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Wednesday 14 August 2013

Ailsa Claire
Chief Executive Officer
Auckland District Health Board
Private Bag 94-052
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Dear Ailsa

**Acceptance of Auckland DHB's Maternity Quality and Safety Programme Annual Report**

Thank you for submitting Auckland DHB's final Maternity Quality and Safety Programme Annual Report. I am pleased to accept this report on behalf of the Ministry of Health.

The reviewers particularly appreciated your DHB's comprehensive maternity statistics and reporting including analysis of the New Zealand Maternity Clinical indicators, and the actions your local programme will undertake to further investigate and address variation.

I strongly encourage you to make this report publicly available, for example via your DHB's website, to further engage your wider maternity sector in local quality improvement activities and to share knowledge and innovation with other regions.

I thank you for the commitment your DHB has made to the Maternity Quality and Safety Programme and I look forward to seeing continued progress on your local quality and safety improvement priorities over the coming year.

Yours sincerely

Cathy O'Malley
Deputy Director-General
Sector Capability and Implementation

cc Maggie O'Brien

# Auckland District Health Board Maternity Quality and Safety Programme

## Annual Report 2012 - 2013

**A report to the Ministry of Health provided by ADHB in fulfilment of requirements of the MQSP Crown Funding Agreement**

**June 2013**

## Foreword

We are pleased to present the 2012/2013 first Maternity Quality and Safety Programme Annual Report for National Women's Hospital at Auckland District Health Board. The Ministry of Health launched the Maternity Quality and Safety Programme, in 2011 as part of its Maternity Quality Initiative; this included the launch of the national maternity standards and clinical indicators. This first Annual Report sets out how National Women's Hospital performs against the maternity standards and clinical indicators.

It has been a very busy year during which the implementation of a new clinical governance structure within Womens' Health has been achieved. The new structure includes an accountability framework involving staff from ward level through to the senior leadership team together with participation from neonatology and anaesthetics, consumer representation, cultural representation, a private obstetrician, a Lead Maternity Carer midwife, and a General Practitioner. This Annual Report describes some of the achievements of the Clinical Governance Groups established as part of the new clinical governance structure. These achievements could not have been achieved without the dedication and commitment of the staff who strive to provide high quality care to women and their whanau.

Sue Fleming — Medical Director

Maggie O'Brien — Director of Midwifery

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# Introduction

## Our Vision:

Excellence in women's health through empowerment and partnership.

## Our Mission:

Evidence informed practice and effective communication within a woman-centred service delivering the best possible outcomes for all pregnant women cared for and babies born in our district.

## Purpose:

The Auckland District Health Board (ADHB) Maternity Quality and Safety Programme (MQSP) aims to provide a maternity service that delivers excellent quality and safety for the women, babies, family, whānau and service providers living and working in Auckland and further afield.

This Annual Maternity Quality and Safety Report details the implementation and outcomes of Auckland DHB's Maternity Quality & Safety Programme (MQSP) in 2012/2013, as required under section 2.2c of the Maternity Quality & Safety Programme Crown Funding Agreement (CFA) Variation (Schedule B42):

This Annual Report:

- Demonstrates Auckland DHB's delivery of the expected outputs as set out in Section 2 of the MQSP CFA Variation
- Outlines progress towards Auckland DHB's MQSP Strategic Plan deliverables in 2012/13
- Describes Auckland DHB's activities undertaken, or intended to be undertaken, to improve the quality and safety of its maternity services in 2013/14

# Background

## Alignment with New Zealand Maternity Standards

This Annual Report has been developed to meet the expectations of the New Zealand Maternity Standards (as set out below). The Maternity Standards Group audits the maternity service against the indicators of the standards, this is included as Appendix 1.

| **Expectations of the New Zealand Maternity Standards:** | |
|---|---|
| Standard One:<br><br>Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies. | |
| 8.2 | Report on implementation of findings and recommendations from multidisciplinary meetings |
| 8.4 | Produce an annual maternity report |
| 8.5 | Demonstrate that consumer representatives are involved in the audit of maternity services at Auckland DHB |
| 9.1 | Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Auckland region |
| 9.2 | Identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs |
| Standard Two:<br><br>Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage. | |
| 17.2 | Demonstrate in the annual maternity report how Auckland DHB have responded to consumer feedback on whether services are culturally safe and appropriate |
| 19.2 | Report on the proportion of women accessing continuity of care from a Lead Maternity Carer (LMC) for primary maternity care |
| Standard Three:<br><br>All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women. | |
| 24.1 | Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility |

## Report:

### 1. Section One: Summary of ADHB Objectives and National Priorities

| Alignment of ADHB Objectives with National Priorities |
|---|
| **Objective one:** Implement a clinical governance framework to support and monitor the implementation of quality and safety improvements. |
| **Action:** A clinical governance framework to support and monitor the implementation of quality and safety improvements has been implemented. This framework is structured to enable an on going, systematic review by multidisciplinary teams who are aligned to specific clinical areas and/or responsibilities. Reporting flows up through the clinical governance structure from level 4 to the level 1 leadership team. Service members /clinicians work together to identify and implement potential improvements to maternity services at each level. |
| **Objective two:** Ensure a complete Clinical Leadership Structure is established |
| **Action:** A Medical Director for Women's Health has been appointed. |
| **Objective three:** Improve timely access to antenatal care. |
| **Action**: ADHB is exploring a range of options to improve timely access to antenatal care. While the approach needs to be multi-pronged, we intend to use the following:<br>• Facebook<br>• Existing Pacific networks to inform women of the importance of booking early with a Lead Maternity Carer (LMC).<br>• NW has increased the number of midwives who are employed in the Walk in Centre. One of the roles of these midwives is to assist women to find a self employed LMC.<br>NW has recently begun to collect data on the date that women book with NW midwives. This data when analysed will enable us to identify the key target areas to increase registration with an LMC before 13 weeks. NW also has data fields on its maternity facility booking forms used by self employed LMCs. This data is not routinely completed by LMCs. Communication will be held with the self employed LMCs to encourage better use of this field to allow better data analysis and therefore targeted measures to improve booking rates. |
| **Objective four:** Implement a partial electronic medical record (EMR) |
| **Action:** A partial electronic medical record (EMR) system has been established. This has |

resulted in data entry at point of care and better access to clinical documentation for NW staff that work in GPs rooms, women's homes and 2 hospital sites.

In addition to the benefit of ensuring that clinical information is presented in a consistent format, the EMR has enabled the use of the GROW chart which is embedded in the programme. We have also developed an electronic fetal ultrasound biometry chart. Self employed LMC scans are plotted on this chart as well as employed LMC scans. This chart is also being rolled out in paper across all of the private scanning services and the 2 other neighbouring DHBs. This will allow for better plotting of data and consistency of reporting.

**Objective five:** Improve communication between care givers.

**Action:** The EMR has enabled better access to clinical information by LMCs. In addition, the EMR now allows for electronic messaging direct to LMCs fax or Healthlink account. This has greatly increased the speed at which LMCs receive vital communication. VPN and terminal server access is being made available for all LMCs, which will enable greater access to all ADHB clinical information systems from outside of the DHB buildings.

In 2013, general practitioners also started to receive electronic discharge summaries. ADHB's intent is that this information will be used by general practitioners to improve patient care for subsequent pregnancies.

**Objective six:** Strengthen our multidisciplinary quality framework for review of adverse outcomes, complaints, morbidity and mortality data.

**Action:** The implementation of a structured clinical governance process with clear reporting lines has started the process of addressing actions arising from adverse events, complaints, morbidity and mortality reviews. The appointment of a clinical governance co-ordinator will further embed this process over the next year.

**Objective seven:** Increase consumer representation within our service.

**Action:** Consumer representation is now well established at our Level 2 and 3 clinical governance meetings. The number of representatives and the meetings they attend is currently under review with the intention of increasing representation at appropriate meetings.

Utilize on line resources such as Reo-Ora – Healthvoice and NW website to enable consumer requests and feedback.

Continue with using the paper form "Tell us what you think" to obtain feedback from consumers.

**Objective eight:** Assess and better understand maternity needs of our population.

| |
|---|
| **Action:** Undertake a detailed demographic and socio-economic analysis of our population to assist with improving access to appropriate maternity services. |
| **Objective nine:** To continue to produce a high quality annual clinical report. |
| **Action:** To undertake detailed analysis of our maternity outcome data and present this in our annual clinical report for 2012. To present this outcome data at an Annual Clinical Report day on 2nd August to which all stakeholders are invited. To ensure that the audit cycle is completed by following up and reporting on the previous year's recommendations. |

# 2. Section two: Statistical information and analysis

## 2.1. Birth numbers by facility

Birthing facilities in the ADHB region include the tertiary facility at Auckland City Hospital (ACH) (7695 birthing mothers in 2012) and a primary birthing unit at Birthcare Auckland (397 birthing mothers in 2012)

Women who live in ADHB do not all birth at ACH. Of women who birthed at ACH in 2012, only 69 percent were ADHB residents. The remainder were from Waitemata (16 percent), Counties Manukau (13 percent), and 1.5 percent were from elsewhere.

Of mothers who birthed at Birthcare Auckland, 66% (264) were ADHB residents, 88 (22%) Waitemata residents, and 45 (11%) Counties Manukau residents. The demographic characteristics of women birthing in Auckland is provided in Table 1.

**Table 1 Demographic characteristics of women birthing at Birthcare and ACH.**

| | Birth at Birthcare n= 398 | | Birth at NW N=7695 | |
|---|---|---|---|---|
| | n | % | n | % |
| **Parity** | | | | |
| Nullipara | 161 | 40.4 | 3778 | 49.1 |
| Multipara | 237 | 59.5 | 3917 | 50.9 |
| **Age** | | | | |
| <21 | 10 | 2.5 | 267 | 3.5 |
| 21-25 | 45 | 11.3 | 862 | 11.2 |
| 26-30 | 121 | 30.4 | 2065 | 26.8 |
| 31-35 | 144 | 36.2 | 2606 | 33.5 |
| 36-40 | 75 | 18.8 | 1555 | 20.2 |
| >40 | 3 | 0.8 | 340 | 4.4 |
| **Ethnicity** | | | | |
| NZ European | 166 | 41.7 | 2696 | 35.0 |
| Māori | 48 | 12.1 | 534 | 6.9 |
| Pacific | 50 | 12.6 | 1023 | 13.3 |
| Other Asian | 38 | 9.5 | 1759 | 22.9 |
| Indian | 6 | 1.5 | 553 | 7.2 |
| Other European | 76 | 19.1 | 847 | 11.0 |
| Other | 14 | 3.5 | 283 | 3.7 |
| **DHB of Domicile** | | | | |
| Auckland DHB | 262 | 65.8 | 5302 | 68.9 |
| Counties Manukau DHB | 46 | 11.6 | 1113 | 14.5 |
| Waitemata DHB | 89 | 22.4 | 1126 | 14.6 |
| North Island Other | 1 | | 91 | 1.2 |
| Northland | | | 39 | 0.5 |
| South Island | | | 14 | 0.2 |
| Overseas | | | 10 | 0.1 |

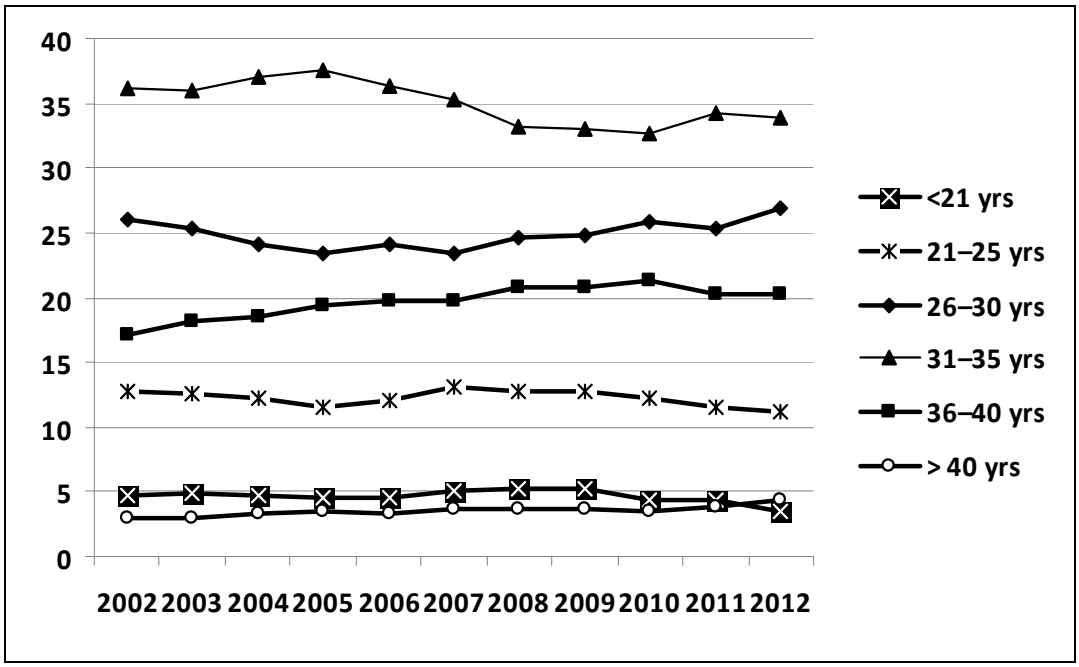



**Figure 1: Maternal age distribution (2002-2012)**

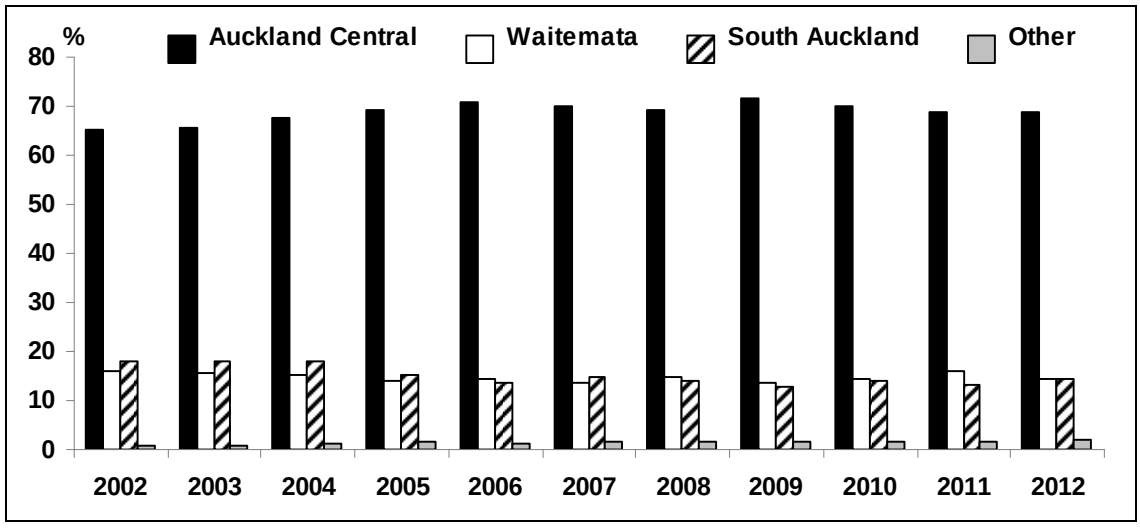



**Figure 2: Domicile (DHB of residence) of women birthing at NW (2002-2012)**

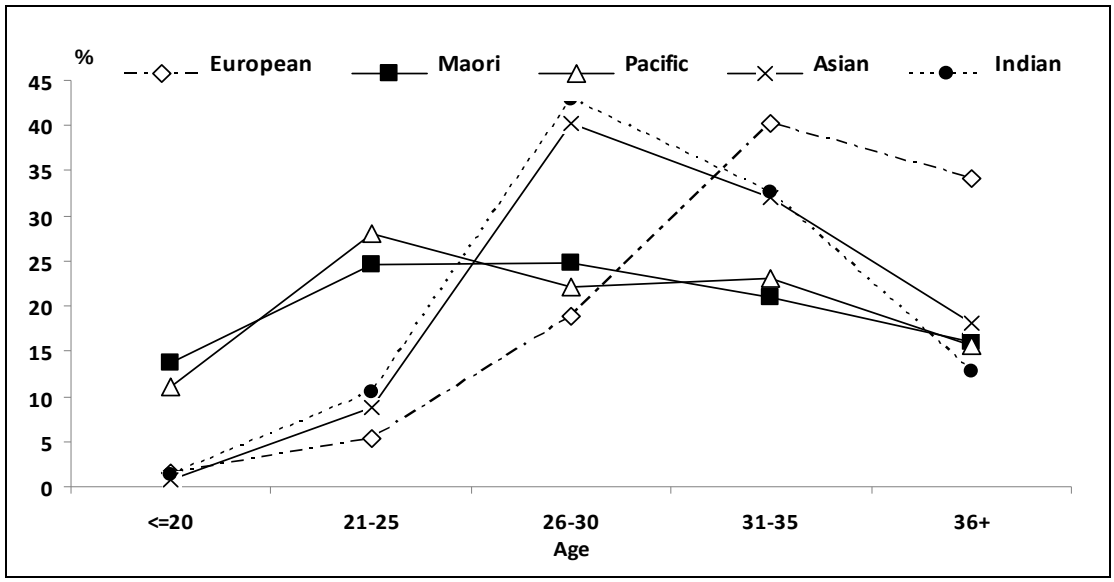



**Figure 3: Maternal age among European, Maori, Pacific, Other Asian and Indian ethnicities (2012)**

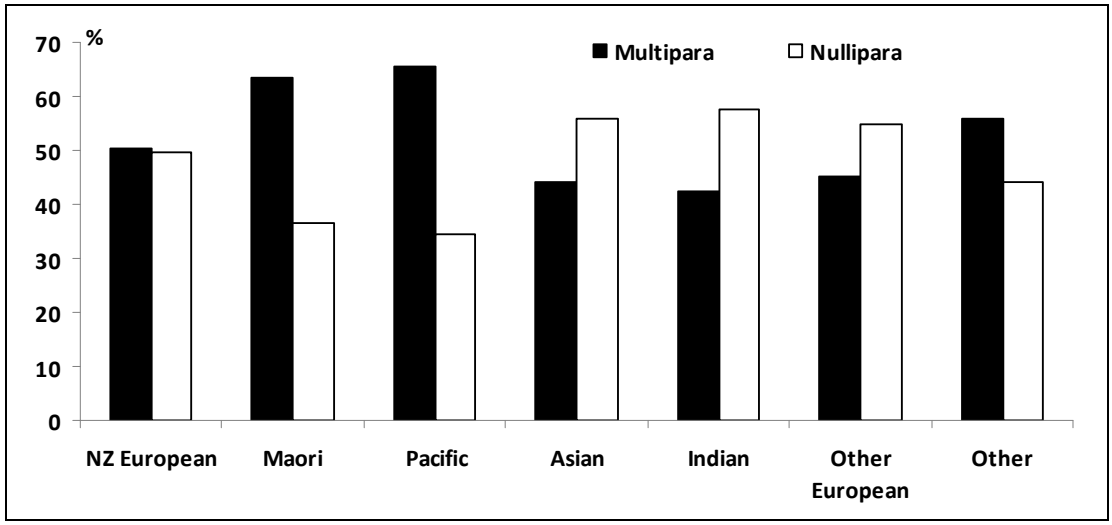



**Figure 4: Parity distribution by maternal ethnicity (2012)**

## 2.2. Demographic characteristics of women birthing in Auckland District Health Board facilities

Demographic information about the women birthing in ACH and in Birthcare are provided in Tables 1-4 below. Maori and Pacific women are over represented in deprivation with over half (51%) of Pacific women being in Q5 and a third (33.2%) of Maori women compared with a fifth of all women. Over a third (36.3%) of the women accessing Community Midwives are also deprived (Q5).

**Table 1: LMC and socio economic deprivation (NZ Dep06) (2011)**

| Depriv-ation decile | Indep midwife | | Private obstet | | GP | | NW community | | NW diabetes | | NW medical | | Other DHB | | Unbooked | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | n=3522 | | n=1672 | | n=56 | | n=1387 | | n=422 | | N=377 | | n=50 | | n=37 | |
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| **1** | 215 | 6.1 | 231 | 13.8 | 3 | 5.4 | 27 | 1.9 | 16 | 3.8 | 19 | 5.0 | 2 | 4.0 | 1 | 2.7 |
| **2** | 345 | 9.8 | 334 | 20.0 | 3 | 5.4 | 65 | 4.7 | 23 | 5.5 | 31 | 8.2 | 6 | 12.0 | 1 | 2.7 |
| **3** | 372 | 10.6 | 246 | 14.7 | 9 | 16.1 | 94 | 6.8 | 26 | 6.2 | 28 | 7.4 | 2 | 4.0 | 2 | 5.4 |
| **4** | 308 | 8.7 | 179 | 10.7 | 6 | 10.7 | 96 | 6.9 | 24 | 5.7 | 32 | 8.5 | 5 | 10.0 | 3 | 81 |
| **5** | 364 | 10.3 | 166 | 9.9 | 2 | 3.6 | 64 | 4.6 | 22 | 5.2 | 34 | 9.0 | 5 | 10.0 | 0 | 00 |
| **6** | 406 | 11.5 | 164 | 9.8 | 6 | 10.7 | 164 | 11.8 | 45 | 10.7 | 29 | 7.7 | 5 | 10.0 | 5 | 3.5 |
| **7** | 398 | 11.3 | 137 | 8.2 | 11 | 19.6 | 146 | 10.5 | 65 | 15.4 | 47 | 12.5 | 6 | 12.0 | 1 | 2.7 |
| **8** | 478 | 13.6 | 96 | 5.7 | 6 | 10.7 | 228 | 16.4 | 86 | 20.4 | 61 | 16.2 | 4 | 8.0 | 8 | 21 |
| **9** | 273 | 7.8 | 65 | 3.9 | 4 | 7.1 | 184 | 13.3 | 67 | 15.9 | 37 | 9.8 | 5 | 10.0 | 7 | 1.9 |
| **10** | 363 | 10.3 | 54 | 3.2 | 6 | 10.7 | 319 | 23.0 | 48 | 11.4 | 54 | 14.3 | 9 | 18.0 | 9 | 24.3 |

## 2.3. Characteristics of providers of maternity services in Auckland District Health Board facilities and timing of booking

The providers of services are mostly private (69%) with about two thirds (47.4% of total) of these being independent midwives and one third (23.6% of total) obstetricians. DHB staff provided either midwifery care for 19%, with specialist services making up most of the remainder at 8%. Half a percent did not book with a provider.

**Table 2: LMC at birth among mothers birthing at ACH (2012)**

| | N=7695 | |
|---|---|---|
| | n | % |
| **Independent Midwife** | **3654** | **47.4** |
| **Private Obstetrician** | **1823** | **23.6** |
| **General Practitioner** | **45** | **0.6** |
| **NW Community Midwifery** | **1447** | **18.8** |
| **NW Diabetic** | **280** | **3.6** |
| **NW Medical/High risk** | **354** | **4.5** |
| **Other DHB – transfer** | **42** | **0.5** |
| **Unbooked – no LMC** | **50** | **0.6** |

The Auckland population appears to be similar to the New Zealand population in relation to timing of booking with a self-employed LMC in 2012 with marginally more women booking earlier than the national average. Just under two thirds (64%) were booked in

the first trimester, just under one third (31.6%) booked during the second trimester with the remaining 4.2% booking in the third trimester.

**Table 3: Trimester at booking for ADHB residents compared to NZ among women booked with self-employed LMC 2011 (excluding women booked with hospital LMC services or unbooked)**

| | Total NZ (excluding unknown) n=62361-19520=53841 | | ADHB DHB of residence n=6563-1607=4956 | |
|---|---|---|---|---|
| **Trimester at registration** | **n** | **%** | **n** | **%** |
| 1 | 33680 | 62.6 | 3174 | 64.0 |
| **2** | 17522 | 32.5 | 1564 | 31.6 |
| **3** | 2562 | 4.8 | 209 | 4.2 |
| **postnatal** | 77 | 0.1 | 9 | 0.2 |

Unknown assumed as booked with hospital LMC: (n=8520 (13.7%) of total; n=1607 (24.5%) of ADHB residents

**Data source: National Maternity Collection, Ministry of Health, 2013.**

## 2.4 Summary of maternity outcomes

The following summary statistics are reported in ADHB's Annual Clinical Report, published in August each year. Below are data for women giving birth at Auckland City Hospital during 2012. A total of 7,695 women gave birth to 7,863 babies in 2012. The number of birthing women at National Women's has been fairly constant around 7,500 since peaking around 9000 during mid 1990s. In 2012 there were 158 women with multiple pregnancies. The following figures show the outcomes for women and babies who have birthed at ADHB.

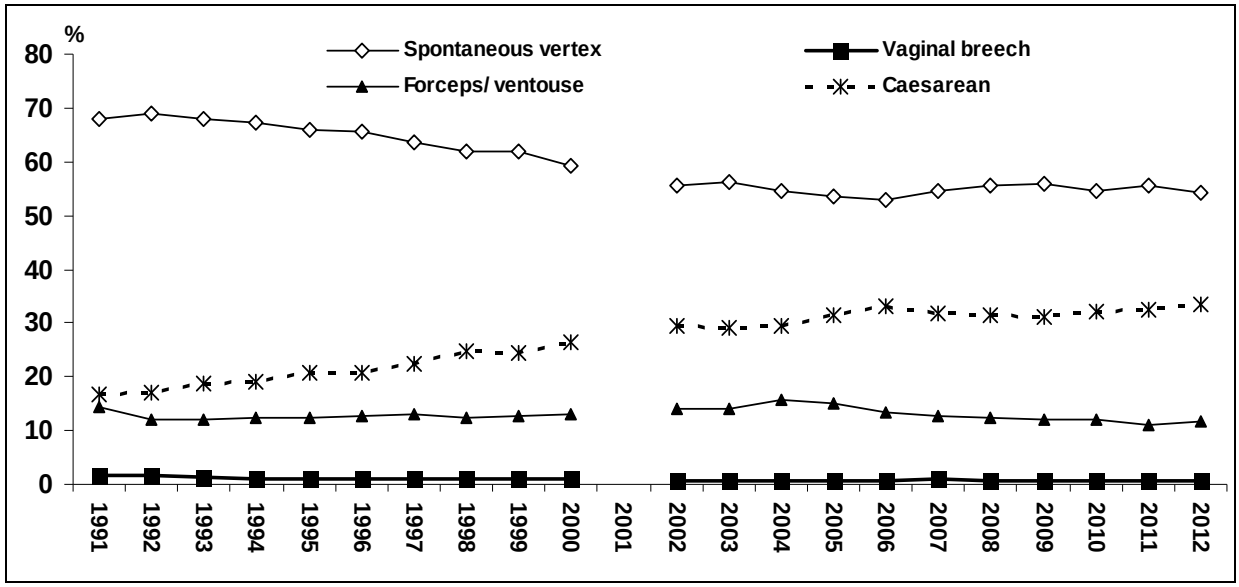



**Figure 5: Mode of birth (2002-2012)**

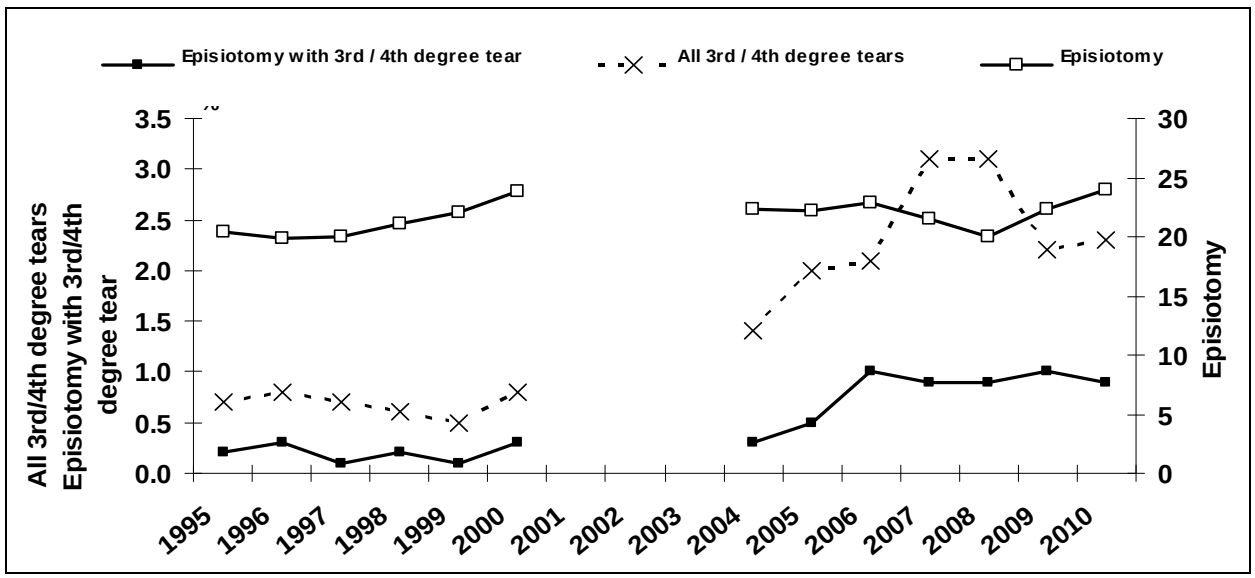



**Figure 6: Perineal trauma rates (2012)**

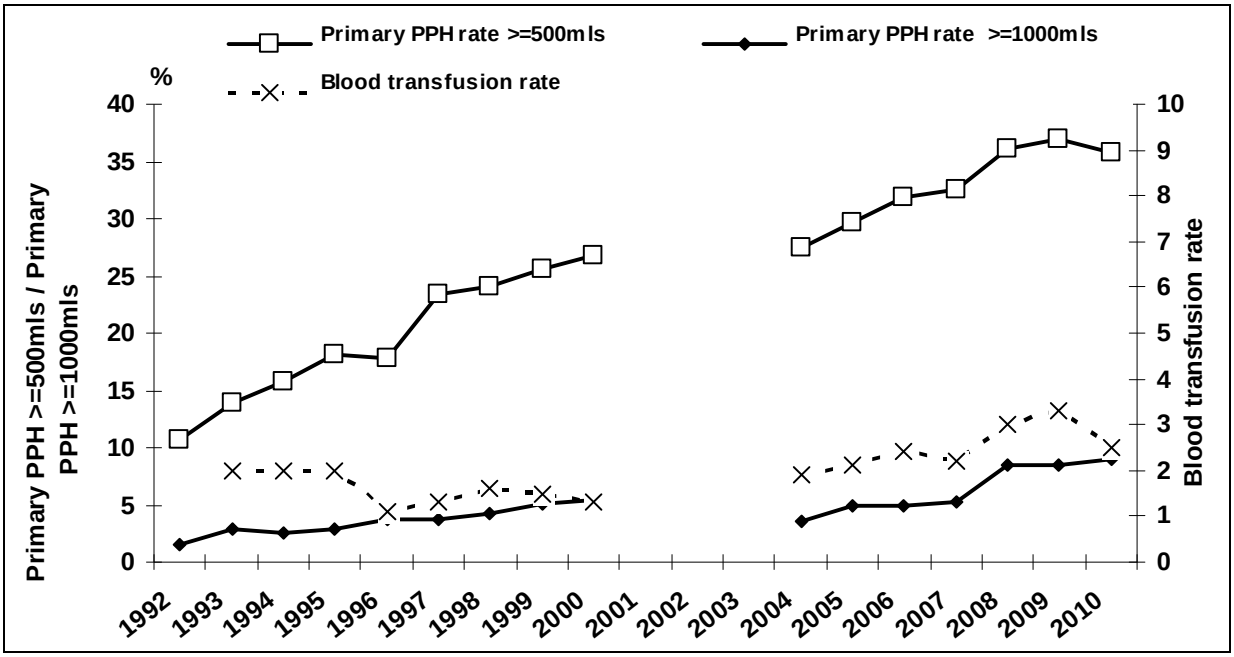



**Figure 7: Postpartum haemorrhage and transfusion rate (2012)**

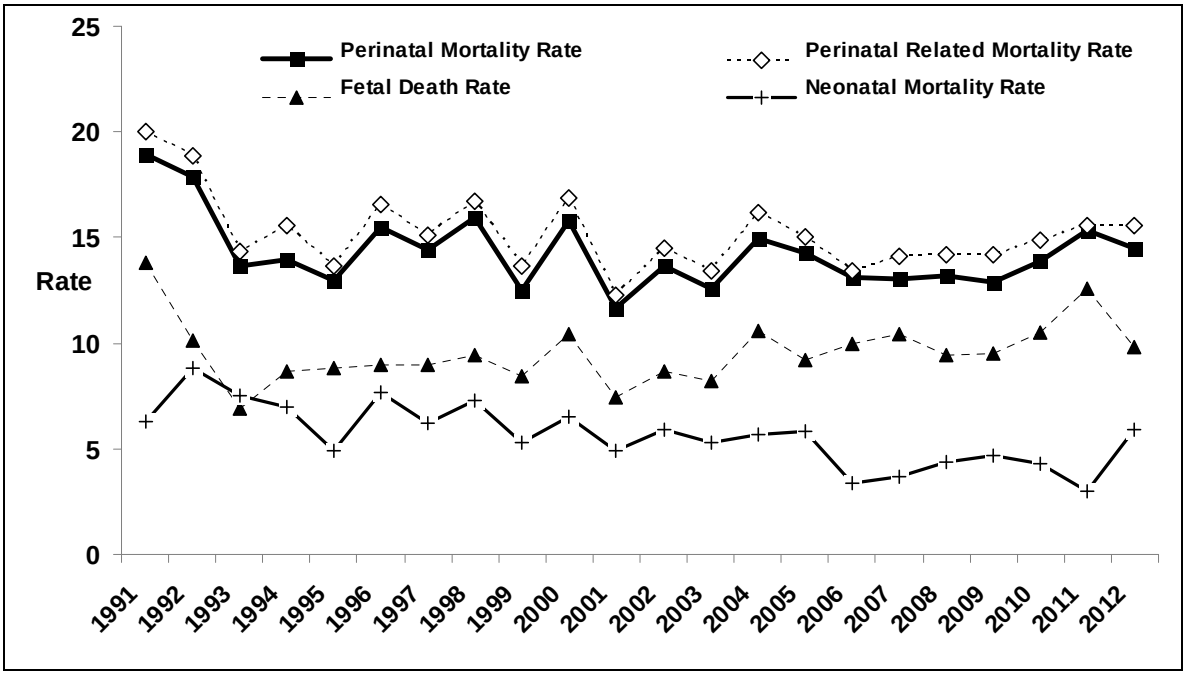



**Figure 8: Perinatal mortality rate, perinatal related mortality rate, fetal death rate and neonatal mortality rate**

The following tables provide data on mode of birth. Caesarean sections now account for 33.4% of births, with 16.6% of these elective. In 2012, there were no maternal deaths.

**Table 4: Mode of birth**

| | Birthing Mothers | | Nullipara | | Multipara | |
|---|---|---|---|---|---|---|
| | n=7695 | | n=3778 | | n=3917 | |
| | n | % | n | % | n | % |
| **Spontaneous Vertex Birth** | 4173 | 54.2 | 1731 | 45.8 | 2442 | 62.3 |
| **Vaginal Breech Birth** | 45 | 0.6 | 15 | 0.4 | 30 | 0.8 |
| **Operative Vaginal Birth** | 907 | 11.8 | 744 | 19.7 | 163 | 4.2 |
| Forceps | 299 | 3.9 | 250 | 6.6 | 49 | 1.3 |
| Ventouse | 608 | 7.9 | 494 | 13.1 | 114 | 2.9 |
| **Caesarean Section** | 2570 | 33.4 | 1288 | 34.1 | 1282 | 32.7 |
| CS Elective | 1278 | 16.6 | 409 | 10.8 | 869 | 22.2 |
| CS Emergency | 1292 | 16.8 | 879 | 23.3 | 413 | 10.5 |

**Table 5: Maternal postpartum outcomes**

| | Birthing mothers | n | % |
|---|---|---|---|
| **PPH >1000mls** | **7695** | **659** | **8.8** |
| **SVB** | **4218** | **268** | **6.4** |
| **Instrumental vaginal birth** | **907** | **84** | **9.3** |
| **Caesarean section** | **2570** | **310** | **12.7** |
| **Episiotomy among vaginal births** | **5125** | **1170** | **22.8** |
| **Third/ fourth degree tears among vaginal births** | **5125** | **158** | **3.1** |
| **Postpartum blood transfusions** | **7695** | **182** | **2.4** |

In section 4.2 we discuss how we are responding to the high blood transfusion rate for women with a Spontaneous Vaginal Birth (SVB).

## 2.5 Summary of neonatal outcomes 2012

Approximately ten percent of babies were born pre-term. Of all babies, just over ten percent (11.3%) were admitted to NICU, approximately half of whom were pre-term. Just over 80 percent of babies were either exclusive or fully breast-feeding on discharge. Babies are discharged to home or to Birthcare for their post-natal stay. Approximately 2455 (31.9) have a postnatal stay at Birthcare Auckland including the 398 babies who were born there in 2012.

**Table 6: Neonatal outcomes among babies born at National Women's in 2012**

| | Babies born | |
|---|---|---|
| | n=7863 | |
| | n | % |
| **Gender** | | |
| Male | 4061 | 51.6 |
| Female | 3798 | 48.3 |
| Indeterminate | 4 | 0.1 |
| **Preterm birth** | | |
| 20-27 weeks | 121 | 1.5 |
| 28-31 weeks | 107 | 1.4 |
| 32-36 weeks | 592 | 7.5 |
| **Term birth** | | |
| 37-41 weeks | 6944 | 88.3 |
| 42+ weeks | 98 | 1.2 |

| | | |
|---|---|---|
| **Apgar at 5 min <7**** | | |
| Preterm | 77 | 0.9 |
| Term | 73 | 0.9 |
| **SGA (by Customised Centile)** | | |
| Preterm | 262 | 3.3 |
| Term | 639 | 8.1 |
| **Admission to NICU** | | |
| Preterm | 479 | 6.1 |
| Term | 413 | 5.3 |

**numerator excludes fetal deaths

**Table 7: Perinatal related mortality 2012**

| | Babies born n=7863 | Rate |
|---|---|---|
| Fetal deaths (Still birth & TOPs) | 77 | 9.8/1000 births |
| Early neonatal deaths | 37 | 4.7/1000 live births |
| Late neonatal deaths | 9 | 1.1/1000 live births |
| Neonatal death | 46 | 5.9/1000 live births |
| Perinatal deaths (fetal & early neonatal) | 114 | 14.5/1000 births |
| Perinatal related deaths (fetal & all neonatal) | 123 | 15.6/1000 births |

Thirty nine percent of all perinatal deaths occurred in women who did not reside in Auckland DHB area. The majority of these deaths were from pregnancies/ babies who required transfer to our tertiary centre for their care. The perinatal related mortality rate for women resident in ADHB area and giving birth at National Women's in 2012 was (76/5381) 14.1/1000 total births which is unchanged compared to the rate last year of 13.3/1000 or 2010 of 13.1/1000 total births.

**Table 8: Infant Feeding at discharge from National Women's**

| **Infant Feeding at discharge from NW facility** (excludes babies admitted to NICU) | | | |
|---|---|---|---|
| Exclusive breastfeeding | 6862 | 5508 | 80.3 |
| Fully breastfeeding | 6862 | 243 | 3.5 |
| Partial breastfeeding | 6862 | 957 | 13.9 |
| Artificial feeding | 6862 | 154 | 2.2 |

National Women's continues to meet the target of 80% exclusive breastfeeding rate. Note that the babies which are excluded from the denominator are those babies who were admitted to NICU. Babies on ward who are less then 2500 gm or less than 36 weeks or whose mothers have medical complications such as diabetes are included in the denominator.

# 3 Section three: Maternity Quality and Safety Programme governance and operations

## 3.1. Clinical governance structure

During 2012 a structured Clinical Governance (CG) framework was implemented in Women's Health at National Women's Hospital (NWH). The purpose of the CG framework is to ensure clinical and process accountability at all levels within Women's Health. The CG structure includes both Women's Health, Healthcare Service Group and Birthcare Auckland, the primary birthing facility contracted by ADHB.

Level 4 Clinical Governance groups (CGG) address directly the issues relevant to the clinical areas they are aligned to. Membership consists primarily of clinicians and charge midwives and nurses. The level 4 Clinical Governance Groups are accountable to and report up to the level 3 Maternity and Gynaecology CGGs. The chairpersons of the level 4 CGGs form part of the membership of the maternity and gynaecology level 3 groups. The maternity level 3 CGG is chaired by the maternity Clinical Director and the Level 3 Midwife Advisor whilst the gynaecology level 3 CGG is chaired by the gynaecology Clinical Director and ward charge nurse. The level 3 CGGs are accountable to and report to the level 2 CGG that provides broad oversight and direction for the clinical governance of the Women's Health service.

The level 2 Clinical Governance Group is chaired by the newly appointed Women's Health Medical Director and Director of Midwifery. Membership includes a representative from all providers of maternity services and includes: Women's Health Clinical Directors, Level 3 Midwifery Advisor, Planning and Funding representative, consumer representatives, Maori and Pacific representatives, a private obstetrician, Chair of perinatal mortality meeting, an LMC representative, a General Practitioner, as well as representatives from anaesthesia, neonatology, clinical epidemiology. This wide range of participants reflects in part the tertiary nature of activity performed within National Women's.

The following issues and topics fall under the Clinical Governance umbrella at ADHB:

- clinical incidents
- risk management
- Identification, ratification and implementation of policies
- reporting on and implementing findings from research and clinical audits
- changes to clinical practice as a result of perinatal and maternal mortality and morbidity meetings
- clinical effectiveness
- issues arising from implementation of the maternity standards and clinical indicators
- consumer feedback
- complaints

The structure of the Women's Health Clinical Governance Groups is shown below

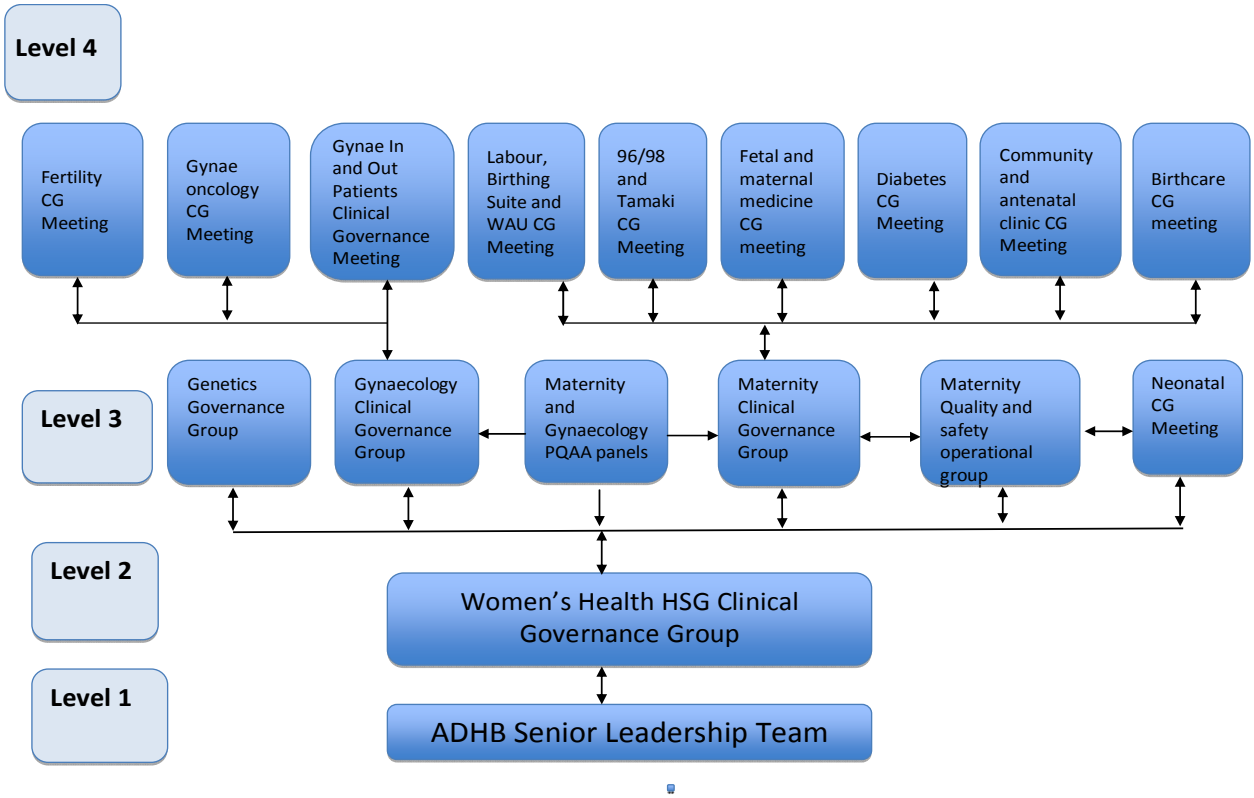



**Figure 9 : Women's Health Clinical Governance Structure**

### 3.2. Consumer input

Consumer representatives were engaged following a request for nominations process sent to known women's advocacy or consumer interest groups. Consumer representation is present at both Level 2 and 3 Maternity CG Groups. Consumers are paid a meeting attendance fee to support their attendance.

Input from consumers is also sought by other means including formal thematic review of complaints and (to a lesser extent) compliments. The on line Reo-Ora – Healthvoice is also utilised at all levels of Clinical Governance. Gathering input from Reo Ora needs further refinement.

Consumer feedback, both positive and negative, is reviewed at Level 4 meetings with themes and actions escalated. This enables the Women's Health Service Group to have an over arching view of issues that matter to the consumer, which helps guide service delivery and change.

The NW website is also managed daily and responds to the many consumer requests for maternity information and feedback about service provision.

### 3.3. Roles supporting clinical governance

The Director of Midwifery consulted on and implemented the new clinical governance framework during 2011/12. A MQSP administrator was appointed in June 2012 and a MQSP coordinator is currently being recruited. ADHB has a strong history of data analysis and the data intelligence team has incorporated the MQSP reporting into their work load. Other senior roles, including the newly appointed Medical Director of Women's Health have been allocated time to ensure the MQSP is fully implemented at ADHB.

### 3.4. Achievements of the clinical governance groups

***Inaugural meeting of the Level 2 Clinical Governance group.***

The initial meeting of the Level 2 Clinical Governance group (February 2012) agreed the new clinical governance structure set out in the consultation document; this included membership of Level 2, 3 and 4 groups. The level 2 clinical governance group agreed the structure and led the implementation of the level 3 and 4 groups which are now operational within their Terms of Reference; there is still work to be done to embed the Level 4 groups in some areas.

The agendas for all meetings were standardised to facilitate a clear reporting mechanism; the work programme has been detailed below to reflect the standing agenda items.

***Review of new and outstanding SAC (Severity Assessment Code) 1 and 2 Root Cause Analyses (RCAs)***

New and outstanding SAC 1 and 2 RCAs are reviewed with the clinical effectiveness coordinator providing an update. Issues are referred to the Level 2 group for implementation. Actions resulting from these have included:

- Discussion regarding the most appropriate clinicians to undertake the RCAs and ensuring that correct process is followed. Cultural support for the families involved has been discussed.
- Review of the implementation of the Early Warning Score in gynaecology and a recommendation that it be implemented in the maternity service.
- Provision of training for junior medical staff and gynaecology nurses in recognising the deteriorating patient which includes experience in the Department of critical care.
- Identification of lack of appropriate services within the mental health service and of the need for all services to work in partnership.

It is anticipated that with the appointment of the clinical governance coordinator there will be a more concentrated focus on 'closing the loop' in all cases.

***Review of new and outstanding complaints***

Any unresolved issues from the Level 3 groups are reported to the level 2 group, along with recommendations from the HDC and Coroners. Actions discussed as a result of this include:

- An extensive multi-disciplinary review of ADHBs "safe sleep" policy following two neonatal deaths, one at Birthcare and one on the National Women's neonatal unit. This policy has undergone extensive consultation, reviewed by experts and is currently being implemented.
- Discussion regarding a report on complaints received by the HDC highlighted that a high proportion of complaints were for 'poor attitude'. The HDC commissioner was invited to attend specially organised staff meetings.

***Review of risk register and the identification of new risks***

- There has been considerable discussion about a RANZCOG recommendation that ADHB staff a second maternity theatre resulting in this risk being added to the ADHB risk register.

***Policies and guidelines***

- The Level 2 CGG has been very successful in leading a drive to update the maternity and gynaecological policies.
- Discussion has occurred regarding the requirement for a policy on caring for obese women in maternity and work will commence on this.
- Consultation on implementation of the national Small for Gestational Age policy has occurred through the level 2 CGG with discussion on raising awareness of its importance.
- The adoption policy is currently being consulted on and discussed at the Level 2 CGG.

***Changes to practice identified through perinatal and maternal mortality and morbidity meetings***

The following are examples of recommendations that have been endorsed as a result of perinatal meetings:

- Reinforce the need for MSU when booking women and during 1st trimester assessment, particularly in diabetic women.
- Women diagnosed as septic (and other serious conditions) should remain in DU under close surveillance with regular senior review.
- All antenatal admissions to have a consultant/registrar review depending on symptoms.
- The maternal pulse must be recorded in the maternal records and on the CTG trace during monitoring of the fetal heart. The date on CTG trace must be checked against the CTG monitor as accurate.
- The implementation of the national sexual health policy.

***Report on the findings of clinical audit and research and implementation of recommendations***

The following is an example of clinical audits undertaken; there is still work to be done to establish a process for the implementation of clinical audit and research.

- The findings of the ADHB recertification audit were discussed resulting in the purchase of neonatal blenders.
- An audit of the number of gynaecological women discharged with discharge summaries from the ward identified a failing in the process; this is currently being resolved via the Level 3 gynaecology CGG.
- As a result of a discussion at this group all research undertaken by staff is now available on the ADHB website.

***Outstanding issues arising from the implementation of the MQSP and the maternity standards***

The Level 2 CGG has led the process of reviewing NW's maternity service against both the maternity standards and the required actions resulting form the MQ&SP action plan. It has done this through establishing a monitoring group, chaired by the Director of Midwifery that reports to the Level 2 CGG, and this process is currently under review.

## 3.5. Performance against New Zealand Maternity Clinical Indicators

**Table 2: ADHB NZ Maternity Clinical Indicators 2009-2011 (Facility rates)**

| No | Indicator | NW 2009 | NZ 2009 | NW 2010 | NZ 2010 | NW 2011 | NZ 2011 | Comment |
|---|---|---|---|---|---|---|---|---|
| 1 | Standard primigravida who have a spontaneous vaginal birth | 62 | 64.8 | 64.2 | 65.5 | 65.1 | 65.6 | stable, maybe improving |
| 2 | Standard primigravida who undergo an instrumental birth | 19.3 | 16.3 | 16.7 | 15.8 | 15.7 | 16 | stable |
| 3 | Standard primigravida who undergo Caesarean section | 18.5 | 17.9 | 19 | 17.9 | 19.2 | 17.9 | stable, within confidence limits |
| 4 | Standard primigravida who undergo induction of labour | 8.8 | 5.9 | 5.2 | 4.4 | 4.8 | 4.8 | continues to improve, postdates project expected to achieve further improvement |
| 5 | Standard primigravida with an intact lower genital tract | 16.3 | 28.8 | 14.4 | 28.4 | 18.2 | 27.3 | concern but probably improving |
| 6 | Standard primigravida undergoing episiotomy and no 3rd or 4th degree tears | 28.8 | 22.5 | 32.2 | 22.3 | 32.4 | 22.1 | stable rate, may be linked to low rate of 3/4 tears |
| 7 | Standard primigravida sustaining a 3rd or 4th degree tear and no episiotomy | 2.1 | 3.3 | 2.3 | 3.2 | 2.3 | 3.2 | excellent |
| 8 | Standard primigravida undergoing episiotomy and sustaining a 3rd or 4th degree tear | 1.9 | 1.4 | 1 | 1.1 | 1.4 | 1.3 | excellent |
| 9 | Women having a general anaesthetic for caesarian section | 7.3 | 9 | 6.6 | 9.1 | 6 | 8.3 | excellent |
| 10 | Women requiring a blood transfusion with caesarian section | 4.3 | 3.8 | 3.2 | 3.3 | 3.8 | 3.3 | concern, measures in place eg iron project, still within confidence limits |
| 11 | Women requiring a blood transfusion with vaginal birth | 2.1 | 1.8 | 1.9 | 1.9 | 2.3 | 1.8 | concern, measures in place eg iron project |
| 12 | Premature births (between 32 and 36 wks gestation) | 6.8 | 6.7 | 6.7 | 6.4 | 7.3 | 6.7 | case mix, tertiary centre ( rate low in the DHB) |

**Key to shading:** Concern | Moderate concern | No concern | Excellent

In 2010, National Women's Health performed very well overall but were outliers on indicators 5 and 6: intact lower genital tract and episiotomy without 3rd or 4th degree tear. This is balanced by the third and fourth degree tears rates, which were lower than the national average. Although it is likely that episiotomy may provide some protective benefit, the CGGs have looked carefully at ways in which the intact perineum rate can be increased. Predictors of episiotomy in our population are: private LMC or obstetrician and use of forceps. Feedback is now being provided to individual clinicians against a number of indicators including 3rd/4th degree tears and episiotomy. The impact is being monitored by the CGG.

### 3.6 Current Quality Improvement Initiatives at ADHB

***Increased attention to family violence screening (FVS)***

An analysis demonstrated that FVS levels were low in women's health. This information was feed back to the FVS service and as a result, the FVS team have increased their focus on screening women in hospital. An increase in coverage has been demonstrated.

***Reducing rates of blood transfusion***

Higher than expected transfusion rates were identified on our analysis of 2011 data. As a result of this and subsequent analysis, the ADHB Post Partum Haemorrhage Guidelines have been updated.

Our rates of transfusion after vaginal birth have risen. This was recognized and has been addressed with a comprehensive approach including the more aggressive use of iron antenatally.

***Diabetes management***

In 2011, following analysis of increasing diabetes clinic referral rates, ADHB agreed with WDHB to 'repatriate' services closer to the woman's home. As a result WDHB women with Gestational Diabetes Mellitus (GDM) are now seen in their local area by WDHB staff. This change in place of service provision has been received positively by LMCs and women.

***Vaginal Birth after Caesarean Section***

Following analysis of vaginal birth after caesarean (VBAC) rates, ADHB established a PBAC clinic (Positive birth after CS) to support women to trial labour. Evidence has shown that trialling labour has been effective in increasing VBAC rates.

***Perineal trauma***

Although our rates of 3rd and 4th degree tear are below the national average we recognize the serious consequence such trauma can have on long term perineal function. In 2010 we established the OASIS clinic to follow up women with significant perineal trauma.

***Virtual Post Dates Clinics***

In 2012 we embedded virtual clinics for post dates pregnancies. This has followed an investigation into the lengthy delays to a post dates clinic and an overuse of the acute assessment unit. The feedback from LMCs and women has been overwhelmingly positive.

***Processes for reviewing policies***

A robust process developed for reviewing policies and ensuring ADHB policies are updated and in line with recommended best practice. The policies have been streamlined and the requirement for prioritization of new policies established. Consumer feedback is now incorporated into policies.

***Implementation of perinatal and maternal morbidity meeting recommendations***

A pathway has been developed for ensuring recommendations from the perinatal and maternal morbidity meetings are implemented. Recent examples of this include: recommendations for blood pressure monitoring post partum; puerperal sepsis recommendations identified and implemented; the need for an Early Warning Score was identified from case reviews.

***Complaints Processes***

An improved process for identifying actions from complaints has been implemented, for example the process for Jadelle insertion has been reviewed (a working group developed and the process implemented for Jadelle insertion, which required further training of staff and a guideline to be developed).

***Adverse Events Processes***

The themes of clinical incidents identified through the risk pro system have been fed back to the level 4 clinical governance groups to enable themes to be addressed and actioned. For example our high error rate with Guthrie cards was addressed and the policy amended.

The recommendations and feedback from Route Cause Analysis of adverse events are reviewed at level 2 and cascaded down to level 4 clinical governance groups and put on the intranet for all staff / LMCs to access.

***Safe Sleep Policy***

A safe sleep policy was developed within our CG structure. Work is progressing around informing women and families about best 'safe sleep' practice. This policy development was in response to serious events in National Women's.

***Electronic Medical Record***

NW has implemented a partial electronic record. This was put in place in response to the issues which occur from working across a split site. There has been positive feedback from the community about this initiative and it has resulted in better access to clinical information. Previously LMCs failed to receive timely communication from NW when women went to the assessment unit or to a specialist antenatal clinic. The electronic maternity record now allows for electronic messaging directly to LMCs' fax or Healthlink accounts. This has greatly increased the speed at which LMCs receive vital communication

The electronic maternity record has facilitated the use of the GROW chart which is embedded in the programme. We have also developed an electronic fetal ultrasound biometry chart. Self employed LMC scans are plotted on this chart as well as employed LMC scans. This chart is being rolled out in paper across all of the private scanning services as well as the neighbouring DHBs. This will allow for better plotting of data and consistency of reporting. In addition, LMCs are now able to access the NW clinical systems from home via VPN and terminal server.

***Maternity to Primary Care Hand-over.***

A review of the newborn handover from Maternity to Primary Care is underway. Background data has been gathered through a data quality review comparing information on the Maternity Healthware System and the National Immunisation Register (NIR) regarding the General Practitioner details for newborn infants.

A cohort of all children who are domiciled in ADHB and born in November 2012 was selected. The NIR and Maternity records of both infant and mother were reviewed to identify the General Practice contact details. Results showed 84% of NIR birth records with a

named GP compared with 97% of Healthware records. The data was analysed for LMC, ethnicity and geographical trends. No LMC or ethnicity related trends were identified and geographical mapping shows DHB wide gaps. These outcomes suggest LMCs are mostly linking women with a GP however that information is not consistently transferring to the NIR. The underlying issues appear to be around data flow. The outcome of this audit will be shared with key stakeholders and a data quality investigation and recommendations are likely to follow.

***Gynaecology***

Ward 97 was proudly part of many quality projects including Releasing Time to Care, Enhancing Recovery after Surgery and Management Operating System. We anticipate seeing positive outcomes with implementation of these projects which will be outlined in future annual reports.

**3.7 Planned Quality Improvement Initiatives**

***Induction of labour (IOL)***

IOL rates in National Women's are high. More detailed analysis and further work in this area will be undertaken during 2013/2014. The rationale for undertaking this work is that any procedure undertaken unnecessarily may result in poorer outcomes for mother and or baby. National Women's aims to deliver the best outcomes for every women and baby cared for by them. Unnecessary interventions also use resources which could be better directed into other activities to improve outcomes for women and babies.

***Gestation at booking with the ADHB employed midwifery team***

Analysis by ethnicity, deprivation and other factors will be monitored and actions proposed to increase the number of women booking by 12 weeks. At this time we are aware of the value of improving access to early antenatal care, but are less certain how to target efforts. Undertaking this analysis will help us better target efforts at women in most need to improved systems and care.

***Review of pregnancy and parenting education in line with MoH service specifications (to be released) and RFP for providers***

This will be a joint project with Waitemata.

***Improve access to maternal/perinatal mental health services for pregnant and postpartum women***

The perinatal and infant mental project report has been completed and this is now a regional mental health action for next year and part of the regional health plan. The details of how this action plan will be implemented have yet to be agreed but it will become an implementation project in July 2013.

**3.8 Communication forums and regional work**

ADHB recognises that we still need to build stronger communication forums or networks to more effectively engage stakeholders.

- We have an email system to transmit information to LMCs. At a recent LMC forum discussion about different forms of communication, all LMCs present preferred the email method from the LMC co-ordinator. There are also regular LMC meeting forums.
- We have a Women's Health GP liaison and hope to build stronger relationships with primary care over the next year.

- We have a liaison staff member who is the conduit for managing issues with LMCs. This relationship is well established and effective.

As a DHB we have been working to improve the quality of feedback we get from the community. This is being achieved through Reo Ora – an on-line consumer feedback mechanism. This does not reach all consumers.

We have also strengthened aspects of the relationship and interface with Birthcare with new terms of reference for the Primary Maternity Steering Group prepared in 2013 and for the Primary Maternity Facilities Providers Committee in 2012. Birthcare representatives also sit on both Level 2 and Level 3 of the Clinical Governance Groups.

ADHB participates in a regional women's health forum with Waitemata and Counties Manukau DHBs. This is a long standing forum which includes Clinical Directors, General Managers, Midwifery leaders along with Planning and Funding. Discussions include whether there are opportunities for regional service improvements across women's health. More recently, ADHB and WDHB have agreed to collaboration around planning for maternity services across a ten year horizon for both districts. CMDHB participates in this group as does a consumer representative.

# 4. Section four: MQSP strategic plan deliverables

## 4.1 Current Deliverables

The following tasks were agreed as part of ADHB's commitment to implement the Maternity Quality and Safety Programme. Progress against these tasks as of 20 March 2013 is shown along with an assessment of whether the task is on track as representing by the colour codes, green, amber, red. Planning and governance activities are working well. The appointment of staff to support the programme will be complete with the appointment of a clinical governance coordinator. Other activities are less well advanced in some areas but we consider we will progress well, especially as we now have a full leadership team comprising General Manager, Director of Midwifery and Medical Director for Women's Health. ADHB is well prepared to provide detailed analysis of services and has been doing so through the Annual Clinical Report for many years now. This presents a solid foundation for additional analysis and for disseminating information to the employed and private work forces providing services to the Auckland population.

| Maternity Quality and Safety Programme Activities and Progress | | | | | |
|---|---|---|---|---|---|
| **Planning Activity** | **Start Date** | **Completed By** | **Responsibility of** | **Status** | **Comments** |
| Draft MQ&SP Strategic Plan | May 2012 | | Planning and Funding | Green | Completed. |
| Consult on Strategic Plan | 1 May 2012 | 31 May 2012 | Planning and Funding | Green | Completed. |
| Finalise MQ&SP Strategic Plan | 1 June 2012 | 30 June 2012 | Planning and Funding | Green | Completed. |
| **Governance Activity** | **Start Date** | **Completed By** | **Responsibility of** | **Status** | **Comments** |
| Establish Level 2 Clinical Governance Group | 1 January 2012 | 28 February 2012 | Director of Midwifery | Green | Completed. |
| Establish Level 3 Clinical Governance Groups | 1 March 2012 | 2 April 2012 | Chairs of Level 3 CGG | Green | Completed. |
| Establish Level 4 Clinical Governance Groups | 1 May 2012 | 30 June 2012 | Chairs of Level 4 CGG | Amber | Strengthening function. |
| Engage Consumer Representatives | 1 April 2012 | 30 June 2012 | Women's Health GM | Green | Completed. |
| Engage private LMC Representatives | 1 April 2012 | 30 June 2012 | Women's Health GM | Green | Completed. |
| **Staffing Activity** | **Start Date** | **Completed By** | **Responsibility of** | **Status** | **Comments** |
| Appoint Medical Director Women's Health | Under way | 2013 | Chief Executive | Green | Completed. |
| Scope new roles and develop PDs | 23 April 2012 | 11 May 2012 | Director of midwifery | Green | Completed |
| Recruit Coordinator | 14 May 2012 | 30 June 2012 | Director of midwifery | Amber | Underway |
| Recruit Administrator | 14 May 2012 | 30 June 2012 | Women's Health GM | Green | Completed. |

| Other Key Activity | Start Date | Completed By | Responsibility of | Status | Comments |
|---|---|---|---|---|---|
| Report and analyse 2011 data through ADHB Annual Clinical Report | Underway | August 2012 | Perinatal Epidemiologist, Women's Health IM Team and Intelligence | Green | ACR held August 2012. In excess of 200 people attended. Planning is well underway for 2013 report. |
| Review national indicators and undertake analysis of areas where NW is an outlier | 1 August 2012 | 30 June 2013 (and on-going) | Maternity Clinical Governance Group and Women's Health Intelligence | Green | Process in place and will be reported on in ACR. |
| Disseminate audit and other data via NW website | 1 April 2012 | On going | Women's Health IM Team and Intelligence | Amber | Planning for Women's Health Information Governance Group. |
| **Other Key Activity** | **Start Date** | **Completed By** | **Responsibility of** | **Status** | **Comments** |
| Obtain consumer feedback through Reo Ora/ Patient Experience Survey | 1 May 2012 | 30 June 2012 (and on going) | Women's HSG Leadership and Quality | Amber | Planned for 2013 |
| Electronic systems enhanced | 1 April 2012 | 30 June 2012 (and on going) | Women's Health IM Team | Amber | Upgrade Healthware (HW) to v12. in testing phase. |
| MQ&SP Quarterly Updates | 1 August 2012 | 30 September 2012 (and on going) | MQ&SP Coordinator | Red | To commence when coordinator in post. |
| Agree Maternity KPIs | 1 September 2012 | 31 October 2012 | Director of Midwifery, CD Obstetrics and Level 2 Leadership | Red | Maternity Scorecard and be developed during 2013. |

| | | | | | |
|---|---|---|---|---|---|
| Develop individual clinical data feedback | 1 November 2012 | 30 June 2013 | Level 2 Leadership | Red | To be progressed once KPIs/Scorecard completed. |
| Implement dissemination of individual clinical data feedback system | 1 July 2013 | 30 June 2014 (and on going) | Medical Director and Level 2 Leadership | Red | Planned for 2013 |
| Prepare options for mandatory training in key skills, PROMPT, CTG, BFHI training. Implement appropriate model. | 1 July 2013 | 30 June 2014 (and on going) | Chair Maternity CGG and MQ&SP Coordinator | Amber | Current processes to be enhanced by defining and governance of competencies and credentialing of all clinicians. |

## Section five: Planned Activities for 2013-2014

ADHB has an ambitious programme of work during 2013-2014 which builds upon the foundations of the Clinical Governance Group. Currently all Terms of Reference are being reviewed and activity and membership of the CGGs refined. This will be completed by September 2013 and ensure that the Maternity Quality and Safety Programme is embedded across all aspects of maternity services in ADHB. In addition, the following tasks are planned for 2013 – 2014.

| Task | Responsibility | Start Date | Completion Date | Inclusions |
|---|---|---|---|---|
| Increase number of women who book with an LMC by week 12 of their pregnancy | MQSP Coordinator, Planning and Funding, Pacific Health Team, Director of Midwifery | 1 July 2013 | Ongoing | • Health Promotion through Facebook, Pacific networks and PHOs.<br>• Establish baseline data, with WDHB.<br>• Appoint ADHB Pacific Midwifery Advisor. |
| Review of pregnancy and parenting education in line | Planning and Funding | When specification is completed | 1 July 2014 (dependent on MoH) | • Joint project with WDHB. |

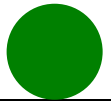
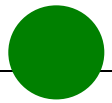
| | | | | |
|---|---|---|---|---|
| with MoH service specifications (to be released) and RFP for providers | | by MoH. | | |
| Improve access to maternal/perinatal mental health services for pregnant and postpartum women. | Planning and Funding – Primary Care and Mental Health | 1 July 2013 | 30 June 2014 (phase 1) | • Increase access to primary mental health by removal of part-charges by PHOs.<br>• Develop screening tool, with WDHB, for pregnant women.<br>• The Perinatal and infant mental project report has been completed and this is now a regional mental health action for next year and part of the regional health plan. The details of how this action plan will be implemented have yet to be agreed but it will become an implementation project in July 2013. |
| Maternity Scorecard in use | Director of Midwifery | 1 July 2013 | 30 June 2014 | • Key indicators are identified and monitored routinely through the Maternity Standards Clinical Governance Group. Service improvements are developed in response to analysis of indicators/performance. |
| Annual Clinical Report Publication and Dissemination is maintained. Data is used to inform service improvement. | Health Intelligence and Medical Director | August 2013 | Ongoing | • Enhancements to the ACR as a result of the MQSP are made, particularly in relation to reporting on activities associated with the CGG Programme and obtaining consumer feedback and using this to inform service improvements.<br>• Analysis of IOL undertaken and recommendations regarding service improvements made.<br>• Tracking gestation at booking with a NW LMC and targeting efforts to the most vulnerable women.<br>• SMO and RMOs receive individual statistics. |

Appendix 1

| Maternity Services Provide Safe, High-Quality Services that are Nationally Consistent and Achieve Optimal Health Outcomes for Babies | | | | | |
|---|---|---|---|---|---|
| **AUDIT CRITERIA** | **MEASUREMENT** | **ACHIEVED** | **ACTION REQUIRED** | **BY WHO** | **WHEN** |
| 8. All DHBs have a system of on-going multidisciplinary clinical quality review and audit of their maternity services, involving consumer representatives and all practitioners | 8.1 Multi disciplinary meetings convene at least three months |  | | | |
| | 8.2 DHBs report on implementation of findings and recommendations from multidisciplinary meetings |  | | | |
| | 8.3 DHBs invite all practitioners linked to maternity care, including holders of Access Agreements, to participate in the multidisciplinary meetings, and report on proportion of practitioners who attend. |  | Will be reported in 2013 Annual Report | | |
| | 8.4 All DHBs produce an annual maternity report. |  | | | |
| | 8.5 DHBs can demonstrate that consumer representatives are involved in their audit of maternity services |  | Consumer representatives attend all CG meetings - discuss how this can occur at next Maternity Standards CG Meeting | MO'B | December 2012 |
| 9. All DHBs work with professional organisations and consumer groups to identify the needs of their population and provide appropriate | 9.1 All DHBs plan, provide and report on appropriate and accessible maternity services to meet the needs of their population |  | Strategy for appropriate and accessible services written, implementation during 2013 and will be reported on in Annual Report. | MO'B/KD/PH/MP | Aug-13 |

| | | | | | |
|---|---|---|---|---|---|
| services accordingly. | 9.2 All DHBs identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs. |  | Some groups currently reported on in Annual Report - to be further refined. | MO'B/LS/MP | Aug-13 |
| | 9.3 All DHBs plan and provide appropriate services for the groups of women within their population who are accessing maternity services and who have identified additional health and social needs. |  | Planned for within new Maternity Strategy - to be implemented in 2013 | Level 2 Leadership Team | Aug-13 |
| | 9.4 The proportion of women with additional health and social needs who receive continuity of midwifery care is measured and increases over time. |  | Planned for within new Maternity Strategy - to be implemented in 2013 | Level 2 Leadership Team | |
| 10. Communication between maternity providers is open and effective | 10.1 Local multidisciplinary clinical audit demonstrates effective communication among maternity providers. |  | Currently occurs within new Clinical Governance Groups - to be further developed and audited. | SF/MO'B | Aug-13 |
| | 10.2 The number of sentinel and serious events in which poor communication is identified as a risk decreases over time |  | To be audited via Clinical Governance | MO'B | Aug-13 |
| 11. A national set of evidence-informed clinical guidelines is implemented with each DHB-funded maternity services. | 11.1 The number of national evidence-informed clinical guidelines in each DHB-funded maternity services increases over time. | Not able to assess | To be audited via Clinical Governance | MO'B | Aug-13 |
| 12. National maternity service specifications are implemented within each DHB-funded maternity service. | 12.1 100% maternity service specifications are implemented in each DHB-funded maternity service. |  | Group established with LMCs - to be audited via Clinical Governance | MO'B | Aug-13 |

**Maternity Services Ensure a Women-Centred Approach that Acknowledges Pregnancy and Childbirth as a Normal Life Stage.**

| AUDIT CRITERIA | MEASUREMENT | ACHIEVED | ACTION REQUIRED | BY WHO | WHEN |
|---|---|---|---|---|---|
| 16. All women have access to pregnancy, childbirth and parenting information and education services. | 16.1 All DHBs provide access to pregnancy, childbirth and parenting information and education services. |  | Currently contact sits with Birthcare and is for review Limited uptake and lack of access by Maori and Pacific. In the future continuity of care teams to provide appropriate childbirth and parenting education | New contract holders | Dec-13 |
| 17. All DHBs obtain and respond to regular consumer feedback on maternity services. | 17.1 All DHBs apply the national tool for feedback on maternity services at least once every five years. |  | Has been discussed at Level 2 clinical governance group, and 2011 results discussed. Tool to be applied before 2016 | MO'B | Before 2016 |
| | 17.2 All DHBs demonstrate in their annual maternity report how they have responded to consumer feedback on maternity services. |  | Planned to occur in next Annual Clinical Report 2014 | MO'B/MP | Aug-14 |
| 18. Maternity services are culturally safe and appropriate. | 18.1 Consumer feedback demonstrates that consumers consider the services to culturally safe and appropriate. |  | On-going audit to be implemented | MO'B/MP | Aug-13 |
| | 18.2 All DHBs demonstrate in their annual maternity reports how they have responded to consumer feedback on whether services are culturally safe and appropriate |  | Planned to occur in next Annual Report | MO'B | Aug-13 |
| 19. Women can access continuity of care from a Lead Maternity Care for primary maternity care. | 19.1 All DHBs have a mechanism to provide information about local maternity facilities and services and facilitate women's contact with Lead Maternity Carers and Primary care. |  | Information provided by Walk in Centre Green Lane | | |
| | 19.2 The Proportion of women accessing continuity of care from a Lead Maternity Carer for primary maternity care is reported in each DHBs annual maternity report. |  | | | |

| **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.** | | | | | |
|---|---|---|---|---|---|
| **AUDIT CRITERIA** | **MEASUREMENT** | **ACHIEVED** | **ACTION REQUIRED** | **BY WHO** | **WHEN** |
| 22. All DHBs plan locally and regionally to provide the nationally agreed levels of primary, secondary and tertiary maternity facilities and services for their population | 22.1 Local services are consistent with the national and regional plans and are accessible and appropriate for the local population |  | Demonstrated in annual report - to be further developed through collaboration with WDHB | Level 2 Leadership Team | Dec-13 |
| 23. Women and their babies have access to the levels of maternity and newborn services, including mental health, that are clinically indicated. | 23.1 Local multidisciplinary clinical audit demonstrates women and babies have access to levels of care that are clinically indicated. |  | Improved access to maternal mental health required for all women. Regional group established. | Regional team | Dec-13 |
| 24. Primary, secondary and tertiary services are effectively linked with seamless transfer of clinical responsibility between levels of maternity care, and between maternity and other health services. | 24.1 All DHBs report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility. |  | To be included in Annual Report | MO'B | Aug-13 |
| | 24.2 Local Multidisciplinary clinical audit demonstrates effective linkages between services |  | To be developed via clinical governance groups | MO'B | Aug-13 |
| 25. All DHBs plan locally and regionally for effective clinical and organisational pathways to respond to maternity and neonatal emergencies | 25.1 All DHBs have local and regional maternity and neonatal emergency response plans agreed by stakeholders including emergency services. |  | To be further developed and strengthened via clinical governance groups | | |
| | 25.2 All maternity providers can demonstrate knowledge of local and regional maternity and neonatal emergency plans. |  | To be audited | Through CG Groups | Mar-13 |
| | 25.3 Local Multidisciplinary clinical audit demonstrates effective communication among maternity providers in cases of clinical emergency. |  | To be audited | Through CG Groups | Mar-13 |

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| 26. Women whose care is provided by a secondary of tertiary service receive continuity of midwifery and obstetric care. | 26.1 All DHBs provide, or accommodate, a model of continuity of midwifery and obstetric care when secondary or tertiary services are responsible for the women's care. |  | To be further developed as part of maternity strategy | SF/MO'B | Dec-13 |
| | 26.2 Consumer feedback demonstrates that an increasing proportion of women requiring secondary or tertiary level of care are satisfied with the continuity of midwifery and obstetric care they received. | Not able to assess | To be developed | SF/MO'B | Dec-13 |