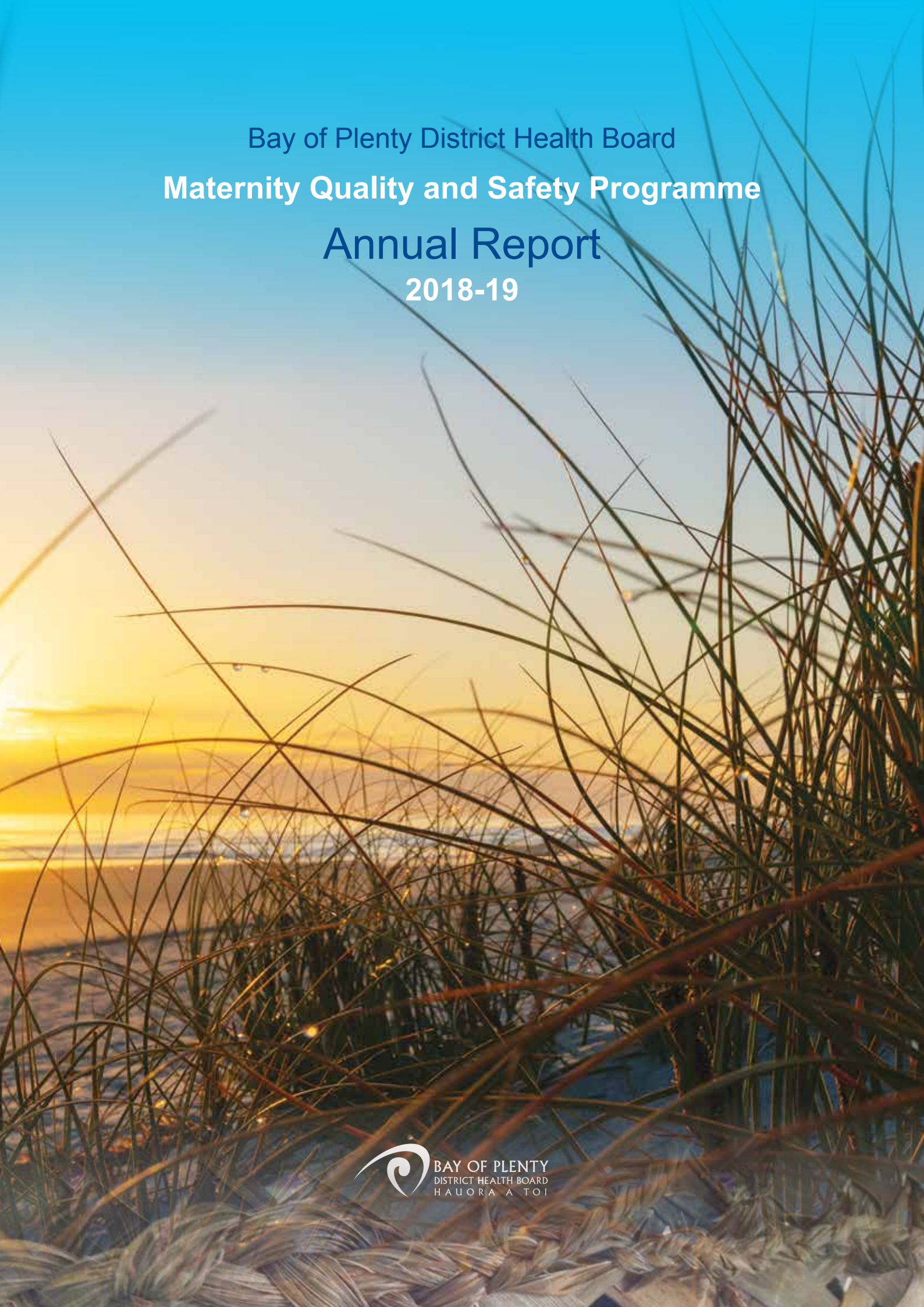
Bay of Plenty District Health Board

Maternity Quality and Safety Programme

Annual Report

2018-19



BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

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Our Mission Tā Mātou Matakite

Enabling communities to achieve good health, independence and access to quality services.

Our Values Ā Mātou Uara

Our CARE values underpin the way we work together to provide you with a better-connected health system that is patient and whānau centred.

CARE means

Compassion • All-one-team • Responsive • Excellence

The CARE values are aligned to our He Pou Oranga Tangata Whenua Māori Determinants of Health Principles.

CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

Wairuatanga
Understanding and engaging in a spiritual existence.

Positive leadership.

Manaakitanga
Show of respect or kindness and support.

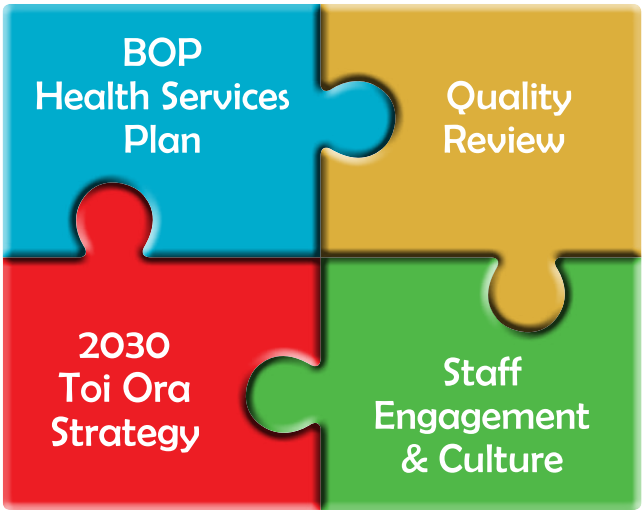
Kotahitanga
Maintaining unity of purpose and direction.

Ukaipotanga
Place of belonging, purpose and importance.

Kaitiakitanga
Guardianship and stewardship over people, land and resource.

Whānaungatanga
Being part of and contributing collectively.

Pukengatanga
Teaching, preserving and creating knowledge.



The BOPDHB aims to make a tangible improvement in the health of our community by being a high performing health system. This will be achieved through our four current Strategic Priorities: Strategic Health Services Plan (SHSP); Staff Engagement and Culture; Good to Great Māori Health; and Quality Review.

Foreword

We are pleased to present the Bay of Plenty DHB Maternity Quality and Safety Report 2018-19.

The journeys of Wāhine/women, pēpi/babies and their whanau/families are the individual stories behind this report and are the focus of everything we aim for in maternity quality improvement.

Our people are unique and their challenges are also unique in each community across the Bay of Plenty. Some of the challenges we have understood and improvements have been made. Some are challenges we have yet to fully identify and understand.

Our starting place to understand the outcomes for Wāhine/women, pēpi/babies and their whanau/families is through gathering the data for our birthing families. We explore reasons for the outcomes to identify ways in which we can improve. What we present in this report is the collective data of those who use the maternity services in the Bay of Plenty region.

The National Maternity Quality and Safety Programme allows us to compare ourselves with other regions of Aotearoa/New Zealand to better identify where we compare well and where we need to continue to focus our attention and resources on improvement.

Some of our challenges are specific to remote rural communities and much emphasis is on understanding barriers to equity for Mana Whenua/Tangata Whenua and other disadvantaged groups. We also look with renewed heart to the coming implementation for Te Toi Ahorangi. This is the first Maori Health Strategy developed by iwi and adopted by Bay of Plenty DHB and will lead us into the future for Toi Ora.

BOPDHB maternity service has identified a need to further develop clinical governance and we look beyond this report to the coming year, bringing changes to our governance structure including stronger mechanisms for engagement with Mana Whenua, maternity health professionals and consumers. We are looking to improve the way we gather and analyse information, with an emphasis on identifying inequities and to how we design and plan services together with the families who use our services.

We hope you enjoy reading about our achievements and the challenges identified for the work ahead.

Kirsty Rance
Midwife Leader
Women Child and Family

Michael John
Head of Department
Obstetrics and Gynaecology

Jeremy Armishaw
Medical Leader
Women Child and Family

Karen Smith
Business Leader
Women Child and Family

Maternity vision and alignment

Improving Māori Health Equity

The BOPDHB is committed to the principles of the Treaty of Waitangi, and improving Māori Health is one of our four strategic priorities. In 2017 Tricia Keelan was appointed as the New General Manager of Māori Health Gains and Development. This position was created to provide leadership and direction to the BOPDHB in all matters affecting the Māori population of Te Moana a Toi, Māori services, and Māori staff, as well as leading the Māori Health Strategy, Good to Great.

Te Toi Ahorangi is the Māori health strategy proposal currently in the development stages. It has been endorsed by the 18 iwi of the BOP.

Institutional racism has been identified within the BOPDHB. To raise awareness and self-reflection on this issue, “Engaging Effectively with Māori” education sessions have been running frequently. So far over 50% of all BOPDHB staff and over 73% of all DHB employed maternity staff have attended.

Quality and Clinical Governance

Flowing the BOPDHB Quality Review and implementation of a revised BPOPDHB Clinical governance Framework, the maternity service has reviewed its governance requirement to align with the new BOPDHB governance framework. The new Maternity Clinical Governance (MCG) process has been developed and is now in the process of being implemented. The revised MCG process provides a more cohesive approach to maternity clinical governance. Maternity is the first service in the BOPDHB to realign its structure with the revised (December 2018) BOPDHB Clinical Governance Framework. The maternity Clinical Governance process includes a new Neonatal Clinical Governance Committee.

The BOPDHB Consumer Council has been established and plans developed for working with the Council to further improve local services. Maternity consumers will be supported by this system. Consumers offer a unique viewpoint and can provide valuable insights into; how services can be improved, where priorities should be set, and where quality issues have arisen in the delivery of health services. Māori, midwives and consumers involvement was sought recently as part of the co-design process used to develop the new Maternity Strategic Plan, where equity of care was the key focus. Moving forward the engagement of consumers in the MCG will provide a foundation for the development of co-design processes in the maternity service.

Staff Engagement and Culture

A clear link is established between staff wellbeing and patient wellbeing. In 2018 the BOPDHB continued to work on the Creating Our Culture campaign. The results of the second Creating our Culture staff and patients’ survey investigated the impact of the Creating our Culture activities and actions. Overall the employee survey shows that there was good progress within the year.

At the beginning of 2018, the BOPDHB launched the evolved CARE values, based on patient, family and staff feedback. New staff name badges were introduced, in response to patients and whanau feedback, saying they want to know who is caring for and supporting them. This year there has been progress with a focus on the “Speak up Safely” campaign.

This year the BOPDHB Midwifery Strategic Plan was reviewed. The starting point for this process involved several focus groups run with multiple consumer groups (mothers under 20 years, Māori and Pacific Island women). The feedback from these groups was taken to a maternity strategic planning meeting, which included attendance by over 50% of the LMC midwives in the area as well as Māori regional health representatives, student midwives, and core staff. The feedback was used to discuss barriers and potential solutions to these along with discussion around where the BOPDHB Midwifery Service needs to focus and develop.

Maternity Facilities

Tauranga

7 primary and secondary birthing rooms with 2 birth pools

4 single bed antenatal rooms

1 double bed antenatal room

10 single bed postnatal rooms (9 with ensuite)

4 double bed postnatal rooms

Lactation consultant service

1 portable bedside ultra sound

12 Cot SCBU - including 2 high needs spaces

2 Boarder mum beds

Hearing screening performed on ward

Women's Assessment Unit for additional monitoring of high risk women

Primary Midwifery Care Service for women without an LMC

Outpatient specialist consult clinics

Whakatāne

3 primary and secondary birthing rooms

1 birthing pool

4 single bed antenatal rooms

1 portable bedside ultra sound

10 double bed postnatal rooms

Lactation consultant service

4 cot SCBU and one high needs space

Hearing screening performed on ward

Outpatient specialist consult clinics

Opotiki

2 primary birthing/ postnatal rooms

1 birthing pool

CTG

Bethlehem Birthing Unit

Antenatal education classes

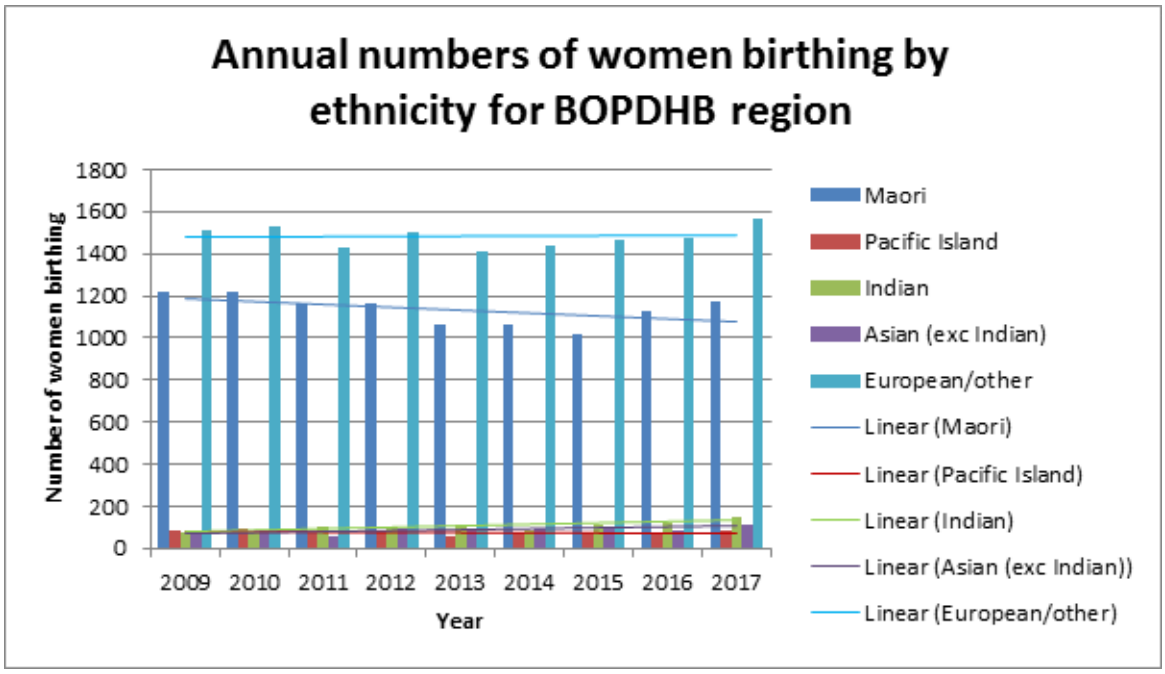
CTG

12 primary birthing/ postnatal rooms with birthing pools

Lactation consultant service

Birthing Population

Due to the geographical layout of the BOPDHB area, those with the highest level of deprivation have the greatest distance to travel to engage with care.



There has been an increase in the total number of births in BOPDHB of nearly 7% from the previous recorded year. This makes five years of increased birthing numbers and an 11% increase in that time.

When broken down into ethnicity of birthing mothers there is an overall consistent trend in birth numbers for European/other and Pacific Island women, a decrease in the numbers of Māori women (4% since 2009) and an increase in the number of Indian (50% since 2009), and Asian women (32% since 2009). The changing demographics of local ethnicity of birthing women needs to be taken into account when planning any co-design to ensure the BOPDHB maternity service is meeting the needs of the evolving population.

The percentage of women birthing in the BOPDHB region continues to be European, Māori, Indian, Asian, and Pacific in decreasing order. The deprivation graphs below show how the ethnicities vary across the region.

Location of Birth

		2013	2014	2015	2016	2017
Primary Facility	Home	155	128	122	130	84
	BBC	-	37	258	327	354
	Murupara	2	2	0	1	1
	Opotiki	42	55	60	62	48
Secondary Facility	Tauranga	1955	1931	1765	1767	1922
	Whakatāne	548	598	534	593	612

Home birth rates in the BOPDHB region have consistently been around five percent. However, there was a notable drop to half this rate in 2017.

Primary unit births vary across the region. Over 18% of Tauranga women birthed at Bethlehem Birthing Centre (BBC) over the last two reported years. Opotiki Maternity Unit continues to provide a care option for primary level women.

Age of birthing population

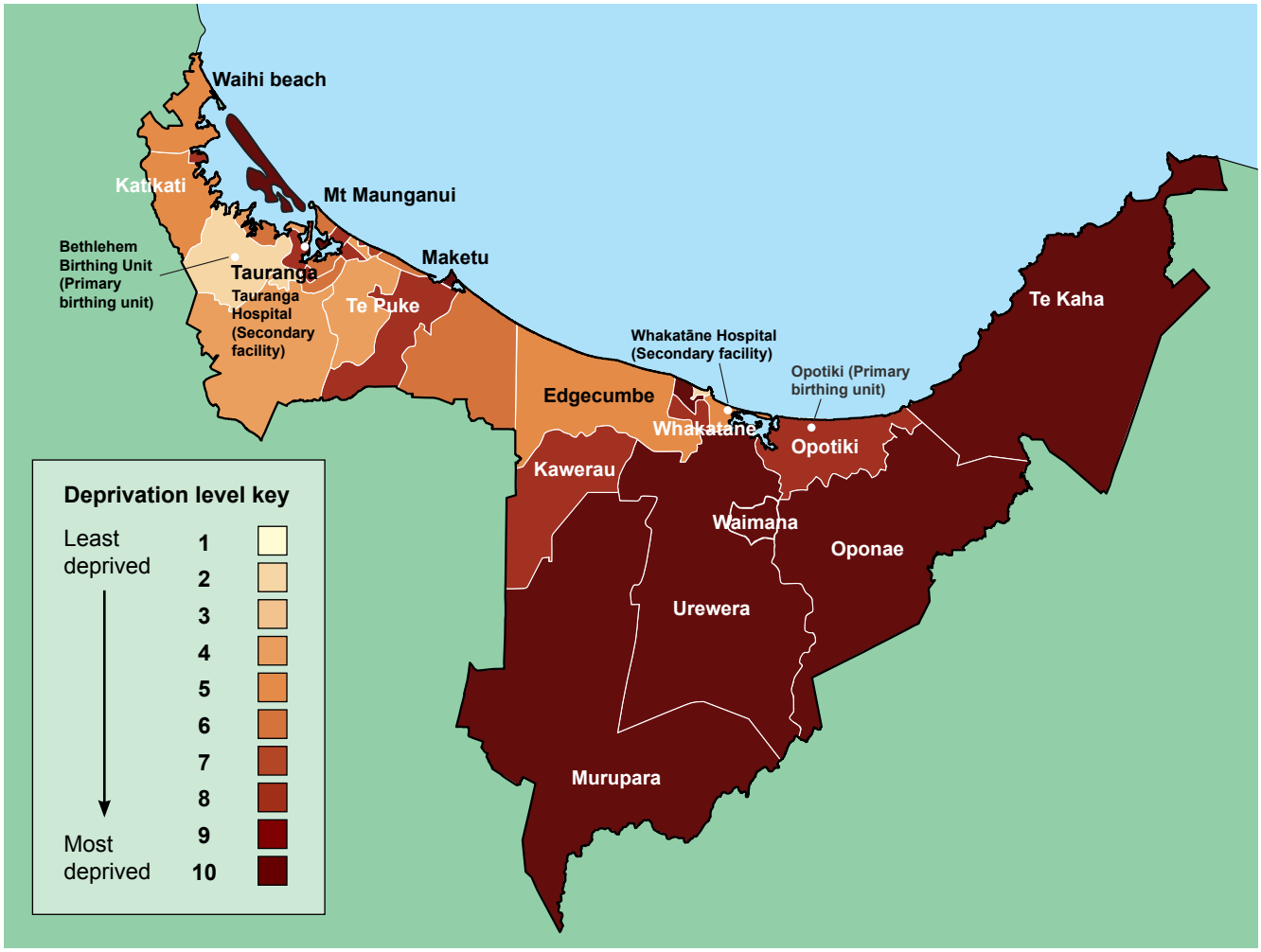
The most common age of birthing women in New Zealand for 2017 was 30-34 years, followed closely by 25-29 years, this is consistent with all previous reported years. In the BOPDHB the common birthing ages match the national data.

However, there is variation when looked at by ethnicity.

The most common birthing age for:

- Māori women in the BOPDHB area was 20-24 years, followed by 25-29 years.
- European and Asian women was 30-34 years followed by 25-29 years.
- Pacific Island and Indian women was 25-29 years.

Deprivation of birthing population



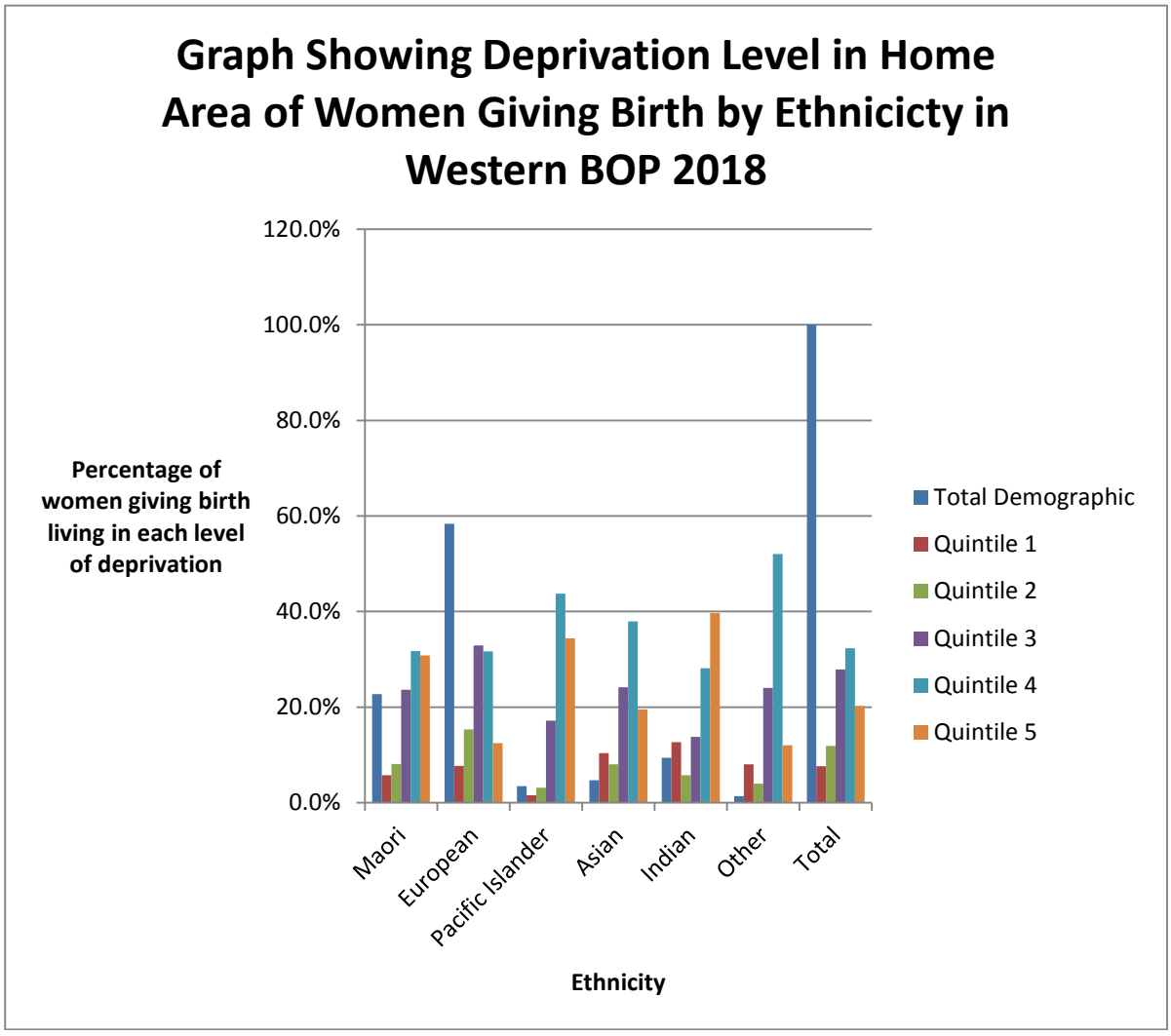
For more information on deprivation effects in New Zealand follow this link http://www.ehinz.ac.nz/indicators/population-vulnerability/socioeconomic-deprivation-profile/

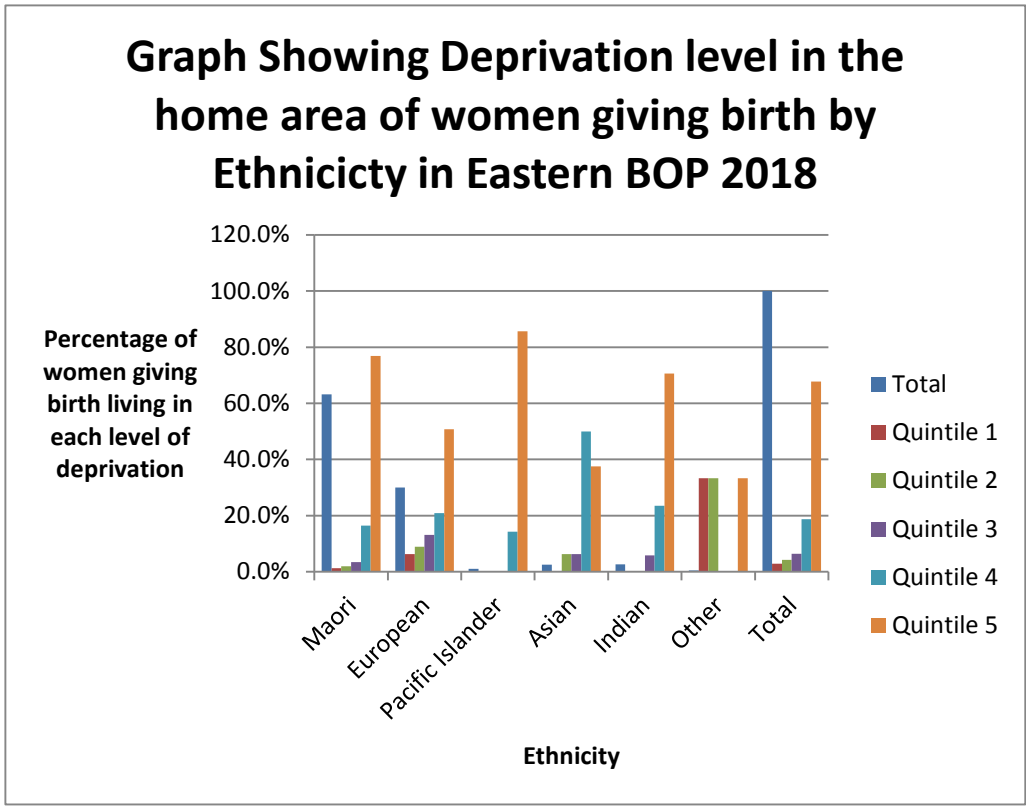
People living in areas of high levels of deprivation (most deprived) are more likely to have poor health and are more likely to experience a stillbirth or neonatal death (PMMRC, 2019). Nationally 20% of the population fit into each of the 5 deprivation quintiles.

BOPDHB in 2018 had the highest number of women birthing coming from quintile five (most deprived). This was the same for Māori and Pacific Island women as it has been for at least the last three reported years. Indian and Asian women were most commonly coming from quintile four. This is a change from 2015 when both were most commonly from quintile five. European women were most commonly from quintile three. This is a change from previously being from quintile four.

The following graphs highlight the inequity across the BOPDHB when deprivation by ethnicity is split to show the variation between the Eastern and Western Bays. In 2018 63% of the women giving birth in the Eastern Bay identified as Māori compared to 22% in the Western Bay. Of these women, 77% of them came from quintile five and 16% came from the next most deprived areas (quintile four), compared to 30% in the Western Bay, where the Māori women birthing were slightly more likely to come from quintile four (32%).

All ethnicities in the Eastern Bay were over-represented in the most deprived quintile with 68% of all women birthing in the Eastern Bay in 2018 coming from quintile five. This was not the same in the Western Bay where the most commonly represented demographics were instead quintile four (32%) and three (28%). Further, only 20% of all women birthing in 2018 in the Western Bay came from quintile 9-10 which aligns with the national average for this quintile. A focus on service access and having the financial means to do need to considered when planning any co-design for the maternity service.





PMMRC. 2019. Te Pūrongo ā-Tau Tekau mā Toru o te Komiti Arotake Mate Pēpi, Mate Whaea Hoki | Thirteenth Annual Report of the Perinatal and Maternal Mortality Review Committee: Te tuku pūrongo mō te mate me te whakamate 2017 | Reporting mortality and morbidity 2017. Wellington: Health Quality & Safety Commission.

Hapu mama, watching her smoking mother do carbon dioxide testing at Wahakura Wananga event.

Duke and little sister Kapua (photo curtesy of Louise Harvey).

Maternity Clinical Indicators

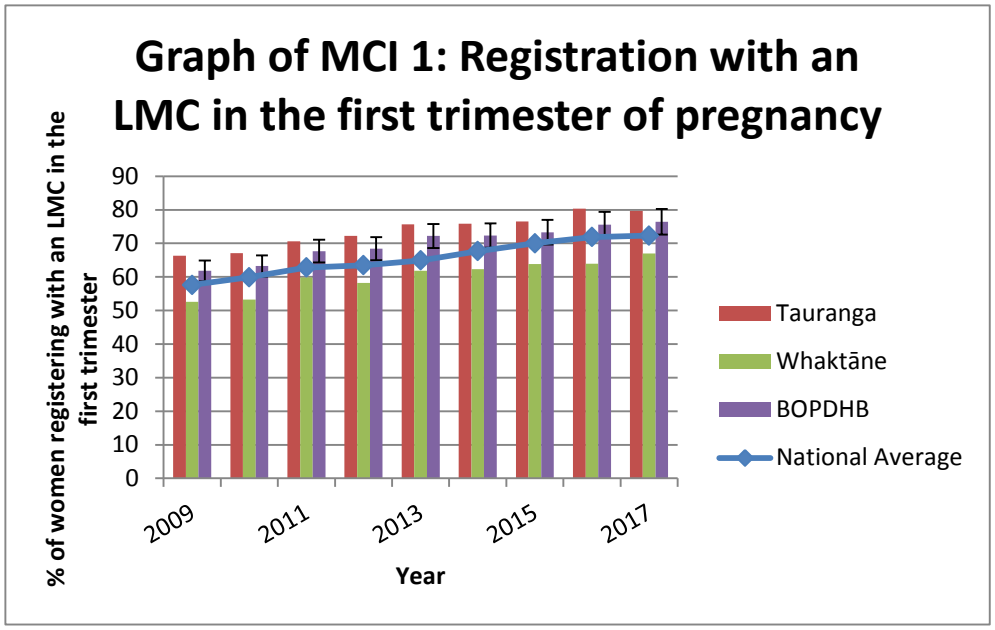
The New Zealand Maternity Clinical Indicators show key maternity outcomes for each DHB region and maternity facility.

Maternity Clinical Indicators (MCIs) in New Zealand are monitored and reported on annually. A national average is calculated and each DHB and maternity facility can benchmark themselves against either the national average, other facilities or their own previous year's results.

The data reported by the MCIs can help draw attention to areas where a facility could perform better and provide a starting point for a review of processes while also highlighting other facilities that may have systems, processes and/or incite that could be shared to help other facilities to improve.

Standard Primiparae

The term Standard Primiparae is used in several of the MCIs (indicators 2-9). A Standard Primiparae is a woman having her first baby, who has no known obstetric complications. As a group, these women make up approximately 15% of the birthing population. They are used as a measure as they are considered to be healthy women with no predetermined reasons not to have a successful spontaneous vaginal birth.



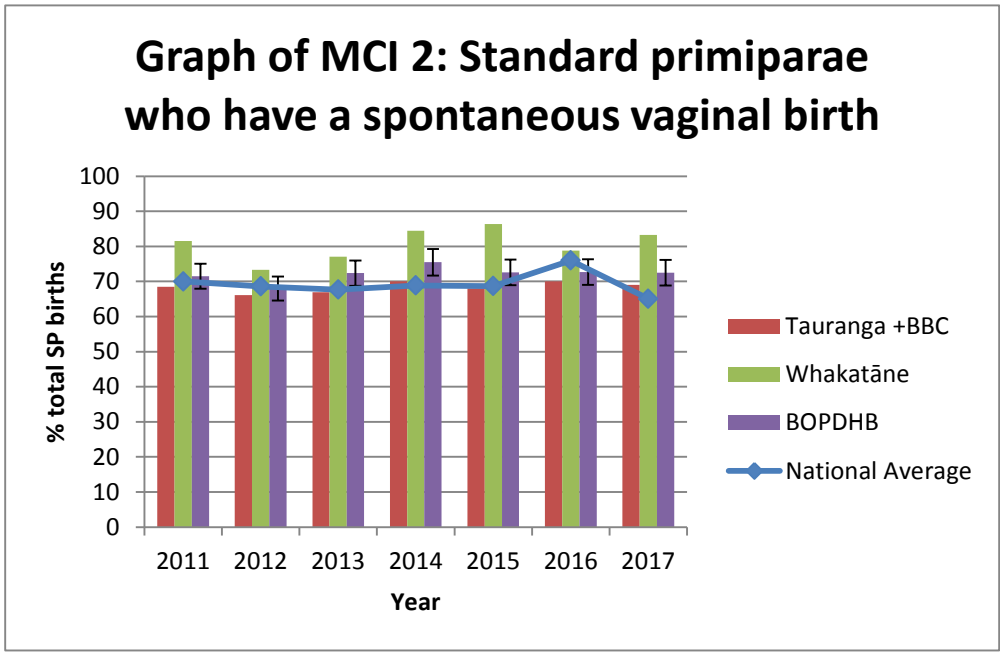
The national trend for registration in the first trimester has risen steadily since 2009.

For 2017 All of BOPDHB and Tauranga was above the national average (NA) (72.3%) with 76.4% and 79.7% of women registering with an LMC before 12+6 weeks gestation.

The rate for Whakatāne, however, is below the NA (67%).

The As Soon As you're Pregnant (ASAP) campaign has been relaunched in the Eastern Bay in the second half of 2019 to promote awareness of the pregnancy priorities relevant to the first trimester.

For all of BOPDHB women of all ethnicities have shown an increase for this indicator since 2009.



The national trend for SP having a spontaneous vaginal birth has remained about the same since reporting started in 2011.

For 2017 all of BOPDHB was above the national average (65.1%) with 72.5% of SP women having a spontaneous vaginal birth.

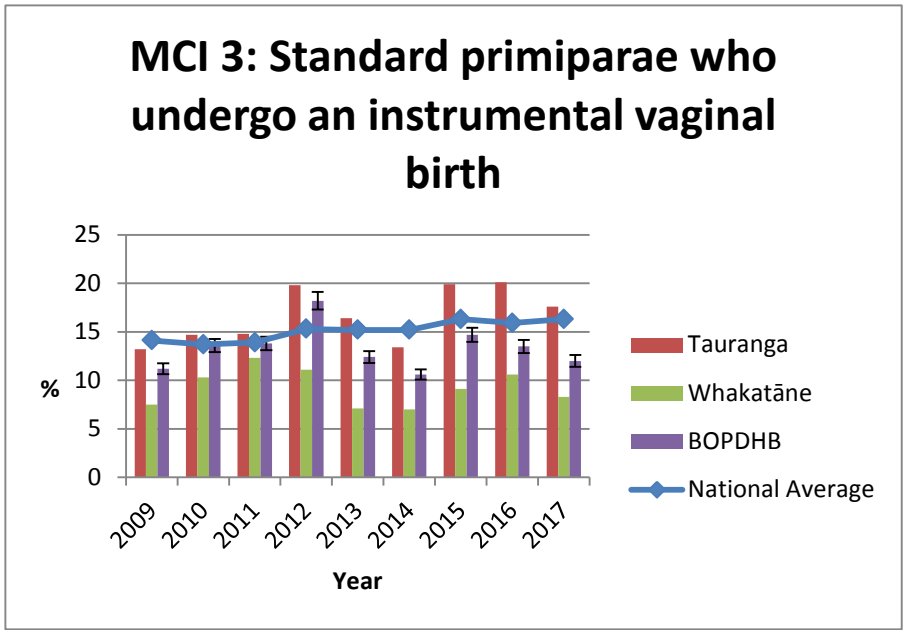
Tauranga had a rate lower than the national average at 60.3% (i.e. approximately 5%lower).

Whakatāne had the highest rate nationally at 83.3%, (i.e. 7% higher than the NA). This represents an over 20% variation between the two BOPDHB secondary care sites. These figures for BOPDHB show little variation for the last three reported years. Further analysis is required to understand the factors involved and the significance of this variation.

In 2015, a nine percent drop in vaginal births was seen coinciding with the opening of the local primary maternity unit and has been maintained since. The data for the whole of the Tauranga area maintains a rate of SP spontaneous vaginal birth that sits inline with the NA.

With the drop in the number of vaginal birth at Tauranga Hospital (those births now occurring at BBC), an associated rise in the relative percentage instrumental birth and caesarean sections is also seen when sites are looked at in isolation.

For all of the BOPDHB, there has been little change in the rate of spontaneous vaginal birth rates for Māori, Asian and European/other women in the region. Indian rates show decline despite increasing numbers of women birthing identifying as Indian. This requires further investigation.



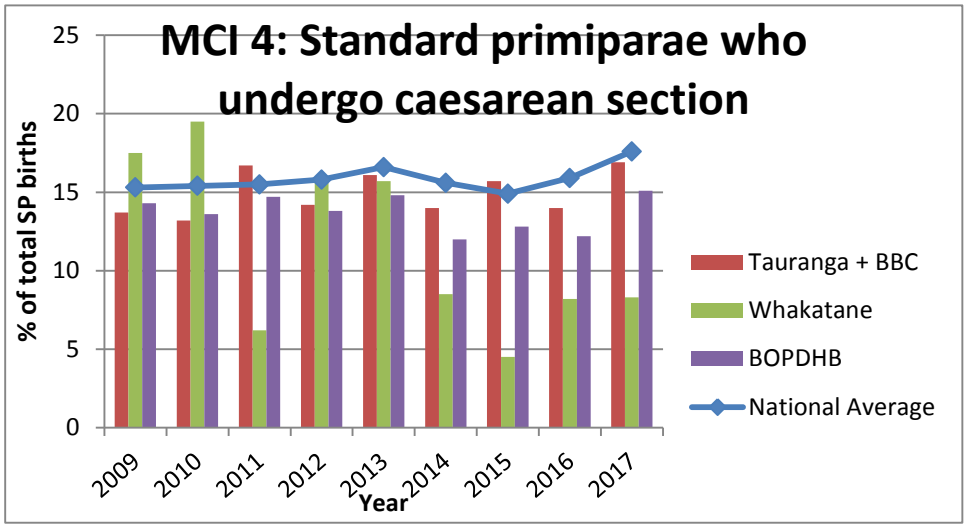
The national trend for SP who undergo an instrumental vaginal birth has increased since 2009.

For 2017 all of BOPDHB was below the national average (16.3%) with 12% of standard primiparae undergoing an instrumental delivery.

Tauranga continued to benchmark above the NA with a rate of 17.6%, as has been the case for the last three reported years. This echos the trend seen in MCI 2 coinciding with the opening of the local primary maternity unit. When the primary unit data is combined with the Tauranga denominator data the rate aligns with the NA for 2015 and 16 and is approximately two percent below the NA in 2017.

Whakatāne had the second-lowest rate of instrumental delivery nationally(approximately half the NA at8.3%). There had been a steady decrease in the rate of instrumental deliveries in the three years 2014-16. The relevance of this decrease requires further investigation.

For all of BOPDHB little change is seen in the rate of instrumental delivery for European/Other women. Māori women show a consistent downward trend. Asian women also show a downward trend, particularly in the last three reported years, there is an increasing trend for Indian women, particularly in the last three reported years. This mirrors the declining rate of Indian women having spontaneous vaginal births.



The national trend for SP who undergo caesarean section has increased since 2009.

For 2017 all of BOPDHB was below the national average (17.6%) with 15.1% of standard primiparae undergoing a caesarean section. This is a significant increase since 2013, after three years of fairly consistent rates, where BOPDHB was in the lowest five DHB's for this indicator, and a rise of three percent since 2016.

Tauranga had an increase of 3.5% from the previous years' rate (21.4%). This is the third year that Tauranga has had rates of caesarean section significantly above the NA. Again this coincides with the opening of the Tauranga primary maternity unit. When the primary unit data is included in the Tauranga Hospital denominator the 2017 rate reduces by over four percent, bringing the rate below the NA.

Whakatāne had the lowest rate nationally (8.3%). There has been minimal change in the rate from the previous year. This data needs further investigation to establish what impact this has.

For all of BOPDHB Māori, Pacific Island and Indian women have shown a decreasing trend in the rate of caesarean sections. European/Other have remained consistent.

For Asian women, there has been an increasing trend toward caesarean section over the last five reported years. This increased caesarean rate is occurring along with a decreasing rate of instrumental vaginal births and warrants further investigation into the equity of care delivery.

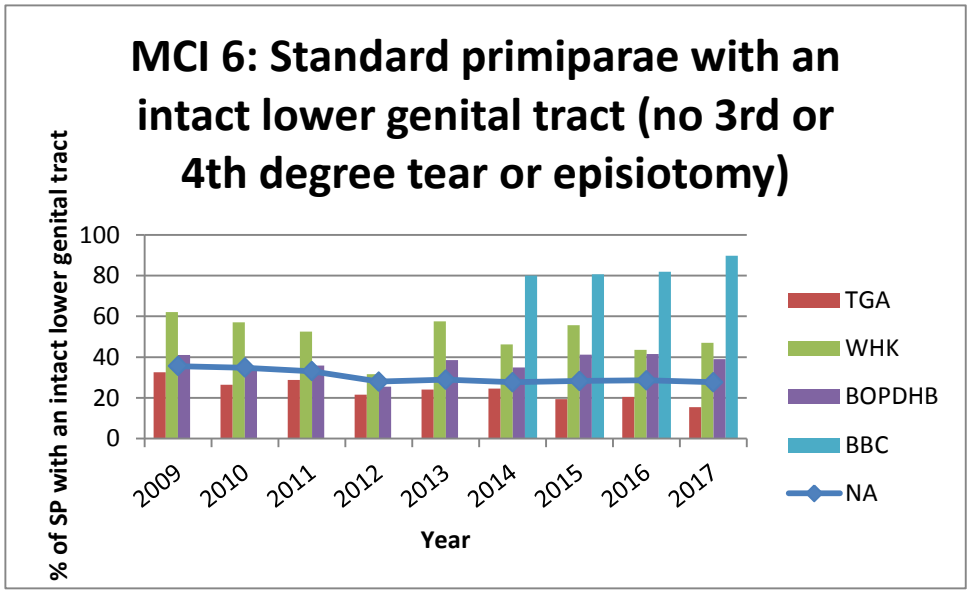
MCI 5: Standard primiparae (SP) who undergo induction of labour

Year	National average %	Tauranga %	Whakātane %	BOPDHB %
2009	4.5	4.2	0.0	3.1
2010	4.0	2.9	1.1	2.5
2011	4.3	3.1	1.5	2.8
2012	4.2	3.2	0.0	2.6
2013	5.2	3.9	1.4	3.1
2014	5.6	5.1	0.0	3.7
2015	5.7	7.2	3.0	7.3*
2016	6.3	9.5	2.4	7.6*
2017	8.4	8.1	6.9	7.6*

The national trend for SP who undergo induction of labour has almost doubled since 2009.

For 2017 all of BOPDHB was below the national average (8.4%) at 7.6%.

* An error has been identified in the data reporting from the primary unit in Tauranga, where women where incorrectly included in the data. This altered the rate for the DHB by 10 women per year from 2015 but will not be shown in the MCI report until the 2018 report. With this error corrected the rate is further below the national average.



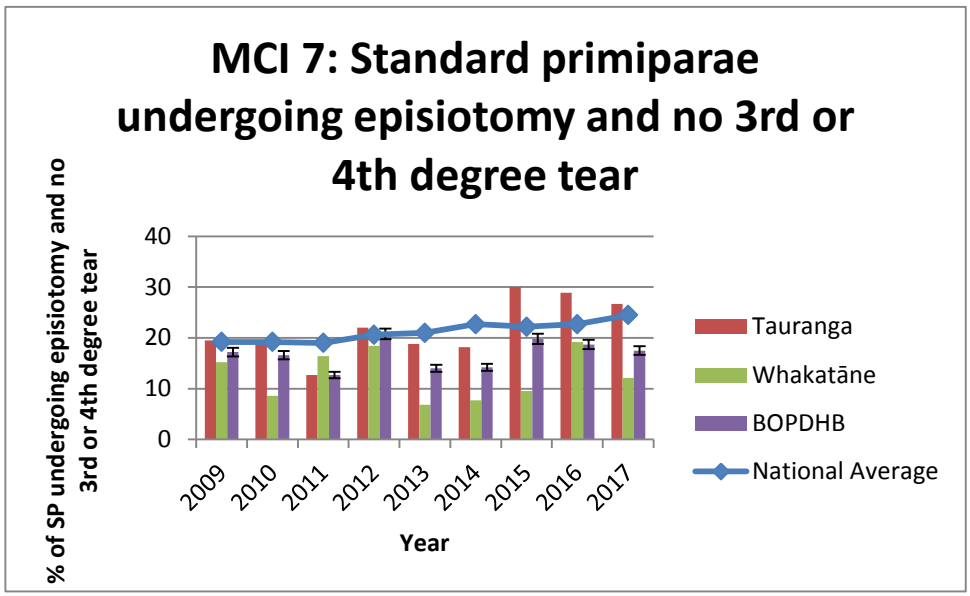
The national trend for SP with an intact lower genital tract (no 1st to 4th degree perineal tear or episiotomy) has dropped steadily since 2009

For 2017 all of BOPDHB was above the national average (27.7%) with 39% of standard primiparae maintaining an intact genital tract.

For Tauranga the rate of intact lower genital tracts has further reduced from 2016 to 2017 to 15.5%This represents an ongoing downward trend since 2009. This warrants further investigation.

Whakatāne had the highest rate nationally (47%). Whakatāne has consistently been above the national average and in the top four hospitals since 2013. Further analysis is required to understand what has contributed to this ongoing improvement.

For all of the BOPDHB, both Māori and Indian women show decreasing rates of intact genital tracts. The rates are consistent for European/Other women. Pacific Island and Asian women have an increasing trend of intact lower genital tract.



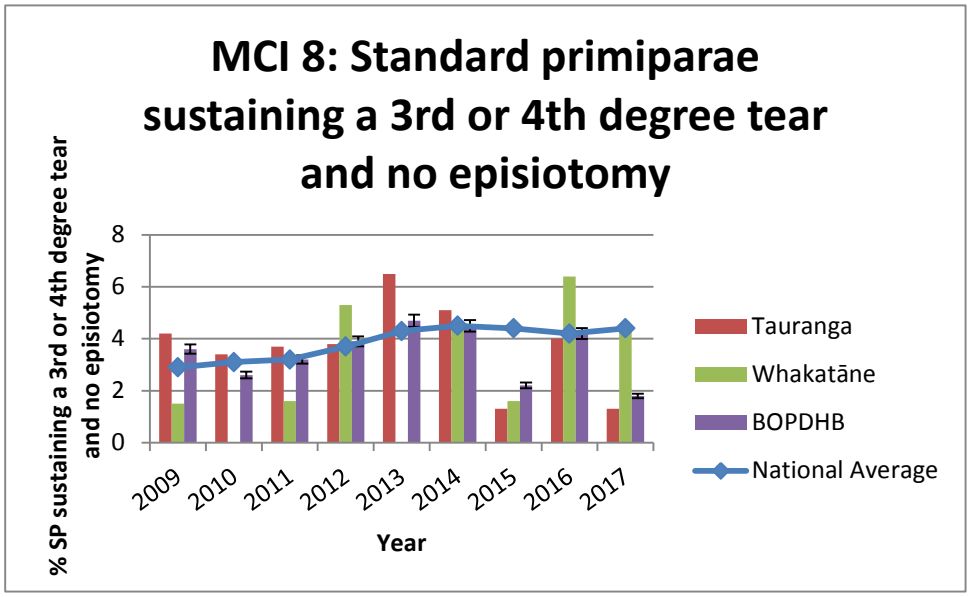
The national trend for SP undergoing episiotomy and no 3rd or 4th-degree perineal tear has risen steadily since 2009

For 2017 all of BOPDHB was below the national average (24.5%) with 17.5% of standard primiparae undergoing an episiotomy without receiving a 3rd or 4th-degree tear. There has been a steady decrease over the last three years for this indicator.

Tauranga mirrors the decrease seen with the DHB rate with 26.7 %. However, Tauranga remains above the national average for this measure.

Whakatāne had a significant drop from the previous reported years' rate to 12.1% more in line with the gradually increasing trend shown since 2013.

There has been an overall downward trend for all ethnicities other than European/Other women who have shown a steady increase in the last five years reported.



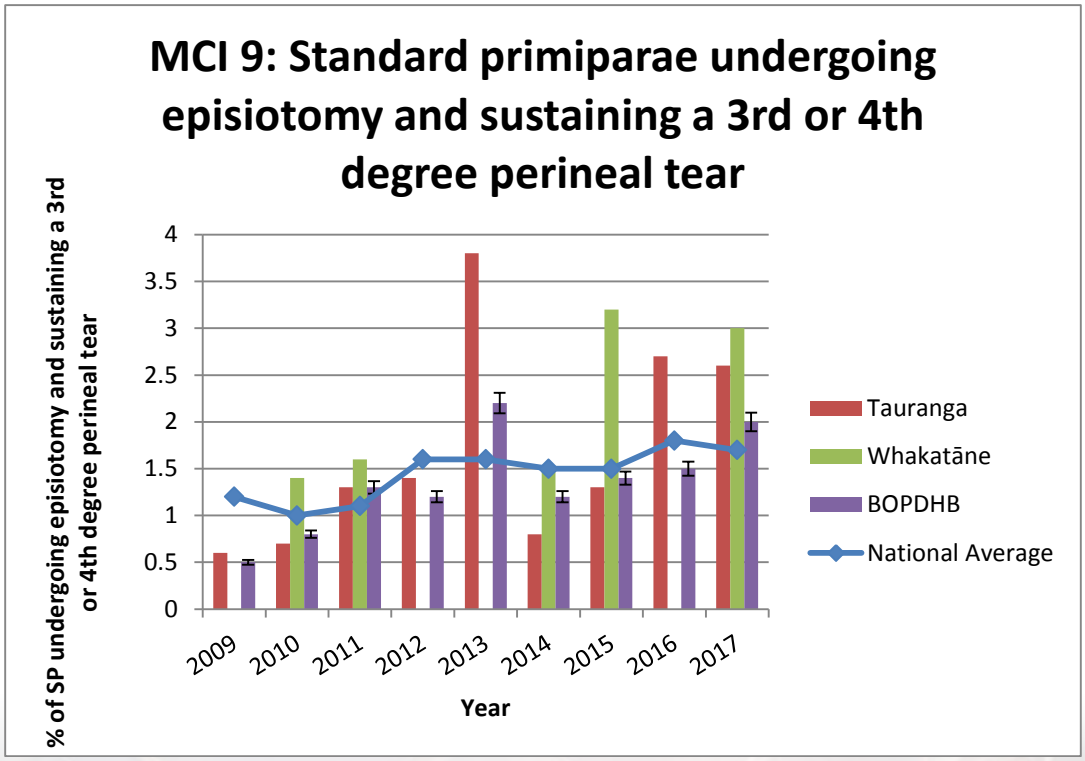
The national trend for SP sustaining a 3rd or 4th-degree perineal tear and no episiotomy rose from 2009 to 2014 but has plateaued since

For 2017 all of BOPDHB was significantly below the national average (4.4%) with 1.8% of standard primiparae sustaining a 3rd or 4th-degree tear with no episiotomy being performed. This is a drop of 2.4% from the previous year. This has been a labile statistic over the last three reported years.

Tauranga had the third-lowest rate nationally (1.3%), and a reduction of 2.7% from the previous year.

Whakatāne had a reduction of two percent (4.5%) from the previous year when it was the second-highest nationally. The current reported rate is in line with the national average.

Both Indian and European/Other women have shown a generally downward trend, the incidence for Pacific Island and Asian women is too sparse for a trend and the rate for Māori women is quite variable from year to year.



The national trend for SP undergoing episiotomy and sustaining a 3rd or 4th-degree perineal tear has risen slightly overall since 2009

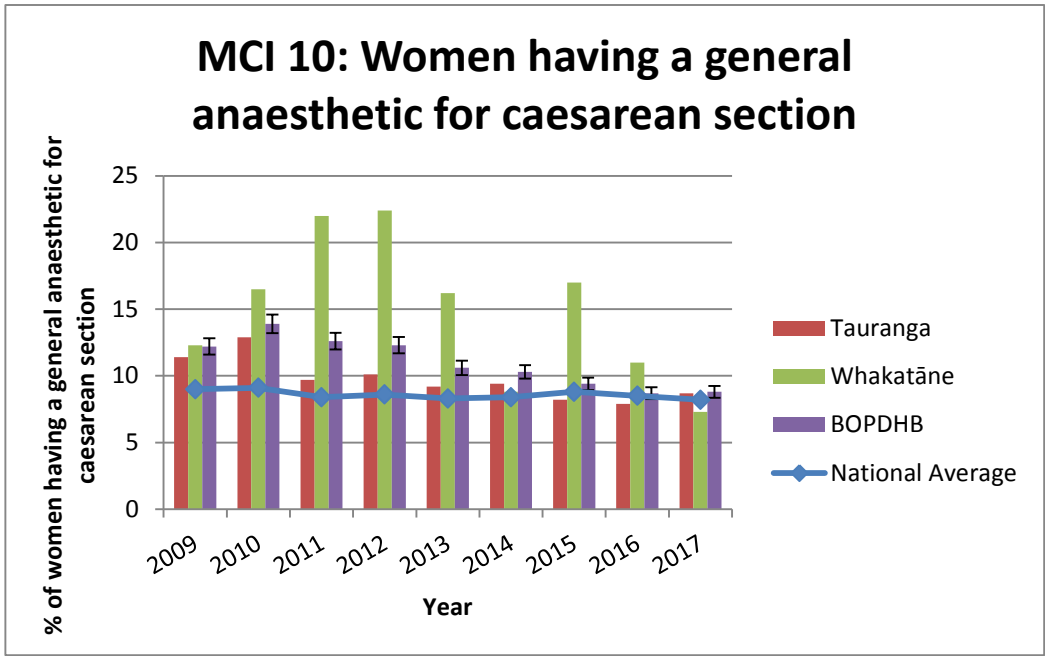
For 2017 all of BOPDHB was above the national average (1.7%) with two percent of standard primiparae undergoing an episiotomy and sustaining a 3rd or 4th-degree perineal tear. This is a continuation of the steadily increasing trend seen since 2014.

Tauranga had a slight decrease from the previous reported year to a rate of 2.6%. Tauranga remains significantly above the national average.

Whakatāne also had a rate significantly above the national average (3%) and a slight decrease from the previously reported rate. Whakatāne was the second equal highest hospital nationally for this indicator.

Due to the variability in incidents from year to year the rates for women identifying as Māori and Asian is too variable to discuss a trend, there has however been a significant increase of incidents since the last reported year for Asian women. There has been a slight increase for both Indian and European/Other women.

There is strong indication here of a need for; a review of practice and, reeducation run on perineal care during the second stage of labour.



The national trend for women having a general anaesthetic (GA) for caesarean section has decreased slightly since 2009

For 2017 all of BOPDHB was slightly above the national average (8.2%) with 8.8% of women having a general anaesthetic for caesarean section. This rate has been decreasing overall since 2010.

Tauranga had a slight increase from the previous reported year to 8.7%.

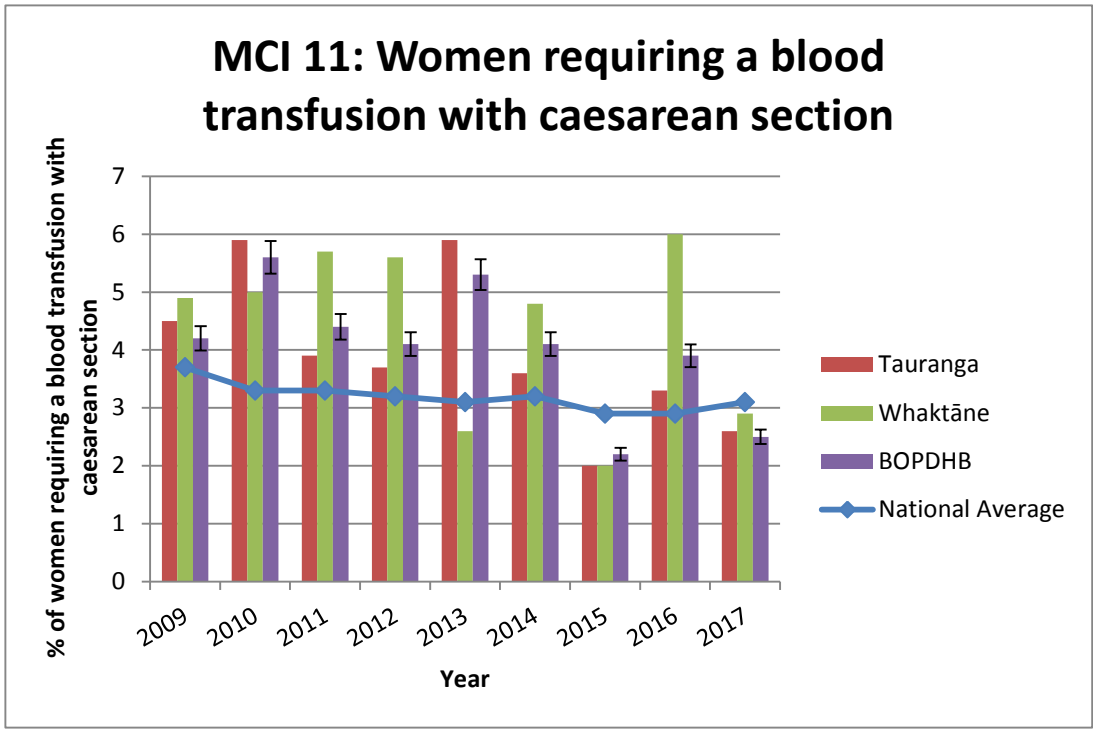
Whakatāne had a decrease of 3.7% from the previous reported year to 7.3%. And a continuation of the marked decrease shown since 2015. This is the lowest rate on record for Whakatāne.

Due to the relatively low numbers of women represented in this indicator for some ethnicities, it is difficult to identify trends. When comparing like for like; there has been a noticeable decrease in Māori women requiring a GA for caesarean in BOPDHB, 10% of Māori women that had a caesarean in 2017, compared to 2010 when 15.5% of Māori women that had a caesarean.

When other ethnicities are reviewed similarly, there has been no notable change for Pacific Island women. There has also been no notable change in the number of Indian women having GA caesareans however the number of Indian women having caesareans has increased by half between 2016 and 2017. While there is an increasing Indian population in the BOPDHB, this shows a disproportionately high rate of GA caesareans for Indian women, suggestive of an inequity. There has been an increase in the number of European/Other women having a GA caesarean since the last reported year.

There has been a considerable reduction in the number of Māori women represented in this indicator in the last five reported years, however, there is a slight increase in the trend over the last five years. There is a steady decrease in the rate for Europen/Other women.

Duke and little sister Kapua
(photo curtesy of Louise Harvey).



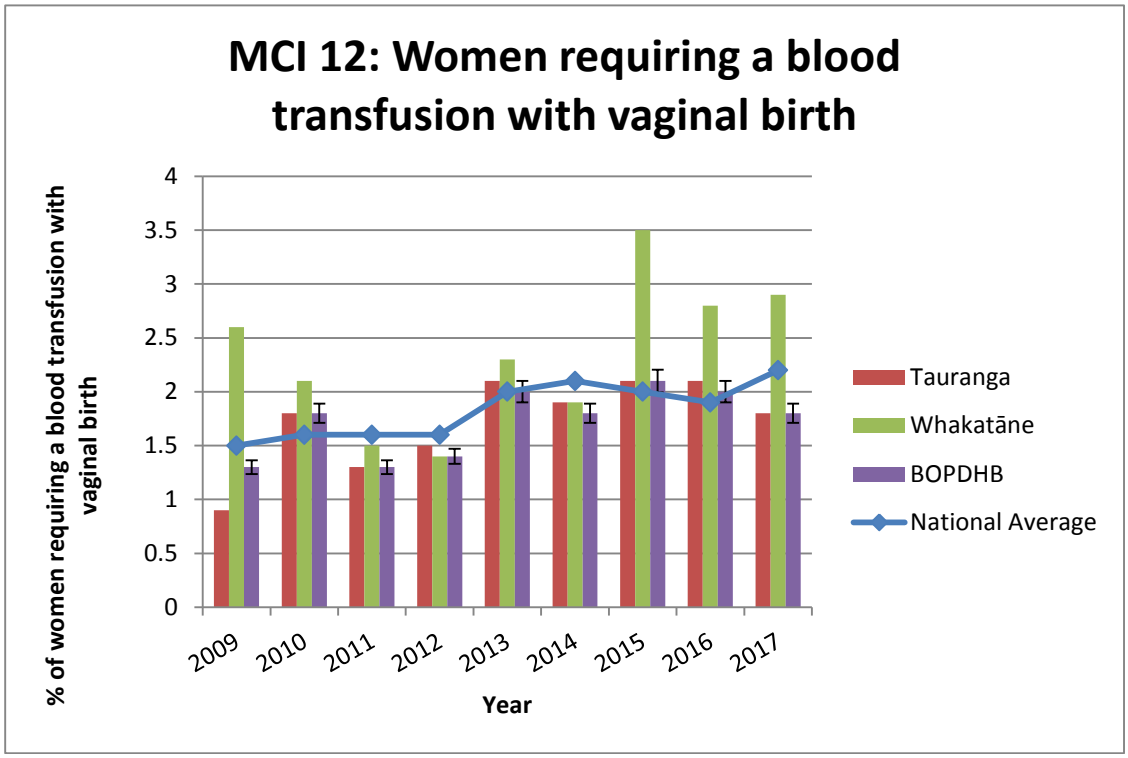
The national trend for women requiring a blood transfusion with caesarean section has decreased since 2009

For 2017 all of BOPDHB was below the national average (3.1%) with 2.5% of women requiring a blood transfusion with caesarean section. There has been a decrease from the previously reported year. However, the rate for this indicator has been quite labile over the last four reported years. There has been a concerted effort, particularly from the anaesthetic department, since 2016 to identify women with low haemoglobin levels antenatally and treat them appropriately before birth. This may be the start of these efforts starting to show in the data.

Tauranga had a decrease from the previous reported year to 2.6% a.

Whakatāne had a decrease of over three percent from the previous reported year when Whakatāne had the second-highest rate for this indicator nationally to 2.9 %.

Due to the generally low rates for this indicator variation is less consistent by ethnicity. Europen/Other women have a generally decreasing trend.



The national trend for women requiring a blood transfusion with vaginal birth has risen slightly since 2009

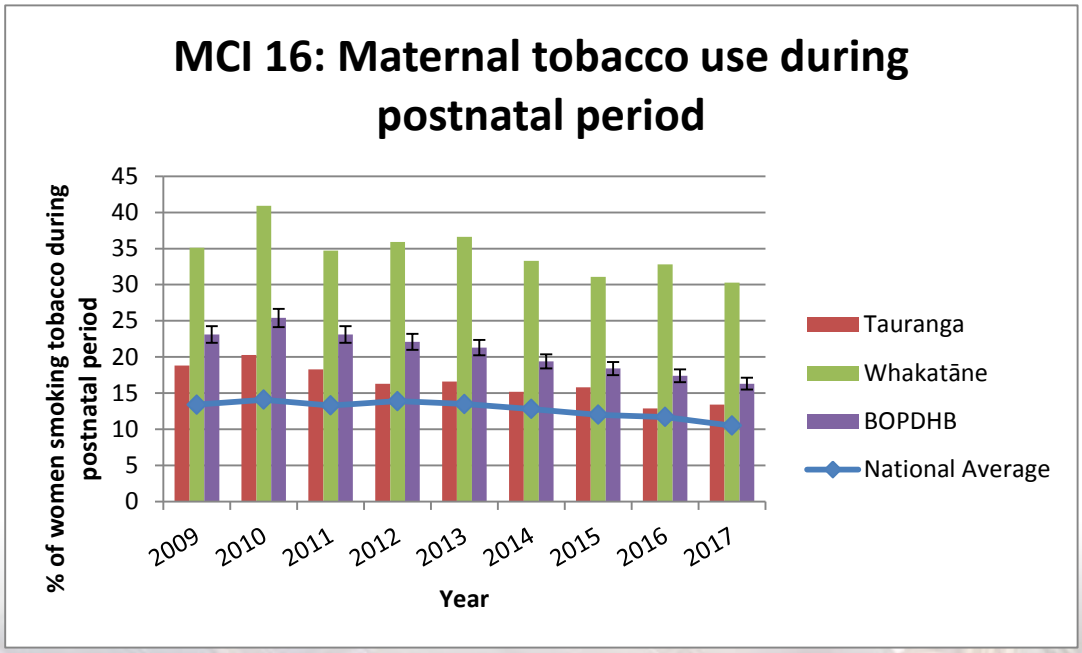
For 2017 all of BOPDHB was below the national average (2.2%) with 1.8% of women requiring a blood transfusion with vaginal birth. This continues the decreasing trend seen since 2015.

Tauranga had a rate mirroring the decreasing trend of the DHB of 1.8%.

Whakatāne had a slight increase from the previous year to 2.9% making Whakatāne the fifth highest nationally for this indicator. This is, however, drop from being the highest hospital for this indicator the year prior.

There has been an increasing rate for Māori women in this indicator, little change for Indian women and a decrease for Europen/Other women to continue a decrease over the last three reported years. This shows an equity issue that needs further investigation.

MCI 13-15: Insufficient data available.



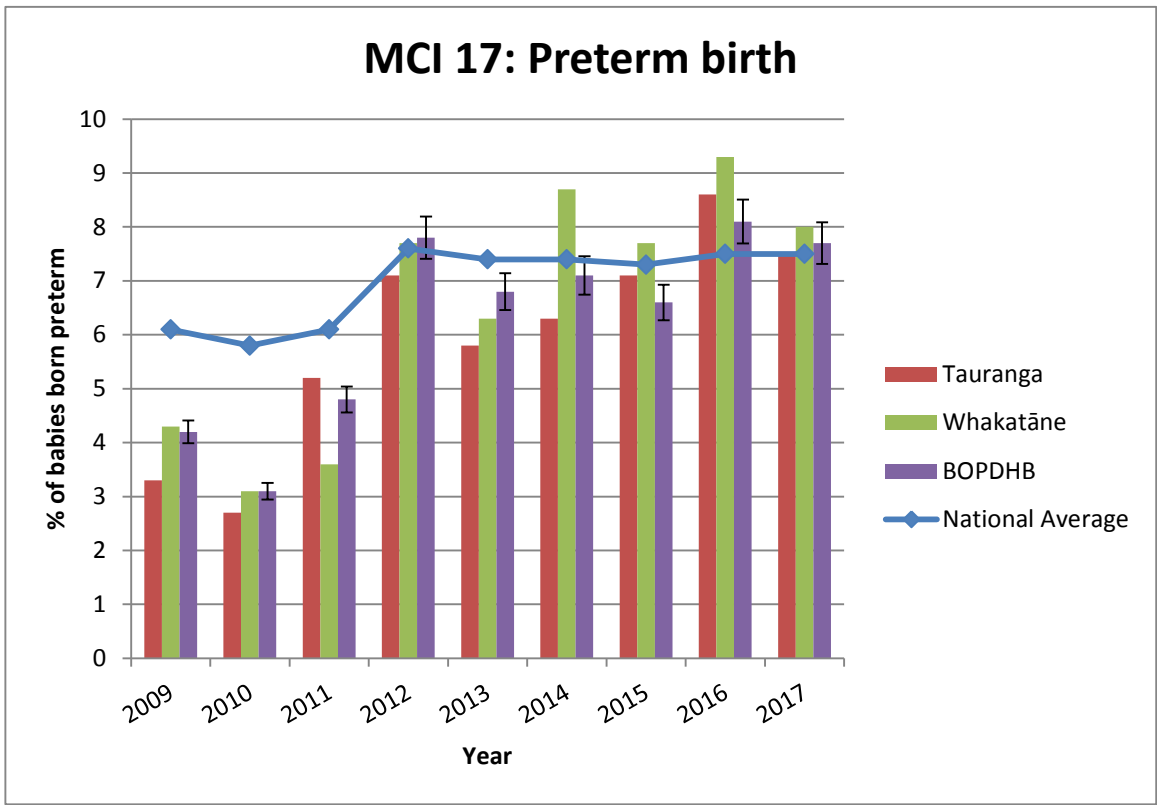
The national trend for maternal tobacco use during the postnatal period has decreased steadily since 2012

For 2017 all of BOPDHB was above the national average (10.5%) with 16.3% of women reported as smoking at two weeks postnatally. This is the lowest reported rate for BOPDHB and a steady decrease in rates continues to be seen.

Tauranga had a slight increase from the previous reported year to 13.4% a.

Whakatāne had a rate almost three times the national average of 30.3%. Whakatāne continues to have the highest rate for this indicator nationally as it has had since reporting began in 2012. There has been and continues to be a large body of work being done in this area around the promotion of the risks to whānau and pepi through the likes of the Wahakura Wananga and Ukaiapo workshops. Work continues around ensuring accurate data is being reported by LMCs and screening being routinely completed at the two-week point to ensure accurate reporting of rates.

There has been a consistent downward trend seen for Māori, Asian and European/Other women for this indicator. Pacific island women have shown little persistent change.



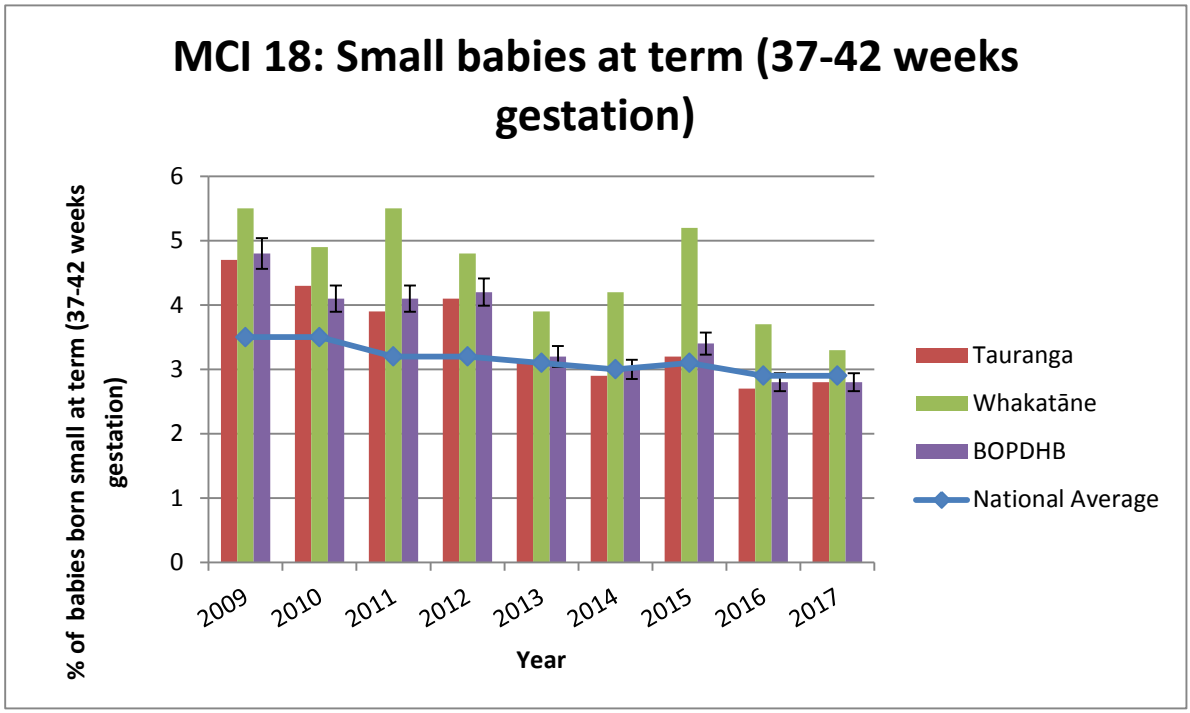
The national trend for preterm birth has been fairly consistent since 2012

For 2017 all of BOPDHB was slightly above the national average (7.5%) with 7.7% of babies being born prematurely (before 32 weeks gestation). This is a slight decrease from the previous reported year.

Tauranga had a rate equal to the national average and a decrease from the previous reported year (7.5%).

Whakatāne had a decrease of 1.3% from the previous reported year to eight percent.

In the last two to four reported years there has been an increase for all ethnicities other than European/Other which has remained generally consistent for the last seven reported years.



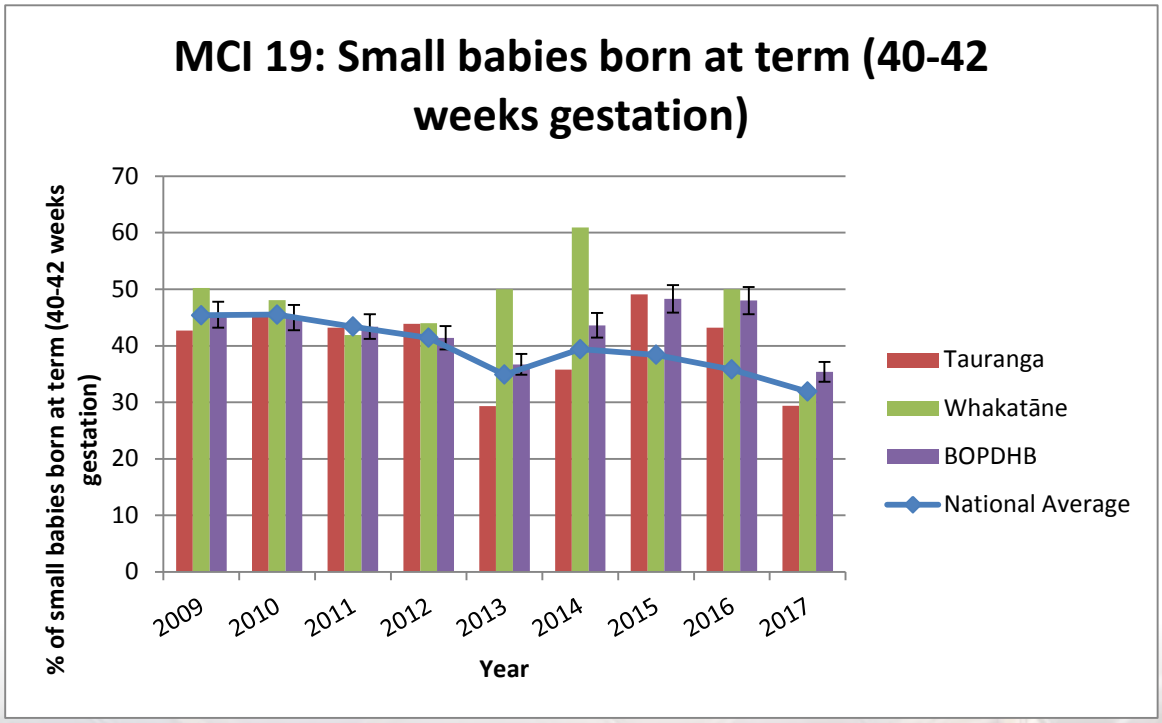
The national trend for small babies at term (37-42 weeks gestation) has decreased slightly since 2009

For 2017 all of BOPDHB was slightly below the national average (2.9%) with 2.8% of babies born a term (37-42 weeks gestation) being small. This is the same rate as the previous reported year. And continues to be the lowest rate locally since reporting started.

Tauranga had a minimal change from the previous reported year to 2.8 %.

Whakatāne had a continuation of the decrease seen since 2015 when Whakatāne had the second-highest rate nationally to 3.3%

There has been a downward trend for this indicator for Māori, Pacific Island and Indian women and some variability for European/other women.



The national trend for small babies at term, born at 40-42 weeks gestation, has decreased by over 10% since 2014

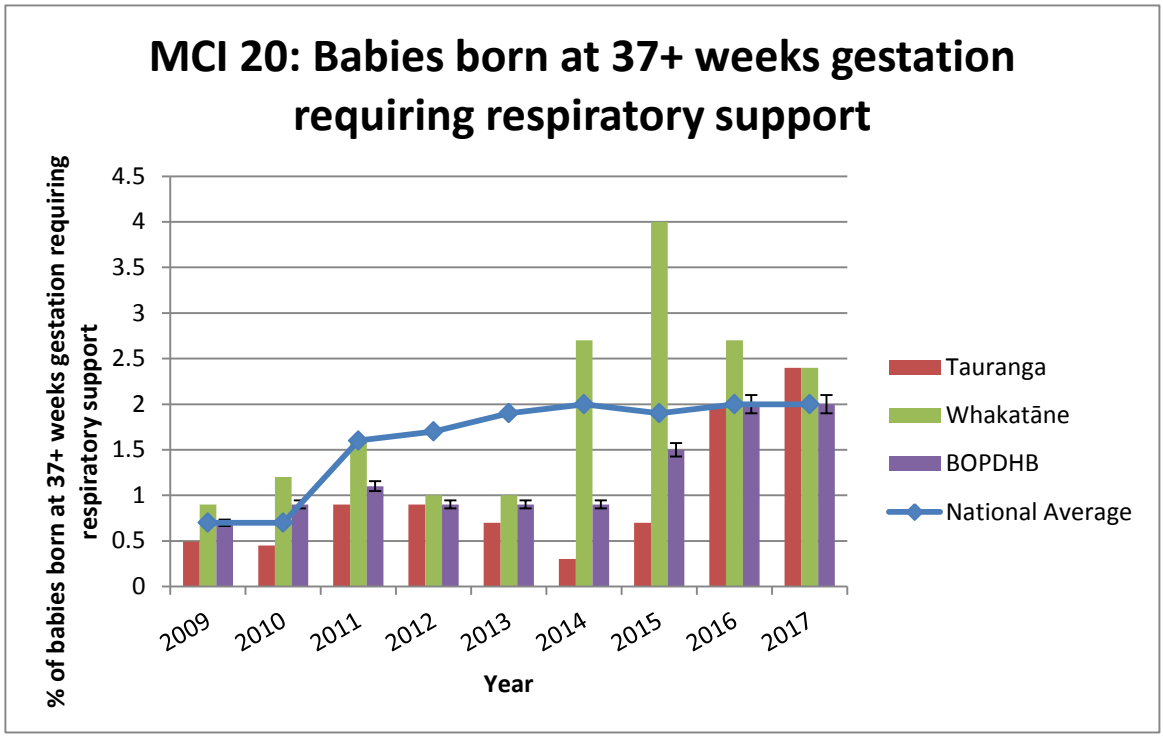
For 2017 all of BOPDHB was above the national average (31.9%) with 35.4% of babies born at 40-42 weeks gestation being small. This is a significant decrease of 12.6% from the previous reported year when BOPDHB was the fourth-highest for this indicator nationally.

Tauranga had a decrease of 13.8% from the previous reported year when Tauranga was the fourth highest hospital for this indicator. Tauranga's rate in 2017 was 29.4 %.

Whakatāne had a decrease of 18.4% from the previous reported year when Whakatāne was the hospital with the third-highest rate for the indicator nationally. The 2017 rate is 31.6 %. This is also the lowest rate recorded for Whakatāne since 2009.

Both Tauranga and Whakatāne hospitals are now below the national average for this indicator.

Both Māori and Indian women have shown a significant drop in incidents for this indicator in 2017, while European/ Other women continue a steadily downward trend.



The national trend for babies born at 37+ weeks gestation requiring respiratory support has risen since 2009 but remained reasonably consistant since 2013.

For 2017 all of BOPDHB was at the national average with two percent of babies born at term (37+weeks gestation) requiring respiratory support. This is consistant with the rate of the previous reported year.

Tauranga had an increase from the previous reported year to 2.4%.

Whakatāne had a continuation of the decrease seen in the previous reported year moving closer to the national average with a rate of 2.4%.

Māori women have shown a steady increase for this indicator in previous reported years but had a significant drop in 2017. European/Other women continue to show a steadily increase for this indicator.

Taurika. This Pou was carved by Stu McDonald for the BOPDHB Planning and Funding Office, Te Whare Whakamana. The whare's designs and graphics tell the story of Taurikuras' journey.

New Zealand Maternity Standards Alignment

Standard One:

Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and pēpi/ infants.

Criteria 8:

All DHB's 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.

Criteria 9:

All DHB's work with professional organisations and consumer groups to identify the needs of their population and provide appropriate services accordingly.

Criteria 10:

Communication between maternity providers is open and effective.

Local evidence:

BOPDHB has several newly formed groups following the restructure of Maternity Clinical Governance: Adverse Events Sub-Committee, Policy Sub-Committee, Clinical Data and Audit Sub-Committee, Maternity Quality and Safety Programme Committee. Each of these groups has multidisciplinary representation and several have consumer and iwi representation. Meetings are held regularly and all report to the new Maternity Clinical Governance Committee (MCGC) for ongoing oversight, coordination and direction.

The objectives of the newly formed MCGC include working to:

Create a quality and equity improvement culture informed by He Pou Oranga Tāngata Whenua, aligned to CARE / Manaakitanga values, which is actively inclusive of stakeholders; ensuring the right people have opportunity to engage in the right dialogue and decision making processes.

Manage maternity quality improvement and decision making processes to ensure opportunities for improvement are identified and acted upon in a timely manner.

Ensure sound data collection and analysis of information is undertaken to guide quality improvement and decision making. Toi Ora (flourishing Hāputanga and Pēpi) data intelligence is supporting the identification of inequity and the imperative presence of the whanau voice.

Standard Two:

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

Criteria 16:

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

Criteria 17:

All DHB's obtain and respond to regular consumer feedback on maternity services.

Criteria 18:

Maternity services are culturally safe and appropriate.

Criteria 19:

Women can access continuity of care from a Lead Maternity Carer for primary maternity care.

Local evidence:

BOPDHB provides pregnancy and antenatal education information online at both the Bay Navigator (hyperlink to both sites) website and the BOPDHB website. There are a number of funded and unfunded groups offering antenatal education, postnatal support and lactation support groups. There are also Māori antenatal education providers delivering Kaupapa Māori focused education.

All consumers have the opportunity to respond to the Patient Experience Survey following discharge. This is an electronic survey sent via email. Currently, this reaches a small percentage of maternity consumers and only approximately 20% of those choose to respond. Work is being done to get more consumers connected via email, to ensure greater equity of access to feedback options. The maternity service national tool was sent to the first 800 women to birth in the DHB in 2019. This had a 20% response rate. More detail of consumer feedback can be read in section ? (add section title or page number here) of this report.

Access to LMC's has been impacted by a considerable change in local community service provision. Both Tauranga and Whakatāne hospitals are providing antenatal, labour and birth care to women unable to access an LMC. The numbers of women accessing this service vary from month to month with a total of 142 women having care provided through the Tauranga Primary Midwifery Care Service between 1 June 2018 and 31 May 2019. The numbers for the same period 2019-20 are expected to be higher.

Engagement with LMC services in the first trimester are lower in some areas of the BOPDHB and work projects have been initiated to identify barriers to access and raise awareness of the importance of early engagement with LMC services.

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.

Criteria 22:

All DHB's plan locally and regionally to provide the nationally agreed levels of primary, secondary and tertiary maternity facilities and services for their population.

Criteria 23:

Women and their pēpi/infants have access to the levels of maternity and newborn services, including mental health, that is clinically indicated.

Criteria 24:

Primary, secondary and tertiary services are effectively linked with a seamless transfer of clinical responsibility between levels of maternity care, and between maternity and other health services.

Criteria 25:

All DHB's plan locally and regionally for effective clinical and organisational pathways to respond to maternity and neonatal emergencies.

Criteria 26:

Women whose care is provided by a secondary or tertiary service receive continuity of midwifery and obstetric care.

Local evidence:

The DHB funds primary maternity units (Bethlehem Birthing Centre and Opotiki Maternity) in both the Eastern and Western BOP. The DHB provides a Primary Midwifery Care Services to women without an LMC. Secondary services are available in Whakatāne and Tauranga. Women requiring tertiary care are transferred to the appropriate tertiary service.

BOPDHB has a designated Maternal Mental Health service for secondary level concerns. Primary care and Kaupapa Māori mental health services provide for the rest of the continuum. The pathway and support for maternal (and whānau/families) mental health services has been highlighted to local maternity services as part of the BOPDHB Maternity Support Directory development and launch.

The introduction of new Handover of Clinical Responsibility stickers to highlight where care has changed hands in clinical notes has been adopted resulting in an improvement in multidisciplinary communication.

The LMC community continue to provide antenatally and postnatally midwifery care for secondary and tertiary care women while they are in the region and labour care on a case by case basis. Consumer feedback demonstrates that women requiring secondary care are generally very satisfied with the continuity of midwifery and obstetric care they received.

BOPDHB MQSP Projects 2018-19

Key: Project complete
Project in progress
Significant work yet to be done on project

Project title	Consumer Feedback	Status
Rationale	MOH recommends using the maternity service national tool at least once every five years. This is the first time this has been used in the BOPDHB.	
Actions	Surveys sent to the first 800 women to birth in the BOPDHB in 2019. Free return postage included. Collected and collated responses.	
Measures	General themes compared to those seen in the BOPDHB Patient Experience Survey emailed to all hospital patients after discharge.	
Outcomes	20% response rate. Mixed responses with some useful suggestions for improvements. General comments in agreement with those gained from the BOPDHB Patient Experience Survey eg mixed/contradicting information from staff, food quality etc.	
Future	Potentially inequitable survey media. Future surveys need to consider a multimedia approach, with a reminder system, to try and capture a wider response.	

Project title	Maternity Support Directory	Status
Rationale	LMC's in Western Bay identified difficulty maintaining current knowledge of community support agencies to help support women with increasingly complicated social needs	
Actions	Directory of community groups complied for full BOP region. Launched with networking event for LMC's and community groups. Directory stored electronically for mobile access and ease of maintaining current data.	
Measures	LMC's and community groups surveyed following the launch. A positive response from those that had tried the directory and awareness raised to those not aware.	
Outcomes	Resource available to the community, both LMC and beyond.	
Future	Ongoing marketing of directory to new LMC's to promote awareness. Update annually or more frequently.	

Project title	Equity of access to ultrasound services (USS)	Status
Rationale	Significantly less service option in Eastern Bay with surcharge in place leading to some women not engaging with service due to cost and travel barriers. Women with high-risk pregnancies being missed or diagnosed late.	
Actions	Increased access to USS in the Western Bay by installing the second machine. Surcharge dropped for the anatomy scan	
Measures	Increased availability of USS appointments. Reduced IUGR/SGA babies unidentified until birth.	
Outcomes	More appointments available, improving ease of access to service. Increased engagement with service due to dropping surcharge. Timeliness of identifying high-risk pregnancy improving. Increased equity of service provision.	
Future	Ongoing monitoring of Maternity Clinical Indicators 18 & 19. These changes will not be visible before 2021.	

Project title	Equity of LMC access	Status
Rationale	Eastern BOP LMC registration at 12 weeks in 12% lower than Western BOP (2017 MCI).	
Actions	Identify standard local practice. Identify barriers/enablers for accessing LMC services. Reactivate ASAP programme to encourage earlier engagement of LMC services.	
Measures	Continue to monitor MCI one data.	
Outcomes	These changes will not be visible before 2021.	
Future	Continue to monitor MCIs 2021+ and change approach if no improvement is seen.	

Project title	MQSP Newsletter	Status
Rationale	Raise awareness of MQSP regionally both within BOPDHB and in the wider community. Provide updates to maternity stakeholders of advances and new developments within the maternity services. Connect groups and services while also raising awareness.	
Actions	Collect updates from various regional groups, present profiles of services to increase awareness of the variety of services available. Present updates on MQSP activities regionally.	
Measures	Newsletter engagement trackable through the MailChimp website. Aim to increase reads and clicks over time as a way of measuring interest and engagement.	
Outcomes	Distributed to over 400 people quarterly including Midwives, General Practitioners and community groups. In the last 12 months, the open rate has increased by half and the click rate of attachments has tripled.	
Future	Ongoing work on presenting engaging content and building networ	

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Future	Ongoing work on presenting engaging content and building network.	

Project title	CTG sticker updated to align with RANZCOG guidance	Status
Rationale	Need for increased clarity around points of handover identified by Quality and Patient Safety.	
Actions	Handover sticker redeveloped. New sticker promoted to staff (maternity and O&G teams) and LMC's. Audit of handover sticker use post-implementation.	
Measures	Audit of sticker use to run at 1/12 post rollout.	
Outcomes	Uptake of sticker use generally positive. Some ongoing education around when to use identified.	
Future	Ongoing periodic audit of use to maintain consistency.	

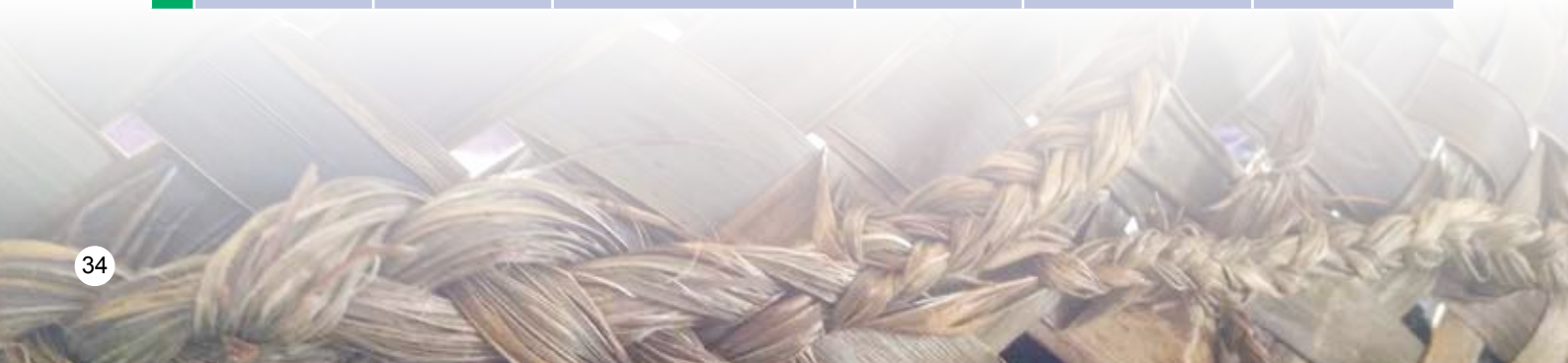
Project title	CTG sticker updated to align with RANZCOG guidance	Status
Rationale	Health and Disciplinary Commissioner (HDC) case highlighted a lack of escalation documentation for concerning CTG traces.	
Actions	CTG documentation sticker replaced with the new version that aligns with traffic light escalation process used in other areas. Promotion and education on the use of new sticker carried out. Audit of sticker use.	
Measures	Audit of sticker use planned for 1/12 post-roll-out.	
Outcomes	Staff and LMC's have adapted to the new sticker with ease. Positive feedback. 100% use of the new sticker.	
Future	Ongoing periodic audit of use to maintain consistency.	

Project title	National Maternity Early Warning System implemented	Status
Rationale	MEWS being rolled out nationally.	
Actions	Embed MEWS in Maternity wards on both sites then roll out hospital-wide across DHB in early 2020 (four-phase approach).	
Measures	Pre-audit each area for 2 weeks pre roll out then weekly in each area for 4-6/12.	
Outcomes	Unavailable as yet.	
Future	Run additional education as identified by audit findings and embed education in orientation package.	

Project title	Sepsis Kit	Status
Rationale	Sepsis kits recommended by the Maternal Morbidity Working Group (MMWG) in 2018 annual report, Due to Sepsis being a high cause of maternal morbidity and mortality.	
Actions	Sepsis education already part of the compulsory emergency midwifery skills day. Sepsis Grab n Go Boxes developed for both maternity wards. Promotion of Boxes along with reminders of signs and symptoms of sepsis	
Measures	Staff awareness of boxes and use them when potential sepsis is identified.	
Outcomes	nil as yet.	
Future	C Sepsis Boxes will be promoted at Midwifery Emergency Skills days.	

Future Projects Planned for BOPDHB MQSP

Initiative /priority		Rationale	Action	Timeframes	Measure	Expected Outcome
1	Quality improvement	Identified need to grow a quality culture in maternity	Maternity Clinical Indicators (MCIs) reviewed and local implications identified Relevant national reports reviewed and recommendations considered Reporting to Maternity Clinical Governance Identify additional local needs	Annually Annually Monthly	Work plan and timeline set Annual MQSP report to MOH submitted Implementation of recommendations for PMMRC, MMWG, NMMG.	Coordination of clinical quality governance MQSP report/work plan achieved Approval/oversight of project plans
2	Clinical data and audit group	Identified need to ensure accurate data to measure maternity improvements	Establish Clinical Data and Audit Subcommittee Identify data requirements Identify clinical audit requirements Identify education requirements Report to MCG monthly	Meet early February November February November/ December March	Appropriate data requirements identified Appropriate routine audit identified Specific additional audit requirements identified Timely audits completed and reported Recommendations forwarded to MCG Monthly report to MCG	Coordination of data management
3	Adverse Events/ Complaints Management	Aim to get the best out of learning opportunities	Establish Adverse Events/ Complaints Subcommittee Triage and review events/ complaints Report to MCG monthly	Meet fortnightly	Improved completion times Improved tracking of events Robust recommendations made MCG oversight of process Monthly report supplied to MCG	Coordination of adverse events management
4	Policy management plan provided to MCG with annual review (including timeframe for completion)	Need identified for improved best practice guidance to set the standards for BOPDHB maternity practitioners	Establish policy subcommittee Coordinate policy development Report to MCG monthly	Meet weekly	Policy development requirements identified Policy management sentence Policies effectively managed	Comprehensive current policies available

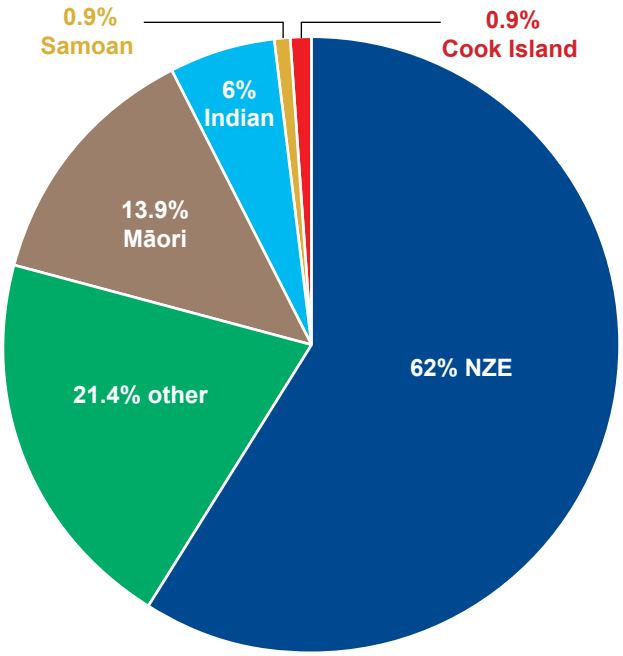


Maternity Consumer Feedback

BOPDHB ran the national Maternity Consumer Survey for the first six months of 2019. This national tool is required, by standard two of the New Zealand Maternity Standards, to be run at least once each five years. The survey is sent to maternity consumers six weeks post-birth until a minimum of 100 responses are received.

Surveys were posted out to the first 800 women who birthed in the DHB in 2019. 162 responses were returned (20%). The respondents (see graph 1) This does not portray a representative response for Māori and NZE women when 33% and 42% of surveys respectively were sent. Future surveys need to consider alternative approaches to survey medium to reduce the barriers to engaging with and returning completed surveys. Further other methods of obtaining feedback are being considered to ensure access is culturally appropriate and equitable.

1. Ethnicity of survey responsders



	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied	Not applicable
How easy it was for you to get the care that you needed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 95

The survey had a combination of questions about aspects of care where the respondent used the satisfaction scale above to show their opinions of the care they experienced. As a whole, the responses were positive, with an average of satisfied to very satisfied for every question except the satisfaction with the food which had an average response of neutral. The rest of the survey was open for the women to write comments relevant to the following phases of the maternity experience; antenatal, labour and birth, postnatal hospital stay, postnatal at home and general comment. For these sections 43% of all responses were positive, 30% negative and 27% constructive. Valuable feedback was provided in the open comment sections.

A quarter of responses offered constructive suggestions for improvement of antenatal experiences. With common suggestions relating to LMC services such as information on accessing an LMC and the shortage of LMCs in the BOP area. There were also suggestions of improved consistency of information, communication, care planning and delivery of care through all areas of maternity services.

Half of all respondents made comment on their care experience during labour and birth. 51% was positive, 31% was negative and 18% had suggestions of areas for improvement. Common themes were the need for; more lactation consultant out of business hours, more baths in birthing rooms, more timely information on pain relief options available, activities for women and their support people when admitted for induction of labour and more support from hospital staff for new graduate midwives.

The highest response rate for comments was around the care experience of women while in hospital with 61% of respondents making comment. 26% of comments were positive, 34% negative and 39% provided constructive suggestions for improvement. There was a strong emphasis on support people being able to stay overnight with appropriate facilities for this. Restricted visiting hours to allow for rest during the day and improvement to facilities provided such as more comfortable seating and air-conditioning were also mentioned

Food was a common theme, with nutritious food for labouring and breastfeeding mothers, the availability of snacks and increased vegetarian meal options being the most common comments.

The question about the experience of care at home received the lowest response rate; (38%). However, the feedback was largely positive (63%), with 15% offering suggestions, such as; more follow up care and information e.g. more physical checks, and physio referrals.

Over half of the respondents took the opportunity to comment further. The local birthing community displayed their awareness of current midwifery issues and the value they place on maternity care. The most common suggestion was to increase pay and improve working conditions for midwives.


"Thanks for taking us in when Waikato had no room for us. All your staff were welcoming, friendly and approachable."
"Sharing rooms with new babies is a challenge. Would be nice to have more privacy as a family."
"The staff at the hospital were fantastic. It was a great experience. The midwives were patient with us when teaching us how to breastfeed. We felt very confident leaving the hospital with what we had learnt."
"The care I received from my midwife and the birthing suite and maternity unit midwives was excellent. At all times I knew what was happening and felt safe in their care."
"My decision to try for a VBAC was very well supported and I felt very informed on the risks and benefits of both options."
"After complicated birth I would have liked a debrief/ explanation from doctor sooner as I wasn't sure why things went wrong with me health-wise."
"I wasn't happy with the pressure from the midwives to breastfeed."
"Such a shame my partner had to leave each night. Leaves dads feeling out of the loop, especially first time dads."

Highlights and achievements

Highlights in outcomes

Over 70% of women

having their first baby in BOPDHB have a spontaneous vaginal birth.

Whakatāne hospital has the highest rate of women with an intact perineum following vaginal birth. nationally.

Quality initiatives

- **Maternity Support Directory to help LMCs connect with community support groups developed to support engangement and wraparound service provision**
- **Additional Health Care Assistants employed and rostered to provide 24/7 support to clinical staff on Tauranga Maternity Ward**
- **Increased clerical support to Tauranga Maternity Ward**
- **Midwife Leader appointed**
- **Increased professional stakeholder enagement processes**
- **All core midwives wear a name badge for ease of women and their whanau identifying carers.**
- **The Maternity Early Warning System has been introduced to the maternity wards at BOPDHB.**
- **Clinical handover sticker revised and reimplmented**

Foetal Surveillance

Over 50% of maternity staff

have attended the RANZCOG fetal servalance training in 2019. Further education planned for 2020.

CTG stickers updated to align with RANZCOG training.

Safe Sleep Intiatives

12 wahakura wananga

held in the BOP community since 2012

44 wahakura made

so far this financial year.


BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI