Southern Maternity
Quality and Safety

2018

ANNUAL REPORT

Southern District Health Board
Piki Te Ora

Kind
Manaakitanga

Open
Pono

Positive
Whaiwhakaaro

Community
Whanaungatanga

CONTENTS

SECTION 1

INTRODUCTION

Foreword

We are proud to report on the achievements of Southern's Maternity Quality and Safety Programme (MQSP) in 2018.

The MQSP provides a forum for maternity stakeholders throughout the southern system to collaborate in identifying opportunities to improve the maternity system for women and babies in our district.

MQSP monitors maternity outcomes, identifies priorities for improvement, takes action to improve services, promotes best practice, and amplifies the voices of services users across the southern district.

Jane Wilson and Catkin Bartlett
Co- Chairs
MQSP Governance Group

While the Southern District Health Board's Primary Maternity Project has been carried out by the Primary Community Directorate – and is not an MSQP project – we are pleased to present it here as a significant piece of work, which provides some context to maternity services in the south.

Lisa Gestro
Executive Director - Strategy, Primary and Community
Southern District Health Board

This document can be found online on the Southern District Health Board's website: https://www.southernhealth.nz

Recognition

Thank you to the people listed below for their work in the southern district.

- **Adele McBride –** Health and Safety Quality Improvement Champion (Queen Mary)
- **Angela Formston** – Falls Quality Improvement Champion (Queen Mary)
- **Annie Paulin** – Education Quality Improvement Champion (Southland**)**
- **Bronwyn Jackson** – Manual Handling Quality Improvement Champion (Queen Mary)
- **Deb Palmer** – KPI Quality Improvement Champion (Queen Mary)
- **Elspeth Greaves** – Safe Sleep Quality Improvement Champion (Queen Mary)
- **Fiona Mair** – Policy and Guidelines Quality Improvement Champion (Queen Mary)
- **Heather LaDell** – MQSP Coordinator
- **Jenny Humphries** – Director of Midwifery
- **Dr Jim Faherty** – Clinical Leader Obstetrics (Southland)
- **Keryn Jenkins** – Policy and Guidelines Quality Improvement Champion (Queen Mary)
- **Kylie Fraser** – Health and Safety and Newborn Life Support Quality Improvement Champion (Queen Mary)
- **Lee Alcock** – Smoke free Quality Improvement Champion (Southland**)**
- **Lisa Gestro** – Executive Director Strategy Community & Primary Directorate
- **Lynlee Heenan** – Newborn Life Support – Quality Improvement Champion (Queen Mary)
- **Mary Cleary Lyons** – General Manager Population Health and Primary Care
- **Michelle Archer** – Primary Birthing Quality Improvement Champion (Queen Mary)
- **Dr Nader Hanna** – Clinical Leader Obstetrics (Otago)
- **Olivia Jenkins** – Consumer Feedback Quality Improvement Champion (Queen Mary)
- **Pauline Moore** – Associate MQSP Coordinator
- **Penny Coggan** – Safe Sleep Quality Improvement Champion (Queen Mary)
- **Rebecca Taylor** – VIP Quality Improvement Champion (Queen Mary)
- **Sarah Clark** – Ongoing Work Quality Improvement Champion (Southland)
- **Susanna McQueen** – Quality Improvement Champion (Southland)
- **Toni Linington** – Infection Prevention Control Quality Improvement Champion (Queen Mary)
- **Tracey Morris** – Newborn Life Support – Quality Improvement Champion (Queen Mary)
- **Wendy Rawson** – Newborn Life Support – Quality Improvement Champion (Queen Mary)
- **Governance Group members** (see page 22).

Strategic Alignment

The following documents inform our primary maternity care.

- **National Maternity Standards**
- **National Maternity Monitoring Group Annual Report 2018**
- **Perinatal and Maternal Mortality Review Committee Thirteenth Annual Report**
- **Maternity Morbidity Working Group Third Annual Report**
- **Southern Primary & Community Care Strategy (Southern District Health Board and WellSouth Primary Health Network)**
- **Integrated Primary Maternity System of Care across the Southern District**

Our pathway

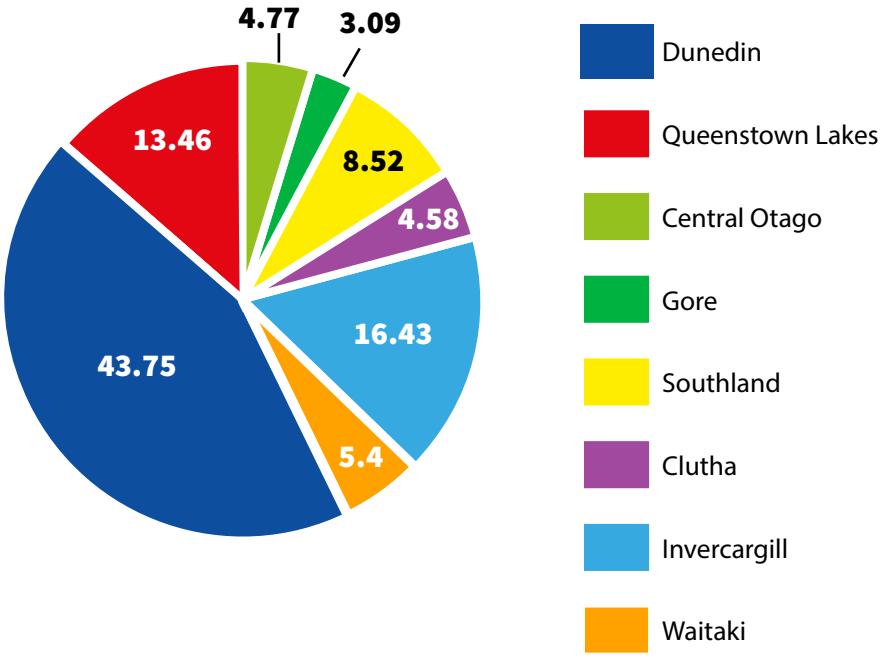
The Southern district is a vast landscape, where resourceful and capable people have built health care structures to enable us to take care of each other. Now we need to bring it all together.

POPULATION & ENGAGEMENT

SECTION 2

Maternity demographics

Women of Birthing Age (15-49 years' old) by District %



Ministry of Health *Report on Maternity 2017.*

Place of birth for women residing in the Southern District in 2017

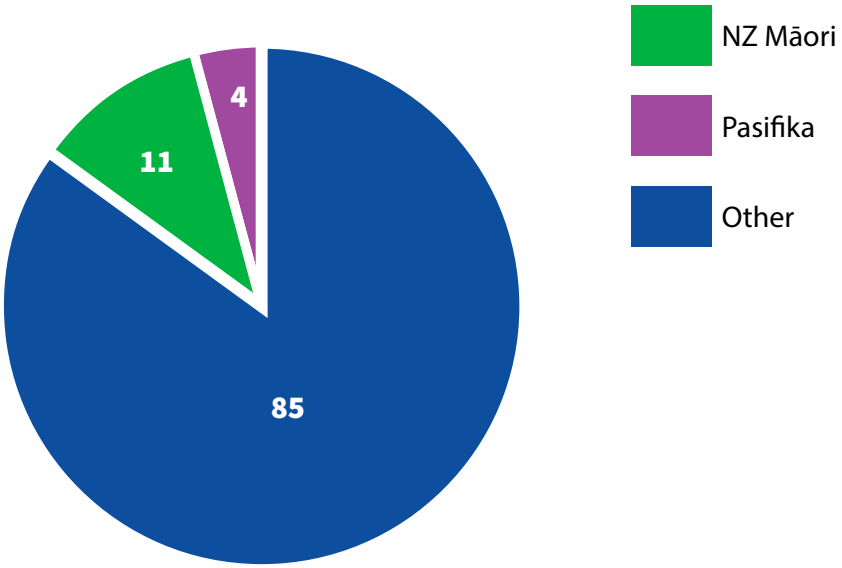
	Number	Percentage
Home birth SDHB	106	3.1
Home birth NZ		3.4
Maternity facility in SDHB	3277	96.2
Maternity facilitiy outside SDHB	24	0.7
Unknown	31	
Total	3438	

Ministry of Health *Report on Maternity 2017.*

3,438 women gave birth

9 babies were born on average each day

Birthing Women Ethnicity %



Southern District Health Board coding data 2018

Primary Maternity Facilities 2018

	Births	Transfer in for postnatal care	Total inpatient	Intrapartum transfer out to base hospital
Oamaru	68	76	144	18 (20.9%)
Clutha Health First	39	69	108	4 (9.3%)
Charlotte Jean	57	152	209	15 (20.8%)
Gore Hospital	76	70	146	20 (21%)
Lakes District Hospital	73	104	177	25 (25%)
Lumsden*	19	17	36	1 (5%)
Winton Hospital	31	153	184	4 (11.4%)
Total for Primary Maternity Units	363	641	1004	87 (20%)

* Data to 1 Sept 2018

Data provided by Primary Maternity Units

Primary Maternity System of Care

A significant area of focus this year has been the implementation of the Integrated Primary Maternity System of Care. It had long been recognised that our existing maternity system of care was no longer fit for purpose. It was an example of a system that had been configured not as the result of a coordinated plan, but rather the legacy of historic and piecemeal decisions.

LMCs were leaving the profession, and the care women received was not equitable across the district. In Southland there were three primary birthing units within around 40 minutes of each other in Gore, Winton and Lumsden. They had low volumes of births particularly in Winton and Lumsden, (with Lumsden staffed 24/7 for less than one birth per week). Meanwhile, other areas – such as Wanaka and Te Anau – had significant population bases but no formal maternity infrastructure.

The Integrated Primary Maternity System of Care followed two years of cownsultation with the community and healthcare providers, establishing principles for a reformed configuration of services:

- Critical mass – understand the population across the district and birthing numbers; meet Ministry of Health birthing population standards; and ensure there are sufficient numbers for a viable service and sustainable workforce, supported by a transfer/ transport system.
- Equity for disadvantaged communities.
- Acceptable travel distances to a facility – in the context of improved support for home birthing and acknowledging the preference for travel towards secondary care locations.

The Integrated Primary Maternity System of Care aimed to take a holistic view to direct resources differently and increase the reach of services across the whole district.

Actions

Maternal and child hubs were created as an additional layer of support in Wanaka, Te Anau and Lumsden to support midwives in those communities and improve integration with primary care services. Additional sustainability payments were introduced for remote rural midwives, with 21 LMCs across the district taking up this additional remuneration.

Outcomes

Around $250,000 in payments were made across the year. Midwives' costs were further alleviated, as the DHB invested in paying for room rental, equipment and consumables through the maternal and child hubs, and provided LMCs paid time off, with a roster of back-up midwives. Overall, the system of care led to a greater investment in primary maternity services in rural areas than previously.

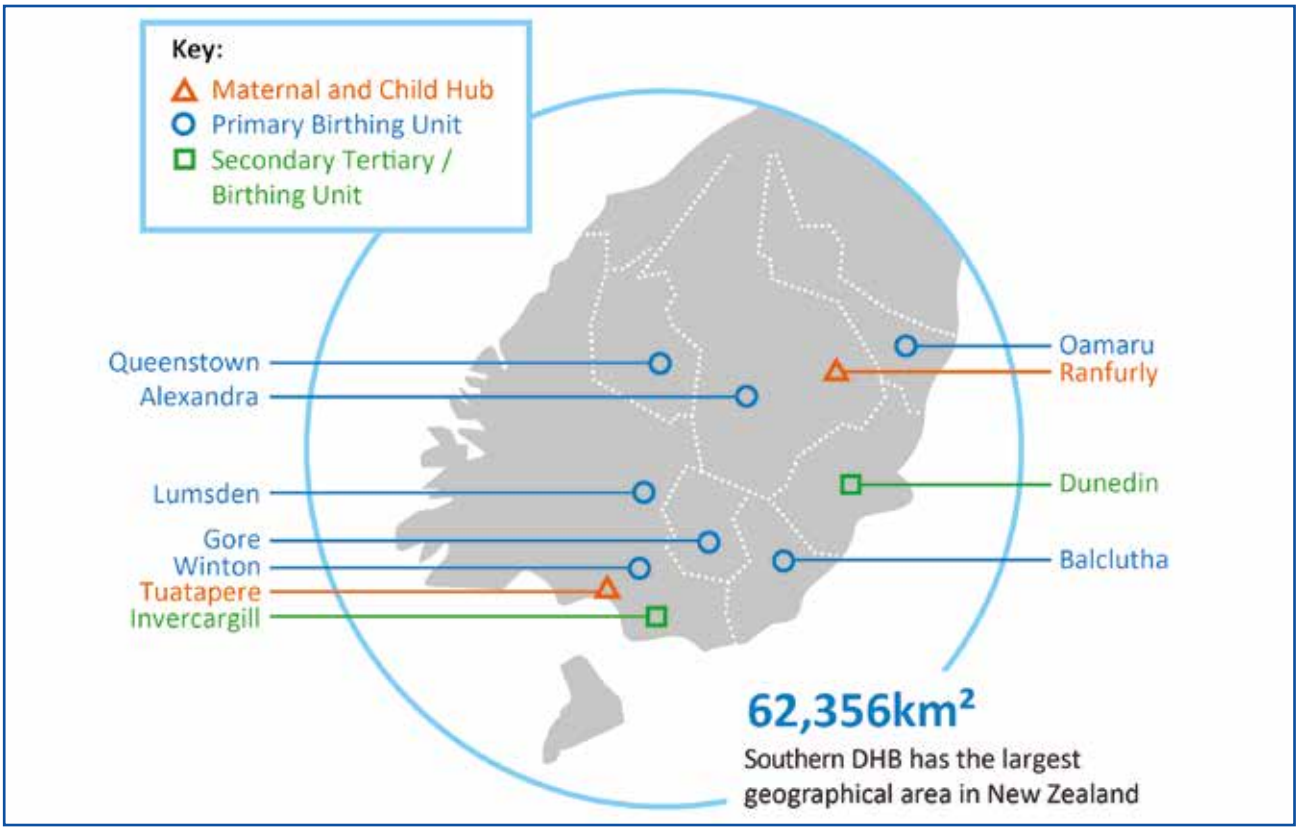
These changes have gone some way to balancing a maternity system that continues to be under strain nationally. Five additional midwives commenced or re-entered practice in the Central-Lakes area since making these changes. New initiatives such as telehealth clinics for women who require specialist care, to avoid making the long trip to Dunedin, proved popular, around 45 consultations taking place in Wanaka, quickly exceeding capacity at the clinic.

Challenges

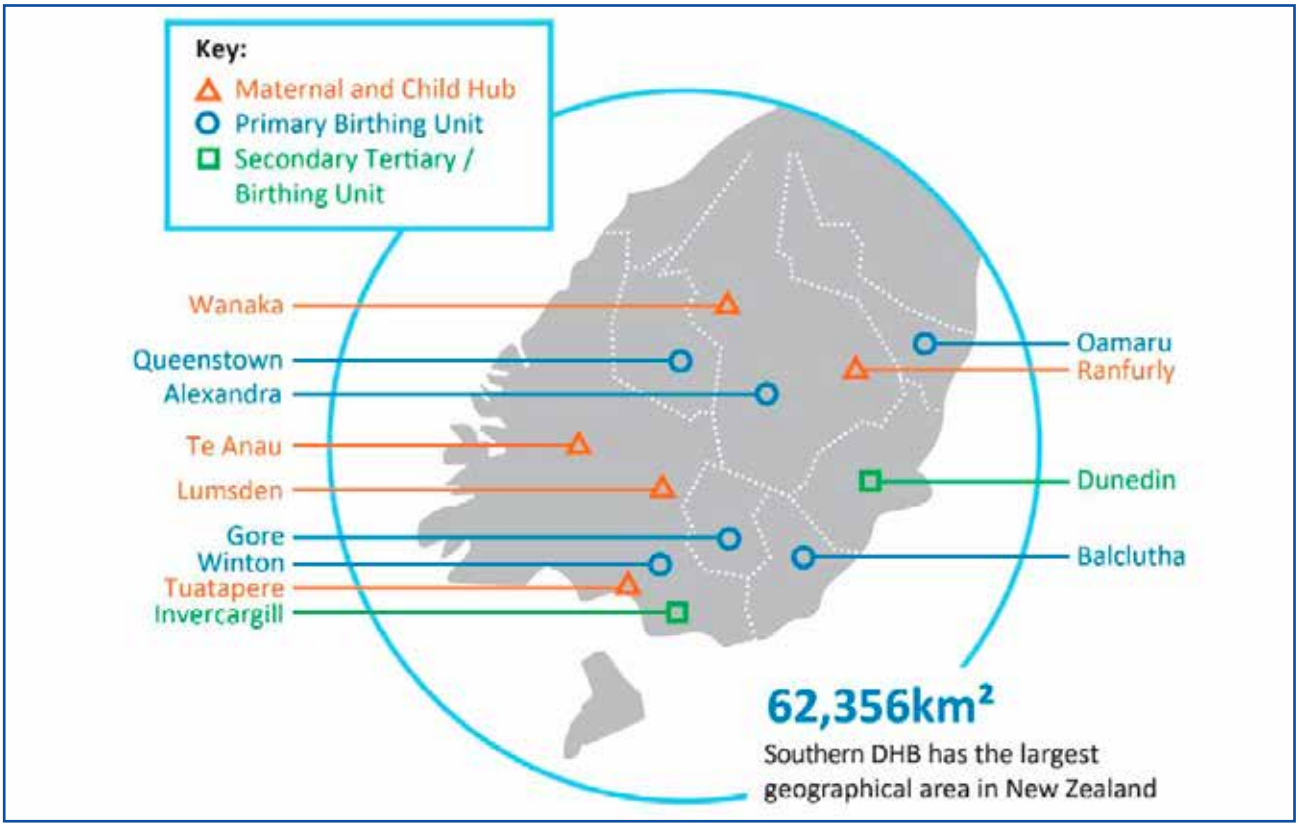
The system of care was strongly opposed in Lumsden, and the transition of the birthing unit to a maternal and child hub in that location was challenging. At approximately one year into our two-year implementation timeframe, we commissioned an independent mid-point implementation review, to evaluate our progress and learn from the challenges we faced.

The pressures within primary maternity care are not unique to Southern and involve many participants, including self-employed LMCs and the Ministry of Health as their funder, as well as the rural trust hospitals, primary care providers and emergency services that support this essential service. The collaboration between these groups that has arisen as we have worked to address the concerns that were expressed represents an important pathway to ensure a sustainable service for our rural communities.

Where we started from



The Plan



Clinical indicators

The Maternity Clinical Indicators are produced every year by the Ministry of Health. They enable us to compare outcomes for mothers and babies across facilities and district health boards.

Many of the indicators compare results for "standard primiparae"; women who would be expected to have similar outcomes across all places of birth throughout the country.

The definition of "standard primiparae' is:

- Aged 20-34 years old
- Giving birth for the first time
- Carrying one baby
- At term 37-41 weeks' gestation
- Cephalic (head down) presentation
- No obstetric complications

Clinical Indicator Overview Based on 2017 Ministry of Health Data		National 2017	SDHB 2017	Desired Position
1	Registered with an LMC within the first trimester	72.3%	78.5%	Above National
2	Spontaneous vaginal birth among standard primiparae	65.1%	69%	Above National
3	Instrumental vaginal birth among standard primiparae	16.3%	14.8%	Below National
4	Caesarean section among standard primparae	17.6%	15.8%	Below National
10	General anaesthetic for women giving birth by caesarean section	8.2%	7.2%	Below National
11	Blood transfusion during birth admission for caesarean section delivery	3.1%	1.8%	Below National
12	Blood transfusion during birth admission for vaginal birth	2.2%	1.4%	Below National
13	Diagnosis of eclampsia during birth admission	0.29%	0.0%	Below National
15	Mechanical ventilation during pregnancy or postnatal period	0.018%	0.0%	Below National
20	Babies born at 37+ weeks' gestation requiring respiratory support	2.0%	1.3%	Below National
17	Preterm birth	7.5%	7.0%	Below National
18	Small babies at term	2.9%	2.6%	Below National
9	Episiotomy and third or fourth degree tear among standard primiparae giving birth vaginally	1.7%	1.6%	Below National
7	Episiotomy and no third or fourth degree tear among standard primiparae giving birth vaginally	24.5%	19.2	Below national
6	Intact lower genital tract among standard primiparae giving birth vaginally	27.7%	27.3%	Above National
14	Peripartum hysterectomy	0.049%	0.087%	Below National
19	Small babies at term born at 40-42 weeks' gestation	31.9%	32.5%	Below National
8	Third or fourth degree tear and no episiotomy among standard primiparae giving birth vaginally	4.4%	6.3%	Below National
5	Induction of labour among standard primiparae	7.6%	10.1%	Below National
16	Maternal tobacco use during postnatal period	10.5%	11.5%	BelowNational

Key to Actual Position: Favourable Equivalent Unfavourable

Ministry of Health.2019.*New Zealand Maternity Clinical Indicators 2017*. Wellington: Ministry of Health.

Third or fourth degree tear and no episiotomy among standard primiparae giving birth vaginally

Some women experience tears to their tissues during childbirth. When those tears involve deep layers around the anus and rectum, they are categorised as "severe" with a grade of third or fourth degree.

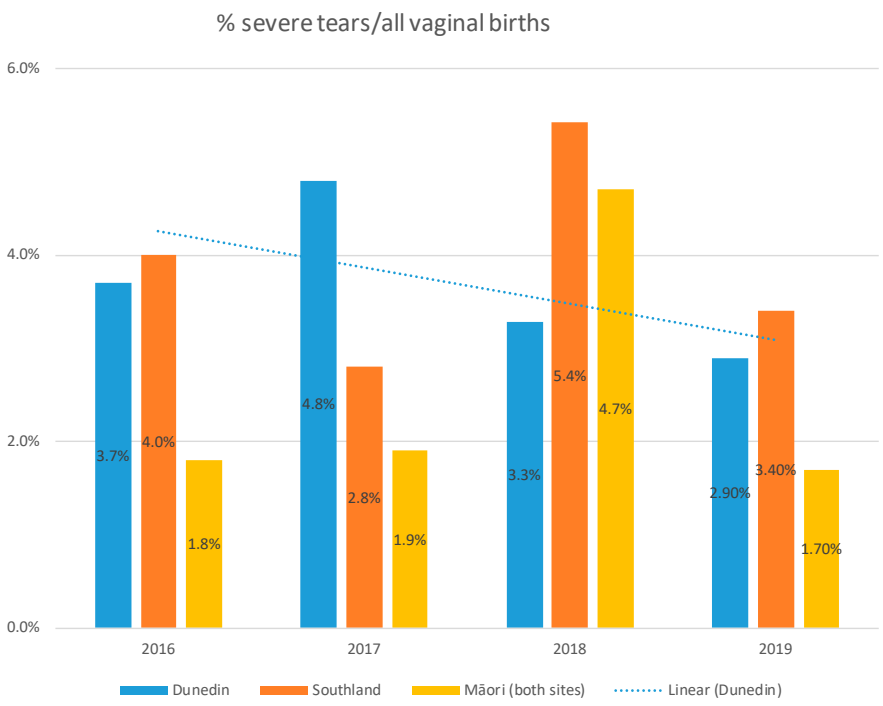
We have focused work on third and fourth degree tears, and our recent local data demonstrates an improvement.

In 2017, a change project was undertaken to reduce the percentage of women who experience severe tears in childbirth. Education sessions for midwives about perineal care during childbirth were delivered across the district and monthly case reviews undertaken of every case of severe perineal harm.

Raising awareness of severe tears appeared to have an initial effect of increasing identification of severe tears. This effect was seen in Dunedin in 2017, and in Southland in 2018.

Of note, in 2019, the rate of severe tears has decreased on both sites and district-wide.

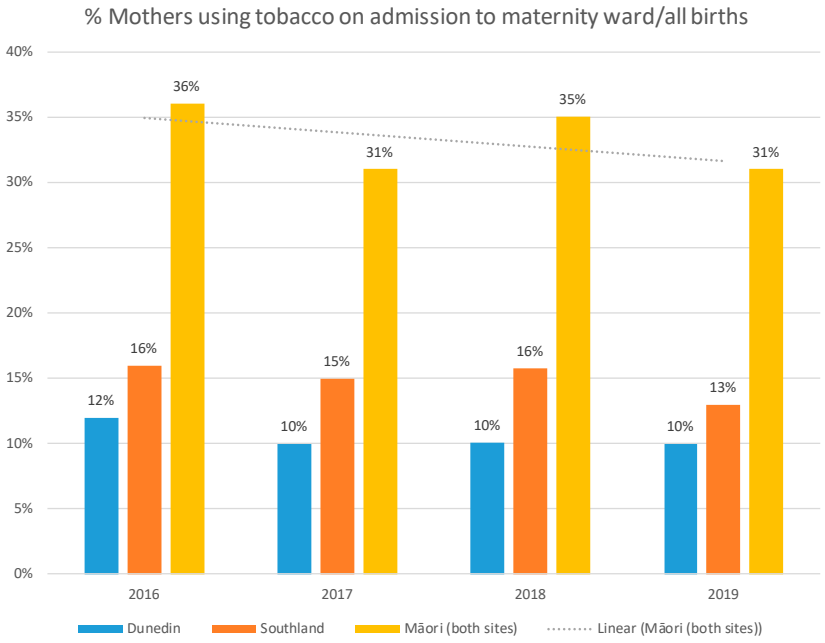
Māori women had a significant increase in the rate of severe perineal harm in 2018, which has now come down to baseline in 2019.



Maternal tobacco use during postnatal period

Tobacco usage in pregnancy is correlated with adverse outcomes such as prematurity, bleeding in pregnancy, low birthweight, respiratory illness in children and increased risk for sudden unexplained death in infancy (SUDI). Tobacco use is a significant equity issue as more Māori wahine enter pregnancy using tobacco and more Māori newborns have been smoke-exposed at birth.

We have a district-wide Southern Stop Smoking Service with special incentives for pregnant and postpartum women to become smokefree. We have increased our incentives' programme and this has resulted in a decrease in tobacco use (seen in 2019). All women who are admitted to hospital in pregnancy, during labour, or postpartum are asked about tobacco use, and 91% of current tobacco users were referred to smokefree services.



Induction of labour among standard primiparae

Methods of inducing labour can include using a catheter to thin the cervix, breaking the bag of waters around baby, and/or using medications to thin the cervix and contract the uterus.

This is the subject of a current audit.

Hospital-based maternity service birth outcomes

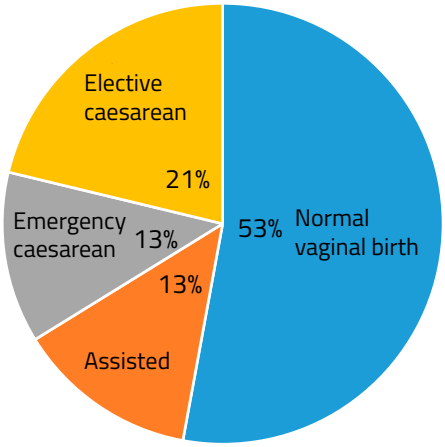
Our two base hospitals provide specialist care for women and babies (obstetric and neonatal services) as well as providing midwife-led care for healthy well women.

The interprofessional maternity team includes community midwives, staff midwives, lactation consultants, healthcare assistants, kaiawhina, mental health workers, social workers, chaplains, obstetricians, paediatricians, anaesthetists and anaesthetic technicians, theatre nurses, physiotherapists, cleaners and the reception team.

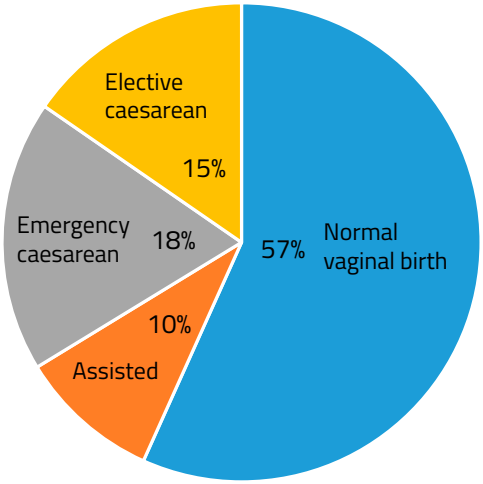
How women gave birth

Normal vaginal birth, with assistance using forceps or ventouse, caesarean section in labour or planned caesarean section

Dunedin Hospital



Southland Hospital

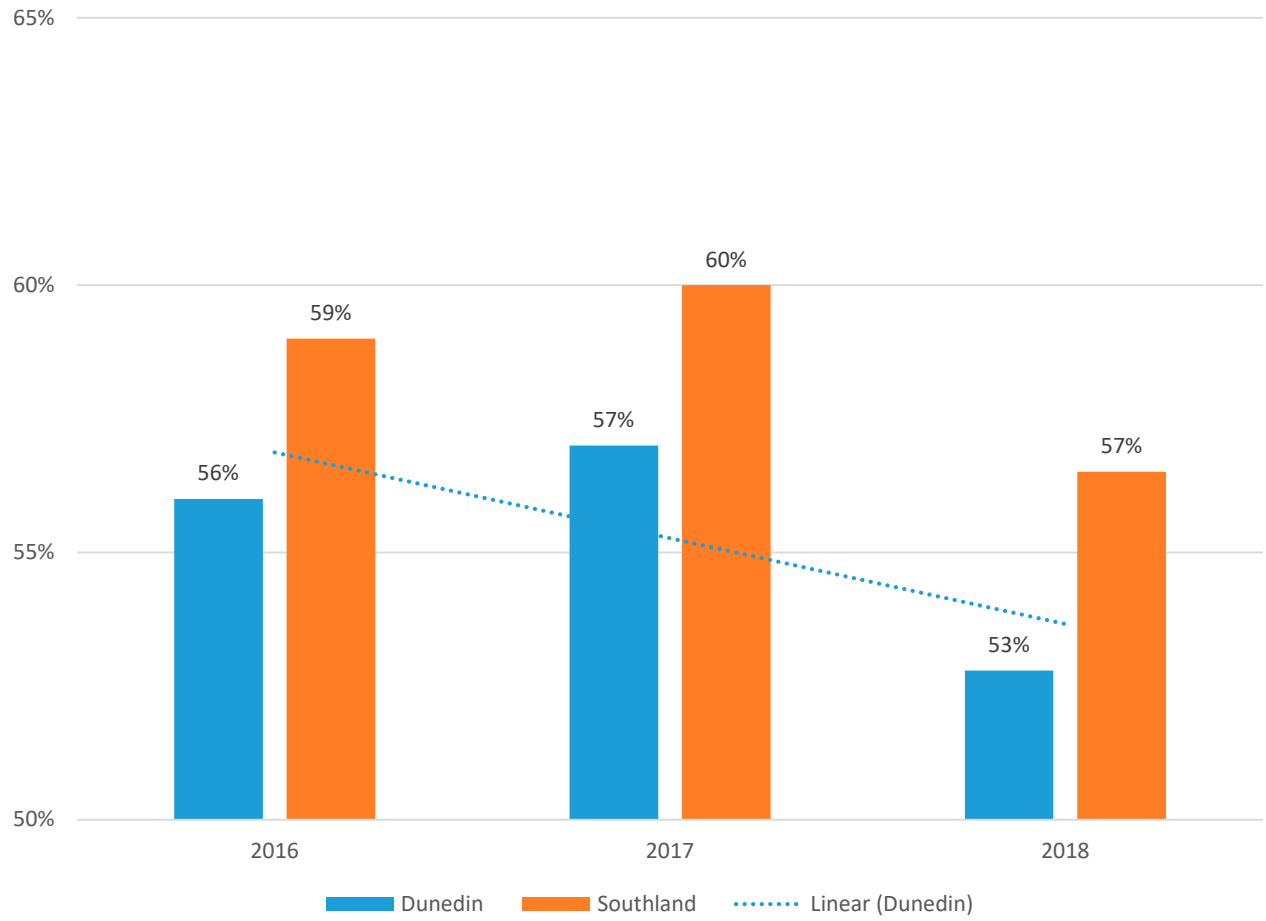


1612 women gave birth at Dunedin Hospital

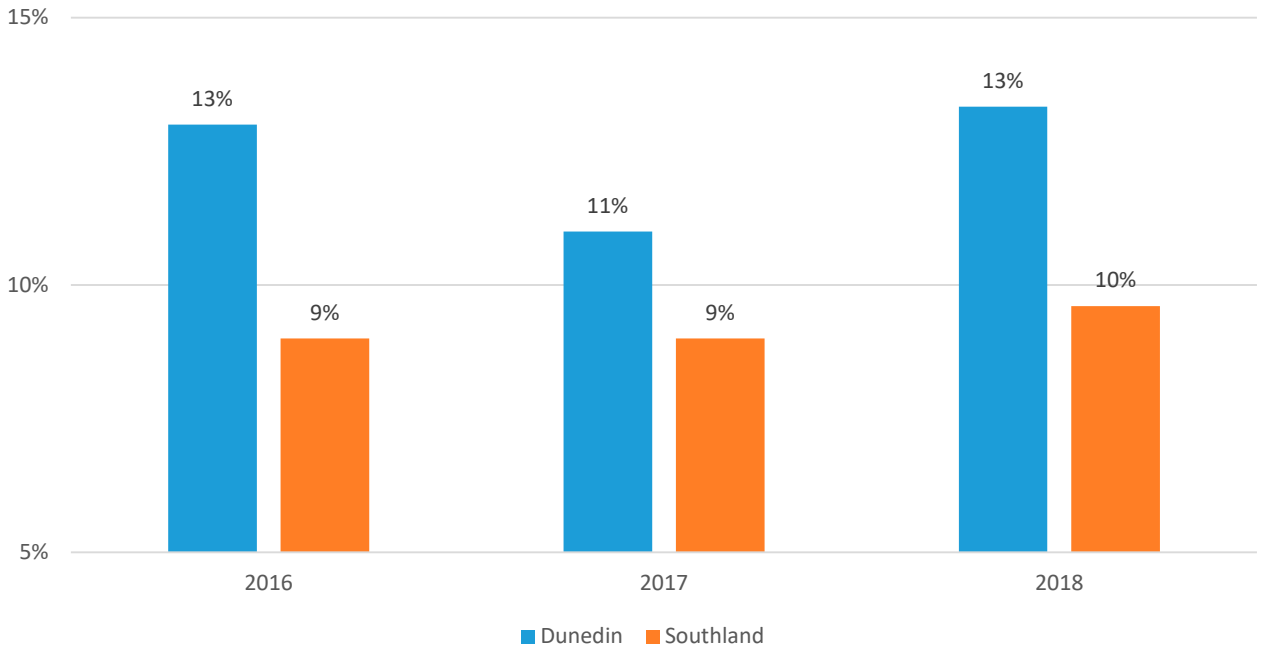
1145 women gave birth at Southland Hospital

Normal vaginal birth - by percentage of all births

Healthy women having a well pregnancy with their first baby are a low-risk population.

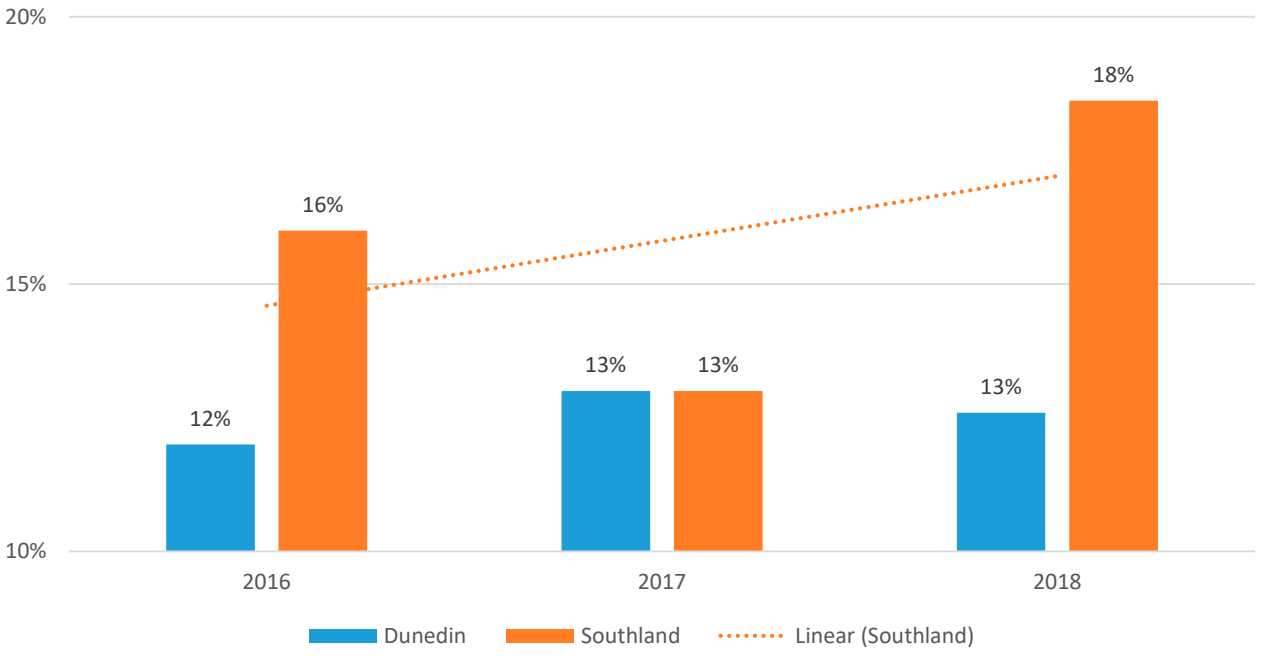


Assisted births by percentage of all births

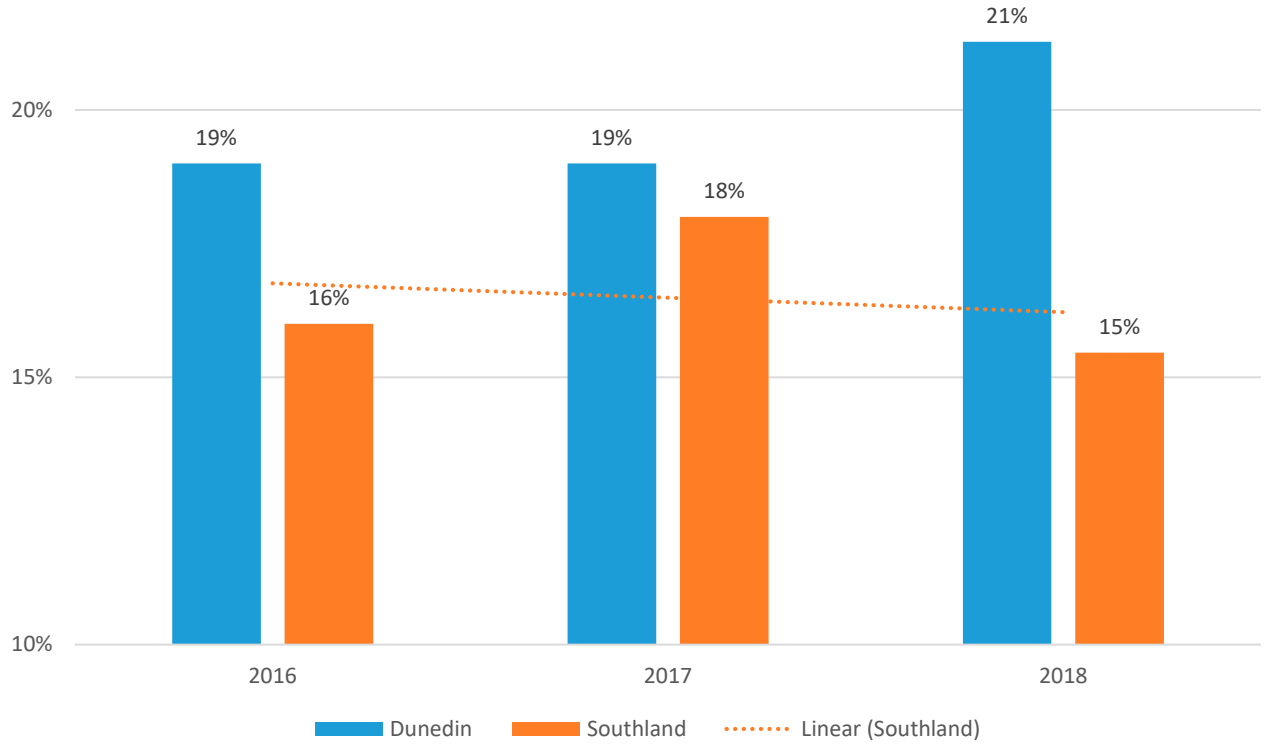


Emergency caesarean section - by percentage of all births

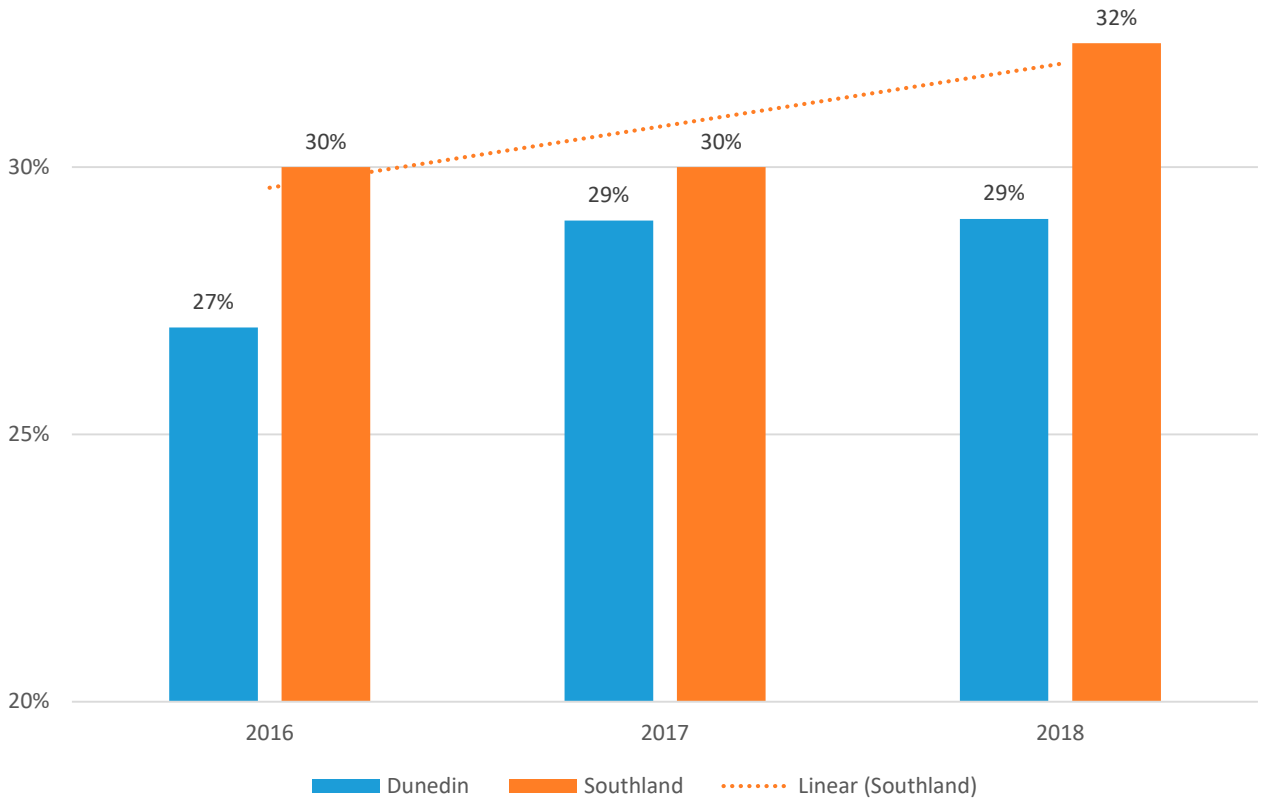
Emergency caesarean sections refer to caesarean sections carried out when the woman is in labour and had been planning a vaginal birth. There is a higher risk to mother and baby in an unplanned caesarean section, compared to a normal vaginal birth or a planned caesarean section. Complications can include bleeding.



Planned caesarean section - by percentage of all births

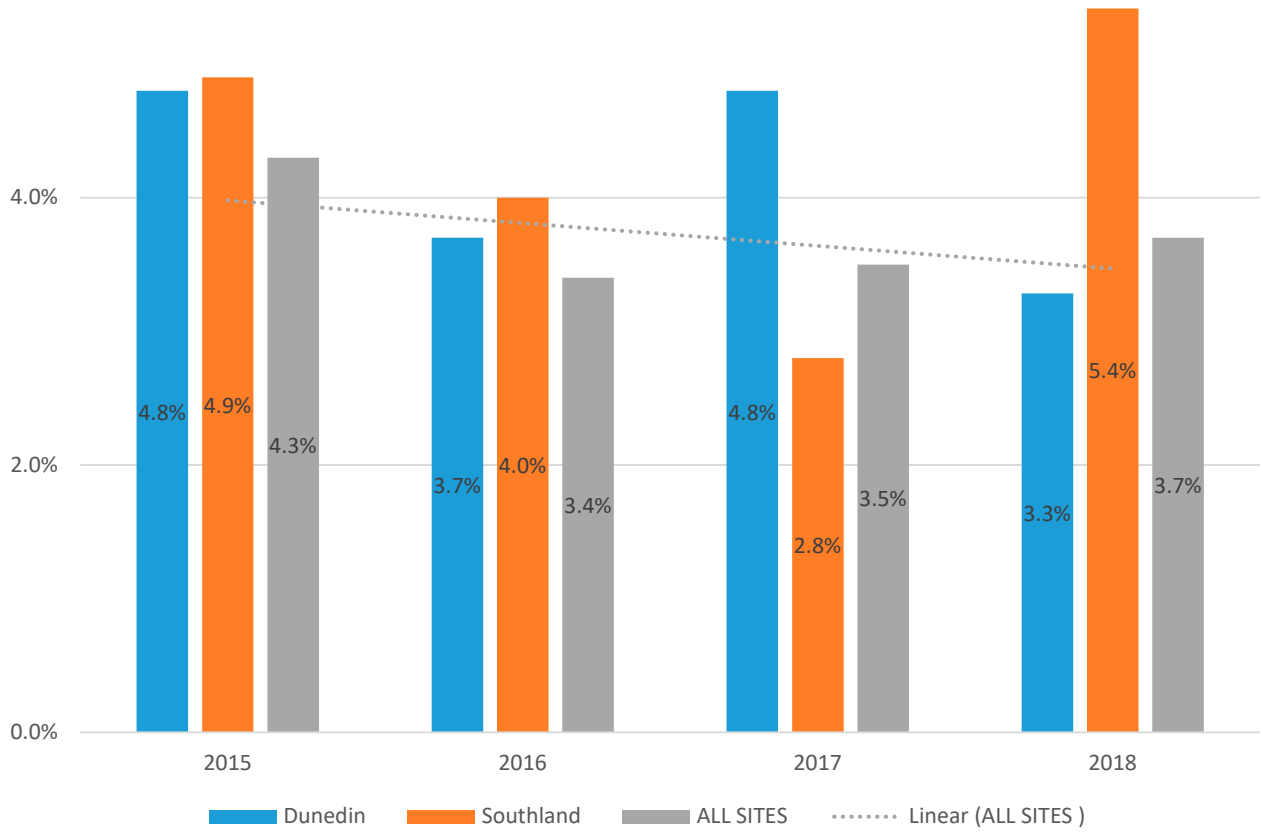


Labour started by induction - by percentage of all births



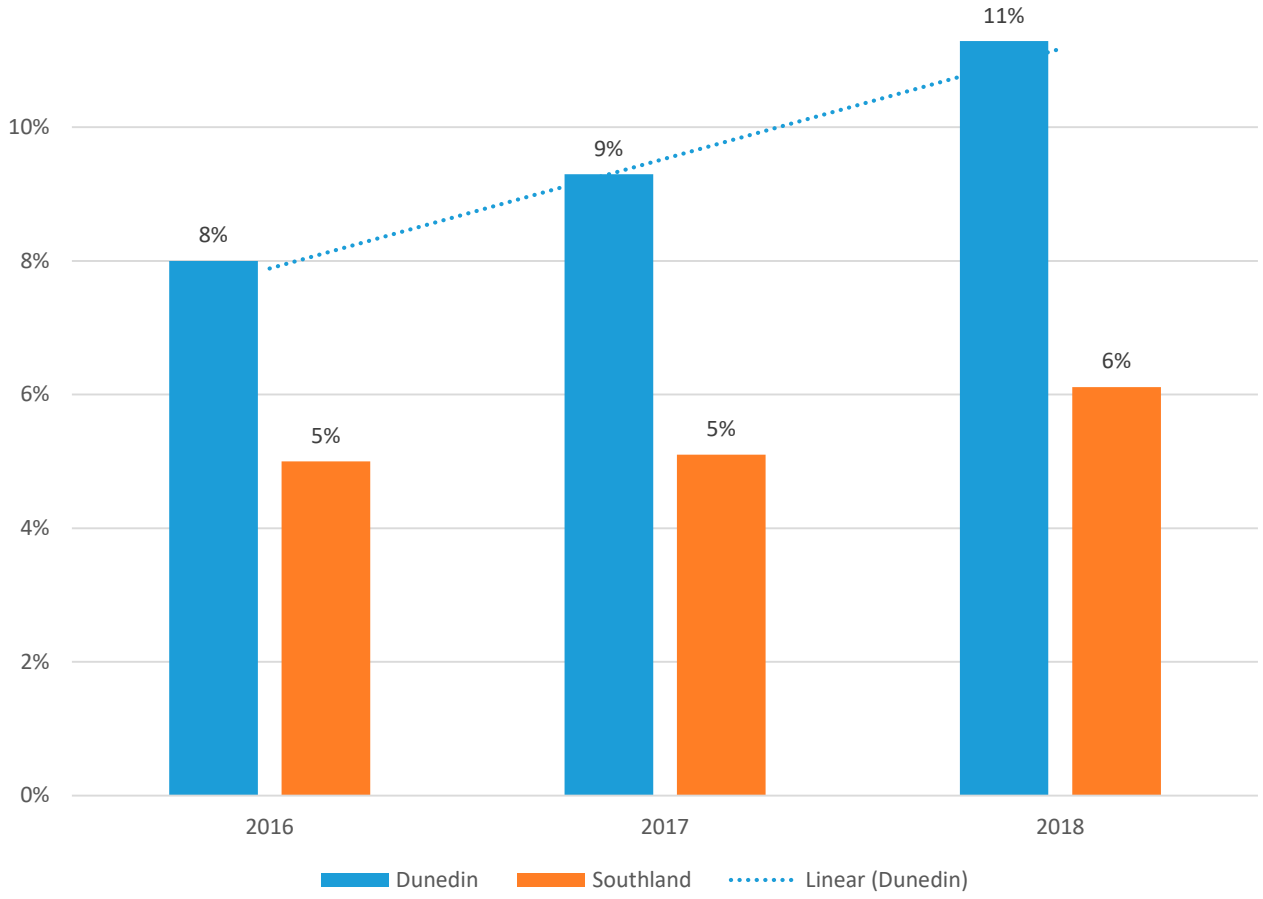
Severe tears by percentage of all births

Severe tears in childbirth are uncommon but can have a significant impact on women. This indicator compares severe tear rates in childbirth for healthy women having their first babies. Southern's Clinical Indicator result in this area was significantly higher than average in 2014. Quality improvement work commenced in 2016 including best practice recommendations (see page 11).



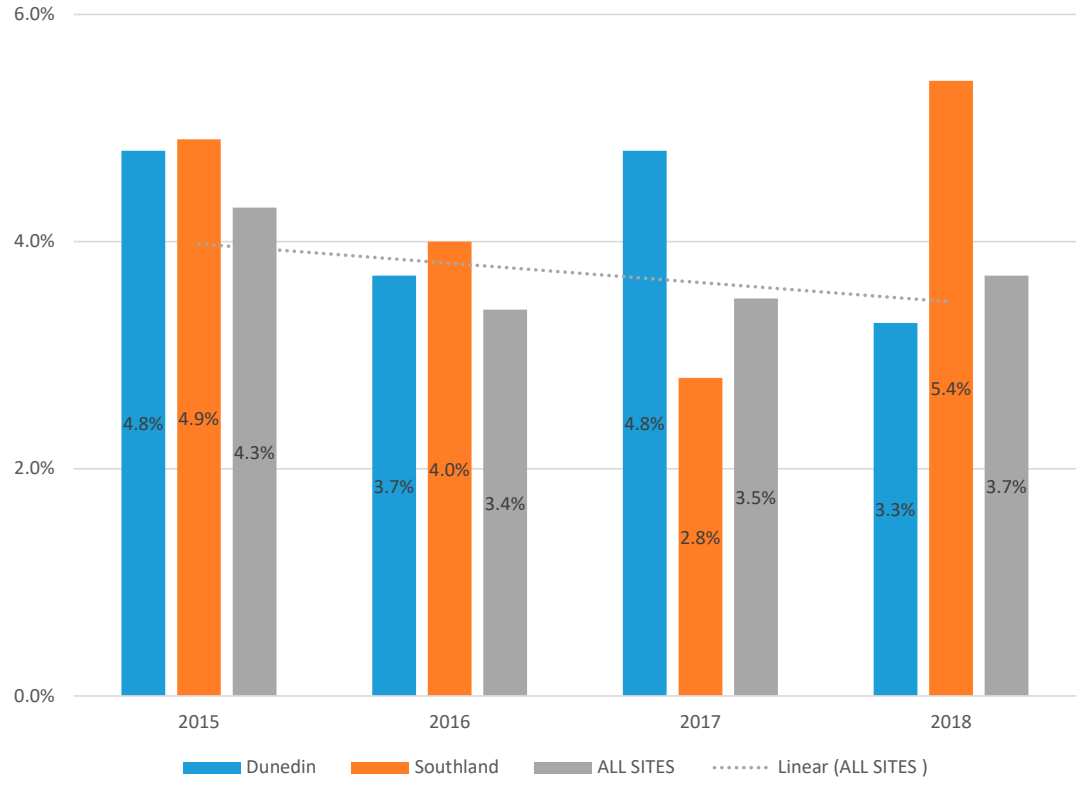
Bleeding following birth - by percentage of all births

% PPH 1000+ ml/all births



Mothers using tobacco on admission to maternity ward by percentage of all births

Smoking in pregnancy and postnatally increases risk to mothers and babies. Increases risk of pre-term birth, placental abruption, low birth weight, neonatal mortality, SUDI, and long-term respiratory problems. Maternity providers work with Southern Stop Smoking Service (Nga Kete Matauranga Pounamu Trust) to provide high-quality and effective support for smokefree whanau (see page 11).



Projects

Project 1: Increase percentage of women from priority populations who book with a midwife in first trimester (Equity priority)

Why this project?

- Low percentages of young, Māori and Pasifika women book with their LMC midwife in the first trimester, compared with overall population average 77.9% (Southern, 2016).
- High-quality early pregnancy care improves health outcomes.
- Geographic areas in Southern District with highest numbers of priority populations are Invercargill, Gore and Waitaki (Oamaru).

Actions to be taken

- Partner with community providers in Invercargill, Gore and Waitaki who work with Māori, Pasifika and youth, to improve linkages to midwifery services.
- Work with primary care to ensure high-quality early pregnancy care at first contact, and that pregnant clients from priority populations are given extra assistance to book in with an LMC midwife.
- Offer maternity-specific (Turanga Kaupapa) cultural competency training.
- Communicate the importance of early pregnancy care to the community.

How will we know we have succeeded?

- **By June 2020**:
  - Increase percentage of first trimester booking by 10%.
  - Māori women: Increase from 70.1% (2016) to 78% .
  - Pasifika women: Increase from 64.3% (2016) to 70%.
  - Women <20 years: Increase from 64.8% (2016) to 71% .

What we did in 2018

- We developed key questions to assess the needs of community stakeholders who are well placed to assist women in priority groups engage with a midwifery care early in pregnancy.
- We began consultation with stakeholders in February 2018 in Oamaru, Invercargill, Dunedin and Central. This highlighted the lack of consistent information and messaging in the community around seeking midwifery care early (especially for priority groups).
- We began development of a leaflet/poster, *Pregnant? See a midwife*.
- We ran a *Pregnancy Care in GP Practice Roadshow* and successfully engaged with GPs and highlighted areas for improvement around use of health pathways, first antenatal visit and use of Find Your Midwife website.
- One of our communications team members shot video which could be used on our Facebook page for community engagement.

Outcomes

- Work-in-progress toward our 2020 goal.

Registered with an LMC within the first trimester 2017

National: 72.3%

SDHB: 78.5%

The future

- Establish requirements of stakeholders to achieve goal.
- Review resources needed to achieve goal.
- Decide on solutions.

Number of women registered with an LMC in the first trimester, Southern DHB of domicile, 2017

Source: The Maternity Collection. Extracted: from the Report on Maternity 2017 dataset

	Maori	Pacific	Asian	European or Other	Total
	415	73	217	1979	2684
<20	27	2	1	59	89
20-24	104	16	9	241	370
25-29	124	21	56	571	772
30-34	91	24	106	661	882
35-39	61	8	37	369	475
40+	8	2	8	78	96
Total	**415**	**73**	**217**	**1979**	**2684**

GOALS

- Increase collaboration between providers who support pregnant and postnatal women
- Increase percentage of women who book with a LMC midwife by 12 weeks, especially women with complex needs
- Increase support to women for healthy behaviours with major health benefits such as becoming smokefree, increasing physical activity, eating healthily, and breastfeeding
- Increased consistency in first antenatal consult through use of HealthPathways
- Consistent information to women and families about their options for care

The goals for the New Beginnings roadshows.

Our draft "Pregnant? See a midwife" leaflet.

Project 2: Increase number of LMC midwives providing care in key rural shortage areas (Access priority).

Why this project?

- More than 700 women (20% of overall birthing population) residing more than two hours away from a base hospital had babies in Otago and Southland in 2017.
- There were acute LMC midwifery shortages in 2018 in rural Otago and Southland, resulting in some women not being able to access LMC midwifery care, or needing to seek care far from home.

Actions to be taken

- A rural LMC midwifery recruitment/retention strategy to be developed and implemented.
- Create new role to provide increased support to primary maternity midwives and facilities: Primary Maternity System Improvement Lead.

How will we know we have succeeded?

- **By June 2020**:
  - Increase from one LMC midwife in October 2018 to 2 LMC midwives retained in Wanaka.
  - Increase from one LMC midwife booking women in October 2018 to four LMC midwives providing care in Queenstown.
  - Retain sole midwife providing LMC care in Te Anau.
  - Retain at least four LMC midwives providing LMC care in Central Otago.

What we did in 2018

- In Wanaka in 2018 we took on a lease of a midwife room, provided consumables and purchased a resuscitaire.
- As part of a joint project with the Primary Maternity Strategy, we introduced a sustainability package. Midwives who provide LMC care to remote-living women were able to start applying for new supplemental payments from October 2018 (backdated to July 2018) to help with the additional costs and challenges of providing care in remote environments. More than 20 midwives signed a sustainability contract.
- We hired a locum midwife in Wanaka to address the crucial LMC shortage.

Outcomes

- The sustainability package helped retain vulnerable midwives in Wanaka, Te Anau and Lumsden.
- We attracted new midwives into Queenstown and Central Otago.

The future

- The rural LMC midwifery recruitment/retention strategy to be reviewed by February 2019.

Project 3: Decrease the distance women need to travel to access obstetric consultation in pregnancy (Access priority)

Why this project?

- Women from Wanaka who qualify for a referral to an obstetric specialist may have to undertake a seven-hour round trip for an obstetric appointment.

Actions to be taken

- Telemedicine obstetric clinic to be initiated in Wanaka by the end of October 2018, to bring specialist care closer to home.

How will we know we have succeeded?

- **By** June 2020:
  - At least 40 women will receive an obstetric consult in a virtual telemedicine clinic, who would otherwise have had to travel to a base hospital.

What we did in 2018

- In October 2018 our monthly telehealth clinics began operating in Wanaka, meaning medical specialists were accessible through teleconferencing.

Outcomes

- More than 40 women have already received an obstetric consult in a virtual telemedicine clinic; without this option they would have had to travel to a base hospital.

The future

- Evaluate the need for additional telemedicine clinics in Central Otago and rural Southland, by February 2019.

Project 4: Decrease the level of unnecessary intervention in childbirth (Quality & Safety priority)

Why this project?

- Unnecessary intervention in childbirth contributes to increased morbidity for women and decreased birth satisfaction without significant benefits for newborns (WHO 2018).
- There is no primary maternity facility option in Dunedin.
- Well women birthing in secondary and tertiary settings places them at increased risk of unnecessary interventions. Clinical Indicators show that "standard primiparae" are less likely to have a normal birth outcome in a tertiary facility than in a primary maternity setting (NZ Clinical Indicators 2017).

Actions to be taken

- Communicate with communities, providers, women and whānau to make informed place-of-birth decisions.
- Communicate WHO recommendations for a positive childbirth experience to pregnant women, families and all maternity providers.
- Provide an annual update to PPE educators about current best practice recommendations.
- Develop and implement "Keep the first birth normal" programme for maternity providers and women and whanau who birth in secondary and tertiary facilities.
- Support RANZCOG and NZCOM's "Choose Wisely" campaign to support women to make informed decisions about their care in pregnancy and childbirth.
- Explore feasibility of a primary maternity facility in Dunedin.

How will we know we have succeeded?

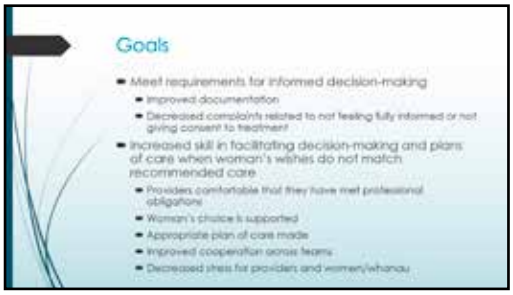
- **By** June 2020:
  - Increase percentage of standard primiparae women who have a spontaneous vaginal birth at Queen Mary (Dunedin tertiary facility) from 59.2% (Clinical Indicator 2, 2016) in 2016 to 62%.

What we did in 2018

- We carried out an audit of care of primiparous women in Queen Mary and presented findings, alongside evidence for supporting normal physiological birth, to core and LMC midwives.
- We recommended a programme of work to improve care for healthy, well women having babies in Queen Mary.

The title page for our case review.

- We initiated a monthly workshop for LMCs and core midwives to look at ways to provide evidence-based care to support normal outcomes.
- We developed and displayed "keeping first birth normal" poster.
- We presented normal birth-promoting evidence to Parenting and Pregnancy Educator providers.
- "Normal Birth Labs" were held in Queen Mary from October, to provide an opportunity for midwives and students to share knowledge and develop a package of labour and birth care that maintains safety and optimises a positive experience for women in their care.
- Birth choices information leaflets for Otago and Southland began to be developed.
- We ran two sessions for the Obstetric Teams in Southland and Dunedin on *Informed Decision-making* and the *Health and Disability*



Part of our presentation.

Commission's Code of Patient Rights, in partnership with HDC Advocacy Service. These sessions were initiated based on women's feedback.

Outcomes

- This project is ongoing. Challenges include care in latent stage of labour and for longer, slower labours; continuity of care; knowledge of alternative pain relief methods; and documenting practice.

The future

- Develop a working group to establish a clearly defined primary birthing space and culture at Queen Mary and provide feedback on a primary birthing unit as part of the Dunedin Hospital rebuild.
- Combine birth options leaflets for Otago and Southland into one leaflet.
- Update Queen Mary booking confirmation letter to include postnatal stay options and a birthing-decision tool (Southland's letter already includes this).

What practice changes would make the most difference?

First stage:

- More latent/early labourcare at home, admission in strong labour(5 cm +)
- More alternative pain relief (water, heat, TENS, sterile water injections)
- More encouragement to stay upright and active
- Keep membranes intact
- Avoid CTG unless indicated

Second stage:

- More encouragement to stay upright and mobile
- Keep membranes intact
- Discourage pushing until uncontrollable urge
- Routinely recommend passive descent 1-2 hours if epidural

Keeping the first birth normal in Queen Mary - a case review of births according to "WHO Intrapartum recommendations for a positive childbirth experience".

Project 5: Continue to decrease percentage of women who sustain severe perineal harm during childbirth (Local priority)

Why this project?

- Severe perineal harm in Southern District reduced from 4.3% in 2015 to 3.5% in 2017 with implementation of perineal harm reduction strategy.

Actions to be taken

- Increase support to midwives and obstetricians in secondary and tertiary facilities to fully implement harm reduction practise recommendations.
- Communicate perineal harm reduction strategies to women and all maternity providers.

How will we know we have succeeded?

- **By June 2020**:
  - Decrease the percentage of women who sustain a third or fourth degree perineal tear during vaginal birth from 3.5% (2017) to 3.15%.

What we did in 2018

- We introduced quarterly dashboards and distributed these widely to maternity stakeholders. If statistically significant changes occur we know about them and we can monitor how we are performing on quality improvement projects like this one. We can also see how outcomes relate to changes we make, i.e. how changes impact practice.

Outcomes and the future

- This work has now become business as usual, as one of our quarterly dashboard indicators.

Queen Mary Maternity Dashboard Quarterly Maternal Outcomes showing mean and upper and lower controls.

Governance and Consumer engagement

SDHB Maternity Quality & Safety Programme Governance Group Members 2018

Chair
- Chief Nursing & Midwifery Officer Jane Wilson

Consumer representatives
- Chair and Trustee, Homebirth Aotearoa Sian Hannigan
- Breastfeeding Peer Support Programme Administrator Catherine (Catkin) Bartlett
- Midwifery Standards Consumer Reviewer Anna Walls

Iwi consumer representatives
- Araiteuru Runaka Ria Brodie
- Murihiku Runaka Sumaria Beaton

Southern District Health Board
- Director of Midwifery Jenny Humphries
- Māori Health Directorate representative Nancy Todd
- Obstetric representative, Southland Lena Clinckett
- Obstetric representative, Otago Jana Morgan
- Charge Nurse Manager, NICU (Dunedin) Juliet Manning
- Manager, Queen Mary Maternity Centre (Dunedin) Fiona Thompson

Primary maternity facility
- Charlotte Jean Maternity Hospital Sue O'Brien

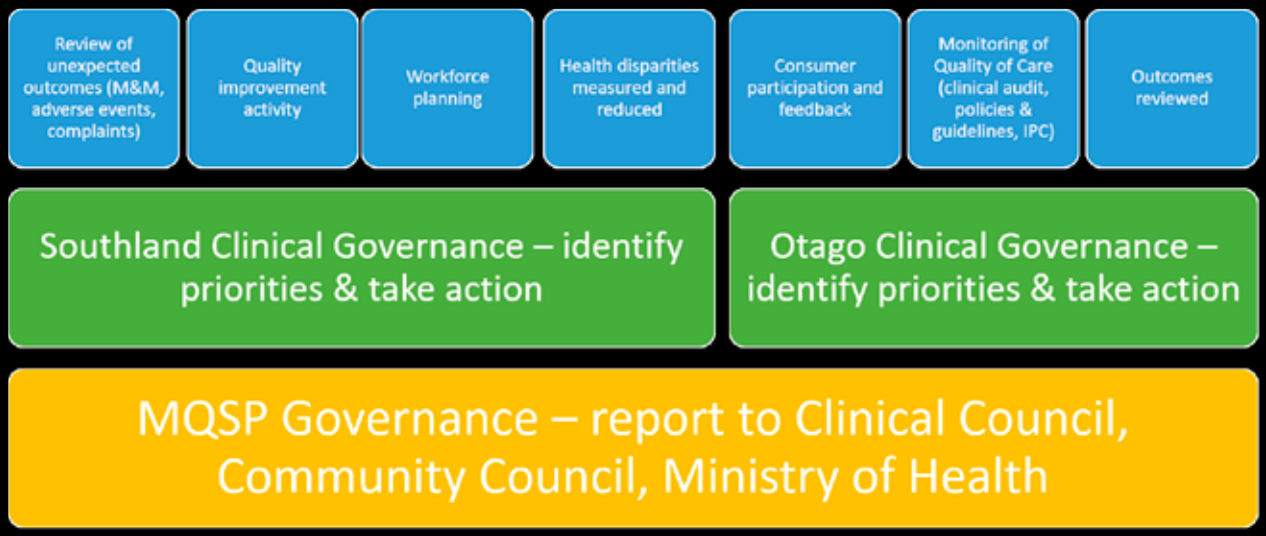
Primary providers

Midwifery
- NZ College of Midwives, Otago Emma Medeiros
- NZ College of Midwives, Southland Nicky Pealing
- NZ College of Midwives, Central/Lakes Morgan Weathington

PHO
- Well South representative (shared role) Wendy Findlay, Nursing Director and Katrina Braxton, Clinical Manager

- **Programme Coordinator** Heather LaDell
- **Associate Coordinator** Pauline Moore

Maternity Clinical Governance Structure



Engagement, feedback and communication

Representation

We are proud to have three consumer representatives and two iwi representatives on our MQSP Governance Group. We linked our consumer members with Southern's Community Council. We also presented to the Community Council and invited their members to meet with our community representatives.

Tablet-based surveys

Last year we set a goal of improving the rate of feedback from maternity facilities by implementing tablet-based consumer feedback surveys and we are pleased this system got underway in 2018.

All women who have an inpatient stay are invited to provide feedback. We have also put essential information on the tablets, such as newborn resuscitation videos, so that providing feedback is a normal part of the discharge process. The questionnaire is based on the National Maternity Survey.

Women tell us they like doing the survey on the tablet and that it is easy to complete. We can provide responses by theme and give staff good-quality feedback on what we are doing well and where we need to improve. We have a response rate of almost a quarter of women who have an inpatient stay, which compares favourably with our previous paper-based surveys which were in the 10-15% range.

LMC/stakeholder engagement and communication

In 2018 we also produced regular e-newsletters that were sent to key maternity stakeholders. We also featured information in our primary and community care e-newsletter.

Above: One of the pages in our survey.

Left: A poster at Queen Mary informing women about the survey. We have a similar poster for Southland.

NMMG Priorities

Pre-term birth

We do not have high rates of pre-term birth. At 7%, we are below the national average of 7.5%.
Women are routinely screened for risk factors including previous pre-term birth. They are referred to an antenatal obstetric clinic for advice when required. We also have an early engagement project and education for GP practices regarding quality in early pregnancy. We promote the First Antenatal Visit Health Pathway, which includes information and advice about screening and referral for risk factors, including prematurity.

Maternal mental health

The Adult Mental Health Service aims to facilitate optimal care of people with serious mental illness and associated disability and/or risk that necessitates specialist mental health services.

Criteria for admision to Adult Mental Health services

- lives within the geographic boundaries of the Southern District Health Board
- and has, or is suspected of having, a serious mental illness. The following ICD-10 disorders are a guide to conditions that may be appropriate for treatment
    - schizophrenia and related psychotic disorders
    - mood disorders
    - anxiety disorders
    - adjustment disorders
    - head injury with associated serious psychiatric disorder
    - substance use disorder with a serious psychiatric disorder
    - factitious and dissociative disorders
    - disorders with onset usually in childhood (e.g. severe Attention Deficit Disorder, Tourette's Syndrome)
    - eating disorders,
    - severe personality disorders
    - somatisation disorders
    - puerperal disorders
- and there is an associated level of disability and/or risk:
    - attempted self-harm or intent of same
    - harm towards others, intent of same or homicidal intent
    - voicing suicidal ideation or intent
    - seriously diminished capacity of a person to take care of himself or herself including poor self-cares
- **and treatment or interventions required are beyond the scope of the primary provider**
- **and the service can provide evidence-based treatment or intervention for the person with the disorder.**

Note: At all times the needs of individual consumers are considered, which may necessitate flexibility around age and team boundaries.

Referrals

All referrals to mental health services are considered against the criteria outlined above. Between 30% and 40% of all referrals are not accepted as they do not meet the criteria. The declining process often involves a lot of communication with the referrer, including advice on other options. Most of the people referred to mental health services are treated/supported within their local community and a very small percentage require an inpatient admission.

Facilities for inpatient care

There are facilities for inpatient care for mothers and their babies . The current acute ward was developed with features like a larger bedroom and fridge/bench and the location of the two rooms identified for such use being close to the nurses' station for improved observation. However, this service is provided in a general acute mental health ward that caters for general admissions and a range of other sub speciality presentations, such as eating disorders, youth and, on occasion, older persons. On one hand this is not ideal, but on the other hand the service can be delivered close to a person's home area, therefore avoiding the disconnect from supportive whanau.

Pathway

Maternal mental health services within the Otago region of the Southern district are not by way of a specific pathway but are seen as an admission either to a community service or inpatient service in a generic sense. Developing a specialised pathway will require a review of the current generic approach to determine what a specialised pathway could look like and the ramifications associated with this.

Supporting pregnant and postpartum women with mild to moderate depression

We have a Psychiatric Consultation Liaison service based at Dunedin Hospital that can be accessed by primary health services when someone has been admitted to the hospital, usually for delivering the baby. The consultation liaison provides expert advice to LMCs. The Mental Health Service also has a 24/7 service that can be contacted by stakeholders in primary health for advice along with the community mental health teams. Additionally, there are well-established networks with the Regional Service, based in Christchurch.
If there is an indication of mental distress or something more obviously indicating mental illness then any referral to secondary mental health will lead to the standard triage and mental state assessment processes, as is the case with all referrals to the service.

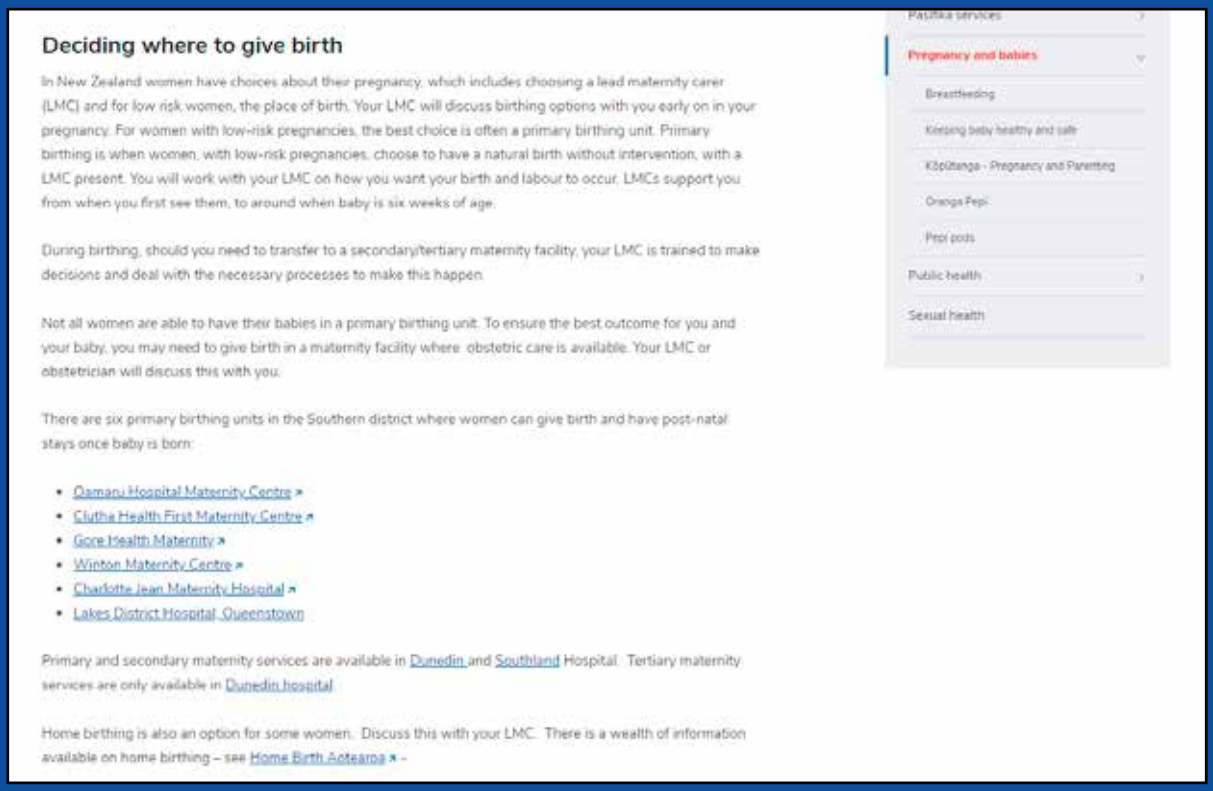
Awareness and support

There are a number of interface points where information and advice is shared and support provided. These include the interface between Queen Mary /LMC midwives and the Mental Health Consultation Liaison service, the interface between LMCs/GPs and the Community Mental Health teams, and using the Emergency Psychiatric Service for expert advice, including advice on the role the Mental Health Act has in certain situations. Education is provided by the consultation liaison nurse and/or the mental health educators on request. Additionally, we receive education from the Christchurch-based Regional Service which is advertised to the midwives and can be contacted directly. The Mental Health Service is always available to provide education/training on risk assessments associated with suicidal tendencies. It can also be approached to provide support post-suicide, either by way of assisting with the debriefing and/or advising what other options there are.

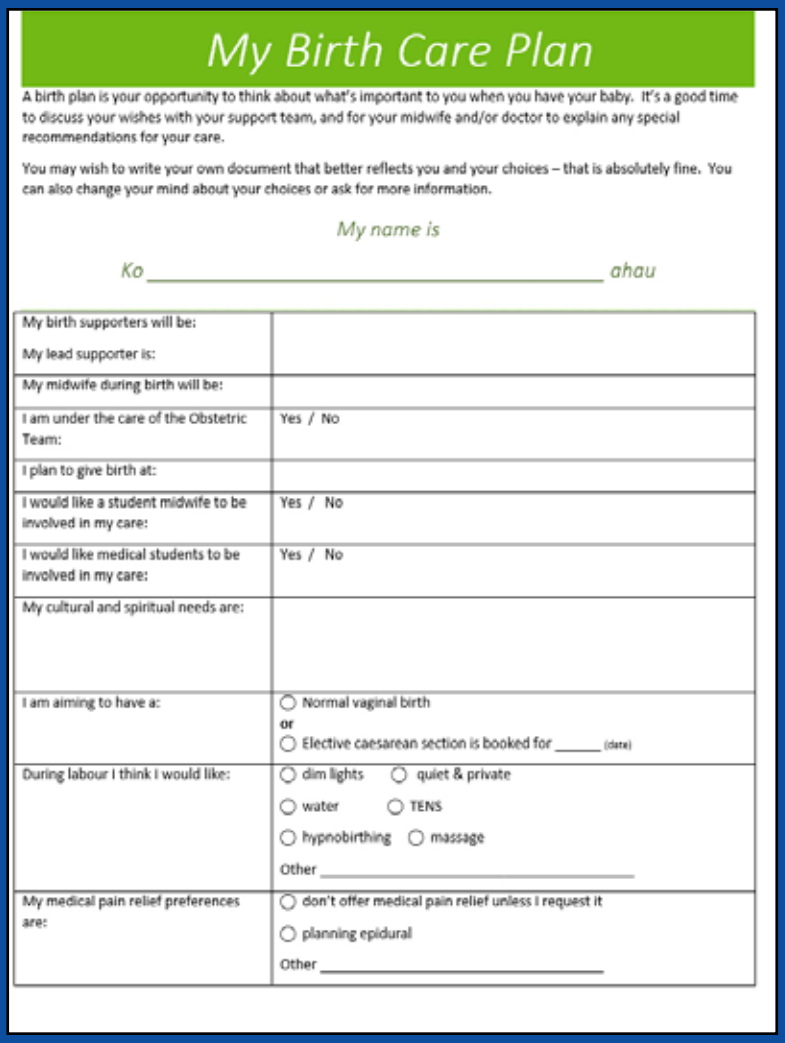
Places of birth

Page 1 of our Otago birth options leaflet.

It is important women know all their options for places of birth. Work has started to help communicate this to them via brochures for Otago and Southland that outline place of birth options, as well as the Pregnancy and Babies section of our website (https://www.southernhealth.nz/getting-help-you-need/pregnancy-and-babies). MQSP Coordinator Heather LaDell also presented to pregnancy and parenting educators in 2018. This presentation included information about women's options for place of birth and current evidence about what women can do to help themselves have the best chance of a healthy normal outcome. We also created and circulated birth plan templates to promote communication between women and their care providers, whether the woman is having a straight-forward or more complex labour and birth. This template was based on feedback from women.



A screenshot of part of our Pregnancy and babies section on the Southern DHB website.



My Birth Care Plan

A birth plan is your opportunity to think about what's important to you when you have your baby. It's a good time to discuss your wishes with your support team, and for your midwife and/or doctor to explain any special recommendations for your care.

You may wish to write your own document that better reflects you and your choices – that is absolutely fine. You can also change your mind about your choices or ask for more information.

My name is

Ko _____ *ahau*

My birth supporters will be: My lead supporter is:	
My midwife during birth will be:	
I am under the care of the Obstetric Team:	Yes / No
I plan to give birth at:	
I would like a student midwife to be involved in my care:	Yes / No
I would like medical students to be involved in my care:	Yes / No
My cultural and spiritual needs are:	
I am aiming to have a:	◯ Normal vaginal birth or ◯ Elective caesarean section is booked for _____ (date)
During labour I think I would like:	◯ dim lights ◯ quiet & private ◯ water ◯ TENS ◯ hypnobirthing ◯ massage Other _____
My medical pain relief preferences are:	◯ don't offer medical pain relief unless I request it ◯ planning epidural Other _____

Page 1 of our birth care plan template.

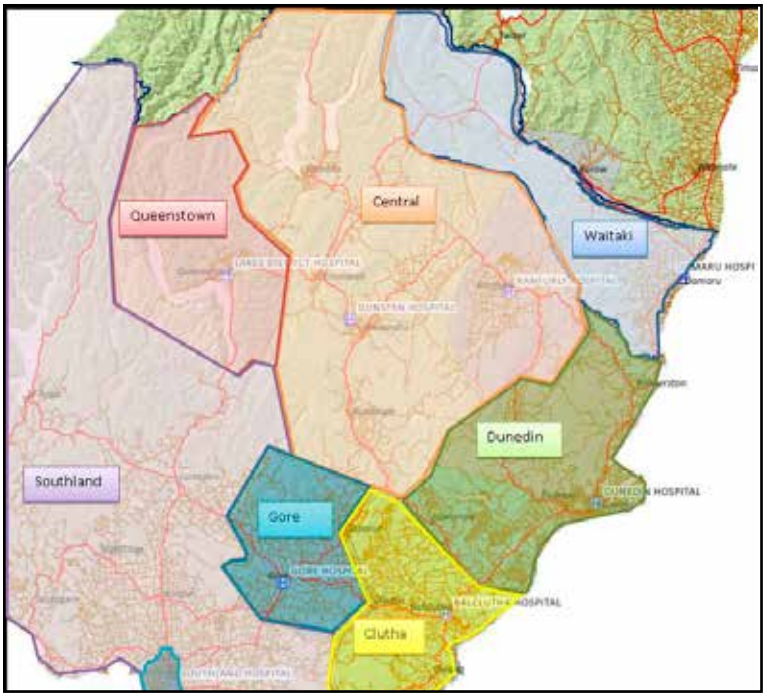
A screenshot of an education presentation.

Maternity services

SECTION 4

Our facilities

At 62,356km in size, the Southern District Health Board is the largest DHB by geographical area and serves a total population of 326,830.



Our district includes 8 territorial areas:

1. Central Otago district
2. Clutha district
3. Dunedin city
4. Gore district
5. Invercargill city
6. Queenstown-Lakes district,
7. Southland district, and
8. Waitaki district.

Maternity care in Southern is provided across 3 directorates:

1. Women's and Children's Health
2. Operations
3. Strategy, Primary and Community

2 base hospitals - Dunedin (Queen Mary) and Southland (Southland Maternity) - provide specialist care for women and babies (obstetric and neonatal) as well as midwife-led care for healthy, well women.

7 rural Primary Maternity Units provide birth care for well women with uncomplicated pregnancies in the rural areas. These facilities provide postnatal care for birthing women and for women transferring from the base hospitals.

Oamaru Maternity
Waitaki community
Two birth rooms and three postnatal rooms.
https://www.waitakihealth.co.nz/maternity

Balclutha
Clutha community
One birth room and three postnatal rooms.
https://www.cluthahealth.co.nz/pages/maternity-centre/

Charlotte Jean Maternity Hospital, Alexandra
Wanaka/Central Otago community
One birth room and three queen-size postnatal rooms. Partners are encouraged to stay.
http://www.charlottejean.co.nz/

Lakes Maternity
Queenstown Lakes community
One birth room and five postnatal rooms.

Lumsden Maternity
Northern Southland community
One birth room and three postnatal rooms.
N.B. Lumsden Maternity transitioned to a Maternal and Child Hub in 2019.

Gore Maternity
Southland community
One birth room and two twin postnatal rooms.
https://www.gorehealth.co.nz/maternity

Winton Maternity
Southland community
Two birth rooms and four queen-size postnatal rooms. Partners are encouraged to stay.
https://www.winton.co.nz/listing/58/Winton-Maternity-Centre

Rebecca O'Donnell (left) and LMC midwife Sharon White.

Our workforce

The Southern Future programme has gone from strength to strength over the past year, with significant momentum gained in supporting our staff to feel safe to speak up in the workplace.

While we continue to build a strong and positive internal culture, the programme has also been focusing on listening, acknowledging and celebrating our incredible staff.

Speak Up

The Speak Up Supporters' programme has been successfully running for over a year, with 50 trained staff available across the organisation to support staff with any workplace concerns. The Supporters are trained, independent peers, who are available to all Southern DHB staff as the firstpoint of contact for support, guidance and to discuss workplace relationship issues and patient or clinical safety concerns. This work continues to be supported by the Speak Up Programme – building a culture that supports high trust, professional behaviour and accountability, and where staff are empowered to speak up.

Staff Engagement Survey

Providing a positive and supportive workplace is the foundation of Southern Future and fundamental to strengthening our organisational culture. One of the many ways we engage with our staff is through the annual Staff Engagement Survey – a safe and anonymous platform for staff to provide feedback about their workplace experiences. The 2018 Staff Engagement Survey had a 50%
participation rate (2234 staff), with feedback confirming our four organisational priorities have improved significantly since the 2017 survey.

Four organisational priorities

1. **Leaders communicate well, so I always know what's going on**
   2017: 37% positive **2018:** 45.6% positive
2. **In the last twelve months I have been subjected to bullying behaviour in my workplace**
   2017: 55% positive **2018:** 50.5% positive
3. **Staff performance problems are identified**
   2017: 42% positive **2018:** 53% positive
4. **I have the equipment and supplies I need to do my job properly**
   2017: 56% positive **2018:** 67.6% positive

Photo competition

An internal photo competition calling for photos representing our values (Kind, Open, Positive and Community) and celebrating Southern proved to be a great success.

Budding staff photographers sent through some beautiful images ranging from landscapes of the Southern region to special moments capturing our staff and patients.

Celebrating our staff

The Southern Future programme recognises the importance of celebrating our staff's success, and we appreciate when others do the same.

Southern DHB awards celebrate outstanding staff. From breaking medical boundaries to the unsung heroes behind the scenes – Southern DHB celebrated some of its remarkable staff from across the district at the first ever Southern Excellence Awards in October 2018. Held simultaneously in the Otago Polytechnic Hub in Dunedin and Bill Richardson Transport Museum in Southland, the Awards evening was established to recognise the diverse ways in which excellence is reflected across Southern DHB.

"With over 4000 staff, we know there's incredible innovations and achievements, acts of kindness and staff constantly going above and beyond the call of duty," says Southern DHB Chief Executive, Chris Fleming.

"The Awards are about acknowledging staff and the very important roles they play in providing care and support across the southern health system."

From left: Midwife and Lactation Consultant Stefanie Kalmakoff, Lead Maternity Carer Sue Nash and Midwife Penny Coggan.

Southern DHB will host the Southern Excellence Awards annually to "continue recognising our staff's accomplishments", says Mr. Fleming. "From the small wins to the big triumphs - it's important to celebrate them all."

Staff innovation celebrated

Southern DHB's Innovation Challenge continues to support ideas brought forward by staff, with 33 entries in 2018.