population identifies as Māori.

Compared with New Zealand as a whole, the West Coast DHB has a lower mean personal income (2006 Census data $20,400 per compared with $24,000 nationally) and a higher proportion of our population are receiving unemployment or invalid benefits, have no educational qualifications and lack access to a mobile phone or motor vehicle.

The average number of births per annum across the West Coast, including home births is approximately 29 babies per month.

TABLE 21 WCDHB BIRTH NUMBERS 2014

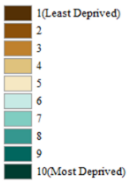
Maternity Facility	Number of Deliveries 2014	
McBrearty Ward, Grey Base Hospital	272	95%
Kawatiri, at Buller Hospital in Westport	14	5 %
Grand Total	286	100%



1.3 Demographics

The West Coast DHB serves a population of 32,900 people; the smallest population of the twenty DHBs and is the most sparsely populated with a population density of 1.4 people per square kilometre and a population of less than 1% of New Zealand's total estimated resident population. The West Coast DHB has two facilities where maternity care is provided; McBrearty Ward at Grey Base Hospital (secondary level care) and Kawatiri Unit (primary level care) at Buller Hospital in Westport.

The following short facts table provides a 'snapshot' of the demographics of the WCDHB. It is based on the National Maternity Collection (MAT) 2014 collated by the Ministry of Health, which presents statistical, demographic and clinical information about selected publicly-funded maternity services up to nine months before and three months after a birth.

Category		WCDHB
	**Birth Rate** 162 babies born every day in New Zealand	350 deliveries in 2014 29 babies per month are born to WCDHB mothers
	**Maternal age**	Highest percentage of WCDHB mothers are in 25-29 years bracket (29%)
	**Maternal ethnicity**	73% European / Other descent 19% Māori 6% Asian 2% Pacific
	**Deprivation**	Quintile 5 – 8% Quintile 4 – 48% Quintile 3 – 21% Quintile 2 – 16% Quintile 1 – 7%
	**Birth by Facility Type**	76% of WCDHB at Grey Base Hospital 4% - Primary Facility (Kawatiri) 10% - Christchurch (Tertiary)
	**Parity**	Partial year only as data collection improved 29% Primiparous 73% Multiparous
	**Body Mass Index**	46% of WCDHB women were a healthy weight
	**Smoking at first LMC Registration**	18% of women were smoking at time of registering with an LMC
	**Smoking 2 weeks postnatal**	77% of those women smoking at registration were smoking 2 weeks postnatal

"Lovely staff and very relaxed atmosphere. I felt very at home there".

Greymouth Hospital

2. Governance and Leadership

CDHB & WCDHB have layers of governance and reporting lines. The table below illustrates the governance levels of the various groups.

Governance level	CDHB General Managers' Group	CDHB Clinical Board WCDHB Clinical Board	WCDHB Executive Management Team
	W&CH Clinical Governance Committee	CDHB & WCDHB Maternity Clinical Governance Committee	
Reporting level	W&CH Clinical Audit Committee	W&CH Maternity Operations Group	Ashburton and Rural Health Services Maternity Continuum Team
	St George's Obstetric Committee	WCDHB MQSP Group	WCDHB Clinical Quality Improvement team
Operational Level	Perinatal and Maternal Mortality Review Committee	Incident Review Groups	Maternity Operations Group

Governance Committee Structure

The committee structure in Figure 9 below is complex due to the spread of maternity services and associated groups and committees both within and across the two DHB's.

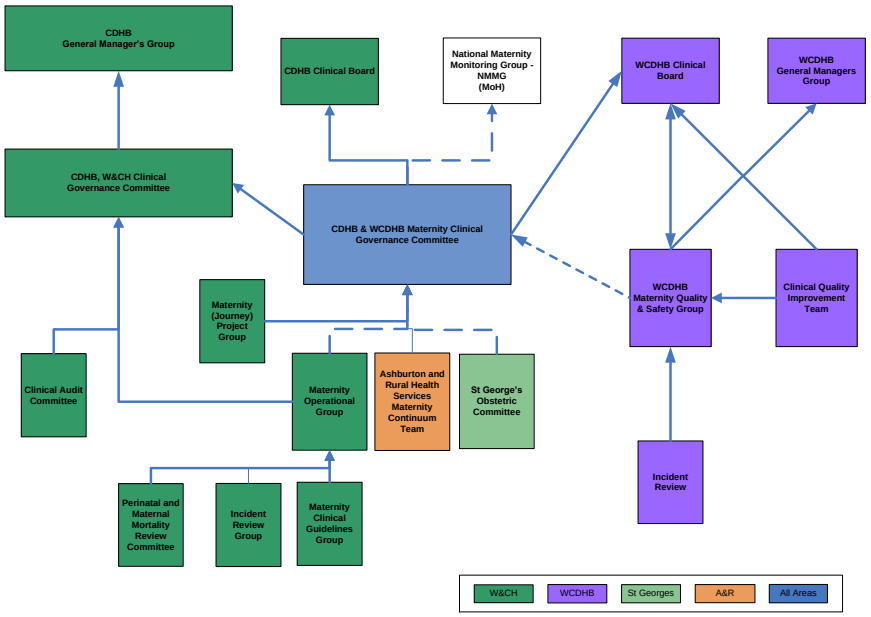


FIGURE 10 GOVERNANCE COMMITTEE STRUCTURE AND REPORTING LINES

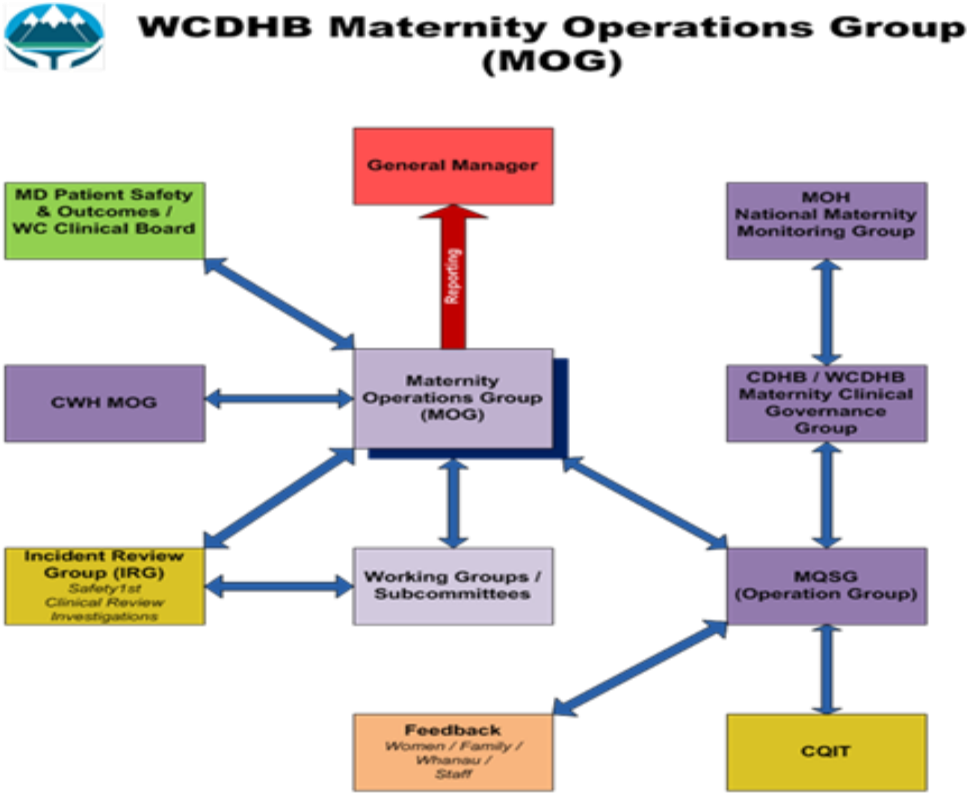


FIGURE 11 WCDHB MATERNITY OPERATIONS GROUP

Funding Utilisation

MQSP funding has been received by WCDHB since October 2015. Prior to this the funding for programme delivery on the West Coast was directed to CDHB in recognition of the 'transalpine' relationship and the work that was needed to establish 'transalpine processes'. As part of this relationship, funding has enabled a CDHB specialist from the CDHB/WCDHB Clinical Governance Group to visit the West Coast to provide clinical peer support.

A local Maternity Quality Safety Programme Coordinator has recently been appointed (April 2016) to drive local initiative now that the 'transalpine' work has moved into business as usual.

During the 2015/16 funding has been utilised to enable the Consumer Representative to regularly attend local MQSP Group meeting and also attend the National Maternity Monitoring Group Consumer Forum. The new Maternity Quality Coordinator and the Charge Midwife Manager will also be attending the National MQSP Forum in June.

Funding has also been used during this period to reprint posters and purse cards promoting the importance of registering with an LMC early in pregnancy following their successful launch last year and a review and update of content during this year.

3. Overview of MQSP Priorities 2015 / 16

The table below outlines the priorities of both the NMMG and the CDHB & WCDHB Maternity Quality & Safety Programme for 2015/16.

MINISTRY OF HEALTH MATERNITY SECTOR GOAL Ensure the same high standard of care throughout New Zealand for all women using maternity services								
NATIONAL MATERNITY MONITORING GROUP Oversees the maternity system in general Oversees the implementation of the New Zealand National Maternity Standards Acts as a strategic adviser to the Ministry of Health on areas for improvement in the maternity sector								
NMMG PRIORITIES								
Referral Guidelines	Pregnant women smoking	Timing of registration with an LMC	Variation in gestation at birth	Maternal mental health services	Primary maternity ultra-sounds	Maternity consumer represent-atives	NZ Maternity Clinical Indicators	DHB Maternity Annual Reports
CDHB & WCDHB MATERNITY QUALITY AND SAFETY PROGRAMME								
MATERNITY CLINICAL GOVERNANCE COMMITTEE								
QUALITY INITIATIVES AND PRIORITIES								
Reduce waste and variation	Improve guidelines, standards, policy, procedures, patient information	Analyse and review local performance in view of the NZ clinical indicators	Continue to audit outcomes of care, service provided	Define and develop processes for clinical case review and formal review of serious and sentinel events				
Promote Māori, Pacifica and younger women attend pregnancy and parenting support classes	Encourage early pregnancy registration with an LMC	Reduce smoking rates in pregnant women	Encourage breastfeeding	Promote use of primary birthing facilities	Promote access to maternal mental health services			
INFORMATION AND COMMUNICATION SYSTEMS		**DATA MONITORING**						
Develop design and content of CDHB Maternity Services website	Prepare for the introduction of the National Maternity Clinical Information System	Monitor access rates to Breastfeeding support services	Support Clinical coding consistency / improve data collection / integrity	Continue audits of Caesarean Sections, and Inductions of Labour	Audit pre-term births 32-36 weeks gestation & mode of birth	Implement trigger tool for reporting all maternity incidents via Safety1st – °1 & °2		
CONSUMER ENGAGEMENT			**SECTOR ENGAGEMENT**					
WCDHB Maternity Services websites	Maternity consumer experiences	MQSP Annual Report published yearly	Formal process for dissemination of information to community based clinicians					

4. Quality Initiatives - Achievements against Priorities 2015/16

This table summarises the quality improvement work undertaken in Maternity Services across **the West Coast DHB** in the 2015/16 years. The work is the result of interdisciplinary collaboration and the involvement of consumer representatives.

- Indicates that the work has been completed and / or in business as usual phase
- Indicates that the work is in progress / underway and nearing completion
- Indicates that there is still a significant amount to achieve before completion

	Priority Area	Progress Report	Status
1	Introduce Newborn Early Warning Score (NEWS)	The Newborn Early Warning Score (NEWS) tool was implemented by December 2015. The audit tool has been implemented and is used for retrieval from primary birthing unit. Education for staff is ongoing.	
2	Promote Māori, Pacifica and younger women attending pregnancy and parenting support classes	Work continues to recruit a Māori representative on MQSG. Poutini Waiora as the local Māori Health provider are representing Māori in the interim. Plunket have taken over the provision of Pregnancy & Parenting Education for the West Coast and have an emphasis on engaging Māori, Pacifica and younger women. They have been meeting with Māori Health service team to identify barriers to access. Poutini Waiora are working on a project to identify barriers to health services for young hapū Māori. Feedback from this will be incorporated into the maternity services plan.	
3	Implement standardised Safe Sleep Policy and education	A Safe Sleep Policy has been implemented. The Midwifery Educator is providing education on the Policy. Audits continue. LMCs have a checklist on their discharge plan that checks safe sleep practice. Postcard sized stickers are on all cots providing guidance on safe sleep practice.	
4	Monitor gestation at birth and appropriate gestation for Induction of Labour (IOL) and CS (Caesarean Section)	2015 data has been audited. Indications for Induction of Labour (IOL) and Caesarean Section in particular have been audited and indicate that these have been appropriate. A target rate of 18% for IOL has been set (previously sat around 25%) and this target is being met. Education has been provided to LMCs.	
5	Implement measures to reduce CS, instrumental delivery and episiotomy rates	The CS audit for 2015 indicates that the rates of CS, instrumental delivery and episiotomy have reduced.	
6	Improve guidelines, standards, policies and procedures	This work is ongoing. Where possible Canterbury DHB guidelines or policies are adapted to fit the West Coast environment. This work is about 70% complete. All policies and guidelines are available on the WCDHB intranet for clinicians to access.	
7	Promote access to care in 1st trimester including early registration with an LMC	This is being achieved. Posters are displayed in public places e.g. libraries, GP practices, supermarkets across the West Coast informing pregnant women how to access an LMC in their first trimester. Purse Cards have been provided to GP practices, and are now in their second print run with the addition of a QR code. Feedback from consumer surveys indicates that women are increasingly accessing the Find Your Midwife website to find and register with their LMC.	

	Priority Area	Progress Report	Status
8	Reduce smoking rates in pregnant women	The new Smokefree Pregnancies Incentive Programme for women who smoke during pregnancy in place where they are provided with supermarket vouchers for continuing to remain smokefree. Referrals made by GPs, self, LMCs and other healthcare providers. Of the 25% of women referred and who took up the programme, 58% of these were still smokefree two weeks post birth. This programme will continue.	
9	Review, restructure and evaluate effectiveness of lactation support services	A free breastfeeding smartphone app is being recommended to mothers postnatally. Education sessions have been provided to all Rural Nurse Specialists across the WCDHB and Mama Aroha breastfeeding information packs and cards have been provided in the rural areas and to LMCs.	
10	Increase use of primary birthing facilities	In the previous 12 months there have been 28 births in the Primary Unit. Buller mothers birthing at the secondary unit are transferred back for further care to the primary unit within 24-48 hours if appropriate. Feedback from mothers using the facility indicates their high satisfaction rates with the care they receive and the standard of facilities.	
11	Promote and support breastfeeding	Particular focus is on the decrease in numbers of inappropriate tongue tie referrals. The Bristol Tongue Assessment Tool has been requested and once available stakeholders will meet to plan the pathway for tongue tie release services.	
12	Promote access to maternal mental health services	The Maternal Mental Health pathway has been implemented. The Post and Antenatal Depression Association (PANDA) facilitated a full day training workshop on maternal mental health attended by LMCs, core midwives and other health professionals.	
13	Introduce new terminology for gestation over 37 weeks – e.g. early term, full term, post term	This topic is still in discussion across Trans Alpine services.	
14	Prepare for introduction of National Maternity Clinical Information System	National roll out of MCIS is on hold. However, staff at the WCDHB have had some training with colleagues at Tairawhiti DHB. Key learnings from Tairawhiti will form the basis of planning for the WCDHB. A visit to the West Coast by the MoH expert is planned whereby they will meet with key stakeholders.	
15	Support Clinical Coding consistency to national standard and communication with maternity clinicians	All data input for the last quarter is consistent with national standards. A new form has been introduced to maternity services to improve the veracity of the data and identifies unusual events for coding. A slight change to administration process means this will ensure better coding.	
16	Analyse and review local performance in view of the NZ maternity clinical indicators	Clinical indicators are reviewed by Maternity Operations Group to see how the WCDHB aligns nationally.	
17	Continue to audit outcomes of care and service provided	"We Care About Your Care" maternity services feedback form and other forms of feedback form the basis of service improvement. Close relationships with the Patient Safety Information and the Quality Team strengthen the link to quality improvement. Public forums have started, across the West Coast, where the maternity services engage with users of the service to identify barriers to access and to identify opportunities for systems improvement. A survey of health professionals has been developed to identify how the changed model of maternity services care (move to independent self-employed LMCs) has impacted on the provision of care.	
18	Review evidence and indications for ultrasound scans	A working group reviewed how our regional guidance on performing obstetric ultrasounds is aligned with best evidence. Their recommendations have been implemented and are now business as usual.	
19	Evaluate effectiveness of information available to consumers	WC maternity services are continually being promoted. The service is conducting "forums" across the West Coast meeting with West Coast mothers to gauge the effectiveness of our services from their perspective. The West Coast DHB maternity web pages are also continually reviewed and updated	

	Priority Area	Progress Report	Status
		and statistics on access to these pages is reported monthly at MQSG Meetings.	
20	Capture maternity consumer experiences / feedback	"We Care About Your Care" maternity services feedback from provided to all birthing mothers across the West Coast by LMCs. Feedback is captured and reported through to the Quality Improvement team, the Maternity Operations Group and maternity services forming the basis for improvement. As discussed above, forums for mothers using the services are being rolled out across the West Coast. The MQSP Coordinator has set up a Facebook page to link maternity services information and to provide another opportunity for mothers to feedback.	
21	Link maternity consumer representatives with community	Maternity consumers are represented on the Safety Group and Trans Alpine Governance Group. However, recruitment for a Māori consumer representative continues with Poutini Waiora currently providing representation.	
22	MQSP aligned with wider DHB quality agenda	The Maternity Quality Safety Programme is aligned with the West Coast DHB Quality Plan and forms part of the annual Quality Accounts report.	

"I APPRECIATED THE ABILITY TO PLAN MY OWN EXPERIENCE WITH GUIDANCE FROM THE MIDWIFE".

West Coast Coastline

5. Quality Improvement Initiatives

5.1 Smokefree Pregnancies Incentive Programme

Smoking during pregnancy can have a harmful effect on baby, both before, during, and after the birth. Maternal smoking increases the risks of miscarriage, pre-term births, low birth-weight babies, difficulties during childbirth, sudden infant death syndrome, and childhood asthma and glue ear. And smoking at any time is harmful for mothers too.

The Smokefree Pregnancies Incentive Programme was established in 2014; a collaboration between the West Coast PHO and the West Coast DHB.

The West Coast Quit Smoking service assists pregnant mothers in having a smokefree pregnancy.
The programme provides the support of a quit smoking counsellor and rewards mothers being smokefree, also helping mothers keep on track for a smokefree pregnancy and beyond pregnancy. Once baby is born, counsellors follow up with the mother and family to assist them in maintaining their smokefree status.

The programme provides grocery or petrol vouchers over a 12 week period for every week that pregnant mothers are smokefree after their quit date, up to a total value of $300. As a bonus mothers will receive a $50 pharmacy voucher if they are still smokefree two weeks after baby's arrival. Smoking/smokefree status is confirmed by a simple breath test that checks for carbon monoxide in the breath (called CO monitoring). The cut-off level for showing that mothers are smoke-free is under 6ppm.

Partners are also assisted by the programme if they want to quit at the same time and if they join the 12–week programme they are eligible to receive incentives up to a total value of $150.

To be eligible for the incentives programme mothers must be no more than 28 weeks pregnant, and agree to keep weekly contact for the first 8 weeks with fortnightly contact for the next 4 weeks.

During 2015, the programme received 48 referrals (received from 3 providers). Fourteen mothers signed up – 12 commenced the programme (2 dropped out soon after commencing). Eight mothers successfully completed the 12 week programme. Seven mothers were still smokefree two weeks post birth. Feedback from smoking cessation providers indicates that this is a significantly higher number of referrals and a higher level of engagement than was the case for the year prior to the programme commencing. Of the 12 on the programme: 10 were referred by midwives, 1 by a health clinic and 1 was a self-referral; 10 were of NZ European ethnicity and 2 identified as Māori.

5.2 Trigger Tool for Maternity Incident Reporting using Safety1st

Safety1st is the database used by all South Island DHBs for reporting incidents occurring within their DHBs. Safety1st went live on the West Coast in March 2015. The database provides a comprehensive system for recording of incidents and the investigation and subsequent follow up of these incidents.

Maternity Services have introduced a Trigger Tool for maternity events for recording in Safety1st. The purpose of the trigger tool list is to:

- Identify and review the severe complications of pregnancy and the puerperium;
- Help learn lessons to improve future care and not finding the fault.

The focus is on identifying opportunities for system improvement.

West Coast LMCs and Core Midwives have access to Safety1st through their DHB login and submit the incidents which are then investigated by the Clinical Midwife Manager. A Severity Assessment Code (SAC) is applied to the degree of harm suffered as a result of healthcare, in line with the Health Quality Safety Commission's consequence matrix. Training sessions have been provided and all staff have access to support from the Systems Administrator.

All SAC1s and SAC2s are reported to the HQSC and a full investigation is carried out using the Root Cause Analysis methodology of review.

SAC3 and SAC4 events are reviewed at Incident Review Group (multidisciplinary group reviewing all incidents occurring at the West Coast DHB) and are also reported through to the Maternity Operations Group for information and follow up.

Safety1st allows the recording of incidents, identifying of trends and allows for targeted education. The West Coast DHB is the only South Island DHB that has implemented Safety1st across both primary and secondary sectors.

5.3 Kawatiri Maternity Unit – Primary birthing facility reopening

The WCDHB maternity services review undertaken in 2013 identified safety concerns in regard to the primary birthing unit in Buller. These concerns included a poor process for ensuring safe transfer of women from Buller to Grey Base Hospital, a lack of coordinated care between midwives and the wider care teams, including emergency response, a disjointed education programme, and a high turnover of staff leading to a lack of continuity of care for women.

The West Coast District Health Board (WCDHB) decided to cease the provision of planned birthing in the unit for a period of time, however it remained available for antenatal and postnatal care. Over the following 18 months work was undertaken to implement the recommendations in the review, including addressing the issues specific to Kawatiri.

Following the transformation of the maternity service on the Coast which included updated processes, improved transfers, the recruitment of a midwifery educator and the implementation of the Primary LMC model, Kawatiri was reopened for full primary service provision in March 2015. Since this time there have been over 30 births in the unit and feedback from women as been very positive with 99 – 100 % satisfaction with the service.

Kawatiri Maternity Unit

5.4 WCDHB – Maternity Services Changed Model of Care

The WCDHB vision is an integrated health system that is clinically sustainable, financially viable and wraps care around people to help them stay well in their own homes. A Maternity Services Review reported:

- A number of serious adverse events
- Workforce shortages
- Over-reliance on locums
- DHB ceasing planned birthing in our Kawatiri Unit in Buller due to safety concerns and workforce issues

Maternity services across the West Coast needed a transformative change. We wanted a safe and consistent maternity service for women and their babies, a better environment and processes for our staff and for the West Coast self-employed midwives. We also wanted to provide our services more efficiently. We needed to be innovative in developing a safe and sustainable service in an area, part of which is quite remote.

We needed to rethink how we delivered our services, to look at a more integrated system that would lead us to transformational change for the West Coast Maternity Service, dealing with workforce and recruitment issues creatively, while ensuring quality and safety. So we developed a Rural Sustainability Package for self-employed midwives, created a cohesive and supported maternity team including DHB staff and self-employed midwives, with a "one team" philosophy.

Baby James

New roles were developed to support the wider maternity team, including a Midwifery Services Educator, Administration assistant and a Maternity Quality and Safety Coordinator. We need to plan a way of reopening Kawatiri; our primary maternity unit for planned birthing in Buller.

To achieve our goal we:

- Developed an innovative facility management contract
- Put more emphasis on multi-disciplinary education
- Agreed clear transport protocols
- Needed improved leadership
- Improved communications within the service
- Further strengthened our transalpine linkages with maternity services at Canterbury District Health Board

In the changed model of care, we have moved from DHB-employed case-loading midwives to self-employed midwives based in the community. A Rural Sustainability Package was developed to support these community midwives to work in our rural and remote community. This has resulted in community-based midwives wanting to work on the Coast, so women on the Coast have improved access to continuity of care. Our new model of care has led to significant savings and we use far fewer locums.

The innovate changes made have improved clinical outcomes with:

- Fewer women now have interventions like inductions – reduced rates of IOL
- Women are accessing care earlier in their pregnancies – primarily within the first trimester (last count up from 60% to 100%)
- The development of a highly functioning Maternity Quality and Safety Group
- An established Maternity Operations Group to ensure operational issues can be discussed regularly within a multidisciplinary context
- Reduction in serious and adverse events

We regularly survey our women and almost all women responding say they are satisfied with our maternity services (up from 60% to 99%).

One of our self-employed midwives comments:

> ***"The package is vital in ensuring my LMC role is financially viable here on the West Coast. Equally important, it has provided women with the opportunity to have greater choice for LMC. I am grateful to the West Coast DHB for providing the package and would hope that is reviewed in a positive light by your planning team."***

One year since the implementation of the changed model of care we have just completed a review and have identified that our Rural Sustainability Package is a key factor in maintaining our workforce.

For the first time in decades, we're fully recruited for both self-employed and DHB-employed (hospital-based) midwifery staff across the West Coast.

West Coast Core Midwives and LMCs

5.5 Midwife Educator for West Coast Maternity Services

The role of the Midwifery Educator was established in June 2015 to facilitate education for the maternity service staff. Although training is organised specific to midwives and LMCs, the Midwife Educator opens up training to all West Coast DHB staff and this has been appreciated by all staff attending the training. She also facilitates training on the West Coast to ensure that the midwives here can meet the requirements of their annual recertification programme without having to leave the Coast.

The Educator commenced the year with a midwifery forum to liaise with West Coast based Lead Maternity Carers (LMCs) and Core midwives as they work so closely together. The forum helped define where primary and secondary maternity care starts and finishes. This forum was repeated in June (six months later) to discuss any issues that had arisen.

Two new midwifery graduates commenced employment in McBrearty Ward in February 2015. The Midwife Educator provided them with an orientation programme that was focused on working as a core midwife in McBrearty ward. They had target education goals that they were able to meet without leaving the West Coast.

Training over the past year has included:

- **Neonatal Resuscitation**
  Run by the Midwife Educator, this course runs monthly with a class size of 6 students. Education about the resuscitaire and its emergency equipment. This equipment has been standardised this year so that the 3 resuscitaire located in Kawatiri, Theatre and McBrearty have all the same equipment on them. It is all boxed and numbered.

- **Helicopter Safety & Retrieval**
  Run annually, this training is new for midwives and a refresher for those attending the previous year. Training centres around safety around helicopters and retrieval / transferring women from the rural areas.

- **Midwifery Journal Club**
  On the last Thursday of the month midwives gather to share and discuss journal articles of interest. Christchurch Women's Hospital midwifery educators and staff often join via VC which further strengthens the bonds across the transalpine model of care.

- **Safe Sleep Workshop**
  Dr Nick Baker, Paediatrician from Nelson presented this workshop which was well attended by health professionals working across the scope of babies and infants.

- **College of Midwives - Midwifery Practice Day**
  Part of the Midwives' compulsory recertification programme this was held on the Coast this year and was well attended by most midwives.

- **Epidural Update Programme**
  Programme of ensuring that midwives are up to date and meeting the core competencies required to gain their epidural certificates.

- **Midwifery Skills Workshops**
  Facilitated by the Midwife Educator and targeted at Registered Nurses, ambulance officers and GPs working in the rural or primary units, these workshops covered neonatal resuscitation, normal labour and birth and some obstetric emergencies. Well received by the ED nurses in Buller who felt that this gave them more confidence when called to assist with births in the Kawatiri, primary birthing unit.

- **Te Hapu Ora**
  Education to support pregnant women who smoke – links to our Smokefree Incentives Programme.

- **PROMPT – Practical Obstetric Multi Professional Training**
  Held in July and August this training was attended by Obstetricians, midwifes, registered and enrolled nurses, RMOs ensuring a good multidisciplinary team mix. This training is lecture and scenario based in our environment with our multi-disciplinary team. There is a maximum of 12 participants in each course.

- **STABLE – Stabilisation and transfer of sick Neonates Programme** *(Sugar and Safe, Temperature, Airway Bloods Labs and Emotional Care)*
  Run by Maggie Meeks and Bronwyn Dixon, Neonatologists from Christchurch Women's Hospital this course was run over two days with 20 participants.

- **Emergency Skills Refresher Workshops**
  The Midwifery Council approved these courses being run at the West Coast DHB in house. Held in November, 10 midwives attended as part of their annual recertification.

- **Other Education**
  - Delayed cord clamping information talk
  - Pelvic floor and back care in pregnancy – run by Physiotherapists
  - Diabetes Workshop

- Breastfeeding workshops held throughout the year as part of the Baby Friendly Hospital Accreditation Programme (WCHDB successfully gained this accreditation for the fourth time)
- Commenced maternity case reviews
- Presentations from the Acting HoD, Obstetrics to midwives on a range of topics including third and fourth degree tears, emergency c/sections, induction of labour.

5.6 Consumer Engagement - We Care About Your Care – Maternity Services Feedback Form

We Care About Your Care – maternity services feedback from was launched in July 2015. The form was developed as collaboration by West Coast and Canterbury DHBs AND is used across Trans Alpine maternity services.

On the West Coast all birthing mothers are provided with a copy of the feedback form which they can complete prior to leaving birthing facilities, or they can take it home, complete it later and send it freepost.

All results from the surveys are collated and a monthly report is provided to the West Coast DHB Clinical Quality Improvement Team, the West Coast Maternity Quality Safety Group, CDHB / WCDHB Maternity Services Clinical Governance Group and to all maternity facilities.

Feedback assists in informing where systems improvement can be made and allows us to identify trends. For example, from the survey results we are seeing an increase in the early registration with an LMC within the first trimester and an increase in the use of the Find Your Midwife website.

This form is also available electronically on the West Coast DHB's maternity webpages: http://coastweb/wcdhb_new/services/maternity/default.asp. A copy of the form is enclosed as Appendix 1.

5.7 Consumer Engagement - Maternity Services Consumer Forums

To ensure the West Coast DHB is meeting the needs in the delivery of maternity Services to West Coast Women and their families / whanau we have planned consumer forums across the West Coast. All women who have used our facilities within the last 12 – 18 months are written to individually and invited to attend a morning tea to discuss their experiences and to provide us with feedback on how we are doing and suggestions for improvement, particularly given the changed model of care introduced over the last 12 months.

The Clinical Midwife Manager and MQSP Co-ordinator have met with Buller women who provided excellent feedback on the quality of care they received and the positive impact the changed model of care has had on the service. They provided some suggestions for improvement which will be followed up. Forums will be rolled across the other main centres on the West Coast during the next few months.

Women at the Buller Maternity Consumer Forum

5.8 Red Hats in Theatre

In February 2016 there was an incident where communication was hindered at an emergency Caesarean Section due to the theatre staff not being aware of who was the midwife in charge of the woman. Often in the Caesarean Section theatre there are 2 midwives, 1 Lead Midwifery Career (LMC) and 1 Core midwife and it is hard to distinguish the core midwife from the rest of the staff in theatre. On this day the theatre staff asked the LMC if she had contacted the Paediatrician the LMC responded thinking the core midwife had done it however as time when on theatre staff became aware that they had been communicating with the wrong midwife and the Paediatrician was delayed. While for this case, there was a good outcome, delayed communication could have impacted negatively as the baby needed resuscitation.

When the maternity team debriefed about the issue they were able to find a very simple solution. Red Hats in Theatre was born. The core midwife, who is responsible for the woman wears a red theatre hat so she is easily detectable in the theatre. Theatre staff know that the person wearing the red hat is the person they should be communicating with as the core midwife. This simple, but effective initiative, is working very well to improve communication in theatre.

6. A Patient's Story – Premature baby in the Rural Environment

"I'd seen Mary, my LMC all the way through my pregnancy, but at 34½ weeks I went into early labour. I live rural and it is a three hour drive to Grey Base Hospital. As birth was imminent, Mary arranged for me to be retrieved from Whataroa by rescue helicopter, so I drove to Whataroa, the closest rural base and was met by the retrieval team and airlifted to Grey Base Hospital.

Anna, one of the midwives at the Hospital who had been my educator for antenatal classes, was part of the retrieval team and it was comforting to see a familiar face and to know I was in good hands, especially being that this is my first baby and him being so premature.

From the second we got to the hospital, I was in amazing hands. It was all very overwhelming, but everybody was so caring, very comforting and very reassuring. I never felt frightened and felt I was in capable hands at all times. Particularly, for me, the biggest thing was that after the birth I stayed on for two weeks in hospital because my baby was so premature and was being tube fed until breastfeeding was established. The education I received from all of the midwives was priceless. The advice I got about feeding and general care was really helpful. I was made to feel that I could make my own decisions, but I got lots of good advice and was guided through the process.

I couldn't rate the team high enough; every single one of the midwives. Everyone had their own approach, but no one was forceful or made me feel I had to do it their way. They are very well educated and their good advice put me on the right path and I felt I was in good hands.

My baby is now three month old, is thriving and meeting all his milestones. The follow up care myself and my baby received was excellent; even to the point of the Paediatrician coming to my home in the rural location. Mary has kept in touch and followed my baby's progress, so I feel as though I've always had guidance and support.

I have full confidence in the healthcare system and I would do it all over again and recommend West Coast maternity services to all first time mothers".

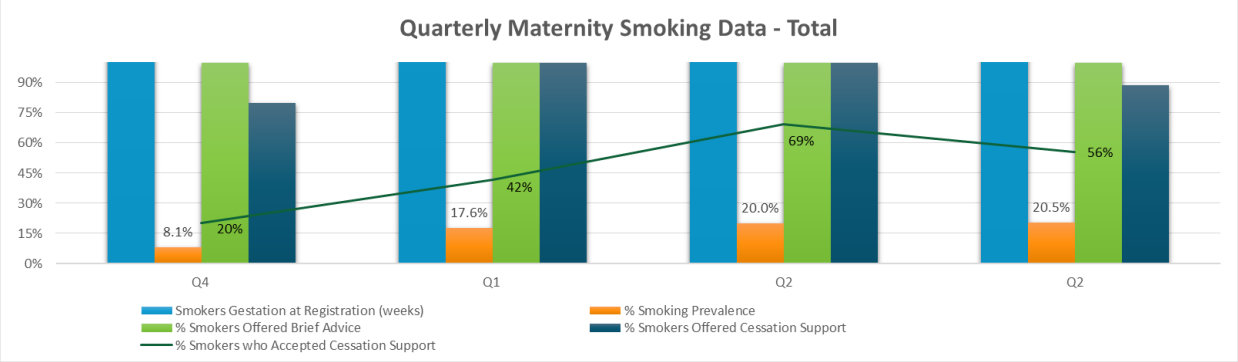
Danielle

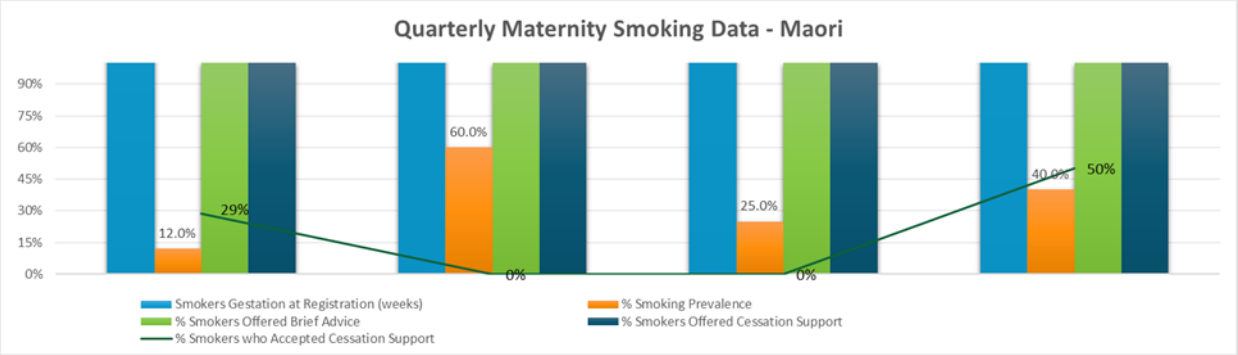
7. WCDHB Goals for Pregnant Women who smoke

Smoking is the main preventable cause of problems in pregnancy. There is NO safe level of smoking while pregnant.
Our aim is to provide every woman high quality support to be smoke free during pregnancy and beyond.

Focus	Target	Goal
Booking	80%	Women have enrolled with an LMC midwife by 12 weeks.
Advice	90%	Pregnant women who identify as smokers are offered advice and support to quit at first registration visit.
Referral	50%	Pregnant women who smoke accept smoking cessation support during pregnancy.
Hospital	95%	Women who smoke will be given support to stop smoking while in hospital.
Home	86%	Mothers are smoke free at two weeks postnatal.
Education		LMCs, core midwives and nurses within CDHB maternity facilities complete a smoking cessation training programme.

WCDHB - Smoking Cessation 2015-16	Q4 (14/15)		Q1		Q2		Q3	
	Total	Māori	Total	Māori	Total	Māori	Total	Māori
Smokers Gestation at Registration (weeks)	7.4	8	12.2	15.7	8.2	13	11	9.5
% Smoking Prevalence	8.1	12.0	17.6	60.0	20.0	25.0	20.5	40.0
% Smokers Offered Brief Advice	100	100	100	100	100	100	100	100
% Smokers Offered Cessation Support	80	100	100	100	100	100	89	100
% Smokers who Accepted Cessation Support	20	29	42	0	69	0	56	50
Number of events	62	8	68	5	65	4	44	45




Quarterly Maternity Smoking Data - Maori
90%
75%
60%
45%
30%
15%
0%
12.0%
29%
60.0%
0%
25.0%
0%
40.0%
50%
Smokers Gestation at Registration (weeks)
% Smoking Prevalence
% Smokers Offered Brief Advice
% Smokers Offered Cessation Support
% Smokers who Accepted Cessation Support

8. Clinical Indicators Analysis

The Ministry of Health's data New Zealand Maternity Clinical Indicators (2014) was published in May 2016. The publication shows key maternity outcomes for each DHB for 2014.

The analysis below, shows the DHBs' performance and position in relation to both the Indicators and national averages. Percentage figures are from either the 'DHB of Domicile' set or the 'facility of birth' as indicated and are based on standard primiparae only (rather than all women giving birth/all deliveries).

8.1. Introduction

The purpose of these indicators is to increase the visibility of the quality and safety of maternity services, and to highlight areas where quality improvements could be made. The data largely refer to 'standard primiparae' (SP) who make up 11.4% of all births in the WCDHB. This group (aged 20-34 years, uncomplicated singleton pregnancy, full term, cephalic i.e. head presentation) represent the least complex situations in which intervention rates would be expected to be low, and can be compared between institutions.

8.2 Analysis of Individual Indicators 2014

Indicator	Title	2013 WCDHB Rate (n)	2014 WCDHB Rate (n)	Change from 2013	Higher or lower than national average	National Average 2014
Indicator 1	Registration with a Lead Maternity Care	45.2% (74)	57.0% (61)	▲ +11.8%	▼	67.7%
The move to the independent LMC model of maternity care, improved communication and publicity, the launch of the WCDHB maternity web pages and bookings from the FYM website have contributed to the number of women booking within their first trimester.						
Indicator 2	Standard primiparae who have a spontaneous vaginal birth (%)	60.4% (34)	60.0% (32)	▼ - 0.4%	▼	68.9%
Spontaneous vaginal delivery rate could be partly attributed to the environment and the facilities available. Clinicians may not be willing to take a higher risk if it impacts on the mother and/or baby as WCDHB does not have an established special care baby unit. This is a reduction in only 4 deliveries. With low numbers, even a small change can impact significantly on the percentage. However, WCDHB is within the national range.						
Indicator 3	Standard primiparae who undergo an instrumental vaginal birth (%)	18.9% (8)	15.0% (6)	▼ -3.3%	▲	15.2%
This rate is within the national average. WCDHB is maintaining standards close to the national average. Again low numbers impact on percentage rates.						

Indicator	Title	2013 WCDHB Rate (n)	2014 WCDHB Rate (n)	Change from 2013	Higher or lower than national average	National Average 2014
Indicator 4	Standard primiparae who undergo a caesarean section (%)	20.8% (11)	22.5% (9)	▲ +1.7%	▲	15.6%
Obesity numbers on the West Coast are higher than the national average (3% higher) which may contribute to the higher rate of c/sections compared to the national average. WCDHB regularly review all emergency C/sections.						
Indicator 5	Standard primiparae who undergo an induction of labour (%)	7.5% (4)	5.0% (2)	▼ -2.5%	▲	5.6%
Total induction rate has reduced from 2013, but due to the small numbers one IOL can impact significantly on the data. For 2013 there were only 4 standard primaparae in this indicator. Education of LMCs has assisted in reducing this rate since our last audit. WCDHB are within the national average.						
Indicator 6	Standard primiparae with an intact lower genital tract (no 1st – 4th degree tear or episiotomy) (%)	26.2% (11)	29.0% (9)	▲ +2.8%	▲	27.7%
WCDHB rate is slighter higher than the national average. LMCs skills are contributing positively on this measure.						
Indicator 7	Standard primiparae undergoing episiotomy with no 3rd – 4th degree perineal tear (%)	21.4% (9)	22.6% (7)	▲ +1.2%	▲	22.7%
Education on perineal suturing for LMCs / core miwives has been held to identify the tears and to teach appropriate technique of suturing. WCDHB is within the national average.						
Indicator 8	Standard primiparae sustaining a 3rd – 4th degree perineal tear with no episiotomy (%)	2.4% (1)	3.2% (1)	▲ +2.4%	▼	4.5%
Improved skills, education and the identification of tears appropriately and appropriate repair has impacted on this figure. WCDHB is within the national average.						
Indicator 9	Standard primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear (%)	4.8% (2)	3.2% (1)	▼ -1.6%	▲	1.5%
Figures show a slight decrease since 2013. WCDHB has improved identification of degree of tear and following up women so they receive more appropriate treatment based on the degree of tear. Again low numbers impact on the figures significantly.						

Indicator	Title	2013 WCDHB Rate (n)	2014 WCDHB Rate (n)	Change from 2013	Higher or lower than national average	National Average 2014
Indicator 10	Women having a general anaesthetic for caesarean section (%)	2.0% (2)	8.1% (8)	▼ -3.2%	▼	8.4%
The rate is at the national average. The WCDHB's unit is small and the factors influencing this rate can be related to the higher number of locums during that period; staffing issues at the time.						
Indicator 11	Women requiring a blood transfusion during birth admission for caesarean section delivery (%)	1.0% (1)	1.0% (1)	▼ No change	▼	3.2%
Blood transfusion rates and post-partum blood transfusion rates are lower than the national average which may be related to our casemix of lower risk patients as high risk patients are transferred to the tertiary centre.						
Indicator 12	Women requiring a blood transfusion during birth admission for vaginal birth (%)	1.8% (5)	0.8% (2)	▼ -1.3%	▼	2.1%
The rate has decreased. Blood transfusion rate is lower than the national average. Most high risk patients are transferred to the tertiary centre.						
Indicator 13	Women with eclampsia at birth admission (numerator)[2]	N=0	N=0			
We have no patients in this group.						
Indicator 14	Women having a peripartum hysterectomy (numerator)[2]	N=0	N=0			
Indicator 15	Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period (numerator)[2]	N=0	N=0			
Not applicable as there are no patients for either of Iindicators 14 or 15.						
Indicator 16	Maternal tobacco use during postnatal period (%)	8.5% (24)	15.7% (25)	▲ +7.2%	▲	12.8%
WCDHB has improved reporting of smoking rates and the data is more accurate. There are incentive packages for pregnant mothers to quit smoking which have been very effective and it is expected that the rates will improve for the 2015 period.						

Indicator	Title	2013 WCDHB Rate (n)	2014 WCDHB Rate (n)	Change from 2013	Higher or lower than national average	National Average 2014
Indicator 17	Women with BMI over 35 (%)	7.7% (23)	8.7% (15)	▲	▼	8.8%
Even though our BMI rates are within the national average, there seems to be a tendancey towards an increase in the number of high BMI patients. There is a small group of patients with BMI greater than 50 and we have put policies in place to provide antenatal and intrapartum care for these women. This higher BMI also may contribute to higher rates of C/section.						
Indicator 18	Preterm birth (%)	8.0% (30)	9.0% (32)	▲ -1.2%	▲	7.4%
WCDHB tries to avoid preterm deliveries within the unit. Guidelines and systems are in palce to transfer the patient to the tertiary centre fo this type of patient. Our aim is to transfer to the tertiary unit in utero where more appropriate services can be provided.						
Indicator 19	Small babies at term (37-42 weeks' gestation) (%)	2.9% (10)	1.3% (4)	▼ -1.6%	▼	3.0%
There seems to be an improvement in identifying the small for gestational age babies and this may be related **to our** changed model of care (self employed LMCs) on the West Coast. WCDHB figures sit below the national average.						
Indicator 20	Small babies at term born at 40-42 weeks' gestation (%)	40% (4)	- (0)	▼ -40%	▼	39.4%
There were no babies during the 2014 year that were small at term; a great result.						
Indicator 21	Babies born at 37+ weeks' gestation requiring respiratory support	0.9% (3)	1.3% (4)	▲ +0.4%	▼	2.0%
This rate sits within the national average. Basic neonatal support is provided by WCDHB employed Rural Hospital Medical Specialists and physicians providing paediatric support for the babies who require it.						

9. West Coast DHB Maternity Data

The data in this section is from local WCDHB Maternity data sources and shows 2013 and 2014 in comparison, with increase or decrease noted. Data here is counted in terms of all 'deliveries' in a DHB facility (as opposed to a count of exclusively standard primiparae as used by the New Zealand Maternity Clinical Indicators.

Gestation at Delivery	2013		2014		Trend
	Number	%	Number	%	
Extremely preterm (<28 weeks)	1	0.4	0	0	▼
Very preterm (28-31 weeks)30	0	0	0	0	–
Moderately preterm (32-33 weeks)	1	0.4	2	0.7	▲
Later preterm (34-36 weeks)	6	2.1	14	5.0	▲
Term (37-41 weeks)	270	95.4	263	93.6	▼
Prolonged (>42 weeks)	3	1.1	2	0.7	▼
Unknown	2	0.7	0	0	–
Grand Total	**283**	**100**	**281**	**100**	

Type of Labour	2013		2014		Trend
	Number	%	Number	%	
Spontaneous	107	37.8	112	39.9	▲
Induction	29	10.2	45	16.0	▲
Artificial Rupture of Membranes	67	23.7	62	22.1	▼
Augmented	31	11.0	21	7.4	▼
Did not labour	47	16.6	41	14.6	▼
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Method of Delivery	2013		2014		Trend
	Number	%	Number	%	
Elective Caesarean	28	9.9	41	14.6	▲
Vaginal	167	59.0	162	57.7	▼
Vaginal Water Birth	7	2.5	13	4.6	▲
Kiwi Cup	14	4.9	17	6.0	▲
Ventouse	3	1.1	2	0.7	▼
Forceps	4	1.4	7	2.5	▲
Emergency Caesarean	57	20.1	39	13.9	▼
VBAC	1	0.4	0	0	▼
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Breech	2013		2014		Trend
	Number	%	Number	%	
No	273	96.5	270	96.1	▼
Yes	8	2.8	11	3.9	▲
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Anaesthetic	2013		2014		Trend
	Number	%	Number	%	
None	147	51.9	154	54.8	▲
Local	28	9.9	18	6.4	▼
Epidural	17	6.0	16	5.7	▼
Spinal/Epidural	86	30.4	87	31.0	▲
General	3	1.1	6	2.1	▲
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Perineum	2013		2014		Trend
	Number	%	Number	%	
Intact	106	37.5	171	60.9	▲
1st Degree tear	50	17.7	53	18.9	▲
2nd Degree tear	20	7.1	30	10.7	▲
3rd or 4th Degree tear	4	1.4	5	1.8	▲
Episiotomy	26	9.2	17	6.0	▼
N/A	75	26.5	5	1.8	▼
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Post-Partum Haemorrhage	2013		2014		Trend
	Number	%	Number	%	
No	253	89.4	261	92.9	▲
Yes	28	9.9	20	7.1	▼
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Blood Loss Amount	2013		2014		Trend
	Number	%	Number	%	
>1500mL	1	0.4	1	0.4	–
<1000mL	230	81.3	240	85.4	▲
≥1000mL ≤1500mL	11	3.9	8	2.8	▼
N/A	37	13.1	32	11.4	▼
Unknown	4	1.4	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Admitted to Neonatal Intensive Care	2013		2014		Trend
	Number	%	Number	%	
No	278	98.2	275	97.9	▼
Yes	3	1.1	6	2.1	▲
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Neonatal Outcomes	2013		2014		Trend
	Number	%	Number	%	
Well Neonates	281	99.3	279	99.3	–
Neonatal Deaths	2	0.7	2	0.7	–
Grand Total	**283**	**100**	**281**	**100**	

Stillbirth	2013		2014		Trend
	Number	%	Number	%	
No	280	98.9	280	99.6	▲
Yes	1	0.4	1	0.4	–
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Small for gestational age	2013		2014		Trend
	Number	%	Number	%	
No	276	97.5	275	97.9	▲
Yes	5	1.8	6	2.1	▲
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

Feeding Method	2013		2014		Trend
	Number	%	Number	%	
Bottle	11	3.9	8	2.8	▼
Breast	269	95.1	272	96.8	▲
N/A	1	0.4	1	0.4	–
Unknown	2	0.7	0	0	▼
Grand Total	**283**	**100**	**281**	**100**	

10. Focus for 2016 / 17

The WCDHB has identified the following areas as our priorities / focus for the coming 2016/17 year:

Increase Consumer Engagement

The WCDHB has a continual challenge to deliver equitable maternity services despite small population spread across a large geographical area. In order to ensure we continue to address the needs of our women it is important to talk to our women about their journeys so we can learn about their experiences and put lessons learnt into action. We are in the process of planning regular consumer forums where we go to our women, in their rural setting, to gather their feedback. We have also set up a Facebook page to post information and links back to our maternity website. We are in the process of recruiting maternity consumers on our Maternity Quality & Safety Group (MQSG) and to provide a consumer voice to the Maternity Clinical Governance Group (MCGG).

Young Maori Women and access to services

Around 19% of our mothers are Maori, yet they are under-represented in the feedback we receive about our services. We will work with Poutini Waiora (our local Maori health services provider) to address the needs of our young Maori women and to ensure that our services are culturally appropriate. Our aim is to raise the voice of young Maori women in maternity services. We are also in the process of recruiting a Maori maternity services consumer to provide a Maori perspective to our MQSG and MCGG.

Address Maternal Smoking Rates

Around 18% of our women are smoking at their first LMC registration and 33% of these are smoking two weeks postnatally. Although we have had some success with our smokefree pregnancies incentive programme, our aim is to increase uptake of smoking cessation support through pregnancy to give our Mums and babies the best start. We plan to trial the use of a carbon monoxide monitor at time of first registration with the LMC to highlight the effects smoking has on health of mum and baby.

Our overarching CDHB and WCDHB MQSP Priorities and Action Plan 2016/17 as endorsed by the Canterbury DHB & West Coast DHB Maternity Clinical Governance Committee is available in Appendix 1.

Appendices

Appendix One – CDHB and WCDHB MQSP Priorities and Action Plan 2016/17

	Initiative/Priority	Action	Expected Outcome	Measure
1.	Monitor the involvement of maternity consumer members in DHBs' MQSPs	Develop good communication systems for consumers to link regularly	Regular meetings with maternity consumers	At least 9 meetings per annum with maternity consumers
2.	Consumer engagement – actively engage and increase the profile of consumer members (19 & 20 of 2015/16 priorities and action plan)	• Review information for women leaflets e.g. for content, availability, languages • Evaluate the effectiveness of the We Care About Your Care maternity services feedback form • Consider development of focus groups and use of social media • Engage our higher needs consumers (young mothers, Maori, Pacific and women with mental health issues)	• All consumer information due for review are reviewed and readily available • Use written feedback from Maternity consumers to improve consumer experience • Use of focus groups to identify quality improvements • Priority consumer groups are engaged in quality activities	• Review data on maternity website hits • Consumer member satisfaction, retention and increased visibility both within the service and in the community
3.	Review the outcomes of work undertaken by the maternity ultrasound advisory group as directed by the NMMG (18 of 2015/16 priorities and action plan)	• Implement revised "in hospital" obstetric ultrasound guideline • Establish local working group to review access, indications and evidence around primary maternity ultrasounds • Determine whether the regional guidance on performing obstetric ultrasounds is aligned with best evidence • Review equity of access for primary obstetric ultrasounds • Work with consumers to develop resources for women around best practice	• Engagement with community providers and pathway developed to align with best evidence • Consumers aware of resources available	• Audit of primary maternity ultrasounds demonstrate appropriate referral • Documents are up to date and easily accessible by consumers and health professionals
4.	Support the ratification of national maternity clinical guidelines and implementation of existing guidelines	• Review published national maternity clinical guidelines and implement • Review accessibility of documents to staff	Guidelines are implemented	Documents are up to date and easily accessible by staff
5.	Continue to review the NZ Clinical indicators data and monitor DHBs variation	• Multidisciplinary review of the maternity clinical indicator data within the DHB, including variation in gestational age and perineal trauma, appropriate	• Data is used to evaluate the effectiveness of previous actions and plan future actions	There is evidence of a direct correlation between clinical indicator data and relevant quality improvement initiatives

	Initiative/Priority	Action	Expected Outcome	Measure
	(4 & 5 of 2015/16 priorities and action plan)	gestation for Induction of Labour (IOL) and CS (Caesarean Section) • Evaluation whether previous actions have impacted on data • Formulate action plan to address areas for improvement	• Capture quality improvement activity resulting from comparing DHB outcomes to national trends	and/or changes in practice
6.	Promote access to maternal mental health services and the use of the maternal mental health pathway	• Review maternal mental health pathways across the two DHBs • Develop an inpatient maternal mental health pathway	• All health professionals are aware of and utilising the maternal mental health pathway • Information about the maternal mental health pathway is available for consumers	An audit of referrals to maternal mental health demonstrate correct use of pathways
7.	Review key maternity sector publications including the MoH's Report on Maternity, 2014	• Establish multidisciplinary review of the key maternity sector publications • Develop KPIs for maternity to match or exceed national performance indicators	• Data is used to evaluate the effectiveness of previous actions and to plan future improvements • A positive movement in the identified trend from the previous year	Direct correlation of quality improvement linking to key maternity publications
8.	Increase use of primary birthing facilities (10 of 2015/16 priorities and action plan)	Promotional material / information reviewed and distributed	Increase in number of women choosing to birth or have postnatal care in DHB primary birthing facilities	Bed occupation and birth location indicates increasing usage of primary birthing units
9.	Identify women with modifiable risk factors for perinatal related death and work individually and collectively to address these	• Review and update promotional material including online resources to promote: • uptake of peri-conceptual folate • pre-pregnancy care for known medical disease such as diabetes • access to antenatal care • accurate height and weight measurement in pregnancy with advice on ideal weight gain • prevention and appropriate management of multiple pregnancy • smoking cessation • antenatal recognition and management of fetal growth restriction • prevention of preterm birth and management of threatened preterm labour • following evidence-based recommendations for	• Women and health professionals are accessing online resources • Up to date information is accessible in appropriate formats (i.e. Paper, electronic)	An audit of "hits" on DHB web pages demonstrates information is being accessed by health professionals and consumers

	Initiative/Priority	Action	Expected Outcome	Measure
		indications for induction of labour • advice to women and appropriate management of decreased fetal movements		
10.	Offer education to all health clinicians [working in the maternity setting] so they are proficient at screening women, and are aware of local services and pathways to care, for the following: • family violence • smoking • alcohol and other substance use (Recommendation 2. Ninth Annual Report of the Perinatal and Maternal Mortality Review Committee (PMMRC, 2015))	• Regular training is available and mandatory for CDHB employed staff working in maternity services • Funded regular training is available for self-employed health professionals through the CDHB and New Zealand College of Midwives	• Health professionals working in the maternity setting are confident to screen for family violence, smoking and alcohol and other substance use effectively • Health professionals are familiar with the appropriate referrals process and can access the correct pathways	Evidence of audits shows: • 70% of pregnant women accessing DHB maternity services are asked questions about family violence • 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking Audit demonstrates women who indicated that they had been exposed to FV were referred to the appropriate services
11.	Multi-disciplinary fetal surveillance training be mandatory for all clinicians involved in intrapartum care	Fetal Surveillance training includes: • risk assessment for mothers and babies throughout pregnancy as well as intrapartum observations • strengthening of supervision and support to promote professional judgment, interdisciplinary conversations and reflective practice	All health professionals working in the maternity setting and interpreting fetal heart rates attend annual mandatory training in intrapartum fetal surveillance	Health professionals are assessed as competent by meeting level 1 in the Fetal Surveillance examination
12.	Improved detection of fetal growth restriction to reduce perinatal morbidity and mortality rates	Develop evidence based guideline encompassing The New Zealand Maternal Fetal Medicine 'Guideline for management of suspected small for gestational age, singleton pregnancies after 34 weeks gestation' (2014).	Evidence in practice of: • assessment and appropriate referral at first antenatal visit and throughout pregnancy • accurate measurement of maternal height and weight at first antenatal assessment • ongoing assessment of fetal growth by measuring fundal-symphysial height in a standardised way,	Audit of cases where fetal growth restriction has been identified shows 100% compliance with referrals, measurements, use of growth charts and action on ultrasound findings

	Initiative/Priority	Action	Expected Outcome	Measure
			recorded at each antenatal appointment, preferably by the same person • plotting of fundal height on a tool for detection of fetal growth restriction, such as a customised growth chart, from 26 weeks gestation • If fetal growth restriction is confirmed by ultrasound, appropriate referral and assessment of fetal and maternal wellbeing occurs and timely delivery are recommended	
13.	Seasonal or pandemic influenza vaccination is promoted for all pregnant women regardless of gestation, and for women planning to be pregnant during the influenza season Vaccination is also recommended for maternity care providers to reduce the risk to the women and babies under their care.	Consult with women and maternity care providers to address barriers to the uptake of influenza vaccination in pregnancy and implement strategies to increase access to and awareness of the benefit of vaccination.	Raised awareness of pandemic influenza vaccination available to women and health care professionals	Increased uptake of pandemic influenza vaccinations for women and health care professionals working in the maternity setting
14.	Utilisation of the CDHB Newborn Observation Chart and Newborn Early Warning Score (NEWS) (CDHB)	Continued evaluation/validation and refinement of the CDHB Newborn Observation Chart and Newborn Early Warning Score (NEWS) as per the quality PDCA cycle.	• Utilisation of the Newborn Observation Chart • Appropriate transfer of neonates to NICU for further assessment and management	• An audit of the CDHB Newborn Observation Chart and Newborn Early Warning Score (NEWS) demonstrates accuracy of scoring in 95% of documented observations • An audit of babies who have scored 3 on assessment and completion of the CDHB Newborn Observation Chart and Newborn Early Warning Score (NEWS) demonstrates they have been appropriately

	Initiative/Priority	Action	Expected Outcome	Measure
				referred to the Neonatal team for immediate review/transfer to the Neonatal Unit
15.	Raise awareness about newborn immunisation (WCDHB)	Provide education and information to women and their families about childhood immunisation.	• Ensure all babies are enrolled with general practice by two weeks of age • Deliver actions against the 2014/15 West Coast Immunisation Advisory Action Plan.	Audit enrolment with General practice
16.	Develop a relevant multidisciplinary review process for maternity incidents (WCDHB)	• Review current process of incident form review • Determine appropriate MDT membership • Develop an appropriate forum for review and discussion of all maternity incidents	• Develop schedule of meetings; oversee outcomes • Includes cycle of regular audit • Audit all transfers of women and babies to tertiary centres to determine reasons for transfer and to ensure transfers are timely and appropriate	
17.	Promote and support breastfeeding (11 of 2015/16 priorities and action plan)	• Implement the Breastfeeding priority plan • Reconfigure tongue tie release services across the hospital and community	• A formal assessment process for tongue ties will be used before referrals are made • Pathway for tongue tie release services developed to include provision in community	• All tongue tie release procedures are necessary and appropriate • All post-discharge tongue tie release procedures are being performed by the most appropriate service provider
18.	Prepare for introduction of National Maternity Clinical Information System (14 of 2015/16 priorities and action plan)	• Business cases approved • Current process mapping completed • New process mapping commenced • Change management planning commenced	Both DHB's make significant progress towards the implementation of the electronic maternity information system	Stated actions have been completed by June 2017
19.	Promote Māori, Pacifica and younger women attending pregnancy and parenting support classes	Receive regular updates on initiatives to meet this priority from the contracted service	Increased attendance of Māori, Pacifica and younger women attending pregnancy and parenting support classes	Reported increase and positive feedback from Māori, Pacifica and younger women attending pregnancy and parenting support classes

	Initiative/Priority	Action	Expected Outcome	Measure
20.	Implement Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines), 2012.	• Finalisation and implementation of the Maternity Consultation and transfer policy • Finalisation of the Consultation and Transfer of Care sticker tool	CDHB/WCDHB policy is published and utilised by all health professionals when consulting and transferring clinical responsibility, as per the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines), 2012.	Documents are up to date and easily accessible health professionals
21.	Evidence based clinical case review and representation of community based clinicians and consumers in the formal and informal clinical review processes to ensure their perspective is considered	• Review all forums where clinical case review takes place, to ensure, where relevant, community based clinicians and consumers are involved in the review process • Review terms of reference to reflect membership of community based clinicians and consumers • Identify minimum requirement of community based clinician and consumer at case review reflected in the quorum	Community based clinicians and consumers are aware of, and involved in, where appropriate, clinical review processes	50% attendance of community based clinicians and consumers at all relevant case reviews
22.	Define processes to: • Implement changes in clinical practices • Reduce unnecessary variation in clinical practice • Define and strengthen clinical pathways • Influence local service delivery, planning and policy	• Develop clear and auditable process to capture and implement recommended changes • Evaluate changes to demonstrate sustainability	Have robust processes for implementing change in clinical practice	Process developed to monitor and evaluate changes in clinical practice to demonstrate their clinical effectiveness and amend as necessary

Appendix Two – We Care About Your Care

Canterbury District Health Board
Te Poari Hauora ō Waitaha

ST GEORGE'S HOSPITAL
A Tradition of Excellence

West Coast DISTRICT HEALTH BOARD
TE POARI HAUORA A ROHE O TAI POUTINI

We Care About Your Care

Maternity Services Feedback Form

Kia Ora and congratulations on the birth of your baby/ pēpi. We care about you and the service we provide and we value your feedback.

West Coast Maternity Services

Please tick the boxes ☐ and circle the faces  ***that best describe your experiences:***

Antenatal care

How many weeks pregnant were you when you booked your midwife? _____weeks

How did you find your midwife?

☐ Word of mouth ☐ GP ☐ Other _____
☐ Hospital ☐ findyourmidwife.co.nz website

How involved were you in choosing your place of birth? *(Please comment and circle a face)*

_____

Very involved To some extent Not involved

Did you attend pregnancy/parenting education classes?

☐ Yes. If yes, where? _____
☐ No. If no:
Was a class offered? ☐ Yes ☐ No
Was it your choice not to attend? ☐ Yes ☐ No
Why did you choose not to attend? _____

Labour, birth and care

Where did you give birth to your baby/pēpi? *(please name the place)*

_____

Month your baby/pēpi born _____

Was this your planned place of birth? ☐ Yes ☐ No

Comments:

_____

Was your place of birth welcoming:

The building/birthing room? ☐ Yes ☐ No
The people who cared for you? ☐ Yes ☐ No

Comments:

_____

Were you given enough information to make decisions during your labour and birth?
(Please comment and circle a face)

Very informed To some extent Not informed

Postnatal care - During your postnatal stay

Where was the majority of your care provided after your baby/pēpi was born? *(Please name the place)*

Was this postnatal unit welcoming?

Your room?	☐ Yes	☐ No
The people who cared for you?	☐ Yes	☐ No
The facilities? *(e.g.bathroom/kitchen)*	☐ Yes	☐ No

Comments:

Did the choices of food meet your needs? ☐ Yes ☐ No
Comments:

Did you feel supported with feeding your baby/pēpi? ☐ Yes ☐ No
Comments:

Were staff respectful of your cultural and spiritual needs? (*Were the important aspects of your life understood, acknowledged and respected?)*

Comments: ☐ Yes ☐ No

Did the visiting hours meet your family/whānau's needs?
(In each section please comment and circle the face that best describes your experience)

Yes, definitely To some extent No, not at all
Comments:

Did staff respect and maintain your privacy?

Yes, definitely To some extent No, not at all
Comments:

Were the staff friendly and quick to respond to you and your baby's/pēpi's needs?

Yes, definitely To some extent No, not at all
Comments:

Did all staff give you consistent information to help you learn to feed your baby/pēpi?

Yes, definitely To some extent No, not at all
Comments:

Were you given enough information about going home with your baby/pēpi?

Yes, definitely To some extent No, not at all
Comments:

What were the two best things about your care?

What two suggestions do you have that would have improved your experience?

About you

How old are you?
☐ 15-19 years ☐ 20 -29 years ☐ 30 – 39 years ☐ 40 + years

Is this your first baby/pēpi? ☐ Yes ☐ No

What is your ethnicity? (*you can tick as many boxes as you want)*
☐ NZ European ☐ Māori ☐ Asian ☐ Pacific Islander ☐
Other:_____

Contact details *(Optional)*

Home: _____ Email: _____

Phone: _____ Address: _____

Thank you for completing this form. Please put this form in the collection box in Maternity or post it to us at a later date.

Bibliography

MoH. (2011). *New Zealand Maternity Standards.* Wellington: MoH.

MoH. (2014). *Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: A Clinical practice guideline.* Wellington: MoH.

MoH. (2015). *2014 MAT Data.* Wellington: MoH.

MoH. (2015). *New Zealand Maternity Clinical Indicators 2013.* Wellington: MoH.

MoH. (2015). *Report on Maternity .* Wellington: MoH.

MoH. (2016). *New Zealand Maternity Clinical Indicators 2014.* Wellington: MoH.

NMMG. (2015). *Annual Report 2015.* Wellington: National Maternity Monitoring Group.

PMMRC. (2015). *Ninth Annual Report of the Perinatal and Maternal Mortality Review Committee, Reporting mortality 2013.* Wellington: PMMRC.

SIWDH. (2016). *South Island Health workforce data.* Christchurch: South Island Alliance.

Back cover for CDHB and WCDHB Annual Report 2015 - 16

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini