DISABILITY SUPPORT ADVISORY COMMITTEE

and

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

A G E N D A

Wednesday, 5 June 2013
10.00 am

Board Room, Level 2, West Wing, Main Block
Wakari Hospital Campus
371 Taieri Road, Dunedin

Our Vision:
Better Health, Better Lives, Whānau Ora

Our Mission:
We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring.

DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 5 June, 10.00 am

Board Room, Level 2, Main Building,
Wakari Hospital, Dunedin

A G E N D A

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6.	**Presentation – Diabetes Care Improvement Package** *(Dr Hywel Lloyd)*	
7.	**Presentation – Hepatitis C** *(Dr Keith Reid)*	
8.	**Report from Public Health South**	**14**
9.	**Maternity Quality & Safety Strategic Plan**	**30**

Closed Session:

RESOLUTION:
That the Disability Support Advisory Committee and Community & Public Health Advisory Committees move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 34, Schedule 4 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i) and 9(2)(j)) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations.
2. New PHO Agreement	Commercial Sensitivity and to allow activites and negotiations to be carried on without prejudice or disadvantage.	As above.
3. Laboratory Services Contract	Commercial Sensitivity and to allow activites and negotiations to be carried on without prejudice or disadvantage.	As above.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	01.03.2012 06.12.2010	1. Member, South Island Neurosurgical Board **Son-in-law:** 2. Partner, Polson Higgs, Chartered Accountants. 3. Trustee, Corstorphine Baptist Community Trust	1. 2. Does some accounting work for Southern PHO. 3. Has a mental health contract with Southern DHB.
Paul MENZIES (Deputy Chairman)	10.02.2010 10.02.2010 06.10.2011 02.08.2012	1. Wife a member on the Southland Child Youth Mortality Review Group. 2. Wife a member on the Child and Youth Health Advisory Committee. 3. Trustee, Southern PHO. 4. Wife a trustee of Number 10, Youth One Stop Shop, Invercargill.	1. Nil. 2. Nil. 3. Appointed as a trustee by Southern DHB. PHO is contracted to the DHB. 4. Possible conflict with funding requests.
Neville COOK	04.03.2008 04.03.2008 04.03.2008 26.03.2008	1. Board Member, Invercargill Licensing Trust. 2. Board Member, Invercargill Licensing Trust Foundation. 3. Councillor, Environment Southland. 4. Trustee, Norman Jones Foundation.	1. Possible conflict with funding requests. 2. Possible conflict with funding requests. 3. Nil. 4. Possible conflict with funding requests.
Sandra COOK	01.09.2011	1. Te Runanga o Ngāi Tahu	1. Holds a "right of first refusal" over certain Crown properties. Also seen as a Treaty partner and affiliates may hold contracts from Southern DHB from time to time.
Kaye CROWTHER	09.11.2007 14.08.2008 12.02.2009 05.09.2012 01.03.2012	1. Employee of WHK South. 2. Trustee of Wakatipu Plunket Charitable Trust. 3. Corresponding member for health and family affairs, National Council of Women. 4. Trustee for No 10 Youth Health Centre, Invercargill. 5. DHB representative on the Gore Social Sector Trial	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of WHK. 2. Nil. 3. Nil.
Mary FLANNERY	17.11.2010 10.11.2011	1. Trustee, Rural Otago Primary Health Organisation 2. Associate Solicitor, Bodkins/AWS Legal, Alexandra. 3. Partner, Tayside Farm Partnership. 4. Director, New Zealand Irrigation Board.	1. Was contracted to Southern DHB – contracts assigned to Southern PHO (will be wound up) 2. Nil 3. Nil 4. Nil

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
James Malcolm MACPHERSON	28.06.2005 09.03.2011 25.11.2010 25.11.2010 25.11.2010 28.08.2007 09.03.2011 09.03.2011 09.03.2011 13.12.2001 22.04.2003	1. Member Otago Polytechnic Council. 2. Contractor and Tutor, Otago Polytechnic. 3. Member Central Lakes Trust. 4. Member Roxburgh Gorge Trail Charitable Trust. 5. Part owner, Alexandra Medical Centre. 6. Co-Principal, Brilliant New Zealand Ltd. 7. Chairman, Jolendale Charitable Trust. 8. Shareholder, Medco Properties Ltd 9. Director, Centennial Health Ltd **Spouse - Susan Elizabeth Macpherson:** 10. GP Principal, Centennial Health Ltd, Alexandra. 11. Branch Medical Advisor, ACC, Alexandra.	1. (OP has training interests in common with the DHB, no) 2. (personal interest.) 3. CLT is a community funder in its region, which includes Dunstan and Lakes District Hospitals, plus a wide range of community and primary services and service providers, and is a possible future funder. 4. Nil. 5. The AMC is tenanted by all of Alexandra's GPs and a pharmacy, and is also occasionally used by related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts. 6. BNZL is a consultancy which may have an involvement with health sector organisations. 7. Nil. 8. MPL will be responsible for the tenancy of all of Alexandra's current GPs and a pharmacy and may also house other related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts, real and theoretical. 9. & 10. Board discussions relating to primary health providers or primary referred services may involve conflicts of interest. Declare where appropriate and withdraw where prudent. 11. ACC is a major customer of the DHB. Remote possibility of an influence, no personal interest.
Tahu POTIKI	15.12.2007 03.04.2008 24.11.2009 03.06.2010 23.04.2013	1. Director, Arataki Associates. 2. Representative to Te Runanga o Ngai Tahu. 3. Trustee of Ngai Tahu Charitable Trust. 4. Board Member, Relationship Services NZ. 5. Board Member, Environmental Science and Research 6. Chairman of He Waka Kotuia o Araiteuru	1. Contracted to Southern DHB, funded provider in the past ie Araiteuru Whare Hauora Ltd. 2. & 3. Treaty Partner - affiliated providers may contract to Southern DHB. Te Runanga o Ngai Tahu has right of first refusal on disposal of property. 4. No apparent conflict. 5. CRI involved in public health research. 6. Possible conflict when provider contract comes up for renewal.
Branko SIJNJA	07.02.2008 04.02.2009	1. Director, Clutha Community Health Company Limited. 2. 0.8 FTE Director Rural Medical Immersion Programme, University of Otago School of Medicine.	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	22.06.2010 07.06.2012	3. 0.2 FTE Employee, Clutha Halth First General Practice 4. Director of Southern Community Laboratories	
Richard John THOMSON	13.12.2001 23.09.2003 29.03.2010 06.04.2011	1. Managing Director, Thomson & Cessford Ltd. 2. Director, Susanna Shaya Imports Ltd 3. Chairperson and Trustee, Hawksbury Community Living Trust. 4. Trustee, HealthCare Otago Charitable Trust. 5. Director, Composite Retail Group. 6. Councillor, Dunedin City Council.	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it. 2. Susanna Shaya Imports is a homeware importing company. It has no dealings with Southern DHB. 3. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 4. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 5. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009 01.05.2010 01.05.2010 10.12.2012	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT). 4. Director of Southern Community Laboratories Otago-Southland	1. May have some Southern DHB patients and staff as clients. 2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at May 2013

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Peter Beirne		tba	
Richard Bunton	17.03.2004 22.06.2012 29.04.2010	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict. 6. No conflict. 7. No conflict.
Donovan Clarke	02.02.2011 18.12.2012 05.04.2013	1. Te Waipounamu Delegate, Te Piringa, National Maori Disability Advisory Group. 2. Director, Great Western Steakhouse, New Lynn, Auckland. 3. The Child and Youth Health Compass Steering Group. 4. Cancer Care Co-ordinator Evaluation Advisory Group.	1. Nil. 2. Nil. 3. Nil. 4. Nil.
Carole Heatly	14.03.2012	Nil.	
Sharon Kletchko		1. GM Strategy & Planning Nelson Marlborough DHB 2. Chair, SI Alliance GMs P&F Network (supported by SIAPO)	

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
		3. Chair, National GMs P&F Network (supported by DHBSS) 4. Member, SIA Service Planning & Integration Team 5. Member, Southern Cancer Network Steering Group 6. Member, National Cancer Coordination Steering Group 7. Deputy Chair NZ Standards Council 8. Registered Health Professional - Specialist Medical 9. Member Royal Australasian College of Physicians (RACP) - NZ Executive 10. Deputy Chair RACP - NZ Policy and Advocacy Committee 11. Chair, Medicines Review Statutory Committee (Minister of Health appointment) 12. Member, Named Pharmaceutical Patient Access (NPPA) Panel 13. Board Member, EVIDEM Collaboration (International group on multi-criteria decision-making)	
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
Lynda McCutcheon	22.06.2012	1. Member of the University of Otago, School of Physiotherapy, Admissions Committee.	
John Pine	17.11.201	Nil.	
Leanne Samuel	01.07.2007 01.07.2007 01.07.2007 29.10.2009	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member of Board of Studies at Southern Institute of Technology. 4. Southland Medical Foundation Inc (member).	1. Southland Hospital Trust. 2. Nil. 3. Potential conflict if the DHB purchases services from this organisation. 4. Southland Trust. 5. Nil.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	01.10.2010	5. Member of National Elective Services Productivity and Workforce Programme Steering Group.	
David Tulloch	23.11.2010 02.06.2011 17.08.2012	1. Southland Urology (Director). 2. Southern Surgical Services (Director). 3. UA Central Otago Urology Services Limited (Director). 4. Trustee, Gilmour Trust.	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 3. Potential conflict if DHB purchases services. 4. Southland Hospital Trust.

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 1 May 2013, commencing at 10.00 am, in the Board Room, Southland Hospital Campus, Invercargill

Present:	Dr Malcolm Macpherson	Chairman
	Mr Neville Cook	
	Ms Sandra Cook	
	Mrs Kaye Crowther	
	Mrs Mary Flannery	
In Attendance:	Mr Robert Mackway-Jones	Executive Director Planning & Funding
	Ms Sharon Adler	Portfolio Manager, Health of Older Persons and Disability (by videoconference)
	Ms Thelma Brown	Portfolio Manager, Public & Population Health (by videoconference)
	Ms Jeanette Kloosterman	Board Secretary (by videoconference)
	Ms Melissa Garry	Media Liaison Officer (by videoconference)

Unconfirmed

1.0 WELCOME

The Chairman welcomed everyone to the meeting and advised that Robert Mackway-Jones, Executive Director Planning & Funding, was attending his last meeting. He expressed the Committees' appreciation for the work Mr Mackway-Jones had done for them and the organisation, and the leadership he had provided, particularly in the rural areas.

In response, Mr Mackway-Jones, acknowledged the contribution made by his team.

2.0 APOLOGIES

There were no apologies.

3.0 MEMBERS' DECLARATION OF INTEREST

Mrs Crowther requested that item 2, Trustee of Plunket Foundation, be deleted from her entry in the Interests Register.

It was resolved:

"That the Interests Register be noted."

4.0 PREVIOUS MINUTES

It was resolved:

> **"That the minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on 7 February 2013 be approved and adopted as a true and correct record."**

5.0 ACTION SHEET

The Committees reviewed the action sheet (agenda item 5) and:

- Noted that the fee was a barrier to many organisations obtaining formal breastfeeding friendly certification;
- Requested that presentations be arranged from the rural trusts.

6.0 PRIMARY AND COMMUNITY

The Executive Director Planning & Funding presented the Primary and Community activity report (agenda item 6) and reported that the Diabetes Care Improvement Programme (DCIP) put in place through the PHO was being held up as an exemplar.

The Committees:

- Extended their congratulations to staff on the success of the DCIP
- Requested further information on the maternity quality and safety model.

Unconfirmed

7.0 PUBLIC & POPULATION HEALTH

Ms Thelma Brown, Portfolio Manager, presented her report on Primary and Community Portfolio activity (agenda item 7) and took questions from members.

The Committees requested:

- A copy of the Child and Youth Health Compass Questionnaire report when it is completed;
- An update on the district-wide Child and Youth Steering Group.

Gore Social Sector Trials

Ms Brown presented an update on the Gore social sector trials (agenda item 7) and summarised the highlights from her perspective.

It was noted that the Gore trial had been extended to June 2014 and another trial was due to start in South Dunedin.

8.0 MENTAL HEALTH AND ADDICTIONS

The Executive Director Planning & Funding presented the Mental Health and Addiction Portfolio activity report (agenda item 8) and took questions from members.

9.0 HEALTH OF OLDER PEOPLE

Ms Sharon Adler, Portfolio Manager, presented her report on Health of Older People (HOP) activity (agenda item 9) and took questions from members.

10.0 HOSPITAL AND SPECIALIST SERVICES

The Executive Director Planning & Funding presented the Hospital and Specialist Services Portfolio activity report (agenda item 10) and took questions from members.

The Committees were informed that:

- Because of their value, the larger hospital based trust contracts would be submitted to Board for approval in June;
- That the new CT scanner was due to be operating at Dunstan Hospital the following week.

Unconfirmed

11.0 FINANCIAL REPORT

The Executive Director Finance & Funding presented the Funder Financial Report for the period ended 31 March 2013 (agenda item 11) and answered members' questions on the financial accounts.

It was resolved:

"That the portfolio and financial reports be received."

CONFIDENTIAL SESSION

At 11.25 am it was resolved that the public be excluded for the following agenda items:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda.	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i) and 9(2)(j) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations.

The meeting closed at 11.45 am.

Unconfirmed

Confirmed as a correct record:

Chairman ....

Date ....

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC) AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

ACTION SHEET

Updated following May 2013 meeting

Meeting	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	"Deep Dive" Presentations	Consideration to be given to inviting representatives: - Rural Trusts - B4 Schools Checks - Mental Health Residential Services (DHB/PACT) - Diabetes Care Improvement Package - Implementation of the HCSS model	GMFF	Presentations for information will be scheduled as appropriate.	Ongoing
Dec 12	**Primary Care Report on after-hours services**	A two monthly progress report was requested from the PHO	PM-PC		
May-13	**Primary & Community (Agenda item 6)**	Further information on the maternity quality & safety model was requested	PM-PC	Agenda item 9	Completed.
May-13	**Public & Population Health (Agenda item 7)**	A copy of the C&Y Compass Questionaire was requested when completed	PM-PPH		

PUBLIC HEALTH SOUTH REPORT TO THE SOUTHERN DHB
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
January and February 2013

RECOMMENDATION:
It is recommended that the Community and Public Health Advisory Committee note this report.

Public Health Services (Southern)

Settings and Lifestyles

Outcome 1 Reduce the impact and incidence of smoking related disease
Outcome 2 Reduce the impact and incident of obesity and overweight
Outcome 3 Reduce the impact and incidence of harm from alcohol and other drugs

Smokefree
Public Health South staff supported Murihiku Waitangi day celebrations this year by providing resources to the Waka Ama Fun Day at the Oreti River. The day began with the blessing and launching of a new Oraka Aparima Runanga waka and was followed by whanau waka races. Ki o Rahi was promoted by the auahi kore hero and enjoyed by whanau. Auahi kore branded signage was posted throughout the event and auahi kore Bloodlines tattoos were distributed to rangatahi. The purpose of including auahi kore messages at this event was to build resilience and strengthen normalisation of smokefree within the Maori community.

Alcohol
An alcohol control purchase operation (CPO) was conducted in Te Anau by Public Health South in conjunction with Police. Te Anau is primarily a tourist town and has a high number of licenced premises. This operation focused on restaurant and cafés with 17 premises being approached by a 16 year old female asking to purchase alcohol. Disappointingly 7 premises sold to the underage volunteer. Two of the seven premises asked for identification, checked the minor's actual driver's licence but still sold the alcohol. The other 5 premises did not ask for any form of identification or proof of age. On a yearly basis Public Health South staff conduct 'drink safe workshops' for licensees and staff to attend in the area. A large component of the workshops covers the importance of ascertaining the patron's age. Police will progress the appropriate penalties of the staff and premises involved.

In February food monitoring was carried out in 12 previously non-compliant premises in Queenstown. Seven premises showed a good improvement on the promotion and availability/ affordability of food, required signage displayed and a duty manager present. Five premises will be followed up by Public Health South staff predominantly for signage requirements.

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

The Communicable disease report is appended.

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

Parenting Teenage Boys in Central Otago

Cromwell Rotary and Public Health South organised the Ride around the Lake for Mental Health Awareness Day 2012. The proceeds from this event funded Celia Lashlie to come to Cromwell. Cromwell College had identified a need for information on parenting teenage boys in the area and Celia had been identified as a popular choice for the delivery of a workshop on the subject. Two hundred attendees came to the evening session which was light-hearted and everyone came away with not only new tools in parenting but also insights into differences in parenting teenage boys and girls. Free tickets were given to identified high-need families with full attendance from them. Feedback from the workshop was very positive. Celia also carried out a professional development session the next morning for health professionals/teachers/public health nurses with an attendance of 30 people. Many had travelled long distances to attend. The evaluation from this session was also very positive.

Health Promoting Schools Across the District

With only 2.3 FTE the ability for Health Promoting Schools staff to have a presence in all 241 Primary, Intermediate and Secondary Schools across the Southern District is simply not possible. Over time the Health Promoting Schools Coordinator in the Dunedin Office has developed a programme of working with groups of schools (clusters) with a focus on higher need (lower decile) schools. Primary schools are encouraged to develop and implement health promotion projects that they showcase though a series of workshops at the end of the year. The Health Promoting Schools Coordinator works with other stakeholder organisations that work in school settings so as to maximise their input and at the same time minimise the inconvenience to schools caused by multiple approaches. A similar approach is taken with secondary schools, however there is a much stronger focus in students leading projects in schools themselves. Generally projects are identified around a theme based on a component of a Māori model for Health. Last year the topic was Tapu. This manifested in students at several prominent boys schools in Dunedin taking a position on bullying. Others manifestations included self image, breakfast clubs etc. In 2012 Public Health South staff worked very successfully with Intermediate Schools in Dunedin with the Health Promotion Agency who had a focus on reducing smoking initiation. Given the evolution of what is seen as a highly successful model of service delivery, this is now being rolled out across the Southern District. Health Promoting Schools staff workshopped this model in February. Ongoing collaborative work between Health Promoting Schools staff in the three offices should see further development of this standardised model of working.

Vaccine Preventable Disease (VPD) Programme

Immunisation Health Target Results

Southern DHB continues to track well for the 8 Month of Age Immunisation Health Target; consistently achieving 93% against the 85% target for 2012/13. This target is aimed to ensure on time vaccinations and disease protection for children in their first year of life. Coverage for children aged 2 years remains a Ministry of Health focus, with coverage holding at 93%. This reflects the national trend of slight coverage reduction due to the count now including coverage of the pneumococcal vaccine.

Funded Boostrix Vaccine for Pregnant Women – Whooping Cough Protection

From 1 January 2013, the Ministry of Health has funded the Boostrix vaccine for all pregnant women between 28 – 38 weeks gestation while the current pertussis (whooping cough) outbreak continues. Evidence suggests that along with on-time vaccination for babies, the most effective way to prevent infants from catching pertussis is to immunise pregnant women so that protection is transferred from mothers to babies.

Education and promotional activities have been undertaken by the VPD Team; with teaching sessions offered to the midwives, media messages for health professionals and families developed and the staff sharing the message in all forums.

2013 Influenza Vaccination Programme

The 2013 Influenza Programme began on 25 January with the release of the vaccine for the public. All those over the age of 65 years and those with a number of chronic conditions are eligible for a funded vaccine from their General Practice. All health professionals are encouraged to be vaccinated, with the Southern DHB Staff Programme being launched on 18 March.

In the Southern district, a number of community Pharmacists are now trained to deliver the Influenza vaccine to members of the public who are not eligible to receive a funded vaccine. The Medical Officers of Health and Immunisation Coordinators have been working closely with this group to support their preparation.

Smokefree Coordination

Secondary care health target results for patients who were offered advice and help to quit for the first two months of the year were 91.5% for January and 92.8% for February. A great deal of activity is underway to reach the health target results of 95% by 1 July 2013. Staff are working with the wards to ensure that all new staff are educated in the ABC system. Staff are also reviewing the current cessation services referral form to increase clarity on how to refer to community cessation providers. Research shows that smokers who access support have a greater chance of making a successful quit attempt.

Cervical Screening Programme

The National Screening Unit has advised that no district data requests will be available until May 2013.The NSU data warehouse stopped functioning in May 2012 and its replacement is taking some time to populate and validate.

The Free/Subsidised Smear programme has been reviewed and will continue for priority group women, through primary care practices, until June 2013. Priority group women are those who remain vulnerable to cervical cancer through under screening. They are either due for their cervical smear, underscreened or unscreened, aged between 20-69 years and are Maori, Pacific or Asian. Priority women are those also aged between 30 and 69 years and have never had a cervical smear or are overdue for a smear for five years. Professional development for smear takers has been a highlight in February with eleven new smear takers trained and one hundred and thirty attending update sessions.

Communicable Disease Report from Public Health South to the Community and Public Health Advisory Committee, Southern District Health Board

Introduction
Recently health surveillance data have highlighted that Southern District has the highest rate of new infections of Hepatitis C in New Zealand. The purpose of this report is to outline the current situation in relation to Hepatitis C infection in the Southern District, to outline measures underway locally to prevent and treat this infection and to propose that a co-ordinated multi-agency strategy for the control of this infection and other related blood borne viruses would be of benefit to the population of the Southern District and so should be developed.

Hepatitis C Infection
Hepatitis C is a blood borne viral infection that is associated with both acute and chronic health problems. Chronic infection is an important cause of liver cirrhosis (in 60-70% of cases) and liver failure or liver cancer (1-5% of cases). There is currently no vaccination against Hepatitis C so preventative approaches are vitally important to controlling the infection. Chronic infection can be treated to clear the virus from the liver and thus 'cure' the infection with the likelihood of successful clearance varying for different sub-types of the virus (and quoted at between 40 and 80%). However, this treatment is burdensome on the patient and health service and expensive with some patients requiring more than one treatment for successful eradication.

Level of Hepatitis C Infection in Southern District
The numbers of new cases notified in each of the last two years were:
- 13 cases during Calendar year 2012 (29 in NZ as a whole)
- 9 cases during Calendar year 2011 (27 in NZ as a whole)

The number of chronic carriers of the infection is not known but is estimated at 1.5% of the adult population (which would be around in 3600 persons in Southern District). Only one in four of those infected is thought to be aware that they have the disease. However, an anonymised sero-prevalence study is underway in Dunedin and this will provide valuable information on the extent of the infection in the wider community. This study involves the testing of blood samples submitted for other purposes for the presence of antibodies to Hepatitis C virus. This approach will enable an estimate of the level of undetected and chronic Hepatitis C infection in the local population to be estimated. This information will then be available to be used to review the level of need in our district and to plan services in response. In order to be effective in our actions against Hepatitis C there needs to be a co-ordinated and strategic approach which includes both preventative approaches as well as encouraging testing and treatment for infected individuals.

Figures suggest that in addition to high rates of new cases of infection there is a high rate of treatment of chronic infection within the local community. These figures were supplied in response to an official information Act request to the Ministry of Health and cover the years 2009 to 2011.

Table – Number of cases receiving Hepatitis C eradication therapy in Southern District by year and proportion of NZ cases treated in SDHB area

Year	**2009**	**2010**	**2011**
Otago	32	44	48
Southland	12	17	6
Total	44	61	54
Proportion of national cases (%	6.1	10.6	11.3

The cost of the medication used in a course of eradication therapy is about NZ$500 weekly for 48 weeks combination therapy with pegylated interferon and ribavirin (estimated at being NZ$24,000, where a full course is completed). There are laboratory monitoring and out-patient costs in addition. As such the total costs are higher at $15000 for 24 weeks and $30,000 for 48 weeks. However, there is significant cost associated with the long-term consequences of infection in

untreated individuals, for example chronic Hepatitis is now a leading cause of listing for liver transplant. Cost-benefit studies have been undertaken in Australia demonstrating the return on investment of preventative strategies aimed at Hepatitis C.

High levels of diagnosis and treatment reflect both awareness of the condition within the medical community in Southern DHB and the willingness to treat chronic infection. As indicated above, this does commit significant resources to the treatment of Hepatitis C. There have been legitimate questions raised about the balance of expenditure between treatment and preventative work. In practice, modest additional expenditure on effective preventative activity will result in a saving on treatment costs in the longer term. An awareness raising and testing strategy will result in the ascertainment of some currently undiagnosed cases and has the potential to increase treatment costs by "bringing forward" diagnosis and treatment – ie cases which may have gone undiagnosed and thus untreated are likely to be diagnosed and treated as a consequence of increasing testing within the local community.

Risk Factors in the Southern DHB Area

Looking at recently diagnosed cases, the single most common risk factor in cases locally is a history of personal IV drug use or of sexual contact with an IV drug user. The second most common risk factor is the use of a tattoo in an unregulated setting. This indicates that important actions to counter Hepatitis C in Southern District should be those aimed at harm reduction in IV drug users and at raising awareness of the risks of using unregulated tattoo artists. However, a more general approach of raising awareness of the risk factors for infection, the latent nature of the infection in many individuals and the provision of testing, counselling and treatment in those at risk of infection is both appropriate and necessary.

Current Preventative Action

The Ministry of Health manages contracts across the country relating to preventative and harm reduction activity, this includes the needle exchange services and Hepatitis C Resource Centres. The DHB has supported the needle exchange service over the last few years providing advice and strategic support through the local reference groups and will continue to work closely with these services. There is ongoing concern that the current level of funding provided by the MoH does not match the need for needle exchange services across our District, particularly in rural areas. Proposals indicating the need for an outreach service within the Southern district have been made to several MoH Portfolio Managers in recent times but no progress has been made in this area. Lack of access to this service does increase the risk of infection and of onward transmission.

Certain pharmacies across the country provide preventative services through the provision of safe equipment for IV drug users that can be purchased by clientele. There are a number of pharmacies that provide this service within the Southern district.

The aim of preventative and harm reduction activity is:

- To reduce the occurrence of hepatitis C infection in the community and therefore to reduce the risk of infection in the community;
- To reduce the overall burden of disease in the community;
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Current DHB preventative activity is focused on a small number of programmes. These include:

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and to work closely with probation and other services particularly during the transition from prison to community.

- Public Health South plays a part in informing local councils around tattoo by-laws but this is more on an opportunistic basis.

Public Health South is actively raising awareness of safe sex practice. Despite this activity it is important to note that the infection rate has been high for two years now. This indicates that additional measures are required to bring the infection rate down.

Recommendation for Action

The view of the report author is that the development of a Hepatitis C strategy for Southern District would be an appropriate response to the current situation. However, planning for the delivery of effective action against Hepatitis C would form only one part of a wider strategy aimed at reducing blood borne viral infections. Such an approach will require multi-agency involvement and will not be successful if it is seen only as a health initiative. It is recommended that a Blood Borne Virus strategy for the Southern District population should be developed through a multi-agency approach.

Dr Keith Reid, Public Health Physician

PUBLIC HEALTH SOUTH REPORT TO THE SOUTHERN DHB
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
March and April 2013

RECOMMENDATION:
It is recommended that the Community and Public Health Advisory Committee note this report.

Public Health Services (Southern)

Settings and Lifestyles

Outcome 1 Reduce the impact and incidence of smoking related disease
Outcome 2 Reduce the impact and incident of obesity and overweight
Outcome 3 Reduce the impact and incidence of harm from alcohol and other drugs

Smokefree
Staff have conducted a pilot session with an early childhood centre aimed at supporting the centre to support a smokefree cars and homes policy. The aim of the Little Lungs/Pukahakahu Iti programme is to offer parents ways of supporting a smokefree environment around their children even if they are not able to give up smoking. An evaluation showed that the majority of participants found the session to be valuable and increased their confidence to incorporate smokefree into their practice. This programme will be rolled out in a further 20 early childhood centres across the district.

Alcohol
Staff recently organized a one day workshop for our alcohol partners to look at tools to record information about licensed premises and risk assessment in a shared database. ACC and public health staff worked together to deliver this and staff are hoping to see a shared approach as the new liquor laws come into effect. There was representation from all local councils including Dunedin City Council. The liquor licensing police from around the district also attended which was very pleasing. From early 2014 the Ministry of Health will require reporting on all ‘special’ licences, for example sports clubs hosting non-member events will require a special licence. Staff are now going to follow up with a similar approach in Southland.

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

‘Keep Your Bugs to Yourself’ Programme
The Keep Your Bugs to Yourself programme is continuing to have positive outcomes. Four sessions have already been delivered this year and there is still demand for more sessions. Participants continue to see the course as worthwhile and are now better equipped to deal with any potential outbreak of gastroenteritis (diarrhoea and/or vomiting) in their early childhood service.

Developed in 2011, the purpose of the ‘Keep your bugs to yourself’ programme is to assist educators in the early childhood sector to identify and manage outbreaks of communicable disease, particularly gastroenteritis. Educators also get to meet public health staff that can advise them. The sessions are designed to be multidisciplinary and presenters are from the Ministry of Education, Public Health Nurses and Public Health.

During March and April a total of 4 sessions were held across the southern district. Two were run for University of Otago students training to be early childhood educators and two for educators

already employed in the early childhood sector. A total of 84 participants have attended the 4 sessions held this year. Evaluations continue to be very positive. Ninety percent of participants completed evaluations indicating that the objectives were met or exceeded and 64% recorded that the objectives were very well met.

A high percentage of early childhood educators from Southland have now attended a *Keep Your Bugs to Yourself* session. The future focus will be on the Otago region which has a lower coverage.

Reports on Influenza and Hepatitis C from Dr Keith Reid are appended to this report.

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

Parenting Teenage Boys in Central Otago

Cromwell Rotary and Public Health South organised the Ride around the Lake for Mental Health Awareness Day 2012. The proceeds from this event funded Celia Lashlie to come to Cromwell. Cromwell College had identified a need for information on parenting teenage boys in the area and Celia had been identified as a popular choice for the delivery of a workshop on the subject. Two hundred attendees came to the evening session which was light-hearted and everyone came away with not only new tools in parenting but also insights into differences in parenting teenage boys and girls. Free tickets were given to identified high-need families with full attendance from them. Feedback from the workshop was very positive. Celia also carried out a professional development session the next morning for health professionals/teachers/public health nurses with an attendance of 30 people. Many had travelled long distances to attend. The evaluation from this session was also very positive.

Health Promoting Schools Across the District

With only 2.3 FTE the ability for Health Promoting Schools staff to have a presence in all 241 Primary, Intermediate and Secondary Schools across the Southern District is simply not possible. Over time the Health Promoting Schools Coordinator in the Dunedin Office has developed a programme of working with groups of schools (clusters) with a focus on higher need (lower decile) schools. Primary schools are encouraged to develop and implement health promotion projects that they showcase though a series of workshops at the end of the year. The Health Promoting Schools Coordinator works with other stakeholder organisations that work in school settings so as to maximise their input and at the same time minimise the inconvenience to schools caused by multiple approaches. A similar approach is taken with secondary schools, however there is a much stronger focus in students leading projects in schools themselves. Generally projects are identified around a theme based on a component of a Māori model for Health. Last year the topic was Tapu. This manifested in students at several prominent boys schools in Dunedin taking a position on bullying. Others topics included self image, breakfast clubs etc. In 2012 Public Health South staff worked very successfully with Intermediate Schools in Dunedin with the Health Promotion Agency who had a focus on reducing smoking initiation. Given the evolution of what is seen as a highly successful model of service delivery, this is now being rolled out across the Southern District. Health Promoting Schools staff workshopped this model in February. Ongoing collaborative work between Health Promoting Schools staff in the three offices should see further development of this standardised model of working.

Vaccine Preventable Disease (VPD) Programme

Immunisation Health Target Results

Southern DHB continues to track well for the 8 Month of Age Immunisation Health Target; again achieving 93% for Quarter 3 against the 85% target for 2012/13. This target is aimed to ensure on-time vaccinations and disease protection for children in their first year of life. Coverage for children

aged 2 years remains a Ministry of Health focus, with Southern DHB coverage holding at 93%. This reflects the national trend of slight coverage reduction due to the count now including coverage of the pneumococcal vaccine.

Immunisation Week: 22 – 29 April 2013
Southern DHB participated in the international immunisation promotion week; promoting *'On time, every time to protect our children – It's free'.* Articles were published in 'Better Health' the Southland Times and Dunedin's Chanel 9. This 'Mum backs free vaccines' article was widely shared on the national 'Stuff' website and through social media. Resources were widely distributed to all providers who promote and deliver childhood vaccinations with many notice board displays set up.

Funded Boostrix Vaccine for Pregnant Women – Whooping Cough Protection
From 1 January 2013, the Ministry of Health funded the Boostrix vaccine for all pregnant women between 28 – 38 weeks gestation while the current pertussis (whooping cough) outbreak continues. Evidence suggests that along with on-time vaccination for babies, the most effective way to prevent infants from catching pertussis is to immunise pregnant women so that protection is transferred from mothers to babies. The Vaccine Preventable Disease team continue to strongly drive education and promotional awareness to all providers who interact with pregnant women and their families.

2013 Influenza Vaccination Programme
The 2013 Influenza Programme is well underway. General Practice is delivering funded vaccines to those over the age of 65 years and those with a number of chronic conditions. Non-funded vaccinations are being provided by General Practice, Occupational Health Services and a number of Community Pharmacists. Southern DHB recommends vaccination for all health care workers with a staff vaccination programme in progress. Indications to date are that national coverage will achieve the 1.2 million dose target for the 2013 season. Please see the report appended to this report for further information on influenza.

Smokefree Coordination

Secondary care health target results for patients who were offered advice and help to quit were 91.5% for March and 92.9% for April. Staff have developed a new referral form that has all the cessation providers available across the district, including Quitline. This is being introduced in May and should make it easier for clients to choose the service they would like to access. The form, in both fax and email electronic format, is being introduced at staff training sessions and will also be available on MIDAS.

Cervical Screening Programme

Following recent smear taker education sessions and follow up telephone calls, an increased number of primary care practices have taken up the opportunity for data matching their enrolled patients against the National Cervical Screening Programme register. At present this is a local manual process and provides practices with an up-to-date screening status report for women aged between 20 and 69 years. Data matches for 27 practices have been completed in the year to date, with nine of these completed in March/April. Eighteen new requests were received from practices in April and will be completed in coming weeks.

Report on Influenza

Introduction

Seasonal influenza is an important illness that leads to significant morbidity and mortality each winter accompanied by increases in healthcare utilisation. This report outlines the measures taken to monitor the spread of influenza in Southern District, the likely impact on healthcare services and briefly outlines the vaccination programme mounted to protect the public.

Seasonal Influenza

Influenza places considerable additional burden on healthcare services each year. In the Southern District this pressure manifested itself in 2012 as an additional 150 GP consultations on average each week during flu season. However, at the peak of the flu season there may be as many as 450 extra consultations with general practice each week. The peak consultation rates are in children aged 1-4 years but the largest number of consultations occurs with those of adult working age.

Seven general practices across Southern District are again contributing to the national sentinel surveillance scheme. They provide information on the levels of consultations for influenza-like illnesses, the proportions of positive influenza cases and the viral strains which are circulating. These practices cover a mix of urban and rural areas and are spread across Otago and Southland.

Nationally in the hospital setting, last year's flu season saw over a thousand cases admitted over the fifteen weeks from June to October; nearly half of these (492) were admitted during five weeks in July. This rate of hospitalisations was the highest since the 2009 pandemic and the second highest since 2000. For New Zealand as a whole, hospitalisations were highest in those under 1 year of age and significantly higher for Pacific peoples than for all other ethnic groups.

Analysis is undertaken each year of the antigenic composition of the circulating viruses to increase understanding of the epidemiology of influenza and to understand vaccine effectiveness and to provide information to aid decisions on vaccine composition in subsequent years. In 2012 the predominant strain of Influenza A was H3N2. The circulation of this strain as part of the normal seasonal influenza is historically associated with a higher level of hospitalisations than other seasonal influenza types. In 2012 in New Zealand there was a change in the type of H3N2 virus which was circulating.

In the United States this winter the majority of Influenza A has been characterised as A/Victoria/361/2011-like strain which formed the H3N2 component of the influenza vaccine in the Northern Hemisphere and is also present in the vaccine currently being administered in New Zealand. However, the United States saw a very large and unexpected increase in the rate of hospitalisations in the over 65 years age group. Levels of influenza hospitalisations on this scale would see an additional 60 – 70 influenza hospitalisations over the course of the season in the Southern District compared with last year. However, the observed pattern of disease in Europe was different with the predominant strain in most European population being the Influenza A H1N1 pandemic strain. Surveillance will enable early detection of the circulating strains and patterns of hospitalisation

The situation in the United States was associated with an apparent significant change in the response to the H3N2 vaccine in the over 65 year old age group. Nonetheless vaccination in this age group still provided significant protection against hospitalisation and complications of influenza.

Vaccination against influenza

Vaccination remains an important measure to protect the vulnerable from the effects of seasonal influenza. Funded vaccination coverage was extended this year to include those less than 5 years of age with significant respiratory illness. This was in addition to those groups already funded: those over 65 years of age; those with chronic health conditions (including cardiac, respiratory, and

renal disease; diabetes; and cancer); and pregnant women. Influenza in pregnancy poses a particular risk to the mother and the unborn baby.

Vaccination uptake among health board staff has been higher this year than in previous years. Current levels of vaccination already exceed those achieved for the whole of the last 'flu season. Given the additional pressure on healthcare services during the influenza season and the numbers of cases of influenza which will be seen there is a compelling case for staff to be immunised: firstly, to protect themselves from becoming ill; secondly, to prevent them from acting as a source of infection to their patients; and thirdly to prevent them from spreading infection through the wider community. Frontline health workers already accept requirements for routine vaccinations to protect themselves against occupational illnesses. As a health board we should aspire to 100% coverage of healthcare workers each winter.

Dr Keith Reid, Public Health Physician

Report on Hepatitis C

Introduction

Recently health surveillance data have highlighted that Southern District has the highest rate of new infections of Hepatitis C in New Zealand. The purpose of this report is to outline the current situation in relation to Hepatitis C infection in the Southern District, to outline measures underway locally to prevent and treat this infection and to propose that a co-ordinated multi-agency strategy for the control of this infection and other related blood borne viruses would be of benefit to the population of the Southern District and so should be developed.

Hepatitis C Infection

Hepatitis C is a blood borne viral infection that is associated with both acute and chronic health problems. Chronic infection is an important cause of liver cirrhosis (in 60-70% of cases) and liver failure or liver cancer (1-5% of cases). There is currently no vaccination against Hepatitis C so preventative approaches are vitally important to controlling the infection. Chronic infection can be treated to clear the virus from the liver and thus 'cure' the infection with the likelihood of successful clearance varying for different sub-types of the virus (and quoted at between 40 and 80%). However, this treatment is burdensome on the patient and health service and expensive with some patients requiring more than one treatment for successful eradication.

Level of Hepatitis C Infection in Southern District

The numbers of new cases notified in each of the last two years were:

- 13 cases during Calendar year 2012 (29 in NZ as a whole)
- 9 cases during Calendar year 2011 (27 in NZ as a whole)

The number of chronic carriers of the infection is not known but is estimated at 1.5% of the adult population (which would be around in 3600 persons in Southern District). Only one in four of those infected is thought to be aware that they have the disease. However, an anonymised sero-prevalence study is underway in Dunedin and this will provide valuable information on the extent of the infection in the wider community. This study involves the testing of blood samples submitted for other purposes for the presence of antibodies to Hepatitis C virus. This approach will enable an estimate of the level of undetected and chronic Hepatitis C infection in the local population to be estimated. This information will then be available to be used to review the level of need in our district and to plan services in response. In order to be effective in our actions against Hepatitis C there needs to be a co-ordinated and strategic approach which includes both preventative approaches as well as encouraging testing and treatment for infected individuals.

Figures suggest that in addition to high rates of new cases of infection there is a high rate of treatment of chronic infection within the local community. These figures were supplied in response to an official information Act request to the Ministry of Health and cover the years 2009 to 2011.

Table – Number of cases receiving Hepatitis C eradication therapy in Southern District by year and proportion of NZ cases treated in SDHB area

Year	**2009**	**2010**	**2011**
Otago	32	44	48
Southland	12	17	6
Total	44	61	54
Proportion of national cases (%	6.1	10.6	11.3

The cost of the medication used in a course of eradication therapy is about NZ$500 weekly for 48 weeks combination therapy with pegylated interferon and ribavirin (estimated at being NZ$24,000, where a full course is completed). There are laboratory monitoring and out-patient costs in addition. As such the total costs are higher at $15000 for 24 weeks and $30,000 for 48 weeks. However, there is significant cost associated with the long-term consequences of infection in untreated individuals, for example chronic Hepatitis is now a leading cause of listing for liver

transplant. Cost-benefit studies have been undertaken in Australia demonstrating the return on investment of preventative strategies aimed at Hepatitis C.

High levels of diagnosis and treatment reflect both awareness of the condition within the medical community in Southern DHB and the willingness to treat chronic infection. As indicated above, this does commit significant resources to the treatment of Hepatitis C. There have been legitimate questions raised about the balance of expenditure between treatment and preventative work. In practice, modest additional expenditure on effective preventative activity will result in a saving on treatment costs in the longer term. An awareness raising and testing strategy will result in the ascertainment of some currently undiagnosed cases and has the potential to increase treatment costs by "bringing forward" diagnosis and treatment – ie cases which may have gone undiagnosed and thus untreated are likely to be diagnosed and treated as a consequence of increasing testing within the local community.

Risk Factors in the Southern DHB Area

Looking at recently diagnosed cases, the single most common risk factor in cases locally is a history of personal IV drug use or of sexual contact with an IV drug user. The second most common risk factor is the use of a tattoo in an unregulated setting. This indicates that important actions to counter Hepatitis C in Southern District should be those aimed at harm reduction in IV drug users and at raising awareness of the risks of using unregulated tattoo artists. However, a more general approach of raising awareness of the risk factors for infection, the latent nature of the infection in many individuals and the provision of testing, counselling and treatment in those at risk of infection is both appropriate and necessary.

Current Preventative Action

The Ministry of Health manages contracts across the country relating to preventative and harm reduction activity, this includes the needle exchange services and Hepatitis C Resource Centres. The DHB has supported the needle exchange service over the last few years providing advice and strategic support through the local reference groups and will continue to work closely with these services. There is ongoing concern that the current level of funding provided by the MoH does not match the need for needle exchange services across our District, particularly in rural areas. Proposals indicating the need for an outreach service within the Southern district have been made to several MoH Portfolio Managers in recent times but no progress has been made in this area. Lack of access to this service does increase the risk of infection and of onward transmission.

Certain pharmacies across the country provide preventative services through the provision of safe equipment for IV drug users that can be purchased by clientele. There are a number of pharmacies that provide this service within the Southern district.

The aim of preventative and harm reduction activity is:

- To reduce the occurrence of hepatitis C infection in the community and therefore to reduce the risk of infection in the community;
- To reduce the overall burden of disease in the community;
- To enable those who misuse drugs to avoid the harm associated with blood borne infection and thus be in a better position to undertake treatment leading to recovery from dependency.

Current DHB preventative activity is focused on a small number of programmes. These include:

- Providing strategic support and advice to the Dunedin and Invercargill needle exchanges through the local Reference Groups.
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Recommendation for Action

The view of the report author is that the development of a Hepatitis C strategy for Southern District would be an appropriate response to the current situation. However, planning for the delivery of effective action against Hepatitis C would form only one part of a wider strategy aimed at reducing blood borne viral infections. Such an approach will require multi-agency involvement and will not be successful if it is seen only as a health initiative. It is recommended that a Blood Borne Virus strategy for the Southern District population should be developed through a multi-agency approach.

Dr Keith Reid, Public Health Physician

SOUTHERN DISTRICT HEALTH BOARD

MATERNITY QUALITY & SAFTEY STRATEGIC PLAN

2012 - 2015

1. INTRODUCTION

The New Zealand Maternity Quality and Safety Programme is a national programme which establishes and builds upon national and local quality improvement activities. At its heart it seeks to ensure the highest possible safety and best possible outcomes for all new mothers and their babies. The Programme takes a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage as per standard 2 of the New Zealand Maternity Standards. This initiative has an immediate focus around the birth even however we know that the best outcomes from a maternity even are driven by a broader range of factors including early engagement with a Lead Maternity Carer (LMC), the mother's socio-economic situation and educational level, her health literacy, age and weight and ethnicity. This initiative takes cognisance of these boarder factors but focuses on activities managed by health professionals around the pregnancy and birth event.

Quality has been identified as a cornerstone of a high-performing system in the New Zealand Health Strategy[1] and is an objective of the New Zealand Disability Strategy[2]. Improvements in quality are necessary to support a vision of people-centred, safe and high-quality services that continually improve and that are culturally competent. "People-centred" requires people involvement and being receptive and responsive to their needs and value.

Quality and safety of maternity services is a key priority for the Southern DHB and, whilst aspects of the proposed program have been developed with varying degrees at individual sites (Otago and Southland), we envisage that this initiative would assist in providing the framework for future integrated regional service provision to our clients and community along with the opportunity to progress the Southern DHB vision of "one service, many sites".

Purpose

The Maternity Quality and Safety Programme aims to enhance maternity service quality and safety for the women, babies, family and whanau and service providers living and working in the Southern District. It outlines structural improvements to support and monitor the implementation of quality and safety initiatives.

This will be achieved through a structured system of ongoing systematic review by a governance group made up of clinical leaders, managers, consumers and Maori representation.

2. DEMOGRAPHIC

Southern District Health Board (SDHB)

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

SDHB is the second largest DHB by geographical area in New Zealand. As a DHB, SDHB is responsible for planning, funding and providing health and disability services to a population located south of the Waitaki River.

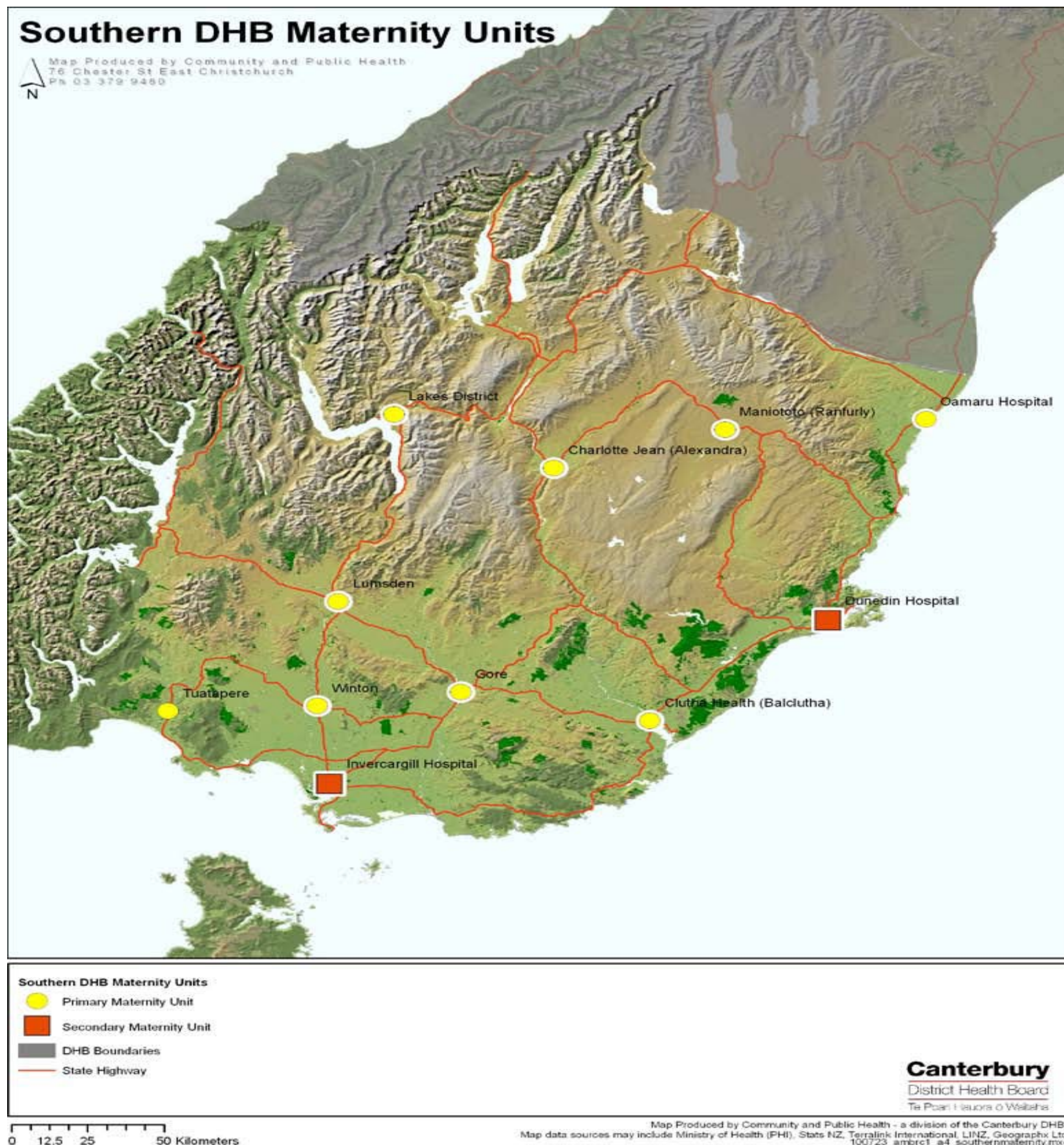
Southern DHB has a staff of approximately 4,500 and is governed by a Board made up of both publicly elected and government appointed members.

2.2 Southern DHB Catchment Population

The SDHB catchment area's resident population measured in the 2006 Census was 286,209. (7.1% of the national population live in the SDHB catchment area).

The catchment area encompasses Invercargill City, Queenstown - Lakes District, Gore, rural Southland, Clutha, Central Otago, Maniototo, Waitaki District and Dunedin City. of the SDHB 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.



2.3 Total Population Growth by area (Southern DHB district)

Overall the Southern DHB population has a projected growth of 3.4% (10,100 people) between 2006 and 2021. However this does not portray the nature of the sub-regional population changes. Queenstown, Central Otago and Dunedin populations are projected to grow, while Waitaki, Gore and Invercargill are projected to experience population decline.

Table 1: Sub-regional population projections for Southern DHB 2006-2021

TLA	2006	2011	2016	2021	Growth 2006-2021
Waitaki	20,700	20,200	19,700	19,000	-1,700
Central Otago	17,100	17,900	18,600	19,200	
Queenstown-	24,100	27,300	30,500	33,400	9,300
Clutha		17,100		16,500	-
Southland	29,200	29,300	29,200	28,900	-300
Gore	12,400	12,000	11,700	11,300	-
Dunedin	122,300	124,100	125,700	127,200	4,900
Invercargill	51,600	51,100	50,300	49,200	-
TOTAL	294,600	299,000	302,500	304,700	

Data source: Statistics New Zealand

2.4 Changes in Age demography for females aged between 15-44 years

The number of birth age women decreased in Otago and Southland, by 4.2% (2800 women) between 1996 and 2006 Census periods (Statistics New Zealand, 2006 Census). This decrease is projected to continue into the future. (Statistics New Zealand, Population Projections)

2.5 Changes in demography by Ethnic group

The ethnicity of birth age women in Otago and Southland has been changing in recent years.

The population of NZ European/Pakeha birth age women decreased 7.45 (4750 women) between 1996 and 2006 Census periods (Statistics New Zealand). During the same period the population of Asian birth age women increased by 50.8% (1270 women) and Maori by 11.5% (630 women).

Birthing data from the area shows that the most significant increase in ethnicity of women giving birth in recent years is Asian women with an increase from 1.9% of all births in 2005/06 to 3.4% of all births in 2008/09. In the same period there was a decrease in the proportion of all births amongst NZ European/Pakeha people (from 72% to 68.3%). The proportion of other ethnic groups has remained relatively stable over this period.

The ethnic profile of the district can be seen in

Table 2. Less than 15% of the population identify as Maori, Pacific or Asian.

Table 2: Ethnicity Profile in Southern DHB - 2012 Estimate

Ethnicity	Population	Percentage
Asian	12130	4.0%
Maori	27650	9.1%
Other	261100	85.5%
Pacific	4600	1.5%
Total	305480	100.0%

2.6 Maternal age across the region

The mean age of women giving birth in the Southern DHB region in 2008/09 was 29.4 years. This is consistent with the national average (30) years**.** The range in age for women giving birth in this period for the Southern DHB region was 14-50 years.

Funded Maternity Services

The DHB also funds pregnancy and parenting services with 14 providers across the district. The DHB contracts with a range of eight primary maternity facilities in the rural areas. The DHB provides primary facility maternity services in the regions two main cities Dunedin and Invercargill as well as Frankton which also provides primary midwifery services.

Rural Primary Maternity Facilities

Southern DHB currently funds nine rural primary maternity facilities in the region. These 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

All pregnant women and their newborn babies must have access to Maternity Services and can choose to birth at any Primary Maternity facility that has a contract with a DHB and where their 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 need for her to be transferred to a specialist. 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.

Table 3 indicates the classification for each maternity facility/unit in the Southern DHB.

DHB **Primary Maternity Units**	**Classification**
Charlotte Jean (Alexandra)	Remote Rural
Clutha Health (Balclutha)	Remote Rural
Gore	Remote Rural
Lakes District	Remote Rural
Lumsden	Remote Rural
Tuatapere	Remote Rural
Maniototo (Ranfurly)	Remote Rural
Oamaru Hospital	Remote Rural
Winton	Rural
Secondary/Tertiary Maternity Units	**Classification**
Dunedin Hospital	Tertiary Unit
Invercargill Hospital	Secondary Unit

Table 4 indicates the distribution of births in the district.

Southern DHB Births	**2010 -2011**
Charlotte Jean	86
Clutha Health First	31
Dunedin Hospital	1724
Lakes District Hospital	48
Gore Health	100
Home Birth	99
Lumsden Maternity	36
Oamaru Hospital	103
Ranfurly Hospital	5
Southland Hospital	1321
Tuatapere Hospital	21
Winton Hospital	42
Total	**3616**

Table 5 Births by DHB, source Stats NZ

Stats NZ - Births by DHB	2007	2008	2009	2010	2011
Southland DHB	1598	1603	1648	1679	1578
Otago DHB	2088	2095	2041	2055	2079
Southern DHB region	3686	3698	3689	3734	3657

Table 6 indicates a very stable birth rate, particularly for the previous Otago DHB area. The Southland DHB region experienced a significant increase in birth numbers prior to 2007 which peaked in 2010 and is now decreasing.

Table 6 Percentage of Babies with a Maori ethnicity recorded by Births Deaths and Marriages.

Stats NZ – % Births of Maori Babies by DHB	2011
Southland DHB	23.6
Otago DHB	16.8

Southern DHB	19.7

The percentage of Maori babies recorded by Births Deaths and Marriages (BDM) is higher than recorded at birth on hospital patient management systems. More accurately recording ethnicity at birth is one of the aims of the quality and safety programme.

3.0 BACKGROUND

Southern DHB was successful in its bid to be selected as a demonstration site for the Ministry of Health's Maternity Quality & Safety Programme in January 2011.

The work of the Southern DHB demonstration site was to implement innovative approaches to clinical quality improvement activities for maternity services. These activities included:

- More visible and broader clinical quality improvement activities in maternity services. This will involve building on the quality improvement activities already in place (such as local mortality reviews and reviews of serious and sentinel events) and a broadening of the scope of review to include a wide range of matters that impact on the quality and safety of maternity services, as well as matters that are of concern to local practitioners and consumers;

- Stronger clinical leadership across both hospital and community-based maternity services so that leaders across the midwifery, general practice, obstetrics and paediatric professions work together to drive clinical quality review activities;

- Local maternity networks, so that practitioners working in maternity services across the community and hospital settings are brought together via a co-ordinated network;

- Effective mechanisms for consumer engagement in the implementation of maternity quality improvement activities. There will be a particular emphasis on consumer participation from high-need populations including Maori, Pacifica and our young mothers;

- This strategic plan leads on from the activities of the pilot. Whilst the innovations of the pilot are either embedded or continue to develop this plan does not specifically redefine them it is expected that their progress will form part of ongoing reporting.

4.0 PROPOSED MATERNITY QUALITY AND SAFETY PROGRAMME

4.1 Governance Structure

Southern DHB was a pilot site for the Maternity Quality and Safety Framework beginning in 2011 and the governance structure set up for that process has remained in place. At this stage there is representation from most stakeholders.

There is value in retaining some aspects of the existing structure as the people involved will have a clear idea of what is required, but as the pilot project becomes business as usual the structure and the membership will need to be sustainable over the longer term and will need to enable participation from providers across the district.

There will be a maximum of twelve people on the Governance group, with the ability to second expertise for specific projects or work programmes.

The meetings will take place monthly initially and participation will be facilitated by the use of Videoconferencing and Teleconferencing facilities.

The Governance group will sit outside the Provider Arm Structure of the DHB and will have the authority to make decisions in consultation with the Southern DHB Planning and Funding.

Funding or service provision decisions will need to be negotiated with relevant parties in conjunction with Planning and Funding as there are many different providers' interests to be considered.

4.2 Clinical Leadership

Clinical leadership positions will include those with designated clinical leadership roles and those who have an interest in quality and governance in the range of settings in which services are provided.

Membership:

- Director of Midwifery
- Obstetricians – two
- Midwives – two
- Community Representatives – one General Practitioner and one maternity facility representative.

Management Representation

One manager from an urban facility and one rurally based.

Consumer Representation

Support for meeting attendance will be agreed as part of the terms of reference

- Maori representation will be sought in consultation with the Southern DHB Maori Health Directorate
- Two consumer representatives will be sought via advertising for expressions of interest.

4.3 Quality Improvement

Each of the organisations with whom the DHB has contracts currently has their own quality structure. That will not necessarily change as the size and scope of the organisations are all very different, but the opportunity to share some aspects of the systems will be explored.

Consistency in policy, procedures and processes will give the opportunity to reduce the administrative burden for all providers.

Current processes for the Mortality and Morbidity Review are provider arm based with input from external professionals. Access to the meetings has been enhanced by video conferencing however the support for primary facilities in particular for clinical review is regarded as early area of enhancement for our programme.

Data collection information over the district has been an ongoing challenge. Women move in and out of our facilities and the bulk of care is provided in the community. Potential developments in maternity electronic record keeping may assist, but at present time as a district we are unable to report locally against the New Zealand Maternity Standards.

Health Round Table and Women's Healthcare Australasia benchmarking information are valued by the DHB facilities, but unfortunately the information gathered does not extend to primary facilities. Linking

the information about care provided across the spectrum of service delivery is a quality improvement activity which will help inform service delivery, service planning and models of care.

For the Southern District the providers and consumers of maternity services will identify and prioritise the goals of the programme.

As part of the pilot programme and the Workshop we have identified as priorities

- the sharing of quality processes
- developing robust clinical review
- information sharing, communication systems and support for involvement of providers across the spectrum of care
- opportunities for education and training accessible and appropriate for providers, both clinical and management

The systems and processes for sharing and disseminating information will be developed with the wider network. The Maternity Quality and Safety Workshop participants identified an Annual forum for providers and consumers as one activity for sharing information.

4.4 Communication and Networking

A communications plan will be developed as part of the work of the Clinical Governance group. Where possible existing networks, communications and meetings will be used so as not to duplicate resource use.

The Southern District is challenged by the distances that women and practitioners have to travel to the secondary/tertiary facilities which are both placed on the coast. It is envisaged that practitioner representatives from outlying areas will be selected as points of contact for their geographical area and be a conduit to two way communication.

This will be in addition to communication with all interested practitioners and providers which will have to be provided in some form of electronic or web based communication system to ensure maximum access for those remotely based. Video-conferencing is currently well utilised in the district, but access is challenging and more available units will be required to ensure reasonable access.

Data sharing and comparison between groups is an issue that will require specific attention. Most self-employed LMC midwives utilise the Maternity and Midwifery Provider Organisation (MMPO) for their practice management tools, but there is no such definitive tool used by GP's who provide maternity care. Accessing information from MMPO could be achieved, but this will not provide information on all care. Initially national data accessed from the Ministry of Health will form the basis of collection and comparison.

A combined provider, practitioner and consumer consultation day was held in early May which Ministry of Health representatives also attended. Feedback from the day was positive and the there was considerable homogeneity of opinion from those that attended. Strategies for further consultation and feedback will be developed as part of the communication plan.

Already a number of provider and practitioners have indicated that they wish to be part of a wider consultation group. This will be developed further from existing GP and midwifery contact lists, and

consumer and interest groups. Whilst the objective is to seek feedback, predominately it is envisaged that this will be an information sharing activity with the opportunity to provide feedback if desired.

4.5 Programme Operations

The Pilot programme demonstrated the value of a designated role to be the contact point, administrator and coordinator and facilitator to support quality improvement initiatives. As the DHB has a large area with widely dispersed service providers the role will be consolidated into one FTE for the district rather than small amounts of funding for each service provider. This will enable the funding to be used most effectively and also facilitate a consistent approach to service provision and quality activities.

As the initial phases of implementation are likely to require extensive resource, the role of programme coordinator will be full time for the first year and then evaluated.

Both community and consumer representation are critical to the success of the programme. Key stakeholder groups will be identified and supported to participate. This will be challenging given the distances and small population centres in our district. The use of technology for communication will be critical to ensure effective communication. It is envisaged that this will be web-based for anytime communication and video conferencing or face-to-face for scheduled meetings.

Whilst Southern DHB is our area of greatest interest, maternity services in New Zealand remain strongly nationally based. In addition there is greater sharing of resources and initiatives across the South Island region. It is expected that the Southern Quality and Safety programme will have strong links with other similar programmes in the region. A number of the activities associated with the program are well established and indeed form part of existing roles. For those roles little change will be evident with the exception of oversight by the governance group which will be district wide, rather than being for DHB services only.

As a reflection of the national expectations of maternity care the New Zealand Maternity Standards will form the basis of the Quality and Safety programme. Specifically standard three, "all women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women" will underwrite all activity. Furthermore the first and second audit criteria and measurement of this standard (as set out below) will be the principles on which the programme will be rolled out on.

Audit Criteria	Measurement
22. All DHBs plan locally and regionally to provide the nationally agreed levels of primary, secondary and tertiary maternity facilities and services for their population.	22.1 Local services are consistent with the national and regional plans and are accessible and appropriate for the local population.
23. Women and their babies have access to the levels of maternity and newborn services, including mental health, that are clinically indicated.	23.1 Local multidisciplinary clinical audit demonstrates women and babies have access to levels of care that are clinically indicated.

In line with the national maternity perspective and the large amount of collaboration between the Ministry of Health and sector the revision of the service specifications has been an important step forward for maternity provision. It is expected that as part of the quality and safety programme all maternity providers will review their services against the specifications.

New Zealand Maternity Standards – Applicable to District Health Boards are to be a starting point for the Q&S Programme

Standard 1:

Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
8. All DHBs have a system of ongoing multidisciplinary clinical quality review and audit of their maternity services, involving consumer representatives and all practitioners linked to maternity care.	8.1 Multidisciplinary meetings convene at least every three months.	September 2012	Work streams from issues identified Current terms of reference Attendance at meetings Minutes and distribution of same	Annual review of terms of reference
	8.2 DHBs report on implementation of findings and recommendations from multidisciplinary meetings.	December 2012	Reports on implementation planning	
	8.3 DHBs invite all practitioners linked to maternity care, including holders of Access Agreements, to participate in the multidisciplinary meetings, and report on proportion of practitioners who attend.	December 2012	Meeting attendance records	Practitioner not attending contacted to access how participation could be encouraged
	8.4 All DHBs produce an annual maternity report.	June 2013	Report produced Distribution of information as available around district	Report produced Distribution of information as available around district Practitioners and providers to establish what information would be valuable to be reported
	8.5 DHBs can demonstrate that consumer representatives are involved in their audit of maternity services	March 2013	Processes developed by which consumers involvement secured	

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
9. All DHBs work with professional organizations and consumer groups to identify the needs of their population and provide appropriate services accordingly.	9.1 All DHBs plan, provide and report on appropriate and accessible maternity services to meet the needs of their population.	December 2013	Ongoing consultation with professional organisation and consumer regarding service provision	Process developed to identify women with additional health and social needs
	9.2 All DHBs identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs.	June 2013		
	9.3 All DHBs plan and provide appropriate services for the groups of women within their population who are accessing maternity services and who have identified additional health and social needs.	December 2013	Existing services mapped	Referrals to users of services reported
	9.4 The proportion of women with additional health and social needs who receive continuity of midwifery care is measured and increases over time.	March 2014	Increase noted	
10. Communication between maternity providers is open and effective.	10.1 Local multidisciplinary clinical audit demonstrates effective communication among maternity providers	December 2012	Audit tools developed and intent audit undertaken	Recommendation for action from previous audit Repeat auditing
	10.2 The number of sentinel and serious events in which poor communication is identified as a risk decreases over time.	Ongoing	Trending of incidents	
11. A national set of evidence-informed clinical guidelines is implemented within each DHB funded maternity service.	11.1 The number of national evidence-informed clinical guidelines implemented in each DHB funded maternity service increases over time.	Ongoing	Implementation plan for evidence informed clinical guidelines	

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
12. National maternity service specifications are implemented within each DHB-funded maternity service.	12.1 100% maternity service specifications are implemented in each DHB-funded maternity service.	Ongoing	Audit of implementation	

Standard 2:

Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage.

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
16. All women have access to pregnancy, childbirth and parenting information and education services.	16.1 All DHBs provide access to pregnancy, childbirth and parenting information and education services.		Access as per coverage expectations	
17. All DHBs obtain and respond to regular consumer feedback on maternity services.	17.1 All DHBs apply the national tool for feedback on maternity services at least once every 5 years	June 2014		Questions from national tool integrated into provider arm consumer feedback form and extended to other facilities
	17.2 All DHBs demonstrate in their annual maternity report how they have responded to consumer feedback on maternity services.	June 2013		
18. Maternity services are culturally safe and appropriate.	18.1 Consumer feedback demonstrates that consumers consider the services to be culturally safe and appropriate.	June 2014	Collated responses from consumer feedback	Remedial requirements established and reevaluation undertaken
	18.2 All DHBs demonstrate in their annual maternity reports how they have responded to consumer feedback on whether services are culturally safe and appropriate.	June 2014	As above	As above
19. Women can access continuity of care from a Lead Maternity Carer for primary maternity care.	19.1 All DHBs have a mechanism to provide information about local maternity facilities and services and facilitate women's contact with Lead Maternity Carers and primary care.	September 2012	Women canvassed as to knowledge of local service provision	Identified information deficits alleviated

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
	19.2 The proportion of women accessing continuity of care from a Lead Maternity Carer for primary maternity care is reported in each DHB's annual maternity report.	June 2013		

Standard 3:

All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
22. All DHBs plan locally and regionally to provide the nationally agreed levels of primary, secondary and tertiary maternity facilities and services for their population.	22.1 Local services are consistent with the national and regional plans and are accessible and appropriate for the local population.			
23. Women and their babies have access to the levels of maternity and newborn services, including mental health, that are clinically indicated.	23.1 Local multidisciplinary clinical audit demonstrates women and babies have access to levels of care that are clinically indicated.			
24. Primary, secondary and tertiary services are effectively linked with seamless transfer of clinical responsibility between levels of maternity care, and between maternity and other health services.	24.1 All DHBs report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility.	June 2013	Any issues regarding the referral guidelines are investigated	Remedial actions implemented
	24.2 Local multidisciplinary clinical audit demonstrates effective linkages between services.	December 2012	Clinical audits undertaken in best practice recommendation aimed to alleviate practice deviation	Implementation of recommendation
25. All DHBs plan locally and regionally for effective clinical and organisational pathways to respond to maternity and neonatal emergencies.	25.1 All DHBs have local and regional maternity and neonatal emergency response plans agreed by key stakeholders including emergency response services.	December 2012	Pathways deviation	Pathways reviewed

Audit Criteria	Measurement of Success	Timeframe	Evaluation	Continuing work plan
	25.2 All maternity providers can demonstrate knowledge of local and regional maternity and neonatal emergency response plans.	March 2013	Audit of knowledge	Ongoing education
	25.3 Local multidisciplinary clinical audit demonstrates effective communication among maternity providers in cases of clinical emergency.	March 2013	Audit specifications of communication following clinical emergency	Implementation of recommendation
26. Women whose care is provided by a secondary or tertiary service receive continuity of midwifery and obstetric care.	26.1 All DHBs provide, or accommodate, a model of continuity of midwifery and obstetric care when secondary or tertiary services are responsible for the woman's care.	July 2013 September 2013	Evidence of collaboration with providers of midwifery care to ensure continuity. Evidence of continuity of obstetrician care	
	26.2 Consumer feedback demonstrates that an increasing proportion of women requiring secondary or tertiary level care are satisfied with the continuity of midwifery and obstetric care they received.	September 2013	Consumer feedback specifically regarding primary and tertiary care and continued education	

Broaden the scope and visibility of maternity quality improvement activities

Southern DHB and will continue to broaden the scope and visibility of clinical quality improvement activities by:

Activity	Measure of Success	Timeframe	Evaluation	Continuing Work Plan
Recruit Coordinator	Position filled	July 2012	Review position role and scope at the end of 12 months	Define role for the next phase of activity
Establish Governance Group	Terms of reference developed Group established Meetings well attended	August 2012	The structure of the new committee is as defined in the terms of reference Records of attendance at meetings	Ongoing evaluation of group and outcomes
Maternity Liaison Roles	Fully operational		Review roles, purpose, objectives, outputs	
Producing comprehensive maternity outcome reports from existing databases and existing reports. Using this data to evaluate services against clinical indictors and identifying variations in practice and areas for further service improvement activity	Comprehensive set of data that spans maternity outcomes As a first point the New Zealand Maternity Indicators 2009 will be used as baseline data for comparison Access to local maternity data at each facility to ensure consumers and providers are aware of clinical outcomes	September 2012 December 2012 August 2012	Distribution of action points from meetings Workstreams developed by group Facilities have reviewed their facility specific clinical indicate reports and reviewed services in light of these Local data is provided for consumers	Implement changes based on review Regular analysis and monitoring of clinical indicators will identify areas requiring further review
Support implementation of the Southern DHB Maori Health Plan	Data is actively used to guide service improvement activity and review practice Preparation, circulation and presentation of an annual report Accurate recording of ethnicity of both women and their babies	December 2012 July 2013	Evidence of review and actions in response to findings Production and sharing of annual report	Review of annual report and implementation of any recommendations

Activity	Measure of Success	Timeframe	Evaluation	Continuing Work Plan
			Numbers of baby's recorded as Maori on maternity service data collection reflects the NIR and Well Child provider data and also BDM data	Continue to educate providers on the importance of accurate recording of ethnicity. Continue to educate parents on the importance of accurately identifying their and their baby's ethnicity. Ongoing evaluation.
Broadening the scope of existing mortality and morbidity meetings to cover a wider range of issues including 'near miss' incidents and indicators of best practice, as well as providing learning opportunities for all practitioners and providing a platform to develop policies and guidelines ensuring the participation of all professional groups Ensure all baby's enrolled on NIR and with General Practices by two weeks of age	Meetings review a broader scope of issues using a range of sources to inform their discussions Improvements identified and actions are followed through	December 2012 Quarterly report describes process of expanding scope of meetings.	Cases requiring clinical review are identified by defined criteria	Multi disciplinary clinical review undertaken and learnings distributed Planned improvements include review of methods to notify staff involved in selected cases to allow them to be present at the M&M meeting.
Ensure all baby's enrolled on NIR and with General Practices by two weeks of age	Enrollment of all babies with Well Child providers and General Practice by two weeks	December 2012	NIR reconciliation	Work with LMC's to ensure that women make arrangements antenatally for their own and newborn enrollment

CLINICAL INDICATORS

The release of The Maternity Clinical Indicators 2009 report provides an opportunity for district health boards (DHBs) and local maternity stakeholders to participate in and add value to the process by undertaking further investigation at a local level as part of maternity quality and safety programmes.

The indicators will be published at least annually. They will be used to help inform a programme of ongoing, systematic review by local multidisciplinary teams that work together to identify ways that maternity services and care can be improved and to implement those improvements. This information will be used in conjunction with other sources of benchmarking such as Health Roundtable and Womens Healthcare Australasia. Other indicators such as length of stay, VBAC and CS infection rates. Others that may be raised will be reviewed as requested. Transfer from planned place of birth.

The Clinical Indicators provide benchmarked maternity clinical data using a standardised definition and presented at the national level in New Zealand and by DHB area. The use of the *standard primipara* definition allows the separate assessment of a group of women for whom interventions and outcomes should be similar. In addition to eight indicators for standard primiparae, there are also three indicators for all women giving birth in hospital and one indicator covering all babies born in hospital. Other indicators will be added over time as improved data becomes available.

A *standard primipara* is defined as a woman aged between 20 and 34 years at the time of birth in a hospital or birthing unit, with no record of any previous birth event in a New Zealand hospital, whose birth is at term (from 37 weeks 0 days to 41 weeks 6 days gestation), where the outcome of the birth is a singleton baby, presentation is cephalic, and the pregnancy has had no recorded obstetric complications that are indications for specific obstetric intervention. The standard primipara represents an uncomplicated pregnancy for which intervention and complication rates should be low and consistent across hospitals

Table 8 Maternity Clinical Indicators 2009

Indicator	**Southern DHB Result**			**NZ Result**
	Spontaneous vaginal births	**Standard primiparae**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 1:</u> Spontaneous vaginal births among standard primiparae, 2009 Number and percentage of spontaneous vaginal births among standard primiparae, by DHB of domicile, 2009	434	649	66.9	69.1
	Instrumental vaginal births	**Standard primiparae**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 2:</u> Instrumental vaginal birth among standard primiparae, 2009 Number and percentage of standard primiparae undergoing an instrumental vaginal birth, by DHB of domicile, 2009	98	649	15.0	14.2
	Caesarean section	**Standard primiparae**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 3:</u> Rate of Caesarean section among standard primiparae, 2009 Number and percentage of standard primiparae giving birth by caesarean section, by DHB of domicile, 2009	112	649	17.3	15.8

	Induction of labour	Standard primiparae	Rate (%)	NZ Rate (%)
<u>Indicator 4:</u> Induction of labour among standard primiparae, 2009 Number and percentage of standard primiparae undergoing induction of labour, by DHB of domicile, 2009	39	649	6.0	4.6
	Intact lower genital tract	**Standard primiparae giving birth vaginally**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 5:</u> Intact lower genital tract among standard primiparae giving birth vaginally, 2009 Number and percentage of standard primiparae giving birth vaginally with intact lower genital tract, by DHB of domicile, 2009	216	532	40.6	35.6
	Episiotomy without 3rd- or 4th-degree tear	**Standard primiparae giving birth vaginally**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 6:</u> Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally, 2009 Number and percentage of standard primiparae giving birth vaginally and undergoing episiotomy without mention of third- or fourth-degree tear, by DHB of domicile, 2009	95	532	17.9	19.4
	3rd- or 4th-degree tear without episiotomy	**Standard primiparae giving birth vaginally**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 7:</u> Third- or fourth-degree tear and no episiotomy among standard primiparae giving birth vaginally, 2009 Number and percentage of standard primiparae giving birth vaginally sustaining a third- or fourth-degree tear and not undergoing episiotomy, by DHB of domicile, 2009	20	532	1.3	2.9
	Episiotomy with 3rd- or 4th-degree tear	**Standard primiparae giving birth vaginally**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 8:</u> Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally, 2009 Number and percentage of standard primiparae giving birth vaginally undergoing episiotomy and sustaining a third- or fourth-degree tear, by DHB of domicile, 2009	7	532	1.3	1.2

	General anaesthetic	All Caesarean sections	Rate (%)	NZ Rate (%)
<u>Indicator 9:</u> Rate of general anaesthetic for women giving birth by Caesarean section, 2009 Number and percentage of women undergoing a Caesarean section under general anaesthetic, by DHB of domicile, 2009	91	1027	8.9	9.0
	Blood transfusions	**All Caesarean sections**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 10:</u> Rate of blood transfusion during birth admission for caesarean section delivery, 2009 Number and percentage of women giving birth by caesarean section and undergoing blood transfusion during birth admission, by DHB of domicile, 2009	32	1027	3.1	3.7
	Blood transfusions	**All vaginal births**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 11:</u> Rate of blood transfusion during birth admission for vaginal birth, 2009 Number and percentage of women giving birth vaginally and undergoing blood transfusion during birth admission, by DHB of domicile, 2009	29	2422	1.2	1.5
	Babies born at 32–36 weeks' gestation	**All babies born in hospital**	**Rate (%)**	**NZ Rate (%)**
<u>Indicator 12:</u> rate of premature birth Percentage of births 32 – 36 weeks gestation , by DHB of domicile, 2009	233	3606	6.5	6.1

Figure 2 Southern DHB region