Introduction

Southern DHB Maternity Quality and Safety Programme (MQSP) has undergone a significant change commencing in late 2015. The change has been to reposition the programme within the wider organisation’s Quality Improvement and Performance Excellence Strategy. In 2016 we plan to report on the progress of the MQSP from an emerging DHB to an established programme. Underpinning all work is our adoption of the Four Fold Aim, the Six Dimensions of Quality, and the utilisation of identified Quality Improvement Methodologies. In 2016 we will also include our progress on Southern Future “It’s up to Us” and the application of our Southern DHB Values. 2015 has commenced the re-energising of our MQSP and we look forward to reporting on its new pace of progress in the future. – Tina Gilbertson, Southern DHB Director of Quality.

Purpose

This report outlines the Maternity Quality and Safety Programme (MQSP) within Southern DHB, as well as providing a general overview of maternity care within our District. The MQSP is a Ministry of Health (MOH) initiative to improve the quality of maternity care services nationally. MQSP builds on work already taking place in District Health Boards (DHBs) to identify ways that care can be improved and to implement these changes. MQSP encourages collaboration by working with the community, stakeholders and with consumers.

MQSP is underpinned by the New Zealand Maternity Standards, New Zealand Maternity Clinical Indicators and the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).
Acknowledgements

We would like to acknowledge all the birthing women and whānau whose stories underpin our determination to provide the highest quality maternity and perinatal care. We would also like to acknowledge the hard work and dedication of the hundreds of maternity care providers working in a diversity of settings and challenges, who strive every day to deliver evidence-based, skilled and sensitive care to the families of the Southern District.

Thank you to all of the Southern DHB employees, maternity facility managers, community-based providers and community partners who contributed to this Annual Report. This document has been created with the support of the Maternity Quality and Safety Programme Steering Committee and Governance Group. – Heather LaDell, Southern DHB MQSP Coordinator

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Executive Summary

This report provides an overview of the maternity services available to the women, babies and whānau of the Southern District. Our District has two main population centres in Dunedin and Invercargill, with a relatively low population spread across the rest of a vast rural District. To serve our population, Southern DHB maintains two main urban secondary/tertiary facilities and funds eight rural primary maternity units. Maternity care is delivered by a diversity of providers who are self-employed, DHB-employed, community Trust-employed and privately employed. Effective collaborative relationships and clear guidelines and pathways of care are necessary to ensure that women and babies receive consistently high-quality care to achieve the best health outcomes. Review of outcomes and the needs of the population provides information for the effective planning of services.

The full implementation of the Maternity Quality and Safety Programme (MQSP) within Southern DHB provides a framework for ongoing review and improvement of our maternity services. The Implementation Plan for the MQSP is currently under development and will be available in August 2016.

The New Zealand Maternity Standards provides an overview of the expectations of DHBs. Southern’s achievements against the Maternity Standards, and plans for improvement, include:

- Multi-disciplinary clinical quality review is well-established.  
  Working toward improved engagement with consumers and community-based providers in review processes.

- Engagement with consumers and professional organizations to identify needs and plan services.  
  Working toward improved engagement with high-needs populations, to ensure improved outcomes for these groups.

- Effective communication between maternity providers.  
  Working toward improved communication between LMC midwives and DHB services, and between rural primary providers and facilities and secondary services.

- Evidence-based clinical guidelines are implemented across the service. Achieved.

- National maternity service specifications are implemented within each DHB-funded maternity service. Audits underway.

- All women have access to pregnancy, childbirth and parenting information and education services. Achieved.

- All DHBs obtain and respond to regular consumer feedback on maternity services. Achieved; working toward improved methods to increase response rate.
• Maternity services are culturally safe and appropriate.  
  This report details some specific examples of work in this area; working toward improved engagement with consumers, including Māori and Pasifika families, to ensure culturally safe and appropriate services.

• Women can access continuity of care from a LMC for primary maternity care.  Achieved.  
  Working toward increased engagement of LMC midwife in the first trimester.

• DHB provides local services that are consistent with national and regional maternity plans and are appropriate for the local population.  
  Working toward review of services to match changing population needs.

• Women and children have access to the services that are clinically indicated.  
  Full range of services are in place; working toward improved review of services to identify gaps in service or access.

• Effective links between primary, secondary and tertiary services to ensure seamless transfer of clinical responsibility occurs when required.  
  Referral Guidelines fully implemented; working toward review of transfer process to demonstrate any areas for improvement.

• Clinical pathways are in place locally and regionally to respond to maternity and neonatal emergencies.  
  Clinical pathways are in place and case review process identifies where changes need to be implemented.  Working toward collaborative review of emergency response including communication and emergency response services.

• Women who require secondary/tertiary care receive continuity of midwifery and obstetric care.  
  Almost all women have continuity of care through their LMC; working toward increased engagement with consumers to learn more about their experience of transfers of care and secondary/tertiary services.
Our Population

Southern DHB was created as a result of the merger of the Otago and Southland DHBs which came into effect on 1 May 2010.

Southern is the second largest DHB by geographical area in New Zealand. There are special challenges to delivering high-quality health services to a low population spread over a large area, as health funding is population-based. Southern DHB is responsible for planning, funding and providing health and disability services to a population located south of the Waitaki River. Our catchment area's resident population measured in the 2013 Census was 297,430 compared to the 2006 Census of 286,209.

The catchment area encompasses Invercargill City, Queenstown - Lakes District, Gore, rural Southland, Clutha, Central Otago, Maniototo, Waitaki District and Dunedin City. Of the Southern catchment population:

- 17.6% live in Invercargill City
- 4.2% live in Gore District,
- 8.0% Queenstown-Lakes District
- 9.9% live in rural Southland
- 41.5% live in Dunedin City
- 5.8% live in Central Otago
- 5.9 % live in Clutha District
- 7.1% live in Waitaki District.

In 2014, 3293 women birthed in Southern DHB, making us the sixth highest DHB population of birthing women in New Zealand. The birthrate was 52.7 per 1,000 women, a fall from 58.6 in 2010. Our highest birthrate is in women aged 30-34 (113.2 per 1,000 women), and Southern birthrates in all age groups are lower than national averages.

Māori women comprised 16% of total births in 2014, Pasifika women 3.7%, Asian women 6.7%, and European/other comprising 73% of the total.

368 birthing women (11% of all births) were living in greatest deprivation (Deprivation Category 5), while 708 birthing women (22%) were living in the least deprivation (Deprivation Category 1). (All maternity data reported from Report on Maternity 2014 Data Tables, MOH).
Southern Maternity

Southern operates two secondary/tertiary facilities in Dunedin and Invercargill. Of the total of approximately 3300 births per annum, 85% occur in these two facilities. Neither city has a primary facility; births in these facilities include secondary and primary events.

Southern DHB funds eight rural primary maternity facilities in the region where approximately 12% of the region's births occur. These facilities also provide a range of maternity services including postnatal care for women who have birthed in a secondary facility and have returned back to their community facility for care close to home. Southern's homebirth rate is approximately 3% annually.

Map used with permission from creator Pauline Dawson
Urban Secondary Maternity Facilities

Southern DHB operates a tertiary maternity facility at Dunedin (Queen Mary Maternity Centre) and a secondary maternity facility at Invercargill (Southland Hospital). The majority of births occur at these two facilities; 1650 births at Queen Mary (50%) and 1161 at Southland Hospital (35%), in 2014. Dunedin Hospital has a Level 2 Neonatal Unit and Southland Hospital has a Level 3 Neonatal Unit.

Many women birthing at Queen Mary or Southland Hospital are low-risk; almost all birthing women have a Lead Maternity Caregiver (LMC) midwife with an access agreement with the facility. Employed “core” midwives also provide support to any woman having an inpatient stay on the antenatal or postnatal ward, and support women and the LMC when additional care is needed on Delivery Suite.

Women throughout the District who have medical complications are referred to the Obstetric Team at either Southland or Dunedin for consultation (advice) and/or care, according to guidelines outlined in the Referral Guidelines of the Primary Maternity Services Notice (MOH, revised 2012). This may be as an outpatient through the antenatal clinics, or as an inpatient on the Antenatal, Delivery, or Postnatal Wards.

Women birthing at home or in a primary birthing facility who develop a complication are transferred to Queen Mary or Southland Hospital after discussion with the woman, Lead Maternity Caregiver, on-call Obstetrician and the Coordinating Midwife for the maternity facility. Transfers may occur by car, ambulance, or rarely helicopter.

The Obstetric Teams are comprised of an on-call Registrar and a specialist Consultant. Trainee Interns (TI) or House Surgeons may also be involved with women’s care.

Babies may be identified as needing specialist input from the Paediatric Team prior to birth, during labour, at the time of birth, or some time following birth. Referral Guidelines provide guidance about identifying babies at risk who require referral to the Paediatric Team. The Paediatric Team may provide advice for the care of the baby, or may recommend that the baby be admitted to the Neonatal Unit. The Neonatal Units are staffed by Neonatal Intensive Care Nurses, Paediatric Registrars, and specialist Consultants. Rarely, a baby will require transfer to a Neonatal Unit outside the District for specialised care.
Queen Mary Maternity Centre

Queen Mary Maternity Centre at Dunedin Hospital is the only birthing unit in Dunedin and provides the full range of primary, secondary and tertiary maternity services for the Otago area. Tertiary (highly specialised) services cover the entire Southern District. The unit offers antenatal, delivery and postnatal services, specialist Obstetric care, and a Lactation Consultancy Service. Birthing suite offers seven private rooms with en-suites, with a tub available for labour and birth and a large bath for comfort in labour.

This kawe (wahakura), woven by talented local Ngai Tahu weavers, greets everyone at the entrance of Queen Mary as a symbol of protectiveness for keeping families/whānau safe. Baby Jacob is pictured happily asleep in the kawe, at the blessing ceremony led by Reverend Wiremu Quigley. The “Weaving a Southern Perspective” project has been led by the Violence Intervention Programme team and symbolizes how protecting families from family violence is woven into all healthcare services.

This year, korowai and waka mate have been woven and gifted to Queen Mary to offer to grieving whānau/families. A midwife and NICU nurse work together to care for, monitor and pay respect to the gifting of these taonga. This is an example of Kotahitanga: the ability to promote unity and establish collective relationships to improve the health and wellbeing outcomes of Māori and all women and whānau/families.

The “Mother’s Nest” opened in 2015. It is a family lounge on the postnatal ward, with toys and comfortable seating for the use of whānau/families during their stay or while visiting Queen Mary. Morning tea is served in the Mother’s Nest to women wishing to socialize and make connections to each other.

New “lazyboy” chairs are now available in the antenatal and postnatal wards, for resting partners or support people.

“All the staff were amazing”
“Midwives were awesome”
“Everyone was very friendly and positive”
“Staff were amazing; their dedication to this important work shows”
“Everyone was very friendly and positive”
“Queen Mary exceeded my expectations”
“Care from and service from the hospital staff was fantastic. Very happy”

97% of respondents were Satisfied or Very Satisfied with their care.

Client Satisfaction Survey Comments, December 2015
Southland Hospital Maternity Centre

Southland Hospital Maternity Service in Invercargill provides primary and secondary maternity services for Southland region, including antenatal, delivery and postnatal services, specialist Obstetric clinics and urgent care, and a Lactation Consultancy Service. The Centre has four birthing rooms and 14 single rooms to support the needs of both antenatal and postnatal women. Specialist antenatal clinics are held Monday to Friday and women will typically be cared for by their Lead Maternity Carer (LMC) during labour with hospital midwives supporting their LMC in the delivery unit.

The maternity unit has several certified lactation consultants on staff to help women establish breastfeeding and should complications arise, staff can arrange for women to see a specialist or obstetrician. After giving birth women can choose to stay at Southland Hospital or transfer a primary maternity unit for post-partum recovery.

Rural Primary Maternity Facilities

Southern DHB funds eight rural primary maternity facilities in the region. Primary birthing facilities provide one on one care to new parents within their local community in a home-like environment staffed by qualified midwives and nurses who specialize in birth and postnatal care. These maternity facilities are not only used for births; they also provide postpartum care for women who have birthed in one of the urban facilities, as well as a range of services including midwifery clinics, urgent care, antenatal education, breastfeeding support, neonatal screening services, and links to community providers.

Women who are experiencing a healthy pregnancy and have no medical complications are good candidates for birthing at a primary birthing unit. Women can choose to birth at any primary maternity facility that has a contract with Southern DHB and where her chosen LMC holds an access agreement. The LMC selected by the woman retains primary responsibility for that woman’s care, unless there is a clinical indication for her care to be transferred to a specialist obstetrician. Some women who have complicated pregnancies or births, birth at the secondary/tertiary hospital but return to the primary birthing facility for a postnatal stay closer to home.

All primary maternity facilities provide support for breastfeeding (all are BFHI accredited), smoke cessation, safe sleep, and family violence prevention and intervention.

Primary maternity facilities are owned and operated under a variety of models:
- DHB owned and operated facilities that provide primary services within the hospital,
- Community owned rural hospitals that operate a primary maternity facility within the hospital,
- Community owned rural trusts that own and operate a primary maternity facility,
- Privately owned and operated primary maternity facility.

The DHB is required under the service coverage schedule (SCS) to provide or fund primary maternity facilities for women living in rural areas where:

- Catchment of 200 pregnancies where the community is 30 minutes from a secondary/tertiary service, or
- Catchment of 100 pregnancies where the community is 60 minutes from a secondary/tertiary service.

The Ministry of Health (2007) defines rural and rural remote maternity facilities as:

**Rural remote maternity facility (RR)** is located more than 60 minutes from a base maternity facility. It does not have caesarean section facilities or on site obstetric services. They are generally located within a local community/general hospital. Most have no on site medical practitioners.

**Rural primary maternity facility (R)** is located at least 30 minutes from a base maternity facility. It does not have caesarean section facilities or on site obstetric services. They are generally located at a community hospital, most have no on site medical practitioners.

**Classification** for each primary maternity facility/unit in the Southern DHB:

<table>
<thead>
<tr>
<th>DHB Primary Maternity Units</th>
<th>Classification</th>
<th>Births in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlotte Jean (Alexandra)</td>
<td>Remote Rural</td>
<td>56</td>
</tr>
<tr>
<td>Clutha Health (Balclutha)</td>
<td>Remote Rural</td>
<td>38</td>
</tr>
<tr>
<td>Gore</td>
<td>Remote Rural</td>
<td>76</td>
</tr>
<tr>
<td>Lakes District</td>
<td>Remote Rural</td>
<td>74</td>
</tr>
<tr>
<td>Lumsden</td>
<td>Remote Rural</td>
<td>17</td>
</tr>
<tr>
<td>Oamaru Hospital</td>
<td>Remote Rural</td>
<td>75</td>
</tr>
<tr>
<td>Tuatapere</td>
<td>Rural</td>
<td>14</td>
</tr>
<tr>
<td>Winton</td>
<td>Rural</td>
<td>30</td>
</tr>
</tbody>
</table>

**Note**: The primary facilities provide postnatal stay services to community women who have birthed at the secondary/tertiary units, which is not reflected in the above numbers.
Oamaru Maternity

Built into Oamaru Hospital, Oamaru Maternity Centre is a rural primary birthing unit, and is the sole provider of maternity care in the Waitaki District. The unit has 2 birthing rooms, three postnatal rooms and 2 antenatal clinic rooms. Three teams of midwives provide maternity care to women within the primary unit and in the community, and nurses care for women and babies who are inpatients. An obstetrician from Dunedin Hospital holds an obstetric clinic once a month in the hospital’s outpatient department.

Oamaru Maternity offers lactation support services and breastfeeding classes. The exclusive breastfeeding rate on discharge is over 90%. Antenatal education is provided off-site.

Charlotte Jean Maternity Hospital

Charlotte Jean Maternity Hospital in Alexandra offers a homely and friendly environment for women in the Wanaka and Central Otago area to birth and stay postnatally. Four independent LMC midwifery teams access the maternity hospital. The birthing room is private and contains a birth pool. There are 3 private postnatal rooms, with queen sized beds so that partners may stay and enjoy those special early days. The lounge and kitchen is spacious for families to enjoy as if they were at home. The hospital is staffed by a team of experienced registered midwives and nurses who ensure families receive a high standard of care and support. In 2015 Charlotte Jean provided care to 53 families who birthed at our facility, and 118 families who transferred in for postnatal care after having their babies at Queen Mary or Southland Hospitals or at home. Charlotte Jean maintains a high exclusive breastfeeding rate. Two staff are also Lactation Consultants and provide a free Community Lactation Service funded by WellSouth.

“The staff were just so friendly and approachable. Made us feel very comfortable as we were getting to know our daughter. Food choices were amazing. Environment felt very homely, easy place to focus on birth in comfortable surroundings. Loved being able to walk around outside as long as I could.” Client Satisfaction Survey, February 2015.

“I was absolutely blown away by Charlotte Jean. The care, respect and personal attention was outstanding. My husband felt he had been included and nurtured. Thanks for this. You guys are truly special.” Client Satisfaction Survey, October 2015.
Winton Maternity

Winton Maternity Centre is run by the Central Southland Hospital Charitable Trust, a Community Trust supported by the people of Central and Western Southland. Winton Maternity provides a home-like environment for labour and birth, and for women who birth in Invercargill and transfer back to Winton Maternity for postnatal care. There are 4 queen-sized bedrooms and partners/support people are encouraged to stay overnight. Nursing staff provide postnatal care, and a team of three midwives are employed to provide 24/7 cover. Twenty-five LMC midwives have access privileges at Winton, and provide full midwifery care to women and babies. Women who birth here tell us, "We are extremely lucky to have such a wonderful facility available to us", and "I don't know how I would have coped without the superb support of the WMC team".

Lakes Maternity

Lakes District Hospital (LDH) Maternity Unit is small rural primary birthing facility in the heart of Queenstown, attached to Lakes District Hospital. In 2015, LDH cared for 64 families who birthed locally, and 154 families stayed for postnatal care. The facilities include one birthing room, three postnatal rooms and two antenatal clinic rooms. Six permanent midwives provide 24/7 cover for the unit, and two local teams of community based midwives provide full LMC midwifery care within the Queenstown area. An obstetric clinic is held monthly and hip clinics and hearing clinics are also held regularly by visiting specialists for baby. 94% of babies born at LDH were discharged home exclusively breastfeeding in 2015. Antenatal and breastfeeding classes are held off site by various providers.
Lumsden Maternity

Lumsden Maternity Centre is owned by the Northern Southland Medical Trust. Recently renovated, it adjoins the local GP practice and provides a calm, comfortable birthing and postnatal environment for the women and families in the Lumsden/Te Anau area. The Centre has a midwife Practice Manager, and a midwife is on-call to provide 24/7 cover for emergencies and to support the LMC midwives for births. Nurses provide 24 hour postnatal care. A spacious birthing room has a deep tub for use during labour, and three postnatal rooms have double beds so partners can be comfortable too. Meals are prepared daily by nurses or a local chef. Newborn hearing screening services are held at Lumsden and in Te Anau, and accredited Antenatal Classes are run three to four times a year.

Clutha Health

The Clutha Health First Maternity Centre is a primary birthing facility operated within the community-owned Clutha Health First integrated Hospital and Health Centre. Clutha Health First offers women and their families a peaceful and friendly atmosphere in which to begin the parenting journey. A team of four LMC midwives is employed to provide full midwifery care, as well as a small team of nurses and midwives to provide inpatient care.

The centre provides a low staff/women ratio to ensure that women can have quality time spent with them when needed. We also cater for fathers/support persons who wish to stay with the mother and baby. The facilities include a birthing room with pool and en-suite, two private bedrooms with a shared en-suite, one private bedroom with its own en-suite, and a family lounge.
Gore Maternity

Within Gore Hospital, Gore Health Ltd has a modern, comfortable primary maternity unit comprising of birthing room, lounge and two twin bedrooms both with en-suite. A Family Room is also utilised. Six self-employed LMC midwives provide full midwifery care and are supported by a team of Gore Health Registered and Enrolled Nurses. Gore Maternity actively promotes and supports exclusive breastfeeding from birth.

“Gore Maternity provides a fantastic service to the local community. Highly skilled, professional staff well supported by midwives. We had great continuity between staff members.” (Consumer feedback May 2016)

“We were so grateful we could come back to Gore and finish our care here. It is such a relaxing place and families get so well looked after and supported that we were confident to care for our baby at home.” (Consumer Feedback March 2016)

Tuatapere Maternity

Tuatapere Maternity Unit is a small primary birthing unit located in Western Southland, nestled in the Waiau Valley. It is run by the Waiau Health Trust.

Tuatapere Maternity provides a homelike environment for labour and birth, and for women who birth at Southland Hospital and transfer back home. The birthing suite has a beautiful pool for use in labour and birth, plus three double bedrooms for postnatal care. Nursing staff provide 24hr care for inpatients, and the LMC midwife provides full midwifery care and oversight for inpatient care.
Maternity Workforce

Whilst the numbers of LMC midwives in Southern are more than adequate, there is a maldistribution. It can be difficult for LMCs to maintain a sustainable workload, due to rurality, oversupply of LMCs in some places, and the funding model. Enhanced engagement and communication with LMC midwives through the MQSP will enable Southern DHB to work with LMC midwives to find pragmatic solutions to this challenge. There are no current vacancies in the core midwifery staffing, and all clinical leadership positions are filled. Obstetric team staffing has remained relatively stable with some pockets of vacancies at both senior and junior levels.

Tikaŋa Best Practice

Tikaŋa Best Practice policies and guidelines have been developed in partnership with the Southern DHB Iwi Governance Committee to support staff to provide culturally responsive services to our Māori population. The Tikaŋa Best Practice guideline flipchart should be available in all main hospital ward reception areas including hospital base specialist services. This resource provides a summary of practical guidelines to deliver health and disability services aligned to Māori cultural practices, protocols and needs.

Ipu Whenua Project

The Ipu Whenua Project was undertaken to allow Māori wahine (women) and their whānau to practice a significant ritual of burial of the whenua (placenta) and pito (umbilical cord). All wahine giving birth will be given the option to take their placenta and/or umbilical cord home in a bio-degradable Ipu whenua (container); previously this was via a paper bag or plastic container. Within traditional Māori culture the whenua (placenta) and pito (umbilical cord) of new-born babies are buried in a special place often with ancestral connection, and is considered a physical and spiritual link to the place of birth. The significance of returning the pito and whenua to the whenua (land) reinforces the relationship between the new-born child and the land of their birth, underpinning the notion of mana whenua – mana held by local people and spiritual authority in a given area.

This tradition comes forth from the idea that tangata whenua (people of the land) were first made from earth, from the body of Papatauānuku (Earth Mother), who birthed all creatures and living beings. Whenua were traditionally placed in hollowed out hue (gourds), earthen pots or woven baskets and then buried to return them to Papatauānuku. These containers are called Ipu Whenua. The whenua and pito of the first human created from earth were buried in the earth.
The Ipu Whenua is currently available at Southland Hospital and work is underway to have the Ipu Whenua also available at Lakes and Dunedin Hospitals. Southern District Health Board has gifted the bio-degradable (able to break down safely) Ipu Whenua for birthing wahine and their whānau to be able to carry out the ritual of burial at a place and location that has significant importance to them.

“He taonga no te whenua, me hoki ano ki te whenua”
*What is given by the land should return to the land*

**Maternity Quality and Safety Programme Overview**

The Maternity Quality and Safety Programme (MQSP) emerged out of the national Maternity Quality Initiative, which was launched in 2009. Every DHB has established a MQSP to bring professional and consumer maternity stakeholders together to monitor and improve maternity care at the local and DHB level. The Maternity Quality and Safety Programme (MQSP) aims to enhance maternity outcomes for women, babies, family and whānau and service providers living and working in the Southern District.

**MQSP Progress**

In 2015, there was limited capacity to carry out new quality initiatives, as the MQSP suffered from no Coordinator and no Governance Group. An Interim Steering Group was established with the support of the Provider Arm Executive, consisting of Marion Poore, Medical Director, Jenny Humphries, Midwifery Director, Jenny Hanson, Nurse Director (all part of the Women’s, Children’s and Public Health Directorate), and Tina Gilbertson, Executive Director of Quality and Executive Sponsor (member of Southern’s Executive Team). The Steering Group successfully recruited a 1.0 FTE Coordinator for the MQSP in March 2016, and she started work in April 2016.

A MQSP structure in now in place that will ensure that Southern is able to meet the expectations of its contract as an Emerging DHB. The Coordinator reports to the Midwifery Director and is supported by the Steering Group. A Governance Group has been re-established with responsibility for setting priorities and reviewing activities of the MQSP, and reports to the Steering Group *(Terms of Reference attached)*.

**Governance Group**

The MQSP Governance Group is responsible for ensuring the MQSP is implemented in Southern DHB. The Governance Group reports to a Steering Committee of senior leadership who will ensure that the Programme meets the contract requirements with the Ministry of Health, and that the Programme is integrated into overall service planning at Southern.

The Governance Group was re-established May 2016 with broad membership to ensure wide consultation with maternity stakeholders. Southern recognizes that optimal care will result from optimal relationships between consumers, community providers, DHB clinicians and facilities.
Membership on the Governance Group includes:

- Clinical Leaders (Midwifery, Obstetrics, Neonatal)
- Facility Leaders (Tertiary and Primary)
- Midwifery Representatives (3, including 2 LMC midwives)
- Southern PHO Representative
- GP Representative (*still being recruited*)
- Māori Health Representative
- Well Child Provider Representative
- Consumer Representatives (three, providing geographic variance)
- Māori Community Representative (*still being recruited*)
- Pasifika Community Representative (*still being recruited*)

The Governance Group provides a forum for communication of all aspects of Maternity Quality and Safety, with particular emphasis on care provided across the pregnancy continuum. The group:

- Coordinates all aspects of communication about MSQP
- Ensures that maternity services meet the needs of the community and the expectations of the purchaser and the Ministry of Health
- Fosters a culture of continuous improvement in service delivery that is consumer focused, based on evidence and best practice and adopts a multidisciplinary approach
- Reviews Clinical indicator data, audits and recommends quality improvement activities to address areas of practice variance.
- Reviews incidents pertaining to maternity services, identifying trends and advising of any system or practice changes that should be implemented
- Reviews/oversees and supports the implementation of recommendations from national bodies such as Perinatal and Maternal Mortality Review Committee (PMMRC), National Maternity Monitoring Group (NMMG), Health and Disability Commission and Ministry of Health

The first Governance Group meeting was held 19 May, 2016. Funding is in place to support consumers and self-employed members to participate. Meetings will be held monthly for the first six months, and face-to-face supported as much as possible in this initial period.

Priorities for the MQSP are re-establishing the Governance Group, strengthening capacity and processes for data review, identifying quality improvement activities as a result of data review, and engagement with consumers and community-based clinicians. In addition, a fully functioning MQSP will increase Southern’s ability to respond to Maternity Clinical Indicators, PMMRC recommendations and National Maternity Monitoring Group (NMMG) priorities.
Quality at Southern DHB Maternity

An initial stocktake of current quality activities at the two urban maternity facilities shows there is a strong structure of clinical leadership, facility leadership, education, clinical pathway review and development, and formal clinical case review in place. The MQSP Coordinator has visited Dunedin, Southland, Lakes Maternity, Clutha Maternity, and Charlotte Jean in May, and will be visiting Gore, Lumsden, Winton and Oamaru in June. Common themes emerged around communication, data collection and review, engagement of LMCs, and engagement of consumers, and this will contribute to prioritizing the Programme Plan for the MQSP.

Many clinical leaders and groups are doing quality work to ensure that maternity outcomes are the best they can be. The MQSP will be able to expand on this groundwork to create a framework for consistent excellence.

Queen Mary (Dunedin) has established a collaborative, team approach to quality. This Quality Team meets with Clinical Leaders and the Midwifery Director monthly, to review issues identified through audits, consumer feedback, incident notifications, etc., and implement change. Recent examples of issues identified and resolved through this collaborative approach, include:

- Detection of an increase in post-surgical wounds led to investigation of each case by a midwife leader and Infection Prevention and Control, factors identified, and changes in equipment cleaning, pre-caesarean patient washing, and clinician hand hygiene reminders.
- Fire drill process identified as less than optimal, Associate Charge Midwives reviewed the Fire Training protocol and implemented a better process.
- Incident notification of improperly labelled blood tubes led to education of core staff about 5 rights regarding medication administration.

Also on Quality Day is the meeting of the Policy & Guidelines Group, chaired by a Midwife Educator, and open to all clinicians, with VC available. It is responsible for the review and development of policies and guidelines for the District. The Clinical Governance meeting is comprised of Clinical and Facility Leaders. The Perinatal Morbidity and Mortality Review meeting is held the day before, along with the Access Holders meeting for LMCs to interface with Facility Leaders.

Similar processes occur in Southland Hospital.
**Case Review**

There are avenues for both formal and informal case review. It has been challenging to establish a forum and process for informal case review with LMC midwifery participation, and this will be an area of focus for the Governance Group.

**Perinatal Morbidity and Mortality Review.** Formal review of cases identified by PMMRC criteria occurs alongside review of less serious cases, in a multidisciplinary forum (obstetrics, paediatrics, midwifery). Otago Region Co-ordinators are Dr Jana Morgan and midwives Sheridan Massey and Tracey Morris; Southland is co-ordinated by a Senior Registrar. Key learning points are identified and circulated to all maternity clinicians. Significant clinical concerns are followed up by appropriate Clinical Leaders. Significant themes are brought to educators for incorporation into next year’s education.

**Obstetric Case Discussion:** Daily handovers are identified as a priority for ensuring appropriate communication and planning of care. In Dunedin, daily morning medical handover includes the Obstetric team, Charge midwife and the Anaesthetist allocated to maternity for the day. Potential problems are identified and priorities for the day set. A similar process exists in Southland. There is a weekly meeting of Obstetrics and Paediatrics to review cases of concern (Dunedin), and a combined Radiology/Obstetric meeting every two weeks (Dunedin). A monthly Obstetric discussion includes presentation of complicated or interesting cases from past month.

**Data Review**

The strategic and comprehensive review of maternity data is an area of improvement for the MQSP. There is some review by Clinical Leaders and Facility of key clinical indicators, such as normal vaginal birth rate, elective and emergency section rate, post-partum haemorrhage, term admissions to NICU, and 3rd and 4th degree lacerations. At Queen Mary and Southland, key clinical indicators are reported monthly and displayed in the lobby of the maternity unit. The MQSP Governance Group will prioritise data review and direct quality activities as a result of review.

**Change in Clinical Practice**

Current avenues for supporting change in clinical practice include education programmes held at the DHB, policies and guidelines, and Access Holders meetings. These pathways can be strengthened through the MQSP.

All clinicians have access to the up-to-date Policies and Guidelines through the on-line portal MIDAS. All clinicians are notified when a policy or guidelines is being reviewed, so that they can provide input if appropriate, and are notified when a new policy or guideline is issued. Currently notification happens via e-mail; an improved communication strategy will be considered by the Governance Group.
Change in Practice to Improve Care for Babies: The Bilicheck Project

An audit of the use of Serum Bilirubin (SBR) testing, which involves an invasive blood test from babies’ heels to detect jaundice, showed that Queen Mary had a high rate of testing. A literature review identified a non-invasive and reliable testing alternative, called the Bilicheck Transcutaneous Bilirubinometer (TcB meter). Funding was obtained to purchase TcB meters, a new policy was developed for management of jaundice on the postnatal ward, and a peer-to-peer education programme was implemented. After a few months, a review of the implementation showed a need to reiterate “the rules” – that the TcB meter was to be used on only well babies over 37 weeks and >2500gms.

An audit of the practice change process in 2015 has been carried out, and showed good uptake of the change in clinical practice with a significant reduction in the need for an invasive SBR and no increase in need for phototherapy.

Key Quality Initiatives

Maternity Clinical Indicators

Four areas were identified from the 2013 Maternity Clinical Indicators where Southern was at significant variance with other DHBs: Perineal trauma (3rd/4th degree tears), Induction of labour, Caesarean section, and Spontaneous vaginal birth. 2014 NZ Clinical Indicators data indicate that caesarean section rates have improved to being in line with national averages, and induction of labour rates in Southland have dropped. Perineal trauma remains a significant issue across the District, and low spontaneous vaginal birth rate, high ventouse and forceps birth rate, and high rate of induction of labour remain a significant issue for Dunedin. This will inform the Governance Group’s setting of priorities for further data review and quality improvement activities.

Perineal Trauma Audit 2015, Otago

As the 2013 NZ Maternity Clinical Indicators showed that Southern had the highest rate of any DHB in New Zealand for Indicator 8 (Third or fourth degree tear and no episiotomy) and the second highest rate for Indicator 9 (Episiotomy and third or fourth degree tear), a formal audit was commenced in both Dunedin and Southland Hospitals. The results of the audit at the Dunedin site are now available, and will inform the MQSP’s development of a Quality Improvement Project for 2016-2017.

The Queen Mary audit looked at the occurrence and management of severe (3rd/4th degree) perineal trauma in the facility in 2015, comparing results against a previous audit done in 2012. Clinical management was also evaluated against national (RANZCOG/RCOG) and local guidelines.

The local Maternity Plus database was used to identify women sustaining third and fourth degree tears, and their clinical notes were reviewed. Sixty women sustained third or fourth degree perineal trauma in 2015.
Results of the audit showed:

- Severe perineal harm increased from 2012 to 2015, with a doubling of the numbers of fourth degree tears.
- 70% of severe perineal harm occurred in normal vaginal birth, and 30% with assisted birth.
- The majority (78%) of severe tears occurred with babies weighing less than 4000 gm.
- Variable documentation leading to misidentification of degree of harm and poor documentation of practices to protect the perineum at birth.
- Despite perineal warm compresses being identified as an evidence-based method for reducing perineal harm, 78% of birth notes did not document whether compresses were used, and 50% of birth notes did not document whether there was perineal protection at the time of the baby’s head crowning.
- There was a large variation in use of antibiotic prophylaxis.
- There was inconsistent follow-up in outpatient clinic.

This report provides valuable direction for the MQSP to develop a relevant Practice Change Implementation Project to improve documentation, improve uptake of evidence-based practices to reduce perineal harm, and improve the evidence-based use of prophylactic antibiotics and outpatient follow-up for women sustaining severe perineal trauma.

**Induction of Labour**
Previously we have reported on audits of Induction of Labour in Southland, with errors in documentation and coding identified. Clinicians have been supported to more clearly identify an induction of labour vs. augmentation of labour, and what the clinical indication is for that intervention. 2014 Maternity Clinical Indicator data shows that Southland’s induction of labour rates are now in line with national averages.

**Vaginal Birth After Caesarean**
Supporting women to choose Vaginal Birth After Caesarean (VBAC) was an initiative in 2015, including reviewing the Obstetric antenatal consultation process, reviewing the VBAC protocol, the development of a new brochure about VBAC with consumer-friendly language, and a trial of an evening sessions for women and partners about VBAC (Otago). The Obstetric Team recognised that there were inconsistencies in the timing of antenatal consultation, the advice given during consultation, and in the timing of planned caesarean section should the woman choose this or not go into labour. The Obstetric Team agreed on consistent consultation plan, and the Policy & Guidelines Group revised the VBAC protocol for the District.
The “Birthing after Caesarean” leaflet (attached) was developed by midwives and obstetricians, with the goal of consumer-friendly language describing the consultation process, positive language around VBAC, and including the protocols for VBAC in the maternity units. The evening sessions were developed when clinicians noted that often partners were hesitant about VBAC but were sometimes not able to attend daytime obstetric appointments. The sessions were well-received by the attendees but attendance numbers were inconsistent, so the emphasis has shifted to positive communication with families at the time of antenatal consultation.

**PMMRC Recommendations**

The Perinatal and Maternal Mortality Review Committee (PMMRC) reviews all perinatal, maternal and neonatal deaths and issues an annual report with recommendations. PMMRC has just issued its analysis of perinatal related deaths and neonatal encephalopathy for Southern DHB for the period 2007-2014 (PMMRC 10th Report, June 2016). Southern’s achievements include:

- perinatal and neonatal death rate is significantly lower than the national rate
- significant reduction in the rate of smokers among mothers of perinatal-related deaths
- improvement in data collection regarding diabetes screening status
- Highly significant increase in screening for family violence among mothers of perinatal deaths
- The neonatal encephalopathy rate at term is consistent with the national rate, and the Southern rate of cooling babies with NE is slightly higher than the national rate

While Southern’s overall perinatal death rate is lower than average, there is a higher rate of unexplained antepartum death. This will be an area of investigation for the MQSP.

The 2015 PMMRC report made recommendations in the areas of perinatal mortality, maternal mortality, and neonatal encephalopathy. Southern is particularly proud of its excellence in:

- Diabetes management. Multi-disciplinary antenatal clinics are well-established in Otago and Southland for pregnant women with diabetes, including an endocrinologist, Diabetes Nurse Specialist, Obstetrician specialising in care of women with diabetes, and Dietician. The national guideline on the Screening, Diagnosis and Management of Gestational Diabetes in New Zealand has been fully implemented across the District and is now a part of normal practice. There has been special clinical education and support for LMCs to implement the guidelines, and Otago developed a flowchart to help LMCs implement the guidance and access the specialist clinics as appropriate. The Diabetes Nurse Specialist is now seeing that most women referred to the Diabetes in Pregnancy (DiP) antenatal clinic for gestational diabetes have had appropriate HbA1c screening in early pregnancy and timely glucose tolerance testing and referral to DiP. Total number of referrals to DiP clinic referrals continue to increase (an increase of 69% over the last 10 years), as do the co-morbidities experienced by this population. Increased and earlier identification of GDM increases the pressures on the DiP clinics, and the resources available need to be reviewed.
• Healthy weight gain in pregnancy education for clinicians and support for women. In 2014, 23.3% of birthing women in Otago were classified as obese (BMI of >30). This is a recognised risk factor for women requiring LMCs to recommend an obstetric consultation. Additional education was provided to LMC midwives to support women to maintain healthy weight gains in pregnancy, an effort led by obesity researcher Dr. Helen Paterson. The antenatal clinic has information promoting the NZ MOH healthy weight gain in pregnancy guidance in the form of posters and patient information. Dr Paterson is offering ongoing clinician education as needed.

• Integrated child protection and family violence services. The Intimate Partner Violence Intervention and Child Protection Coordinators, Child Protection Nurse, and a Child Youth and Family DHB Liaison Social Worker share offices, provide training and lead collaborative practice.

• Queen Mary (Dunedin) commenced in-patient Partner Abuse Screening in November 2014 and there is now an identified Violence Intervention Programme Champion in Queen Mary.

• Maternal Care Wellbeing and Child Protection Multi-Agency Group (MCWCP) to ensure coordinated care for women with special needs for mental health, family violence and/or child protection services. Around 60% of the referrals to the MCWCP are initiated by the Police Family Violence Interagency Response System team. Police practice of inquiring about pregnancy when they attend domestic incidents is providing an opportunity for early identification of need, risk, and intervention.

• Smoking cessation education for clinicians and resources for women. In 2014, 17.5% of women were smoking at the time of registration with their LMC, and 78.7% of these women were still smoking 2 weeks after giving birth. Southern has recognised the need for better support for women to quit, and has several initiatives in place to support women and clinicians. Smokefree Babies is a targeted incentive programme for smokers less than 28 weeks pregnant living in three geographic areas identified as having high numbers of smokers. Southern is monitoring the rates of LMCs offering brief advice to quit and referrals to smoking cessation providers at booking. The Hapu Ora programme provided education for LMCs around supporting women to quit smoking. Southern maternity facilities have an “Inpatient ABC” programme to screen every woman admitted to a maternity ward for their smoking status, and offer every smoker brief advice to quit and a referral to smoke cessation providers, with a target of 95% of smokers offered brief advice and referral to smoke cessation providers. In 2015, only one maternity facility (Oamaru) met this target, with 96% of smokers offered brief advice to quit and a referral to smoke cessation providers. This is an area for improvement for Southern DHB.
• Foetal surveillance clinical education available to all clinicians involved in maternity care, including the FSEP and PROMPT courses. PROMPT multidisciplinary education is going to be offered in a rural maternity setting for the first time in 2016.

• Every LMC received influenza vaccination in pregnancy materials and education offered to support LMCs to recommend influenza vaccination in pregnancy. Influenza vaccination in pregnancy availability advertised in antenatal clinic space. Free influenza vaccination available and promoted for the maternity workforce. Pertussis vaccination information was also sent to LMCs to support LMCs to recommend pertussis vaccination in pregnancy. Free pertussis and influenza vaccinations were offered to maternity clinicians on International Day of the Midwife (5/5/16).

**NMMG Recommendations**

The National Maternity Monitoring Group (NMMG) Annual Report 2015 recommendations will be considered by the MQSP Governance Group, including consistency in the quality of first trimester care and variation in gestation at birth; however, many of the recommendations are already either areas of excellence or are being addressed at Southern, including:

• **Registration with an LMC.** The majority (99.5% in 2014) of birthing women in Southern book with Lead Maternity Care midwives, and 75.4% of women register with their LMC by the end of the first trimester, one of the highest levels in the country (*Report on Maternity 2014 Data Tables, MOH*). The Find Your Midwife website has been well-publicised across the District and is well-utilised by women and referrers such as GPs. Almost all LMC midwives are listed on the site. The Governance Group will consider how to best reach the 25% of women who are not registering with their LMC by week 12.

• **Maternal mental health.** Southern has two different pathways for perinatal and infant mental health, depending on region (Otago and Southland). There is a working group to establish District-wide consistent service delivery pathways. Southland has a single-point-of-entry system for maternal and infant mental health, with two 2 FTE working with mothers and babies providing strong linkages with Maternity Services, Lead Maternity Carers and Plunket. Otago has a number of resources in place to enhance communication between providers when pregnant/birthing women have additional mental health needs, including the Maternal Care Wellbeing and Child Protection Multi-Agency Group, the psychiatric liaison nurse at Dunedin, and the Southland maternal mental health team. The Southern DHB integrated pathway for maternal mental health is attached. The Christchurch Mother and Baby Unit in-patient unit is provided for women who require this level of support, and they also provide education to the sector with four days for the Southern Region.
**Consumer Engagement**

Every maternity facility has a process to gather feedback from birthing women. Response rates vary among facilities, from around 20% to around 50%. The MQSP Governance Group will be reviewing these processes to identify what is working well and what can be improved.

Every birthing woman is given a facility feedback form with results of the forms reviewed by a manager and any issues arising, addressed. We will be exploring using utilizing new formats to improve our response rates.

Consumer feedback is, on the whole, very positive about maternity experiences. Quotes from families have been included in this Report with information on the maternity facilities.

Consumer engagement is an area for significant future work. Three Consumer Representative have been appointed to the Governance Group, and we are seeking a Māori community representative and a Pasifika community representative to improve our engagement with these communities. We envision holding maternity Consumer Forums as part of our Consumer Engagement strategy. We also envision creating an online forum for communicating with consumers about Maternity Quality outcomes and activities, with the opportunity for Consumers to provide feedback.

**Breast Feeding**

All maternity facilities in Southern DHB are Baby Friendly Hospitals, most having been accredited three times, with Queen Mary Maternity Centre in Dunedin Hospital achieving their fourth accreditation. Queen Mary has a long history of high exclusive breastfeeding rates, and the rate is increasing with 2015 at 85.5%. Breastfeeding education for staff is comprehensive and in 2015 included information about hypoglycaemia and formula consent processes.

Primary maternity facilities pride themselves on excellence in postnatal care in a homelike environment. For example, at Charlotte Jean Maternity Hospital, the average exclusive breastfeeding rate on discharge for babies born in the facility was 93 %, and the average exclusive breastfeeding rate on discharge for all babies (including the transfers-in) was 90 %.

**BURP app**

Public Health South and partner WellSouth PHO developed an innovative app for android and iPhones assists parents in identifying places in the community where they can go to breastfeed their baby. Use of the app has really grown this year, with 586 total users currently. There has been a focus to increase the number of venues listed in high deprivation areas.
World Breastfeeding Week and The Big Latch On

World Breastfeeding Week (WBFW) 2015 was celebrated throughout Otago and Southland in 2015. Activities were organised by Breastfeeding Networks in the region. Southern worked collaboratively with WellSouth, La Leche League, The Breast Room Dunedin and The Heart Foundation to implement the celebration. Activities to celebrate WBFW included nine Big Latch On events throughout the region. In Dunedin 44 women latched on in the Meridian Mall – the biggest number yet and 94% said they would attend again showing a high level of satisfaction with the event. A children’s colouring competition in Dunedin attracted 88 entries and the artwork was displayed in the Dunedin Library afterwards. In addition mothers giving birth in maternity hospitals received gifts and information about breastfeeding. Promotional and information materials were widely distributed, notice board displays were put up in maternity units and GPs surgeries, 80 breastfeeding resource folders were distributed to Early Childhood Education Centres and 8 community support agencies. Media releases were created and resulted in publicity in newsletters, newspapers, on TV and radio and on websites.

In keeping with the WBW 2015 theme 'Breastfeeding and Work - Let's Make it Work!' efforts were made to engage and partner with organisations such as trade unions, employers groups and women’s groups to raise awareness about breastfeeding in the workplace. Two unions, 2 employer organisations and 3 women’s groups were provided with information which was used to email to members, post on websites and Facebook, and place in newsletters. One union created a special publication for its members called “Know Your Rights”. Eighteen workplaces were also approached and 8 agreed to meet or have information provided on how to support breastfeeding in the workplace. At least 4 employers made changes to improve breastfeeding support in the workplace.

Safe Sleep

The Pépi-Pod sleep space programme is a coordinated approach to delivering infant health and safety education to families of more vulnerable infants, and at the same time enabling action on safe infant sleep recommendations. The programme was developed and coordinated by Public Health South staff. Pod distribution by key services including Well Child providers and maternity facilities is a joint project between Public Health South (PHS) and Well Child Tamariki Ora providers.

Priority is given to reaching the more than 1,000 newborns (<2 weeks) in Southern who are vulnerable to SUDI due to one or more of the following: Māori, smoke-exposed, premature (<37 weeks) or low birth weight (<2500 grams). The programme in which the safe sleep is embedded, directs a package of infant health promotion to the most vulnerable families.
Shaken Baby

This programme was rolled out across the District in 2015. The national coordinator undertook education sessions in four geographical areas with a total of 45 participants. A policy and implementation programme was developed and provided in a template for the non-DHB primary units to adapt for their needs. Reporting of staff numbers having undertaken education and monthly audits of participation in the programme by birthing women is an expectation. Waitaki Hospital, in Oamaru, lead the way in this initiative with their monthly reports showing high numbers participating.

Conclusion

Birthing women, babies and whānau in the Southern District receive maternity care from highly skilled maternity providers. This dedicated workforce spans a variety of contexts, from remote rural areas to urban centres, from experts in the normal to specialists in managing medical complications of pregnancy birth and the neonatal period. Almost every woman is able to access a LMC of her choice to provide one-on-one continuity of care within the community. Southern provides a diversity of birthing settings throughout the District, and women have a high level of choice in care provider, birth setting and postnatal care. PMMRC data is encouraging and shows us that our outcomes for babies are above average and generally improving. Maternity Clinical Indicators data show us that we have room for improvement in promoting normal birth. Women and maternity providers are navigating a complex web of facilities, services and expectations, and Southern can improve its coordination, collaboration and transparency to improve the experience of birth for women and for maternity care providers in our District. The Maternity Quality and Safety Programme offers us a framework for improvement, and we look forward to reporting our progress in the 2016 Annual Report.
Whakataukī

Hutia te rito o te harakeke
Kei hea te kōmako e kō
Kīmai ki ahau
He aha te mea nui o tēnei ao
Māku e kī atu
He tangata, He tangata, He tangata

If the centre shoot of the flax is pulled out (and the flax dies)
Where will the bellbird sing?
If you were to ask me
What is the most important thing in the world?
I would reply
It is people, it is people, it is people
Attachment A  MQSP Governance Group Terms of Reference

Southern DHB Maternity Quality & Safety Programme Governance Group Terms of Reference

These terms of reference are to provide guidance to the Governance Group on its objectives, membership, meeting and reporting functions.

Maternity Quality & Safety Programme Governance Group

Purpose

The Maternity Quality and Safety Programme aims to enhance maternity quality and safety outcomes for women, babies, family and whānau and service providers living and working in the Southern District. The programme is based on the NZ Maternity Standards.

The governance group is responsible for ensuring the MQSP is implemented in Southern DHB.

Functions and Responsibilities

Provide a forum for communication of all aspects of maternity quality and safety, with particular emphasis on care provided across the pregnancy continuum.

Ensure maternity services are aligned with the needs of the community and the expectations of the purchaser.

Foster a culture of continuous improvement in service delivery that is consumer focussed, based on evidence and best practice and adopts a multidisciplinary approach.

Review quality improvement activities arising from clinical indicator data and audits with particular regard to areas of practice variance.

To review and understand trends in incident review work and provide advice about any system or practice changes that should be implemented.

To support the programme co-ordinator in the implementation of recommendations from national bodies such as the Perinatal and Maternal Mortality Review Committee (PMMRC), National Maternity Monitoring Group, Health and Disability Commission and Ministry of Health.

To ensure effective linkages with other programmes that focus on improving health outcomes for children and families.

Accountability / Reports To

TBA – MQSP Steering Committee, Clinical Governance body of the DHB

Director of Midwifery

Clinical Leaders Women’s Health – Invercargill and Dunedin or nominee

Midwifery Representatives – two nominated by NZCOM Otago and Southland, to reflect professional and geographical variance; additional LMC rep.

Southern PHO representative

General Practice representative

Maternity Facility Manager – Urban

Maternity Facility Manager – Rural

Māori Health representative

Paediatric / neonatal representative

Three consumer representatives

Māori representative

Pasifika representative

Well child / tamariki ora rep
Secretariat function - Maternity Quality and Safety Programme Coordinator

Additional members may be co-opted for specific needs

Quorum
Fifty percent of confirmed members, plus one

Roles
Representatives to provide their professional expertise and guidance to ensuring the programme achieves the stated outcomes. They will take responsibility for communicating with the group they represent

Chair
Chair to be agreed by the Governance Group

Agenda
To be distributed five days prior to meeting

Minute Taker
Volunteer from the Governance Group

Minutes distribution
To Governance Group members

Meetings
Monthly; either face to face or VC/teleconference; duration to be determined by chair

Associated Documents:
- NZ Maternity Standards
- Southern DHB Maternity Annual Report
- Perinatal and Maternal Morbidity Review Committee Annual Report 2015
- NZ Maternity Clinical Indicators
- Southern DHB MQSP Implementation Plan
Attachment B

Maternal Mental Health Pathway Southern Mental Health Services

**Routine referral source**
- Midwives
- GP’s
- Obstetric Staff
- Plunket Nurses
- Plunket/WCTO Nurses
- Internal Mental Health Clients

**Screen and managed by rural mental health service with support.**

**Southland Mental Health Maternal Service**
(Invercargill, Te Anau, Western Southland, Gore/Balclutha)

Or Dunedin Mental Health Services
Queenstown, Central Otago, Oamaru

**Advice from Maternal Mental Health Liaison clinicians. Dunedin/Invercargill Mental Health Services**

**Accepted to Service. Keyworker/Case Manager**

**Initial Screening Assessment**

**Refer back to Referrer**

**Dunedin referral - Consult Liaison**

**Southland referral – Mental Health Maternal Team**

**Hospital Inpatients Referral Pathway**

**Emergency Referral**

New clients during work.
EPS (Dunedin)
SMHET (Southland)
0800 467846
What are my options?

You are reading this leaflet because you have had a previous caesarean birth and are pregnant again or planning a pregnancy.

For many women who have had a caesarean birth it is safe to decide to try for a vaginal birth in a later pregnancy. In some cases, it is not safe to do so, either because of events during your last birth, or because of something about your current health or pregnancy.

More questions?

Your midwife will be able to answer many of your questions. You will also be offered an appointment with an obstetrician between 28 and 34 weeks in this pregnancy to discuss your birth plan. This will take place in the antenatal clinic.

Birth: after Caesarean (District)

Queen Mary Maternity Centre, Dunedin Public Hospital, 201 Great King St, Dunedin.
Tel: (03) 474 0999

Maternity Unit, Southland Hospital, Kew Road, Invercargill.
Tel: (03) 218 1949

Information for women who have had a previous caesarean birth

Southern DHB 50085 V3
Issued 06/04/2016 Released 06/04/2016
Planning a healthy labour and birth

For most women who have had a previous caesarean birth, it is safe to try for a vaginal birth after caesarean (VBAC – pronounced “Vee back”) in a subsequent pregnancy. At Southern DHB we support VBAC and are keen to help you make decisions around your birth plan. Some women may also wish to consider a repeat caesarean birth.

In some cases, another caesarean will be recommended for medical reasons, such as if your current pregnancy is complicated by a placenta issue or how baby is positioned. Other reasons may be to do with your previous birth(s). You will need to check with your midwife and obstetrician who will help to assess your history and plans.

Elective repeat caesarean section is generally very safe; the main risks have to do with your health, and include damage to internal organs, blood clots, increased pain after birth, and risk of infection. One of the main things to think about with a repeat caesarean is how many more pregnancies you are likely to have. Some issues (such as placental and surgical risks) increase with the number of caesarean births you have had.

For any pregnant woman with a scar on her uterus from previous surgery, there is a risk of weakening or separation of the scar on the uterus during the pregnancy, or during labour and birth.

The risk of a scar separation is around 1 in 100-200. This means that it is relatively uncommon, but when it does happen it is a serious risk to the well-being of both mother and baby. We do not recommend VBAC for women who have had more than one caesarean birth in the past.

Trying for a vaginal birth after a caesarean is successful for 60 to 80% of women. Your chance of success is improved if you have had a previous vaginal birth, are a healthy weight, and have an averaged-sized baby.

Most things are the same for a woman who is birthing vaginally after a caesarean as for other women, but we do make some recommendations for your safety and the baby’s well-being (see right). All methods of pain relief that can be used in normal labour and birth may be considered for women having a birth after caesarean.

If you go past your due date and are planning a VBAC, we will make the same assessment of your health and the baby’s well-being at 41 weeks as we would for any post-date pregnancy. We do not offer an induction using prostaglandins (Prostin gel or Cervidil), as this has been shown to increase the risk of scar rupture. A ‘stretch and sweep’, breaking your waters artificially, or cervical ripening with a Foley’s catheter may be offered. Most doctors are also happy to use synthetic oxytocin to help you get into labour if you are overdue.

Recommendations for safety and well-being during VBAC

Place of labour and birth

We recommend that women planning to have a VBAC do so in a hospital setting. You should come to the birth suite relatively early in labour, your midwife will help you to decide when the time is right.

Bloods and an ‘IV’ line

Your midwife will ask your permission to place a ‘drip’, or intravenous line in your arm in early labour. She will send a sample of your blood to the laboratory, in case of any problems during the labour or birth.

Continuous monitoring of baby’s heartbeat

A change in your baby’s heartbeat or your contractions can be an early sign that something is not right. We recommend that your baby’s heartbeat is monitored continuously throughout your labour and birth.