



HUTT maternity

Hutt Valley Maternity Care



Maternity Services Annual Clinical Report 2013

www.huttmaternity.org.nz

HUTT VALLEY DHB



We would like to acknowledge the contribution of:

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- Howard Clentworth, Obstetrician
- HVDHB Community Midwives Team
- HVDHB Lactation Consultant
- Kylie Bolland, Audiologist
- HVDHB Maternity Clinical Governance Group
- Nemisha Chhana, Obstetrician
- Nicky Jackson, BirthEd
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Published by Hutt Valley DHB June 2014

Message from the Director of Operations

Hutt Maternity services continue to move forward with the Maternity Quality and Safety programme and self auditing against the New Zealand Maternity Standards and service specifications. There were some ambitious objectives set in 2013. Some of these are being consolidated in the upcoming year.

Our Maternity Clinical Governance Group (MCGG) has expanded their networks within the hospital setting and into the community. There has been integration with other priority areas and key programmes with a wider focus of risk relating to women and children. These include the Violence Intervention Programme, Safe Sleep, Shaken Baby and Vulnerable Women and Babies.

With my role now across Wairarapa and Hutt Valley DHB's maternity services, there is a great opportunities to integrate and share aspects of both programmes.

***Sarah Boyes, Director of Operations,
Surgical, Women's and Children's Directorate***

Hutt Maternity is a very harmonious unit to work in. We are glad to have our second Annual Report out and see ourselves meeting the national standards. We have a great culture in our unit where primary and secondary care work together and strive towards setting standards. We look forward to meeting our new targets for 2014.

***Meera Sood,
Clinical Head of Department, Obstetrics***

2013 was an invigorating year in regards all of our planning strategies, implementing quality initiatives and getting our heads around writing our first annual report. As we reviewed our services and Clinical outcomes for the 2013 year, we have continued to refine and evolve our annual report. This demonstrates great progress in many areas of Maternity Quality and Safety for our women and babies.

Now we can look forward to our next steps slightly more organised, slightly more focused and with a willing team keen to improve the maternity service for our community.

***Jo McMullan,
Clinical Midwifery Manager***

Hutt Valley DHB Vision, Mission and Values

Our Vision

Whanau Ora ki te Awakairangi

Healthy people, healthy families and healthy communities.

Our Mission

Working together for health and well-being

We commit to work cooperatively, as an active part of the health sector and the Hutt Valley community.

Our Values

'Can do' - leading, innovating and acting courageously

Hutt Valley DHB leads the New Zealand health sector. We are committed to quality and innovating to improve the health of our people.

Working together with passion, energy and commitment

We are passionate about our work. We direct our energy to doing the best for our clients and the community.

Trust through openness, honesty, respect and integrity

We regard trust as essential to success. The people we serve must have confidence in us. We are open, honest, and respectful. We act with integrity.

Striving for excellence

We aim for excellence, individually and as an organisation. This commitment defines us, the services we provide, the way we work with each other and how we shape our systems.

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Executive Summary

Welcome to our second Maternity Services Annual Clinical Report for the 2013 year. We are pleased to have built on work under taken since the inception of the Hutt Valley DHB Maternity Demonstration Pilot in 2011, and first year in the Maternity Quality and Safety Programme (MQSP) 2012.

Initially we based our work streams on the 7 elements in the MOH document “Implementing the Maternity Quality and Safety Programme in your DHB – A Guide”, and in the 2013 year are please to have extended this work and developed further objectives with a local focus outside of the MOH guide. This is more reflective of our community and sector needs.

Our report outlines the DHB’s general profile and Maternity service configuration. HuttMaternity has not undergone any significant service structural changes or developments in the 2013 year.

The New Zealand Maternity Clinical Indicators are reviewed in section three. The indicators provide clinically based information and analysis on Hutt Maternity services for the twelve national Key Performance Indicators. Comments at the end of each indicator contextualise the statistics.

Section four describes our quality and safety progress. It outlines the inroads through our set objectives for the 2013 year. Highlights have been our Sector engagement “Road show”, the launch of our HuttMaternity website early in the year, the develop of the DHB wide safe sleep policy. In this section we include an overview of compliments, reportable events and complaints.

Service development under the MQ&SP is outlined in our final section. Identifying our incomplete objectives from 2013; and planning goals and objectives for the upcoming year have been conceived.

We are pleased how our Maternity Quality and Safety Programme has further evolved over the 2013 year, and continues to encourage quality awareness amongst our maternity community.

Section One: Hutt Valley DHB Profile

The Hutt Valley District Health Board plans, funds and provides government-funded healthcare and disability support services for 145,000 people in the Hutt Valley. Of these 104,000 people live in Hutt City and 41,000 live in Upper Hutt City.

Around 17% the Hutt Valley population is Maori (around 25,585 people). 8% are Pacific people. We also have sizeable Asian and refugee populations. Most Maori and Pacific people live in Hutt City. The Maori and Pacific population is younger than other ethnic groups with around half under 25 years old, and experiences higher levels of deprivation than non-Maori.

An estimated 27,000 (17%) Hutt Valley residents have some form of disability and around 16,000 of those people are younger than 65 years. Most disabled people live in the community, with only 13% of older disabled people in residential care and less than 1% of disabled people under the age of 65 in residential care.

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

When compared with national figures, our population has:

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

When compared with national figures, our population experiences higher population rates of chronic conditions; diabetes prevalence, asthma prevalence, chronic obstructive pulmonary disease prevalence, and chronic mental health disorder prevalence. Hutt Valley people experience similar leading causes of mortality, with the addition of stroke.

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

- Working closely with primary care to address long term conditions and avoidable hospitalisation, and to reinforce education and prevention, particularly amongst Maori and Pacific and people with higher needs.
- Continuing our positive engagement with our community providers, including through the cluster of Whanau Ora providers, with a focus on education, prevention and outreach services particularly amongst Maori and Pacific people

- Continuing our emphasis on undertaking actions to better link our hospital with our primary care providers; and
- Positioning ourselves to meet the changed demand for services which will result from an aging population.

Our Hutt Valley DHB annual budget is \$442.9 million and the DHB employs over 2,200 staff. Most work in our “provider arm” – at Hutt Hospital or for community or regional health services.

A governance board oversees the DHB. It has seven community-elected members and four members appointed by the Minister of Health (including the Chair) and a Crown Monitor. The Board ensures the DHB will meet our local and national health objectives.

We share our board Chair with Capital and Coast DHB. Our advisory committees also reflect this joint approach: the Community and Public Health Advisory Committee and Disability Services Advisory Committee share members from each DHB.

In the 2012/13 year, the DHB committed to:

- Improve, promote and protect the health of communities within the Hutt Valley.
- Reduce health disparities and improve the health of Maori and Pacific people.
- Enable the community to take part in improving healthcare and planning health services changes.
- Ensure anyone who needs health services or disability support gets effective help.
- Supporting people with disabilities to take part in the community.
- Ensure that health services in the Hutt Valley are seamless and coordinated.

To meet the wide range of needs in our community we buy services from health and disability service providers. These include:

- Primary healthcare providers (including general practices and youth health services).
- Maori and Pacific health providers
- Aged residential care and home support services
- Mental health providers
- Pharmacies
- Laboratory and radiology providers
- Local, regional and national hospitals.

We would like to acknowledge the above information has been sourced from the Hutt Valley DHB Annual Report 2013

Section Two: Maternity Service Configuration and Facilities

Maternity Services

The Hutt Valley DHB is a mid sized service providing both primary and secondary facilities. Hutt Valley DHB maternity service supports approximately 2000 births annually from an urban population of 145,000. Of our birth population: 20.5% are Maori, 9.5% Pacific Island, 8.8% Asian, 3.5% Indian, 55.5% NZ European and 2.6% belong to other ethnic groups.

The Hutt maternity unit is the only birthing facility in the DHB.

Table 1. Births in NZ and Hutt

	2008	2009	2010	2011	2012	2013
Births in NZ (NZ Statistics)	64,850	62,927	64,315	61,923	61,178	Not avail
Births at Hutt Valley DHB	2,198	2,205	2,161	1,969	1,982	1,849
% of all NZ births in Hutt	3.3%	3.5%	3.3%	3.1%	3.2%	Not avail

Primary maternity care is provided by LMCs (midwives and obstetricians), who have an access agreement to use the facility. For those unable to access LMC care there is the DHB Huttmaternity Midwifery Team.

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

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

There are no GPs practicing obstetrics in the Hutt Valley.

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

Workforce

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

The maternity service includes the following clinical staff:

- Director of Operations, Surgical, Women's and Children's

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

The DHB Operations Centre was established in 2013, it has introduced Trend Care to the organisation with staged roll out. Maternity will be incorporated into Trend Care in 2014. These tools will provide better utilisation of workforce and bed management across the DHB.

Birthing Suite

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

The Birthing suite is staffed by core midwives, providing midwifery care for DHB primary and secondary care women, as well as those women under a private LMC obstetrician. The midwives provide emergency care 24 hours a day, 7 days a week, and support LMC midwives as required. Medical staff is rostered to cover an on call system 24 hours a day. This consists of a Consultant Obstetrician, Senior Registrar or Senior House Officer.

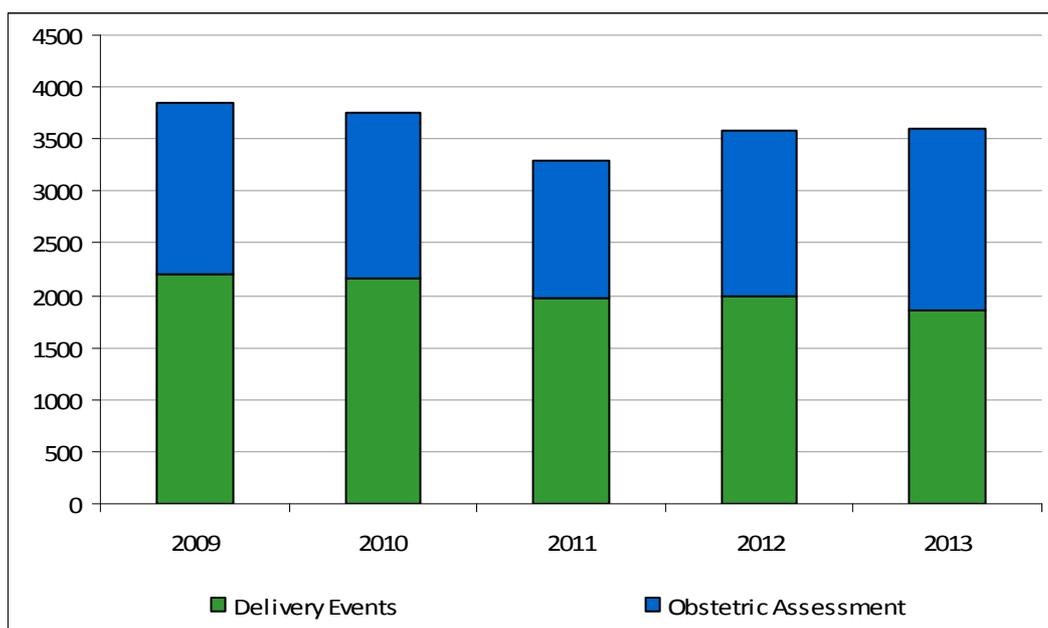
Maternity Ward

The maternity ward is made up of 13 single rooms, 2 double rooms and the facility for an extra 5 bed spaces within the unit.

The maternity ward caters for both antenatal and post natal inpatients, and also if required, provides rooms for women 'rooming in' with babies in the Special Care Baby Unit (SCBU). The ward is staffed by Midwives with assistance from Nurses and Health Care Assistants (HCAs).

The below graph indicates all **inpatient** birth events (delivery events), and non-birth admissions and urgent obstetric assessments undertaken in the Maternity Unit on level 2. This demonstrates although there is a slight decrease in birthing numbers, the number of assessment has increased.

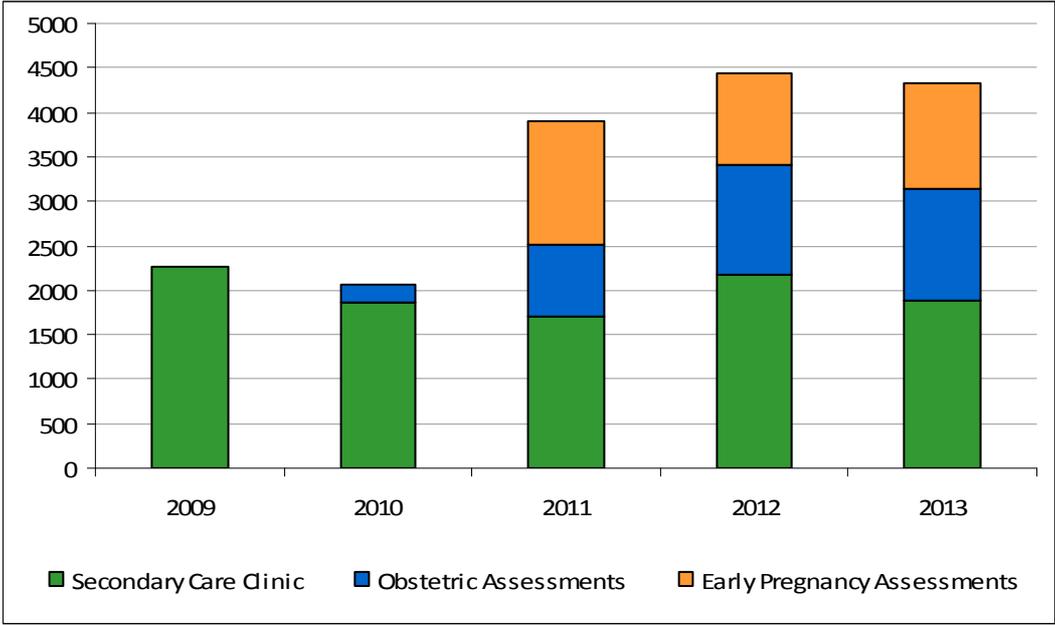
Figure 1: Maternity Ward and Birthing Suite events/activity



Maternity Assessment Unit (MAU)

MAU is a Monday to Friday acute assessment area, and works as an outpatient facility. The facility is utilised by both community based LMC and women under DHB maternity care. Women requiring inpatient care are transferred to the birthing suite or ward. The unit incorporates the Secondary Care Obstetric Clinics, Obstetric Assessments and an early pregnancy assessment service.

Figure 2: Maternity Assessment Unit Total Patient Events



Maternity Ward Events	2009	2010	2011	2012	2013
Secondary Care Clinic	2264	1864	1707	2183	1875
Obstetric Assessments	0	191	805	1236	1253
Early Pregnancy Assessments	0	1	1396	1014	1200

There are now three main work streams in MAU:

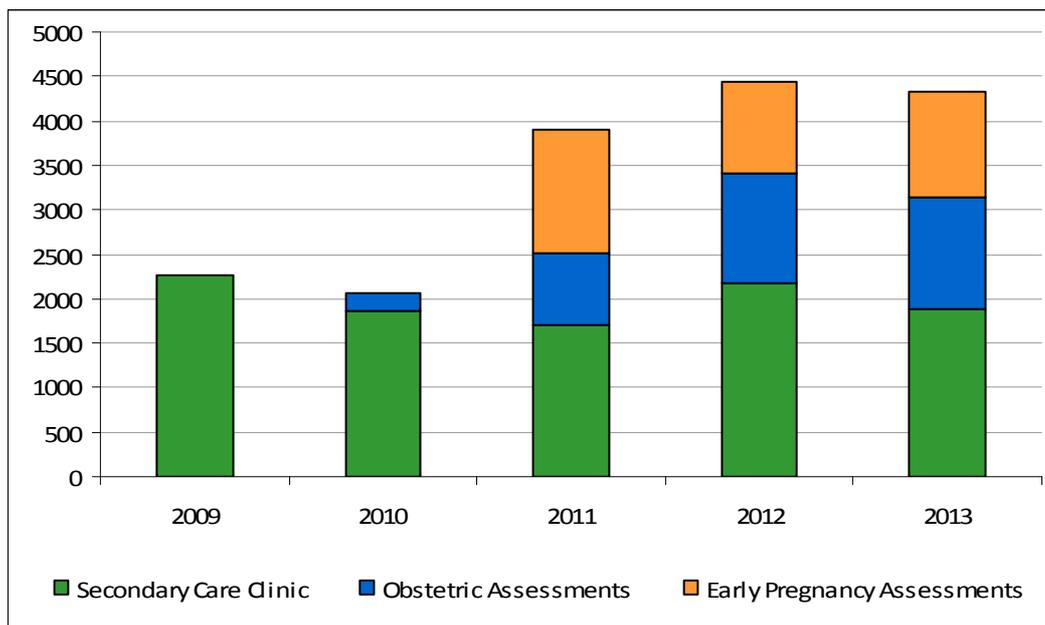
Secondary Care Clinic episodes refer to women seen by an Obstetrician at the Secondary Care Obstetric Clinic in MAU. These women have been referred to the Secondary Care Obstetric Clinic under the Guidelines for Referral and Consultation (2012) for an obstetric opinion.

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

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

Overall Workload

Figure 3: Overall Maternity Services Patient Events



Maternity Ward Events	2009	2010	2011	2012	2013
Delivery Events	2205	2161	1969	1982	1849
Obstetric Assessment	1652	1778	2121	2832	3007
Early Pregnancy Assessments	0	1	1396	1014	1200
Secondary Care Assessments	2264	1864	1707	2183	1875

Comment:

The total birth numbers has decreased fractionally in the last year; there has been an increase in the number of Obstetric Assessments.

Huttmaternity Midwifery Team (HVDHB)

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

Lactation Consultants/BFHI Coordinators

HVDHB has 1.1 fte for Lactation Consultants (Registered Nurses) who provide specialist assistance with breastfeeding for inpatients throughout the hospital and for outpatients up to six weeks postnatally.

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

They are supported by two DHB employed Midwives who also have Lactation Consultancy qualifications to provide Ankyloglossia services.

Other Links

Social Worker

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

CYF Liaison

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

Operating Theatre

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

SCBU

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

Acupuncture Clinic

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

Stretch Class and Physiotherapy Services

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

Ionazone Treatment

Our Women's Health Physiotherapist provides this free service.

Pregnancy and Parenting Education

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

Maternity Providers

Maternity provider at time of registration data was not collected by the DHB. In the 2013 year we instigated a collection system to gather current data. However, this has been reviewed, and does not currently provide robust enough data for us to comment on for the 2013 year.

MOH have provided data from HealthPac for the 2012 year. This table depicts the facility where women birthed, and at what point in the pregnancy their registrations document by HealthPac.

Hutt Valley DHB LMC registration in the first trimester was 55% for the 2011 year with slight improvement to 58% for the 2012 year. The national average for 2012 sits at 64%. (National Maternity Monitoring Group.)

Table 2. Timing of registration and birth facility type

Year 2011		Birth facility type/location				
Trimester of Registration	Tertiary	Secondary	Primary	Homebirth	Unknown	Grand Total
1	68	889	1	45	4	1007
2	35	727	1	15	11	789
3	1	41		1		43
Postnatal		1				1
Unknown	41	180				221
Grand Total	145	1838	2	61	15	2061

National maternity Collection, Ministry of Health, 2011

Year 2012		Birth facility type/location				
Trimester of Registration	Tertiary	Secondary	Primary	Homebirth	Unknown	Grand Total
1	67	980	2	33	4	1086
2	30	685	1	15	5	736
3	1	48	0	1	1	51
Postnatal	2	4	0	0	0	6
Unknown	19	116	0	0	0	135
Grand Total	119	1833	3	49	10	2014

National maternity Collection, Ministry of Health, 2012

We note that volumes of Non-LMC first trimester claims, (excluding claims for miscarriage or TOP) by registered DHB region of practitioner by year of claim for the 2012 year is 998 events. This equates to approximately 50% of our birth rate and indicates a large portion of women access their GP in the first trimester.

This may contribute to a delay in registering with LMC care in the first trimester. Hutt Maternity undertook a road show to primary practices May-July 2013. One of the focuses was early engagement in pregnancy care, and early registration with an

LMC. The practices were provided with information on the Huttmaternity website with links to up-to-date LMC availability lists and www.findyourmidwife.co.nz

The exclusion of 135 women with unknown timing of registration includes the women which come under Hutt Primary Maternity care. We are currently establishing data collection systems for Primary Maternity Data.

We are in the process of establishing a working group to outline an action plan for ongoing sector and consumer engagement. We have recently engaged an experienced community midwife to lead this group. The following information was provided to MOH in our HVDHB Maternity Services Quality & Safety Programme Update 2013 and Strategic Plan 2014.

Objective Five 2014: First Trimester LMC Registration. To continue work commenced in 2013 our Sector and Consumer Engagement Working Group (SCEWG) need to investigate ways to engage with our population. This work carries over from the 2013 year.

Our services would like to establish walk-in clinics for pregnancy diagnosis, choices in pregnancy and supporting appropriate next steps. We have current restraints in regards to available space. The DHB is currently looking at options for this.

Our Secondary Care Obstetric Clinics are developing further services with a wider range of specialist clinics eg MMH, Cardiology, Obstetric Physician – this is aiming to increase engagement with at-risk women. Previously for these services women would often have to go off-site for visits.

The Maternity Services would like to facilitate Primary Health Care education forums to promote the importance of early registration with an LMC and referral to secondary care services. This will be facilitated by an Obstetrician and Midwife.

Along side the above, the recommendations made by the NMMG have also been included in the brief for the Sector and Consumer Engagement Working Group (SCEWG). This work stream is overseen by our Maternity Clinical Governance Group, which has consumer representatives.

Sub-regional work has also commenced on developing regional specific Health Pathways. We have a team of clinicians participating in this work stream.

Births Events in Hutt Valley Facilities

Figure 4: Figure 4: Births in Hutt Valley Facilities

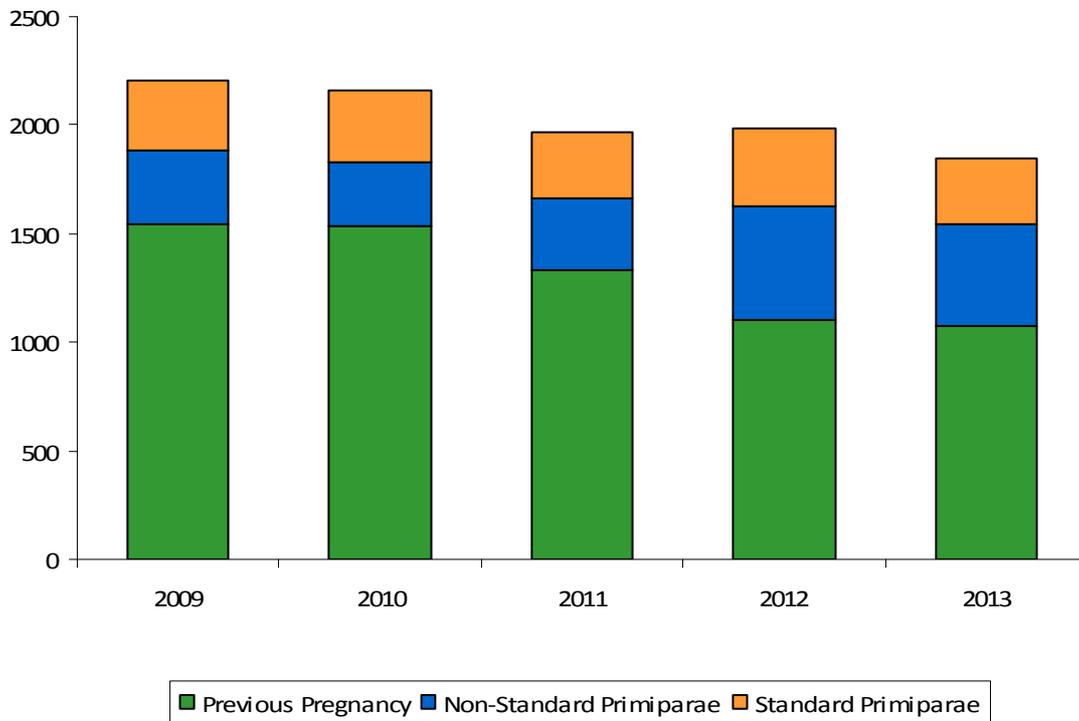


Table 3. Women giving birth in Hutt Hospital 2009 to 2013

Parity Type	2009	2010	2011	2012	2013
Previous Pregnancy	1548	1534	1331	1107	1078
Non-Standard Primiparae	339	293	337	520	467
Standard Primiparae	318	334	300	355	304
Grand Total	2205	2161	1968	1982	1849

Table 4. Age and Ethnicity of women giving birth in Hutt 2013

Ethnicity & Age	Under 16 Years	16 to 19 Years	20 to 24 Years	25 to 29 Years	30 to 34 Years	35 to 39 Years	40 plus Years	Grand Total
Maori		53	117	80	67	47	13	377
Pacific		20	43	54	44	26	6	193
Asian			9	39	64	37	8	157
Indian			7	26	29	8		70
European	1	36	156	224	324	208	66	1015
Other			7	8	7	8		30
Not Stated		1		3	2	1		7
Grand Total	1	110	339	434	537	335	93	1849

Table 5. Parity of birthing cohort by Age 2013

ParityType	Under 16 Years	16 to 19 Years	20 to 24 Years	25 to 29 Years	30 to 34 Years	35 to 39 Years	40 plus Years	Grand Total
Standard Primiparae			107	108	89			304
Non-Standard Primiparae	1	92	67	88	113	77	29	467
Previous Pregnancy		18	165	238	335	258	64	1078
Grand Total	1	110	339	434	537	335	93	1849

Table 6. Parity by Ethnicity 2013

Parity & Ethnicity	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Standard Primiparae	44	28	34	17	173	7	1	304
Non-Standard Primiparae	81	38	39	25	280	2	2	467
Previous Pregnancy	252	127	84	28	562	21	4	1078
Grand Total	377	193	157	70	1015	30	7	1849

Body Mass Index for Births in 2013

Table 7. Body Mass Index by Age Group

BMI	Number	Percentage
< 35	1559	84.32%
35 - 49	258	13.95%
>= 50	17	0.92%
Not Stated	15	0.81%
Grand Total	1849	100.00%

Comment:

HVDHB Data collection for BMI will be standardised with PMMRC criteria by the end of 2014. This will enable us to benchmark against National Standards, and sits within a large pocket of work on changes to our electronic Birthing Unit Summary and Discharge Summary from the DHB.

Smoking rates in pregnancy for 2013 (at birth)

Table 8. Number of patients identified as smokers at time of birth

Number of Smokers	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Under 16								
16 to 19	22	2			7		1	32
20 to 24	65	7			45			117
25 to 29	36	7	1		34			78
30 to 34	20	3		1	17			41
35 to 39	12	5			10			27
40 plus	6				1			7
Total	161	24	1	1	114		1	302

Table 9. Smoking Rate

Smoking Rate	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Under 16	0%	0%	0%	0%	0%	0%	0%	0%
16 to 19	42%	10%	0%	0%	19%	0%	100%	29%
20 to 24	56%	16%	0%	0%	29%	0%	0%	35%
25 to 29	45%	13%	3%	0%	15%	0%	0%	18%
30 to 34	30%	7%	0%	3%	5%	0%	0%	8%
35 to 39	26%	19%	0%	0%	5%	0%	0%	8%
40 plus	46%	0%	0%	0%	2%	0%	0%	8%
Total	43%	12%	1%	1%	11%	0%	14%	16%

Comment:

The number of young Maori women who smoke at the time of their delivery appears very high. However, it should be noted that the LMCs and midwives are consistent in their approach to these women. Evidence from coded data for women delivering in Hutt Hospital and from MMPO data (quarter 1, 2013-2014) shows that more than 95% of women who smoke during pregnancy are asked about their smoking and advised to quit. This would suggest that smoking is a wider societal problem for young Maori women, a problem that needs approaching from a variety of services, and a problem that needs to be tackled beyond the realm of primary and secondary care.

All midwives in Hutt Hospital are trained to deliver the ABC Smoking Cessation programme and as new midwives come on they receive this training. Five new midwives were trained in 2013.

Staff at Hutt Hospital and across the DHB will continue with their best endeavour to advise smokers to quit. The Smokefree Coordinator and the Maternity Service will strengthen the connection between the service and the funded smoking cessation providers. In 2014 the Aukati Kaipapa (AKP) smoking cessation service will be

making direct visits to patients in the hospital. Also, the Quitline have developed a special service for pregnant women and all LMCs will be registered with the Quitline text referral service. This allows LMCs to make very quick and easy text referrals to Quitline. The Quitline are also working from a shared care perspective and will pass on clients to more suitable services such as Pacific Health, or Aukati Kaipapa AKP if they are required.

Home Births in Hutt

Hutt Valley DHB does not currently collect data on Homebirths. The Ministry of Health has provided the data for the 2011 and 2012 calendar years are sourced from the National Maternity Collection. Provisional data on homebirths for the 2013 year has come from the number of Referrals to the National Immunisation Register.

	2011	2012	2013*
Number of Homebirths	61	49	40
Percentage of total birth number	3.1 %	2.5 %	2.2 %

***Provisional Data from National immunisation Register.**

Comment:

This shows a decrease in the number of homebirths, which is consistent with our decrease in total birth numbers within the DHB region.

Most LMCs submit a hospital 'booking' for homebirth women. When the woman births the LMC notify Maternity Enquiries and this pre-admission is then cancelled. No metrics or clinical information is collected within our DHB.

Breastfeeding rates at discharge from Hutt Facility 2012

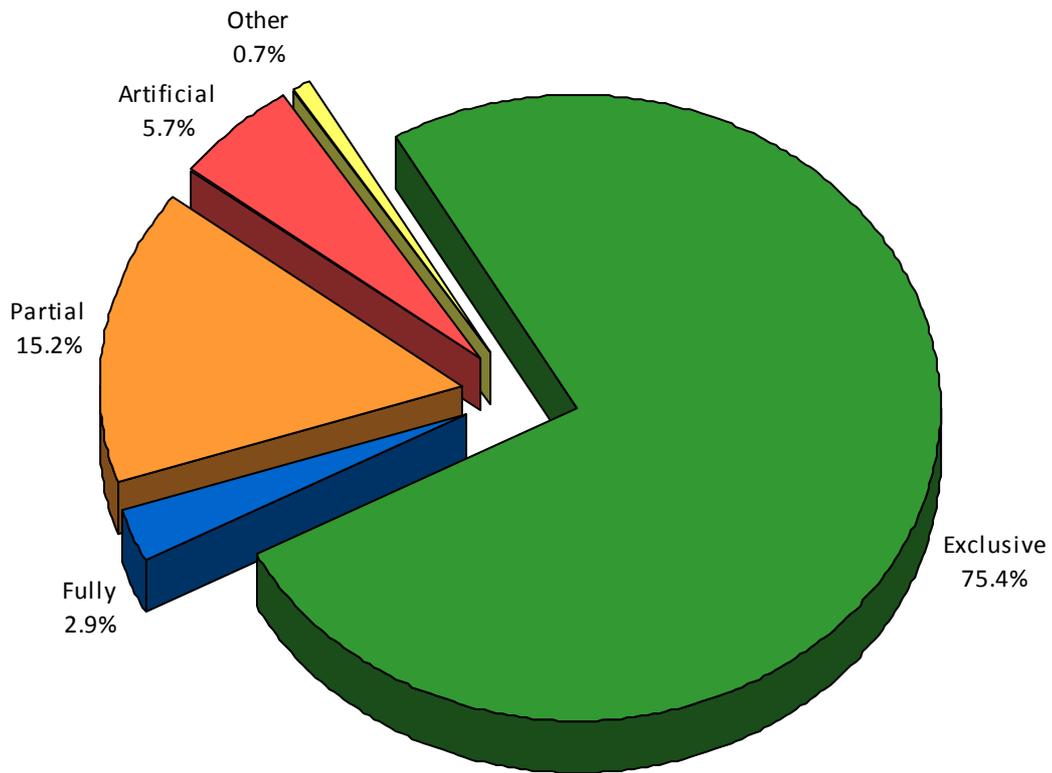


Table 10. Feeding Type by Ethnicity

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

Table 11. Percentage of Feeding Type by Ethnicity

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

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

Breastfeeding rates at discharge from Hutt Facility 2013

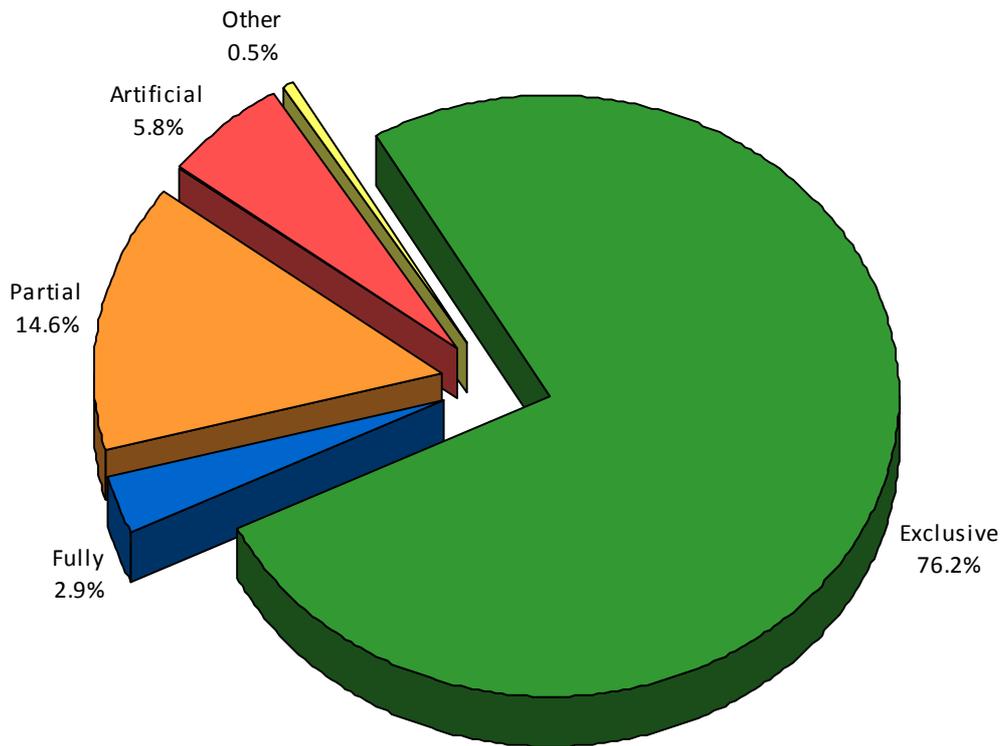


Table 12. Feeding Type by Ethnicity

Feeding Type	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Exclusive	268	131	97	43	726	23	5	1293
Fully	11	3	3	2	29	1		49
Partial	34	35	39	13	123	1	2	247
Artificial	32	12	5	1	47	1		98
Other	2	1	2		4			9
Total	347	182	146	59	929	26	7	1696

Table 13. Percentage of Feeding Type by Ethnicity

Feeding Type (%)	Maori	Pacific	Asian	Indian	European	Other	Not Stated	Grand Total
Exclusive	77.23%	71.98%	66.44%	72.88%	78.15%	88.46%	71.43%	76.24%
Fully	3.17%	1.65%	2.05%	3.39%	3.12%	3.85%	0.00%	2.89%
Partial	9.80%	19.23%	26.71%	22.03%	13.24%	3.85%	28.57%	14.56%
Artificial	9.22%	6.59%	3.42%	1.69%	5.06%	3.85%	0.00%	5.78%
Other	0.58%	0.55%	1.37%	0.00%	0.43%	0.00%	0.00%	0.53%

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

Hutt Maternity recently completed their 2013 Baby Friendly Hospital Initiative Audit. We will establish a breast feeding working group in 2014 to investigate ways of improving our breast feeding rates.

Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP)

Newborn Hearing Screening commenced at Hutt Valley District Health Board (HVDHB) in July 2009 and is now offered nationally through all the District Health Boards. The aim of the programme is the early identification of permanent congenital hearing loss with specific goals of completing screening by 1 month, diagnosis by 3 months, and interventions offered by 6 months. Early medical and educational intervention before 6 months has been demonstrated to significantly improve long-term outcomes for children with hearing loss and their whanau.

Screening is offered to all newborns in the Hutt Valley DHB area through inpatient and outpatient services. We have a staff resource of 2 Screeners and 1 Screener/Team Leader (2.0 FTE). The screening team leader is a National Screening Unit (NSU) approved Screener Trainer who was also selected as a Screening Representative on the UNHSEIP National Audit Team.

Screening is available 6 days per a week in the Maternity and Special Care units and 3 weekly outpatient clinics are run in the Audiology Department. In response to an analysis of attendance to outpatient appointments a home visit service was commenced in November 2013. The aim of this initiative is to improve access for screening for families who, for a range of circumstances, find it difficult to travel to Hutt Hospital.

The programme is managed through the Audiology Department under the Surgical, Women's & Children's directorate and is included in the Maternity Clinical Governance Group. Data is collected daily, analysed monthly, and reported quarterly to the NSU. The service maintains a high quality screening programme through continuing to meet all NSU performance indicators.

Next years work plan includes our first routine national audit by the NSU in February 2014, and quality projects which include a consumer survey and review of our home visit service.

Table 14. HVDHB Universal Newborn Hearing Screening Programme Volumes 2013

Newborns Offered Screening 1941	Completed Screening	1915 (99%)	First screen as Inpatient	1408 (73.5%)
	Declined Screening	14	First screen as Outpatient	507 (26.5%)
	Screening Not Completed	12	Ref for Audiology Assessment	48

		Unilateral	Bilateral
Audiology	Confirmed Sensorineural Loss	0	5
	Confirmed Conductive Loss	3	12

Early Intervention	Referred to ENT Specialist	5
	Referred to ENT Specialist	5

Pregnancy and Parenting Education (PPE)

There are 2 primary providers of PPE within the DHB region, Parents Centre which is privately run, and HVDHB contracted services from BirthEd. We are unable to source data from Parents Centre, but BirthEd provided quarterly data to the DHB.

BirthEd provides high quality childbirth and early parenting education and support to women and their partners or support people, so they can make safe, well informed choices about the birth of their baby and their parenting. We are based both in the hospital and in the community with courses running from Upper Hutt to Wainuiomata, including youth classes at Vibe. BirthEd is contracted by Hutt Valley District Health Board and Capital and Coast District Health Board to provide a range of free courses for adult and youth in the Hutt Valley and in the greater Wellington area.

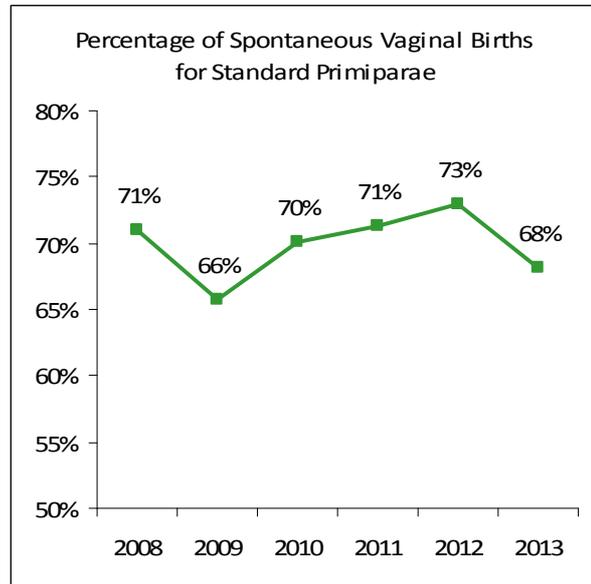
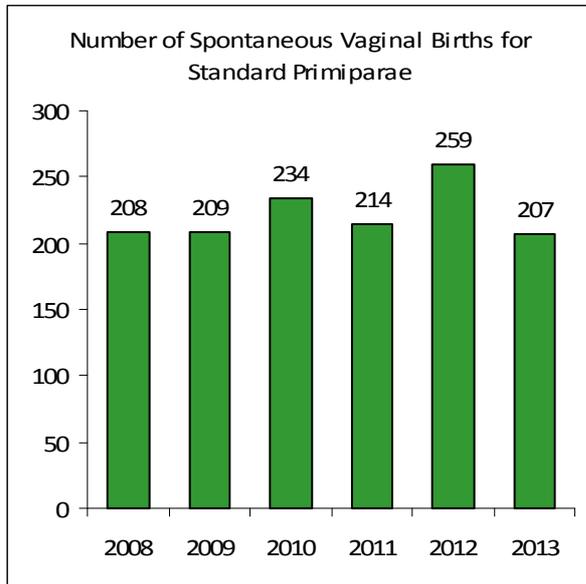
In the 2013 year BirthEd proved, 19 Mainstream Antenatal, 7 Youth Antenatal, 19 Mainstream Post Natal, 6 Youth Post Natal, 10 Baby Cares, 11 Breastfeeding and 13 Baby Safety classes. There were 588 women enrolled in BirthEd classes, with 511 actually commencing and a completion rate of 94%. 92% of attendees were primips. 12% of attendees were under 20, 21% aged 20-24, and the remaining 67% over 24 years.

Table 1: Ethnicity of women enrolled

Ethnicity Number %	Annual total	Percentage
NZ European	302	51%
Maori	50	9%
NZ European / NZ Maori	37	6%
Cook Island Maori	2	0%
Fijian	9	2%
Niuean	0	0%
Samoan	21	4%
Tokelauan	0	0%
Tongan	1	0%
NZ European/Pacific Island	0	0%
NZ Maori/Pacific Island	8	1%
Chinese	23	4%
Sth East Asian	57	10%
African	7	1%
Middle East	1	0%
Indian	28	5%
Other European	41	7%
Other	1	0%
TOTAL	588	100%

Section Three: Maternity Services Clinical Outcomes 2013

Indicator One: Standard primiparae who have a Spontaneous vaginal birth



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

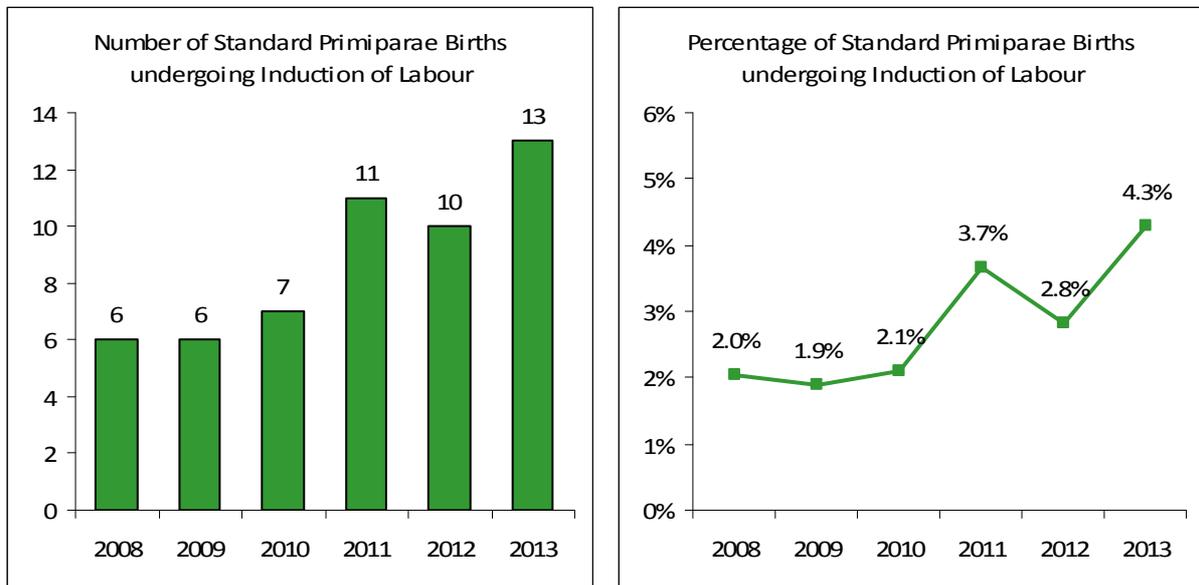
Denominator: Total number of standard primiparae who give birth

Comment:

This indicator continues to track above the national average and the differences between 2012 and 2013 are not significant.

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

Indicator Two: Standard primiparae who undergo induction of labour



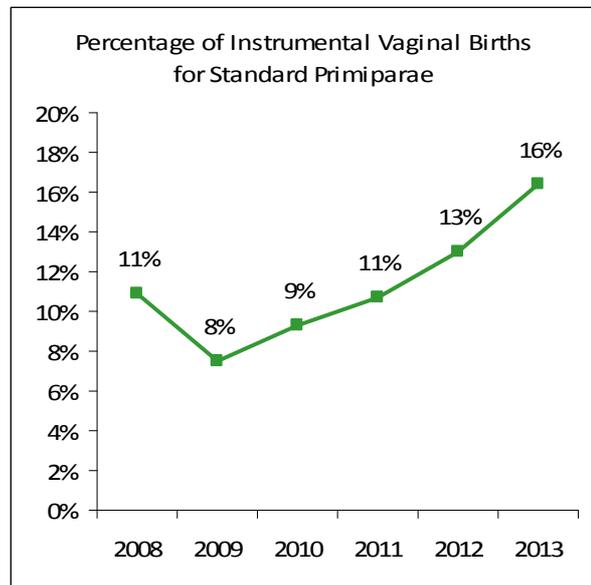
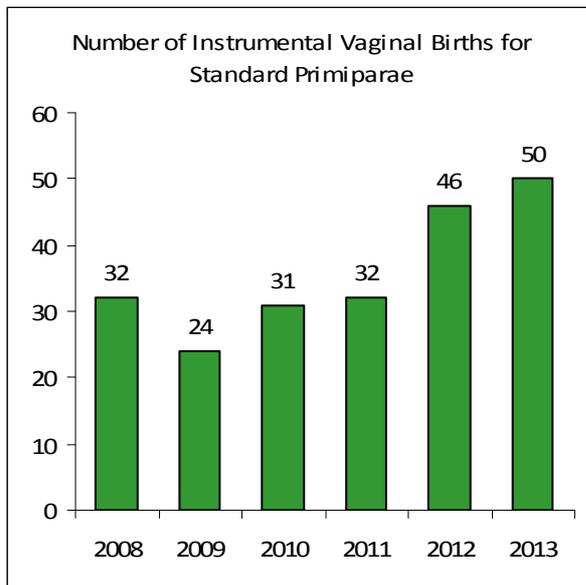
Numerator: Total number of standard primiparae who undergo induction of labour

Denominator: Total number of standard primiparae who give birth

Comment:

This indicator has risen slightly but remains below the national average the units policies remain sound and we will track this indicator with interest this year.

Indicator Three: Standard primiparae who undergo an instrumental vaginal birth



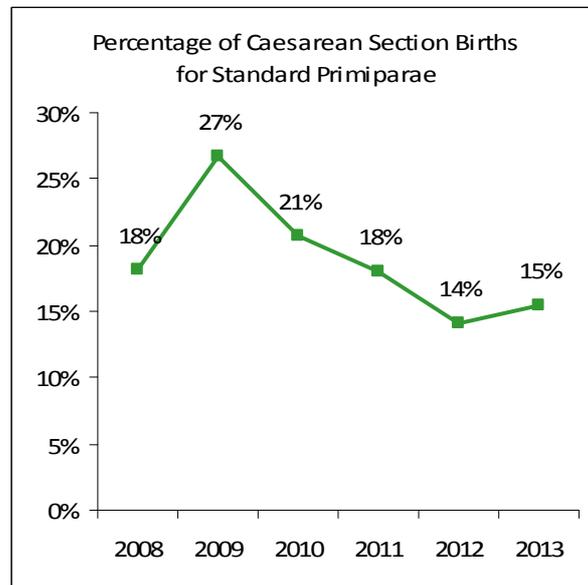
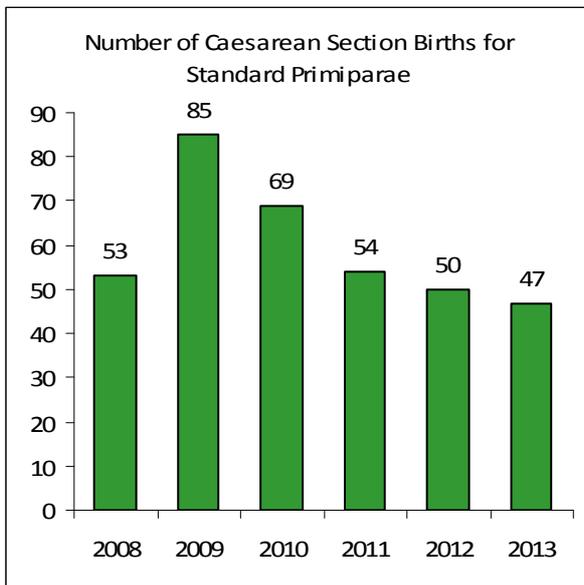
Numerator: Total number of standard primiparae who undergo an instrumental vaginal birth

Denominator: Total number of standard primiparae who give birth

Comment:

This indicator has risen significantly over the past 3 years and reflects the focus the unit has had in supervising and teaching registrars.

Indicator Four: Standard primiparae undergoing caesarean section



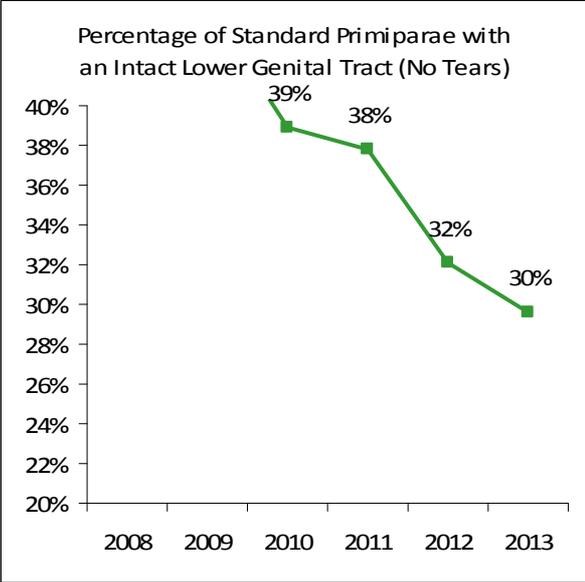
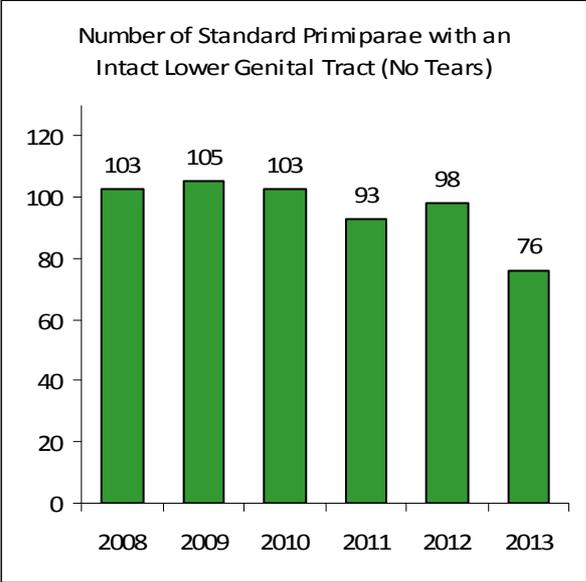
Numerator: Total number of standard primiparae undergoing caesarean section

Denominator: Total number of standard primiparae who give birth

Comment:

This indicator has pleasingly fallen from the highs of 2009. The fall almost certainly is related to the rise in instrumental deliveries as a result of the increase teaching effort.

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

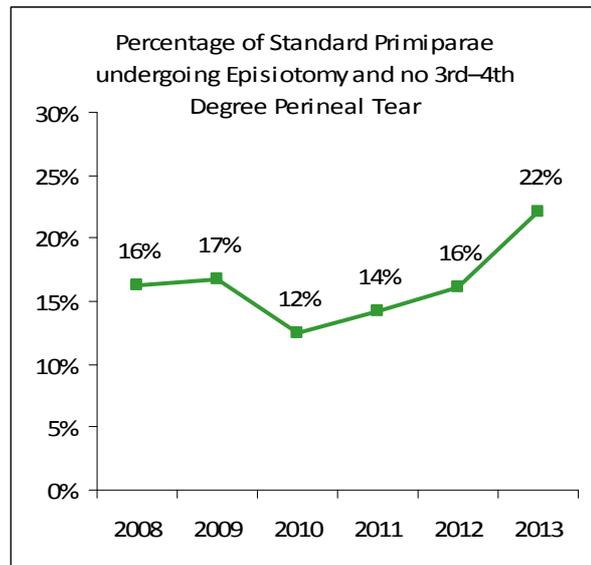
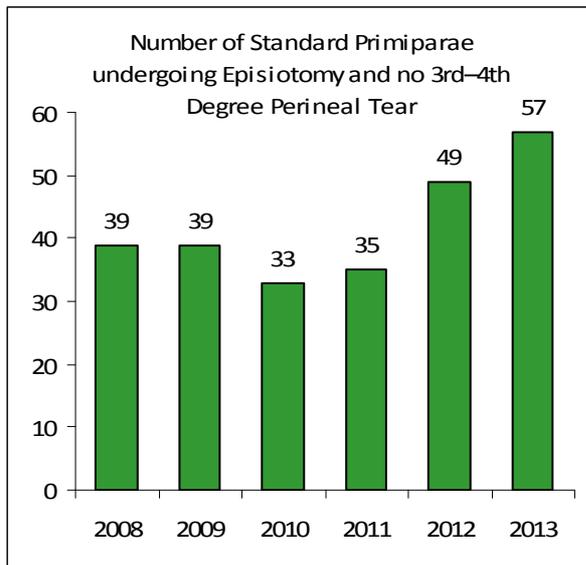


Numerator: Total number of standard primiparae with an intact lower genital tract
Denominator: Total number of standard primiparae who gave birth vaginally

Comment:

Hutt Valley DHB remains consistently below the national average.

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



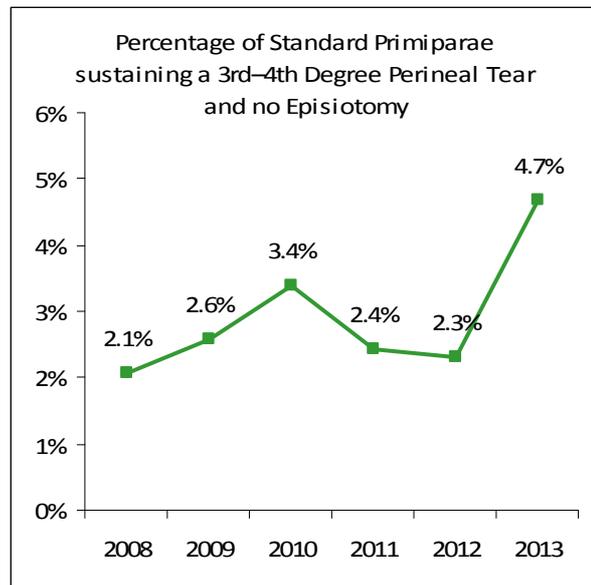
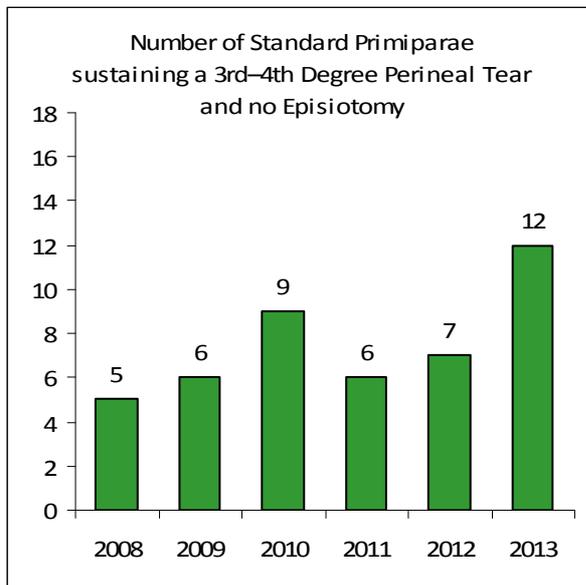
Numerator: Total number of standard primiparae undergoing episiotomy and no 3rd-4th degree perineal tear while giving birth vaginally

Denominator: Total number of standard primiparae who gave birth vaginally

Comment:

There has been a significant rise in this indicator which probably relates to the rapid change in the demographics and co morbidities of the patients that are being seen.

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



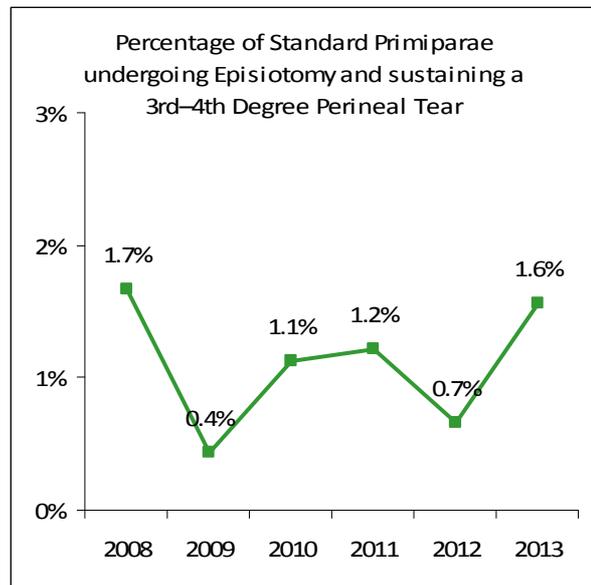
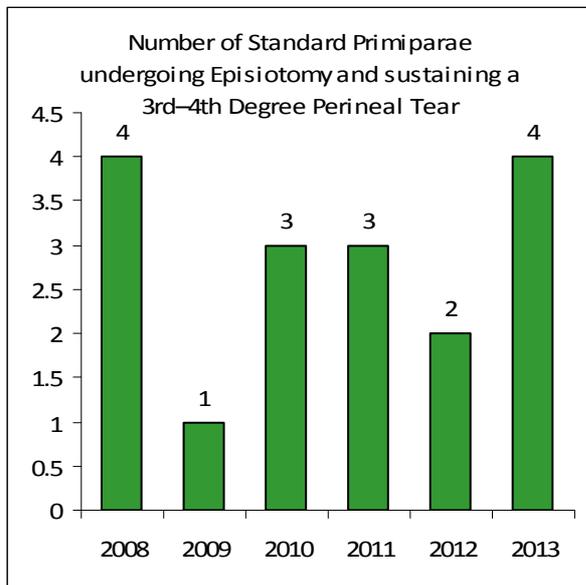
Numerator: Total number of standard primiparae sustaining a 3rd-4th degree perineal tear and no episiotomy

Denominator: Total number of standard primiparae delivering vaginally

Comment:

Our third and fourth degree tear rate in standard primiparae has increased. However, with registrars having attended OASIS workshops and having had dedicated teaching sessions on third degree tears, this may merely represent improved detection of third degree tears rather than increased incidence.

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



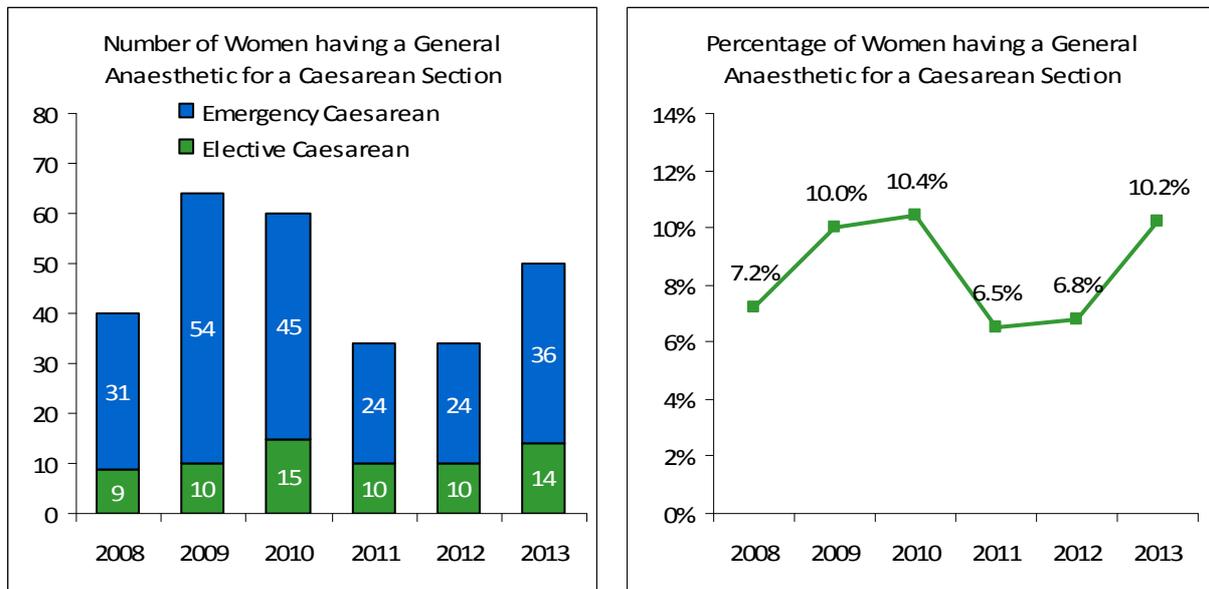
Numerator: Total number of standard primiparae undergoing episiotomy, and sustaining a 3rd-4th degree tear while giving birth vaginally

Denominator: Total number of standard primiparae delivering vaginally

Comment:

The number remains at a level that is too low to draw any significant conclusions.

Indicator Nine: General anaesthesia for all caesarean sections



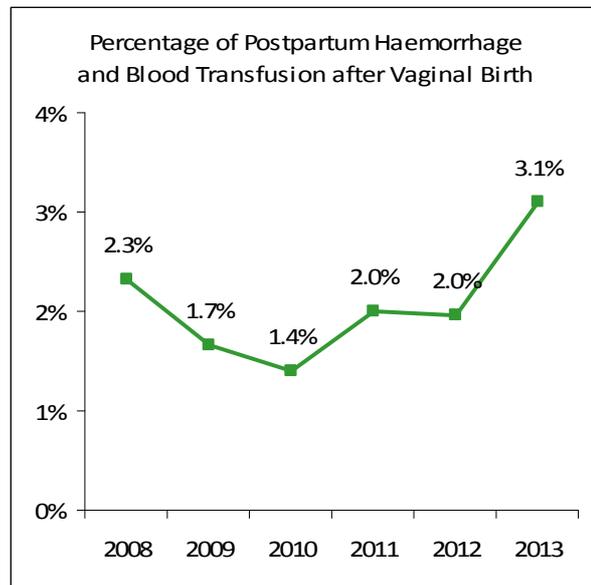
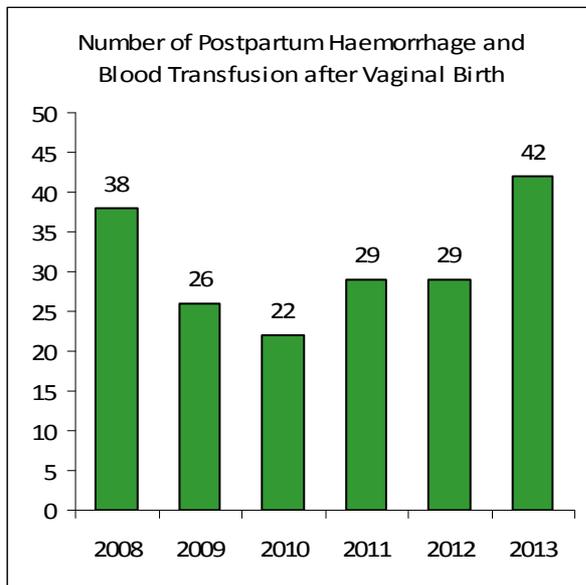
Numerator: Total number of women having a general anaesthetic for a caesarean section

Denominator: Total number of women having a caesarean section

Comment:

There are sporadic but not significant variations in this number which relates to a small rise in very acute operations, a small increase in the number where it is physically impossible to use local regional blocks and a small rise in the number of patients whose anticoagulant management contraindicates local blocks.

Indicator Ten: Postpartum haemorrhage and blood transfusion after vaginal birth



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

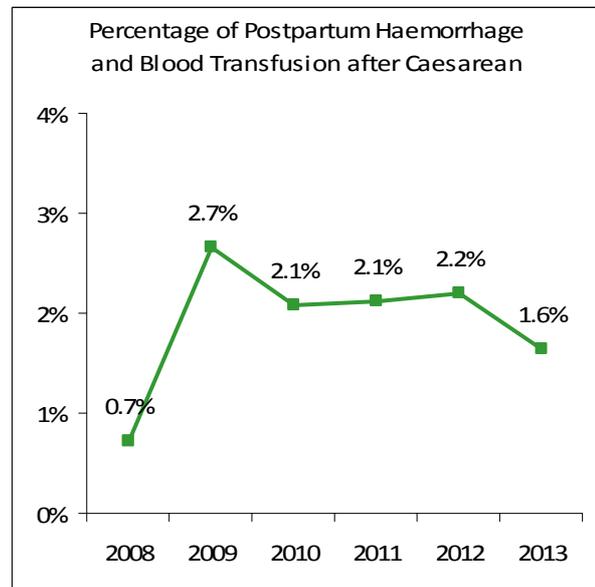
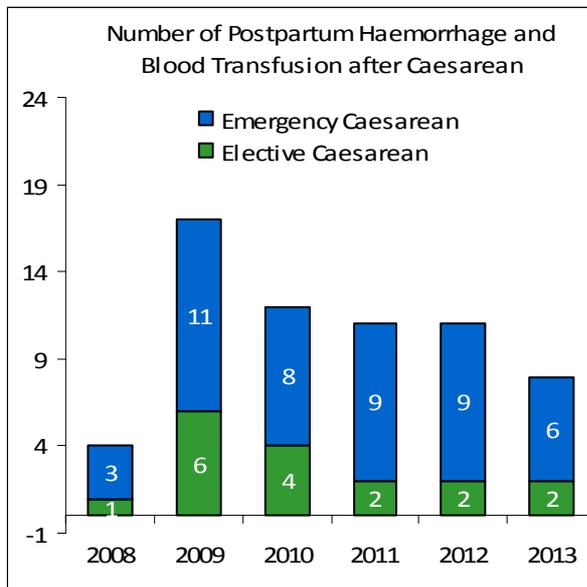
Denominator: Total number of women who give birth vaginally

Comments:

There have been 2 audits undertaken on PPH in the 2013 year. They used different proforma and criteria.

Both audits demonstrated a number of practice points, including the need for diligence checking antenatal Hb and providing Fe supplementation, recognition and management of PPH and accurate documentation.

Indicator Eleven: Postpartum haemorrhage and blood transfusion after caesarean section



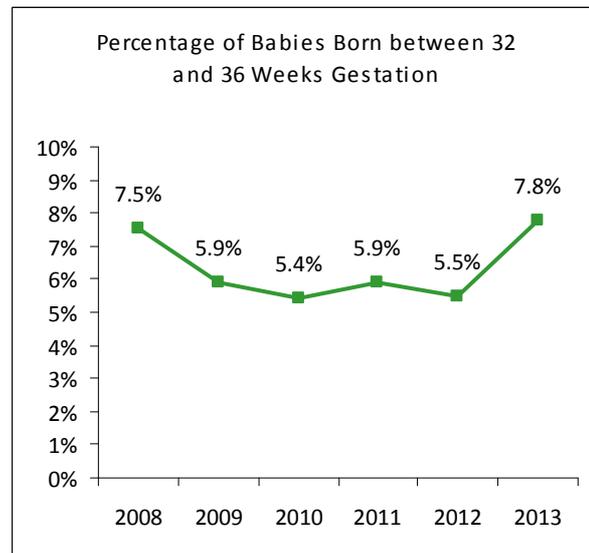
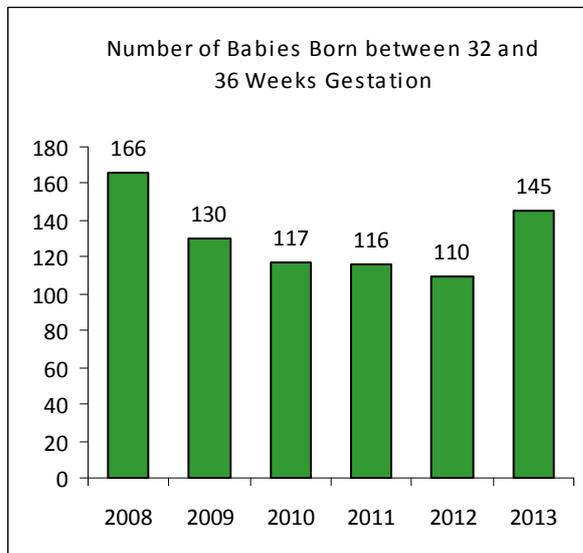
Numerator: Total number of women undergoing caesarean section with a Postpartum haemorrhage who required a blood transfusion during the same admission

Denominator: Total number of women who give undergo caesarean section

Comment:

As a result of the audit into post partum haemorrhage the management of the immediate post operative period has been reviewed.

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



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

Comment:

This is an indicator over which we have little influence. There has been a focus on seeing women with a past history and more actively managing them in an attempt to prevent recurrences. We have chosen to undertake an audit for this in the 2014 year.

Section Four: Maternity Quality & Safety 2013

The Ministry of Health Maternity Quality and Safety Programme was provided establishment funding for a limited timeframe. In the 2014 year we will be exploring ways of sustaining our present and evolving programme beyond mid 2015.

Aspects of our programme are embedded already with our Coordinator sitting within the Directorate not just maternity services. Processes and quality pathways for our multiple forums are now well established and sustainable as business as usual.

Core staff representation on our MCGG such as our core midwife, CMM, Paediatrician, Obstetrician, Quality Team are currently absorbed into the operational budget of their respective services. Our main concern will be the on going funding of consumer, LMC and Primary Care Health representatives and costs of initiatives to improve quality and safety.

Other Governance and Clinical Leadership

Hutt Maternity has a well established Governance Structure, with minor changes of the position of Chair within our Quality Forums in the 2013 year.

Our over arching Maternity Clinical Governance Group (MCGG) has had some changes of Paediatric representation, the loss of 2 of our Consumer Representatives. These will be advertised early in 2014 to ensure representation of Consumers on our Governance Group. This will follow the same recruitment process as the 2012 year. Advertising In local papers and via our stakeholder network will be undertaken. Previously unsuccessful applicants from the 2012 year will also be contact to ascertain their interest in re-applying. Once the recruitment process is complete, consumer representative contact details will be forwarded to the NMMG and their consumer representative. A large focus of our 2014 objectives is consumer engagement, and our consumer representatives will be involved in this work stream.

We will in the 2014 year extend the Terms of Reference for the MCGG to a term of 2 years, rather than the current 1 year.

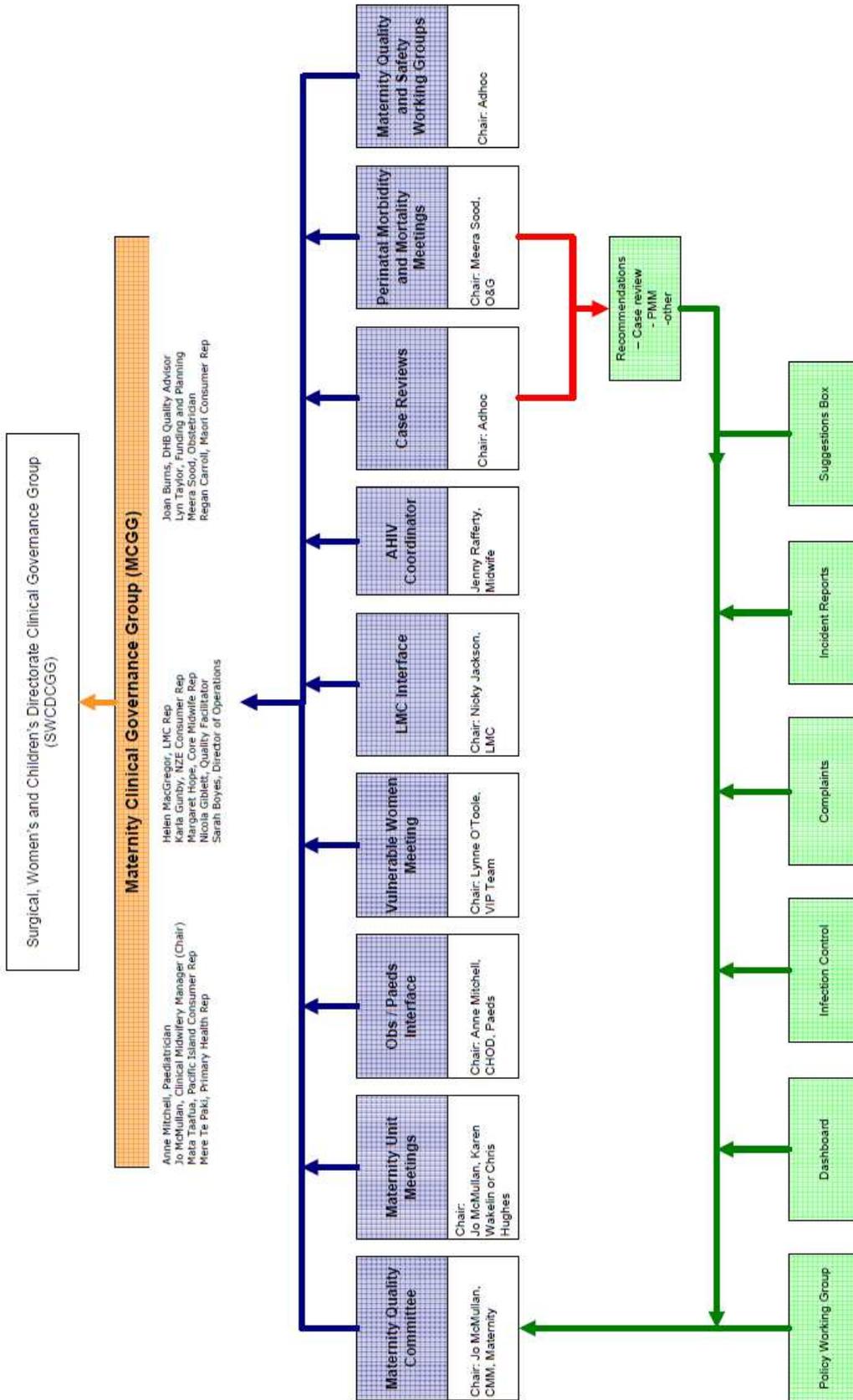
There were 10 meetings of the MCGG. The HVDHB MCGG Consumer Representatives have liaised with their contemporaries at CCDHB for support and networking.

Early in 2013 we orientated a further Antenatal HIV Coordinator. This role now sits under the MCGG, rather than the Director of Operations, Surgical Women's and Children's, and reports to the MCGG.

In October 2013 discussions were held with the Head Audiologist and Team Leader for Newborn Hearing Screening regarding alignment within the MCGG for their clinical governance needs. This was accepted by the MCGG, and has now been formalised.

In the 2014 year we will be investigating our compliments/complaints/events reporting and risk/trigger management systems. To start this process we have agenda compliments and complaints as a standard item on our MCGG agenda.

Maternity Quality and Safety Structure - 2013



Data

A Data, Dashboard, Documentation Working Group (DDDWG) was established. Time has been spent reviewing our current data capture for reporting, our electronic Birthing Unit Summary and Discharge Summary. Consultation occurred with key stakeholders (LMCs, Primary care and Core staff) for their input into these documents. We are now at the stage of making changes and are waiting our IS department assistance. This work will continue into the first part of the 2014 year.

Changes were made in May and our Caesarean Section operation note is now completed electronically. This has improved access to this information for all practitioners.

Sector and Consumer Engagement

Our Sector and Consumer Engagement Working Group (SCEWG) continued in 2013. On 10th April the Huttmaternity website went live.

The Clinical Midwifery Manager presented at the HVDHB 'Grand Round' an open forum for all staff and primary care representatives in May. This sat alongside our maternity "Road Show".

In May, June and July our MQ&SP Co-ordinator and the Antenatal HIV Co-ordinator undertook a "Road Show" out to the Primary Sector. This was for a variety of reasons including sector engagement.

Huttmaternity has now published 3 service specific newsletters. These have been well received, and we have asked what our primary sector would like included going forward.

Regular education planning has occurred to co-inside with our Perinatal Mortality Meetings. This commenced in November with the feedback from a Post-Partum Haemorrhage Audit, and a schedule will be set with next year's PMMs.

A main focus for the SCEWG in the 2014 year will be sector and consumer engagement as outlined in Section Five.

Quality

Obstetric Physician: Late in 2013 we commenced a combined clinic with an Obstetrician and an Obstetric Physician. Prior to this women may have had to attend multiple clinics.

Cardiology: Prior to 2013, women who required obstetric/cardiology care would attend CCDHB clinics. We now have access to a Cardiologist with Obstetric experience at HVDHB.

Obstetric Paediatric Meeting: This was embedded as usual practice over the 2013 year. We have had an increasing number of women discussed, with formal birth and postnatal plans put in place. Our Obstetric Physician also now attends these meetings.

Vulnerable Women and Unborn Babies Group: This meeting commenced informally in 2012, and has now is well utilised by both LMCs and core staff. We are currently exploring

metrics for this cohort of women, and awaiting the Maternal Care, Child Well Being and Protection Groups tool box, due out early 2014.

Policies: Over 2013 we continued to improve the system and process for review and sign off of our departmental policies; this is now embedded as the normal process. Policies are accessible online internally for staff and LMCs, and available in hard copy. In 2014 they will be accessible on the Huttmaternity website.

Post Partum Haemorrhage Audit: In response to data from our 2012 Annual report we undertook an audit on PPH. This was a large pocket of work reviewing over 200 sets of clinical notes. This was presented at our November Perinatal Mortality Meeting, and we have received recommendations from the Audit. We are awaiting the National Guidelines to ensure best practice is promoted.

Safe Sleep: Hutt DHB has one of the highest rates of Sudden Unexpected Death in Infancy in NZ. We began work to standardise the policies across the DHB into one. Links have been established with community stakeholders and this will carry across into the 2014 objectives. We supported the National Safe Sleep day on 6th December with in house education sessions, and displays.

Health 4 Life: Hutt Hospital Regional Public Health is part of the Health 4 Life project. We have both a core midwife and the Clinical Midwifery Manager as part of the team for this project.

Triple Enrolment: A Project Manager has been recruited to look at improving enrolment to Well Child providers and information transfer, enrolment to Oral Health Services, and enrolment to General Practice. They sit under the SIDU team, and this work is from a 3DHB approach.

Paediatric Resuscitation: Our Paediatric Resus/equipment trolley has been standardised with the trolley in SCBU, to assist practitioners working across both areas.

Emergency Calls: Work has been undertaken on our Emergency Calls pathway. Our codes and processes have been refined as a result of a case review recommendation.

Support/Partners Staying: In mid-2013 we piloted the option of support people staying in our postnatal ward. One of our core staff, a member of our MCGG, has recently completed an audit looking at views from staff and the women, and their supports. She is currently working on the policy reflect these changes.

Role of LMC in Theatre: Liaison has occurred with Theatre around the role and responsibility of LMCs in theatre.

Administration Processes: Alongside clinical improvements we have been reviewing administration processes, this focus mainly around the area of Secondary Care Clinic appointments. We are currently changing from a manual system to electronic letters. We have also instigated e-text to LMC's advising of women's appointments.

Facility: Our facility has previously had an issue with floor covering and is in the process of laying new flooring that will be easier to keep clean and more aesthetically pleasing.

Sub Regional Links (CCDHB and WDHB): Links were made with the first Wairarapa MQSP Coordinator. They were provided access to all our documentation, frameworks and

ongoing support was offered as required by them. Several meetings were held at HVDHB as they requested, followed up by availability via phone.

Further support was provided with the Wairarapa Team whilst they went through the transition of a new MQSP Coordinator and new CMM. Meetings were held between the HVDHB CMM, HVDHB MQSP Coordinator and the Wairarapa CMM at different times as needed.

The Clinical Midwifery Manager attends the Central Region Midwifery Leaders Group quarterly and is involved in on going work streams.

National Maternity Monitoring Group Priorities

The following were issues high on the priority of the National Maternity Monitoring Group (NMMG). We have outlined our progress or plans to date, in each of these priorities.

Early LMC engagement

Foundation work began in the 2013 year with sector engagement. We undertook a “road show” to Primary practices with a focus on early access to care, and early registration with an LMC. Our 2014 year focus is on further sector engagement, with our highest priority being consumer engagement.

We went live with our Huttmaternity website which is aimed at consumers. This will be reviewed in the 2014 year, once work has been undertaken on consumer engagement and their needs. We will continue to update the Huttmaternity Website with up-to-date lists of midwife availability. This is easily accessible to women and primary health care providers. The website also links to NZ College of Midwives' site www.findyourmidwife.co.nz.

We produced 3 newsletters in the 2013 year. Our aim is to continue these 3 – 4 times a year. We have asked primary care and our stakeholders what they would like us to include in the newsletter.

In the 2013 year we introduced changes on our data collection on Date of Registration, and LMC at registration. This has now been recorded for several months; we need to evaluate this change in collection for accuracy and robustness before any reporting.

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In 2012 our Primary Midwives service moved to home visits from a static clinic in consulting rooms. This has provided women with better access to care.

Our Secondary Care Obstetric Clinics are developing further services with a wider range of specialist clinics eg MMH, Cardiology, Obstetric Physician – this is aiming to increase engagement with at-risk women. Previously for these services women would often have to go off-site for visits.

Preterm Births

We have highlighted this as a priority in the 2014 year and will undertake an audit on our 2013 statistics.

Maternal Mental Health (MMH)

In 2013 we produced a specific pathway for MMH referrals. This is to support LMCs using the most appropriate and effective referral modes. It outlines external agency options, then linking to DHB agency referral through Secondary Care Services. This was presented to Primary Care providers in our Maternity Road Show.

We have also initiated a Specialist Obstetric Clinic for those referred to our service; this includes the support of a Nurse Specialist from the regional Maternal Mental Health Services.

Implementation of the Referral Guidelines

Hutt Valley DHB Maternity has always used the Guidelines for Consultation, and copies are readily available within the Maternity Ward and Birthing Suite, Maternity Assessment Unit & chart room, and on several occasions have been sent to LMCs.

Strengthening communication pathways to assist the three-way discussion between LMC midwife, obstetrician and women/whanau in secondary consultations and non-emergency transfer. This will be aided by the change in provision of named obstetricians for women referred to secondary care.

We have a method of “Red and Blue labels” within our Secondary Care Clinics to indicate transfer of Clinical Care and Responsibility to Secondary Care Services and back to LMC. The use of this is to be audited and evaluated.

We will also audit documentation in our Birthing Unit specifically looking at documentation at the time of emergency transfer.

We will be developing a coding system for better data capture; this will be reviewed for accuracy and trends. It will also enable us to look at reason for referrals and number of referrals received to evaluate our clinic capacity.

Hutt DHB is covered by Wellington Free Ambulance services. We generally have no transportation concerns. However the clinical issues that may arise are dealt with directly with Ambulance Services.

Hutt Maternity hosts paramedic student placements. This ongoing initiative strengthens relationships and education about maternity needs.

Our emergency transport policy and Referral to Secondary Care Services are due to be reviewed in 2014.

In April 2014 we are planning a forum on the Guidelines for Consultation.

Compliments

We have had 48 praises registered with the DHB Quality Team for 2013. The themes of these compliments relate to care and staff professionalism.

“We truly could not fault any aspect of our care and we particularly want to thank the midwife team for their professional and caring approach throughout my wife’s stay.”

“I was extremely grateful for the care & support & help all the midwives provided with breast feeding, ideas for comforting baby and support for myself.”

Reportable Events, Serious Events and Complaints

HVHDB had no adverse serious (SAC2) or sentinel (SAC1) events in the 2013 year.

For our internal event reporting there were 28 inpatient and ward events, and 20 events for employee and affiliates. These include such events as needle sticks, slips and trips, and strains. All events are reviewed by the Clinical Midwifery Manager and line managers as appropriate.

The main categories of these events were:

- Care service coordination issues: These include such issues as equipment problems and handover between staff members.
- Medication and Fluid events
- Environmental events concerning the physical environment of the post natal ward and delivery suite.

Complaints

In the 2013 year there were 9 complaints registered with the DHB Quality Team. These can be summarized into the following categories:

Communication:	1
Treatment:	5
Cleaning:	1
Nursing care:	1
Environment:	1

All complaints where the complainant can be identified are responded to in writing. In addition to the above, there were also 3 complaints where the complainant could not be identified.

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

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

Clinical reviews and recommendations from June 2013 to February 2014

There have been five case reviews held in the unit since June.

The recommendations from the reviews have been put in place and communicated to the staff if there has been a change in systems or practice. As yet there has not been a repeat of the events which triggered the reviews since recommendations have been introduced.

However a recommendation for an upgraded neonatal resuscitaire remains in progress.

Resolving on-going issues with the 777 calls are hindered by the emergency system being updated by the hospital. One of the complicating factors is that the Obstetric Senior Medical Offices do not carry pagers and the emergency system is set up for a paging system only. A working group has been introduced to facilitate a functional outcome.

Perinatal Mortality Cases

In 2013 there were 11 stillbirths and 2 neonatal deaths. The age range of the mothers was 23-43 years with representation across Maori, Pacifica, and New Zealand European. This included 8 multiples and 4 primips, only 2 were current smokers. One mother would be classed as morbidly obese. Five of the still births/neonatal deaths were between 20-21 weeks, three were between 24-34 weeks, and three at term.

There were a variety of reasons with no trend.

Unfortunately there were two maternal deaths in the 2013 year. One through suicide and the other through pre-existing epilepsy.

Five Post Mortems were requested; two placentas sent to histology and the 2 mat deaths under the coroners

The small numbers do not allow for any statistically significant analysis, however, we are aware of the PMMRC recommendations that we endeavour to incorporate into practice

Section Five: Forward Planning 2014

Hutt Maternity was very ambitious in our 2013 year objectives. We have carried across incomplete recommendations from 2013 and set work streams for 2014.

2013 objectives were based on the seven elements in the MOH Implementation Guidelines.

Governance and Clinical Leadership Structure

Objective One 2013: Recruitment of a Sub-Regional Director of Midwifery. The proposal for this was submitted to the CEO, and currently sits with the Director of Nursing and Midwifery for the sub region. It has been held up by sub-regional/regional 3D restructures.

Objective Three 2013: Align the Maternity Clinical Governance Group with HVDHB governance framework and structure.

Co-ordination and administration

Objective Five 2013: Hutt Maternity has a MQSP coordinator. We have developed a business case for administration support. This currently sits with the Director of Operations and we are awaiting an outcome.

Consumer Engagement/Sector Engagement

In 2013 we proposed a Sector and Consumer Engagement Working Group. The group did some work with the Huttmaternity website and a sector road show. This work needs to be continued and further developed in the 2014 year.

Objective Eight 2013: Our Huttmaternity website went live in the second quarter of 2013. It is proposed that the above working group will plan phase 2 of our website.

Objective Nine 2013: The working group will need to investigate further consumer and sector interface methods and action plan.

Data monitoring

Data monitoring and reporting was a large section of work under the MQSP. Hutt Maternity established a Data, Documentation and Dashboard Working Group. This group has been working through the above areas and initiated an action plan. We were able to report on the 12 MOH KPIs.

Objective 14 &15 2013: Ongoing monitoring of KPIs. This will continue into the 2014 year, with work being undertaken on aligning our currently DHB Maternity Services KPIs and the 12 MOH KPIs.

2014

Objective One 2014: Our Maternity Assessment Unit opened in 2010 and was fully operational mid 2011. We will be undertaking a review process for MAU and include our Community Midwives Team aiming for a Maternity Ambulatory Services.

To do this we will be using the Health Check Framework and 4 Quadrants for quality improvements. This process involves undertaking a stock take for current status, staff participation of issues and areas for improvement, then recommendations and actions. This work is proposed to start late December 2013.

Part of this work process will be instituting speciality clinics that include educational support from clinic midwives eg VBACs to ensure women received accurate information consistent with the current policies.

We will also be promoting continuity of care from Obstetricians and clinic midwives for secondary care women and midwives for primary team women by having a named Obstetrician and/or midwife.

Objective Two 2014: Our Vulnerable woman meeting started in 2012, and has continued to grow. At the time it was established no metrics were put in place. Our 2014 plan is to develop a monitoring system of measurable outcomes for this group of women. The metrics will be established in Jan – March 2014, with a review phase in April with any modifications. By mid 2014 we hope to have a set group of measurable outcomes that we can monitor.

Objective Three 2014: To investigate current methods for identifying triggers in obstetrics, and how this process will be managed.

Objective Four 2014: Work commenced in late 2013 reviewing our policies re safe sleep in alignment with contact from HQSC and Change for our Children. We have identified that there are currently 5 different policies within the DHB. Work is being done on having one policy within our DHB covering all clinical areas. Policy work will be completed by the end of 2013, with work commencing on a Safe Baby Action Plan across the wider DHB and stakeholders in 2014.

As part of the Action Plan we will be addressing breast feeding, smoke free, immunisations, and other new born safety priorities.

Objective Five 2014: First Trimester LMC Registration. To continue work commenced in 2013 our Sector and Consumer Engagement Working Group (SCEWG) need to investigate ways to engage with our population. As stated above in Object nine this work carries over from the 2013 year. The SCEWG needs to outline an Action Plan.

We will continue to update the Huttmaternity Website with up-to-date lists of midwife availability. This is easily accessible to women and primary health care providers.

The website also links to NZ College of Midwives' site www.findyourmidwife.co.nz.

In May/June 2013 we undertook a 'Road Show' to community primary care providers for a variety of reasons. We need to continue to build the relationships established at this time. The SCEWG will address this in their action plan

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The Maternity Services would like to facilitate Primary Health Care education forums to promote the importance of early registration with an LMC and referral to secondary care services. This will be facilitated by an Obstetrician and Midwife.

Objective Six 2014: Hutt Valley DHB Maternity has always used the Guidelines for Consultation, and copies are readily available within the Maternity Ward and Birthing Suite, Maternity Assessment Unit & chart room, and on several occasions have been sent to LMCs. There are several other strategies we will undertake to continue to implement the Guidelines.

Strengthening communication pathways to assist the three-way discussion between LMC midwife, obstetrician and women/whanau in secondary consultations and non-emergency transfer. This will be aided by the change in provision of named obstetricians for women referred to secondary care.

During 2013 there was development of an electronic operation note. This is currently imported into a woman's discharge summary from our facility in full. We will be investigating the use of a formal letter to women who have had a primary caesarean section stating whether they are good candidates for future VBAC, rather than the complete content of their operation note.

We have a method of "Red and Blue labels" within our Secondary Care Clinics to indicate transfer of Clinical Care and Responsibility to Secondary Care Services and back to LMC. The use of this is to be audited and evaluated.

We will also audit documentation in our Birthing Unit specifically looking at documentation at the time of emergency transfer.

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with Ambulance Services. Hutt Maternity hosts paramedic student placements. This ongoing initiative strengthens relationships and education about maternity needs.

Our emergency transport policy and Referral to Secondary Care Services are due to be reviewed in 2014.

As noted in the above objective for LMC Registration, the Maternity Services would like to facilitate Primary Health Care education forums to promote the importance of early registration with an LMC and referral to secondary care services. This will be facilitated by an Obstetrician and Midwife.

Objective Seven: Pre Term Birth. We acknowledge this is a priority work-stream for the National Maternity Monitoring Group. We will be completing an audit on Pre-term Birth at Hutt Maternity. There will be particular focus on elective or planned deliveries and the clinical reasons for these. We note there are discrepancies between data rates from NMMG and our figures for 2011. We hope the Audit will provide further information for our analysis in this area.

Appendix One: Data Information

Data Sources

Data for birth numbers and clinical indicators was sourced from hospital events stored in the Hutt Patient Management System (IBA) and the Hutt Maternity Database (Concerto). Data from the Hutt PMS is reported to the National Minimum Dataset (NMDS) and coded using ICD-10-AM-v6 clinical codes. Therefore the coding rules followed for extracting patients to meet the specifications of this report were obtained from the Ministry of Health's Analytical Services team.

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

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

Coding extract rules for Mothers

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

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

Coding extract rules for Babies

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

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

Standard Primiparae

Must meet all the following criteria:

- No previous pregnancy of 20+ weeks, and
- Maternal age 20-34, and
- Cephalic presentation, and
- Singleton, and
- Term gestation, and
- Without specified medical complications

New Zealand Maternity Clinical Indicators

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

	Indicator	Numerator	Denominator	Coding Rules
9	General anaesthesia for Caesarean section	Total number of women having a general anaesthetic for a Caesarean section	Total number of women having a Caesarean section	All Caesarean Births (1652000,1652001,1652002,1652003 or O82) with a 92514XX procedure
10	Postpartum Haemorrhage and Blood transfusion with Caesarean section	Total number of women who undergo Caesarean section who require a blood transfusion during the same admission	Total number of women who undergo Caesarean section	All Caesarean Births (1652000, 1652001, 1652002, 1652003 or O82) with one of the following procedures 1370601, 1370602, 1370603, 9206000, 9206200, 9206300, 9206400 and a diagnosis of O72.0, O72.1,O72.2 or O72.3
11	Postpartum Haemorrhage and Blood transfusion with vaginal birth	Total number of women who give birth vaginally who require a blood transfusion during the same admission	Total number of women who give birth vaginally	All Vaginal Births (9046700 or O80) with one of the following procedures 1370601, 1370602, 1370603, 9206000, 9206200, 9206300, 9206400 and a diagnosis of O72.0, O72.1,O72.2 or O72.3
12	Premature births (between 32 and 36 weeks gestation)	Total number of babies born at between 32 weeks 0 days and 36 weeks 6 days gestation	Total number of babies born in hospital	