Te Whatu Ora
Health New Zealand
Te Tai o Poutini West Coast

Canterbury and West Coast
MATERNITY CARE

Maternity Quality & Safety Programme

Annual Report

2023

Cover Photo Lane Malloy DOB 08/10/2023 with his parents Andrea and Craig

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Te Tai o Poutini Maternity Quality and Safety Operational Governance Group

Te Tai o Poutini Commissioning Team

Te Tai o Poutini & Waitaha Maternity Clinical Governance Committee members

A big thank you to the lovely whānau and staff that so kindly gave their time and permission to use their photographs in our Annual report.

Disclaimer

While every effort is made to ensure the accuracy of the information contained in this report, Te Whatu Ora Te Tai o Poutini cannot guarantee the integrity of the information or data supplied.

Foreword

Kia ora koutou,

It is with great pleasure that the 2023 Te Tai o Poutini annual maternity report is presented in the following pages. It has been a busy year. The health system reforms have dominated the landscape but despite change and some uncertainty the entire multidisciplinary maternity team of Te Tai o Poutini continue to provide quality care to hapū māmā and whānau.

The focus of the maternity team is to provide equitable safe and sustainable maternity care for women close to home. Te Pae Tata and our obligations under Te Tiriti underpin all that we do. Maternity has a strong connection to community and whānau voice and this continues to play an important part in how we shape the system and service for now and into the future. The community council continue to work hard to bring community voice to the service and help make improvements for whānau. Iwi Māori partnership boards will also inform us of our priorities as we head into the next two years. The newly formed National clinical network for maternity and the work plans under Kahu Taurima will also help remove variation and bring consistency across the motu in maternity guidelines and priorities.

This report shows cases some of the great work the maternity team in Te Tai o Poutini have done in 2023. The MQSP workplan is progressing well with national standards and indicators being actioned with local solutions.

The quality programme is progressing well with a shift in the last 12 months of incident reviews being combined as a transalpine meeting allowing a larger cohort of clinicians, objectivity and links into the Christchurch quality team to aide in reporting. The safety first reporting against a trigger list is working well for the Coast.

Staffing continues to be a challenge for this remote and rural workforce. The team always pull together in the busy times to ensure safe care for whānau which is a highlight of working on the West Coast. Te Rau Kawakawa was opened in 2023 which allows a primary birthing option in a beautiful facility in Westport. Sustainability for midwives for Westport continues to be a challenge.

The rural generalist model is proving to be the solution to medical workforce challenges with a stable workforce of two resident O and G specialists, three RGO's and two transalpine O and G's with a third to commence in 2025 as a result of registrars coming to the West Coast for training with the visiting transalpine O and G. This model is starting to become the envy of other rural locations in New Zealand .

The following pages report on the outcomes against the national clinical indicators set out by the NMMG and also reports against the ten groups classification (Robson) system which is proving to be helpful to identify areas for further improvement in obstetric outcomes and allows Te Tai o Poutini to compare against other units. It was fantastic to see this small unit present their data at a national obstetric outcomes meeting in October 2024 with many wanting to know about this unique high performing small team.

We hope you enjoy reading our report.

Kathleen Maki
Interim Director of Midwifery
Te Whatu Ora Te Tai o Poutini & Waitaha

Emma Jackson
Clinical Director, Obstetrics
Te Whatu Ora Te Tai o Poutini & Waitaha

Maegan Cameron – Maternity Consumer Representative

Kia ora koutou, Ko Maegan Cameron toku ingoa. I am a māmā of two boys aged 6 & 4 who were both born here on the Coast, and I am the Maternity Consumer Representative for the West Coast.

During my 18 months in this role, the Maternity Consumer Council has been re-established, with 3 district representatives in Hokitika, Greymouth and Westport who engage with their community at a local level, and 10 active members coming together to meet monthly.

The Maternity Consumer Council have many meaningful and informative discussions with maternity consumers across the West Coast. We have, as a group, now seen 3 projects completed which are being utilised in the community. These projects are focused on nutrition for postnatal Māmā, the implementation of a beautiful photograph from a local photographer as a mural in the new birthing unit in Westport, and an initiative implemented to ensure consumers know how to change Well Child/Tamariki Ora providers easily if they wish too.

Another key area of discussions for us currently is in regard to the practical and financial impacts for West Coast families having to transfer and birth in Christchurch.

I look forward to continuing to connect with maternity consumers within our community and I embrace opportunities to ensure voices of minorities are heard and experiences are used to bring about change into the future.

Nga mihi nui

Maegan

Contents

Baby Hiedi Wiffen DOB 4/11/2023 with big sister Lucy and mum Kate

Glossary

Apgar Score	An assessment of a baby at 1, 5 and 10 minutes after birth during which the health care provider will examine the baby's: breathing effort, heart rate, muscle tone, reflexes and skin colour. Documented in retrospect, each category is scored with 0, 1, or 2, depending on the observed condition. The APGAR rating is based on a total score of 0 to 10. The higher the score, the better the baby's condition.
ARM	Artificial Rupture of Membranes; "breaking the water," is a procedure to break a pregnant woman's amniotic sac. The amniotic sac is a pouch of fluid that surrounds and protects the baby. Breaking of the amniotic sac releases hormones that signal your body to begin or intensify labour contractions.
Caesarean section	An operative birth through an abdominal incision.
Bishop's Score	System used by medical professionals to determine how likely it is you will go into labour soon. Used to determine whether induction should be recommended and how likely induction will result in a vaginal birth.
Core LMC	A secondary services-based core lead maternity carer.
Episiotomy	An incision of the perineal tissue surrounding the vagina to facilitate or expedite birth.
Gravida	Number of pregnancies a woman has had.
Maternity facilities	A maternity facility is a place that women attend, or are resident in, for the primary purpose of receiving maternity care, usually during labour and birth. It may be classed as primary, secondary or tertiary depending on the availability of specialist services (Ministry of Health 2012). This section describes women giving birth at a maternity facility.
LMC	Lead Maternity Carer; usually a community-based midwife who will provide each woman with continuity of midwifery care throughout pregnancy, labour and birth and the postnatal period, within a partnership model of care from the time she registers with the LMC to six weeks post-partum.
Multiparous	A woman who has given birth one or more times.
Neonatal Death	Death of a baby within 28 days of life.
Nulliparous	Medical term for a woman who hasn't given birth to a child; also applies to women who have had a miscarriage, stillbirth or elective abortion, but has never given birth to a live baby.
Parity	The number of previous pregnancies that resulted in live births or stillbirths (counting twins or multiple births as one).
Primiparous	A woman who has not given birth.
Post-Partum	Means "after the birth" and refers to the period after the woman has birthed.

Primary facility	Refers to a maternity unit that provides care for women expected to experience normal birth with care provision from midwives. It is usually community-based and specifically for women assessed as being at low risk of complications for labour and birth care. Access to specialist secondary maternity services and care will require transfer to a secondary/tertiary facility. Primary facilities do not provide epidural analgesia or operative birth services. Birthing units are considered to be primary facilities. Primary maternity facilities provide inpatient services for labour and birth and the immediate postnatal period.
Postpartum Haemorrhage	Excessive bleeding after birth that causes a woman to become unwell.
Primary Maternity Services	Primary maternity services are provided to women and their babies for an uncomplicated pregnancy, labour and birth, and postnatal period. They are based on continuity of care. The majority of these maternity services are provided by Lead Maternity Carers (LMCs).
Rural Generalist	Rural Hospital Medical Specialists with special scope in procedural obstetrics commence acute Obstetric call after credentialing at Christchurch Women's Hospital.
Secondary facility	Refers to a hospital that can provide care for normal births, complicated pregnancies and births including operative births and caesarean sections plus specialist adjunct services including anaesthetics and paediatrics. As a minimum, secondary facilities include an obstetrician rostered on site during working hours and on call after hours, with access to support from an anaesthetist, paediatrician, radiological, laboratory and neonatal services.
Standard primiparae	A group of mothers considered to be clinically comparable and expected to require low levels of obstetric intervention. Standard primiparae are defined in this report as women recorded in the National Maternity Collection (MAT) who meet all of the following inclusions: • delivered at a maternity facility • are aged between 20 and 34 years (inclusive) at delivery • are pregnant with a single baby presenting in labour in cephalic position • have no known prior pregnancy of 20 weeks and over gestation • deliver a live or stillborn baby at term gestation: between 37 and 41 weeks inclusive • have no recorded obstetric complications in the present pregnancy that are indications for specific obstetric interventions. Intervention and complication rates for such women should be low and consistent across hospitals. Compiling data from only standard primiparae (rather than all women giving birth) controls for differences in case mix and increases the validity of inter-hospital comparisons of maternity care (adapted from Australian Council on Healthcare Standards 2008, p 29).
Stillbirth	The birth of an infant after 20 weeks gestation, which has died in the womb and weighed more than 400 grams.

Abbreviations

BFHI	Baby Friendly Hospital Initiative
CDHB	Canterbury District Health Board – now Waitaha
DHB	District Health Board
GDM	Gestational Diabetes Mellitus
GP	General Practitioner
HDU	High Dependency Unit
IUCD	Intra Uterine Contraceptive Device
ICU	Intensive Care Unit
IOL	Induction of Labour
LARC	Long Acting Reversible Contraceptives
LMC	Lead Maternity Carer
MIRG	Maternity Incident Review Group
MQSGG	Maternity Quality and Safety Governance Group
MOH	Ministry of Health
MQSP	Maternity Quality and Safety Programme
NICU	Neonatal Intensive Care Unit
NMMG	National Maternity Monitoring Group
PMMRC	Perinatal and Maternal Mortality Review Committee
PPH	Postpartum Haemorrhage
RMO	Resident Medical Officer
SGA	Small for Gestational Age
SUDI	Sudden Unexpected Death in Infancy
SMO	Senior Medical Officer
UNHSEIP	Universal Newborn Hearing Screening Early Intervention Programme
VBAC	Vaginal birth after caesarean
WCDHB	West Coast District Health Board – now Te Tai o Poutini

Background

This is the tenth Te Tai o Poutini Maternity Quality and Safety Annual Report since the establishment of the Ministry of Health (MoH) Maternity Quality and Safety Programme (MQSP) in 2011. The National Maternity Monitoring Group (NMMG) came into operation in 2012, as part of this programme, to oversee the maternity system in general and the implementation of the New Zealand Maternity Standards.

The New Zealand Maternity Standards (MoH, 2011) are a fundamental part of the Quality and Safety Programme providing guidance for the provision of equitable, safe and high-quality maternity services throughout New Zealand. Te Pae Tata will provide the frameworks and goals of maternity quality. The Standards consist of three high-level strategic statements to guide the planning, funding, provision and monitoring of maternity services by the Ministry of Health, Te Whatu Ora Localities, service providers and health practitioners:

• Provide safe, high-quality maternity services that are nationally consistent and achieve optimal health outcomes for mothers and babies;

• Ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage;

• 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.

It is noted by the Te Tai o Poutini team that equity is not a part of these Standards and neither is the requirement of the Articles of Te Tiriti o Waitangi to provide a guide to all we do within our health system evident in the frameworks to date.

Purpose

The purpose of this report is to provide information about Te Tai o Poutini:

• Improvements made in relation to overall aims and objectives;

• Achievements against the quality improvement goals set for 2023;

• Contribution towards addressing the priorities of the NMMG and Perinatal and Maternal Mortality Review Committee (PMMRC);

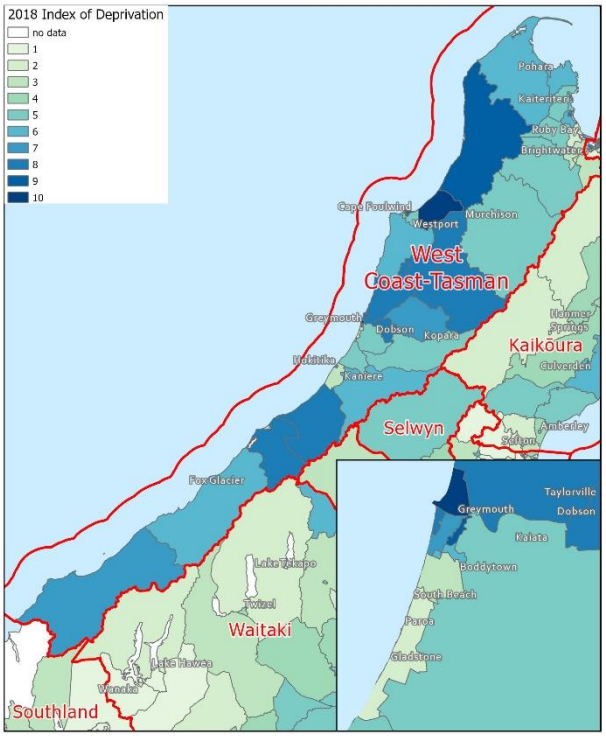
• Performance in relation to the Ministry of Health's New Zealand Maternity Clinical Indicators 2020;

• Response to consumer feedback and ongoing consumer involvement;

• Quality initiative goals for 2024.

Te Whatu Ora Te Tai O Poutini West Coast

We have the smallest population of any health locality in New Zealand with responsibility for 33,390 people an increase of 5.7% from 2018 and only 0.67% of the total New Zealand population (2023 Census). We employ approximately 1,100 staff (including casual staff) in our health service (705 FTE).



Although we are the smallest by population we have the third largest geographical area, making Te Tai o Poutini the most sparsely populated Health locality in the country with only 1.4 people per square kilometre, and a seven-hour travel time by road from end to end.

The West Coast has the third highest level of deprivation in New Zealand averaging 6.8 on the 2018 deprivation index. As demonstrated in the electoral map of West Coast-Tasman shown there are wide variation across the district from the least deprived in Paroa at 2, to the most deprived in Westport scoring 10.

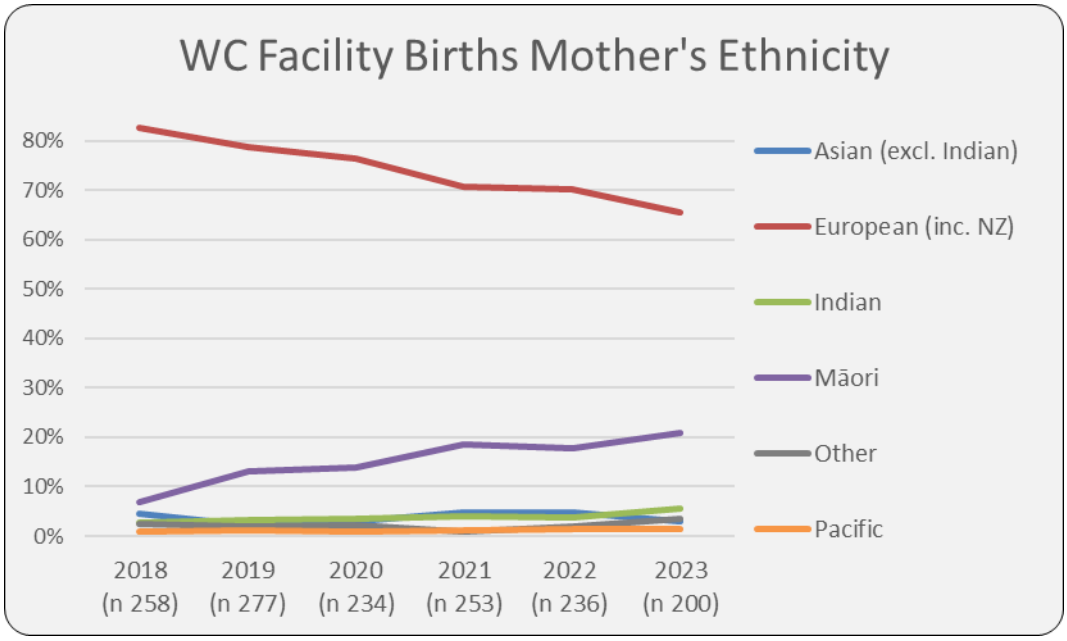
There are three Territorial Local Authorities:

- **Grey District** has the largest population, with an estimated resident population of 14,000 people.
- **Buller District** has an estimated resident population of 10,500 people.
- **Westland District** has an estimated resident population of 8,900 people.

After 10 years with an almost static population, the 2023 Census reported an increase of 5.7% from 2018. Te Tai o Poutini has a diverse population with a large and growing Māori population comprising 13.5% of our population, European 89.7%, 4% Asian, 1.6% Pacific Peoples (percentages are for total response and therefore will add to over 100%). 8% of the population are women of childbearing age (15-44).

Tangata Whenua on the West Coast is Poutini Ngai Tahu with two main rūnanga; Te Rūnanga o Ngāti Waewae based in the northern part of the West Coast and Te Rūnanga o Makaawhio in the southern part. Māori are highly connected through whakapapa and the wellbeing of individuals is strongly associated with the wellbeing of the whānau whānui (wider family).

On the West Coast there are also many Māori who whakapapa to iwi in other parts of Aotearoa. Irrespective of where they reside, many Māori hold strong connections and sense of belonging to their tūrangawaewae and marae, and their ability to access and participate in Te Ao Māori (Māori world view). These familial and cultural connections provide a strong and enduring sense of identity and are prerequisites to good health. There is a need to increase support and understanding to better reflect these views in our health system in this locality, including and especially in maternity services.



Te Tai o Poutini Maternity Services

Our Vision

Te Tai o Poutini maternity services provide for the maternity needs of all māmā and whānau as and when needed during their maternity journey in order to enable the best start to life for all pēpi and the ongoing wellbeing of mothers.

Our Values

Mana Taurite - *Equity*

Every person has the opportunity to access culturally appropriate services. Those who work across the maternity system reflect the community in which we live, and understand, value and support cultural practices that may be different to their own.

Whānaungatanga -*Everyone belongs*

The whole whānau is included and important, with each person feeling comfortable and as though they belong. Interaction with the maternity system is a mana enhancing experience.

Manaakitanga - *Respect for all*

The maternity system is hospitable through being welcoming, and respectful. We provide the utmost care for each other.

Tino rangatiratanga - *Empowering whānau*

Whānau are empowered and supported to make their own informed decisions.

Oranga tonutanga - *Health and wellbeing*

Whānau have optimal physical, mental, dental and sexual health before, during and after the birth of pēpi. People have the opportunity to enjoy clean smoke free air and clean water wherever they live, work and play (wai ora).

Aroha - *Love and empathy*

Without bias every person[1] is treated with love, compassion and empathy.

[1] When we say "every person" this is inclusive regardless of sexual orientation, gender identity/expression, sex characteristics, ethnicity, age, religion, culture.

Maternity Facilities

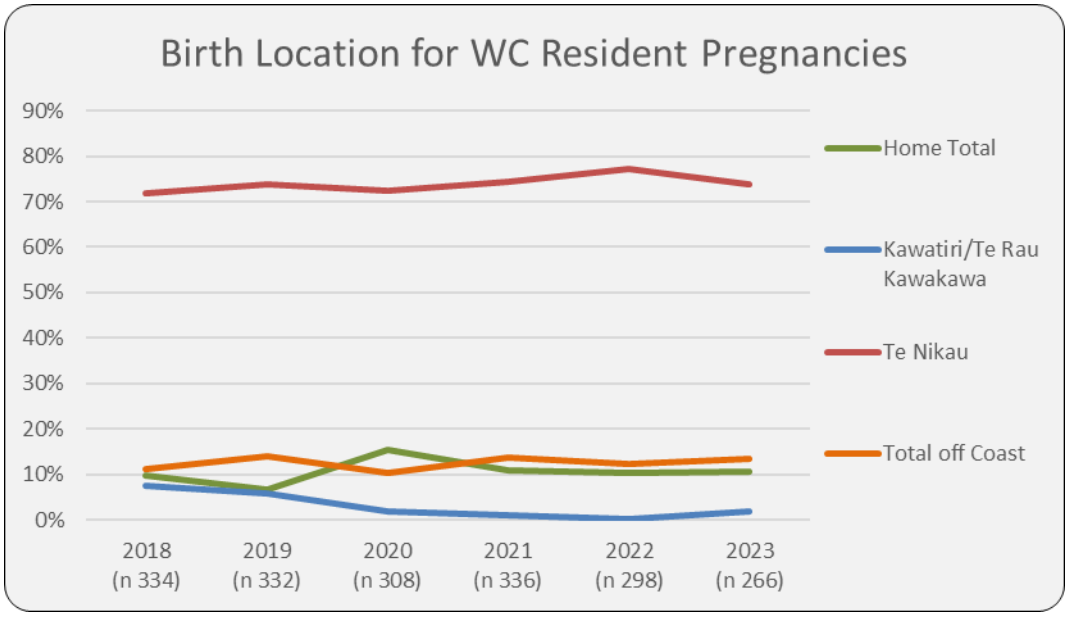
There are two facilities available to women living on the West Coast with the majority of births at the larger Te Nīkau Hospital and Health Centre. This is a secondary maternity unit providing care for uncomplicated pregnancies and those with extra needs requiring consultation or care by obstetric services.

Te Rau Kawakawa, the new Integrated Family Health Centre in Westport opened in May 2023 with a new purpose-built primary birthing space, welcoming its first birth in October.

Christchurch Women's Hospital is the tertiary facility for the West Coast and is located in Canterbury. They accept referrals from Te Tai o Poutini and we work closely with their team when women and/or their babies require more complex care and a higher level of support at any point in their maternity journey.

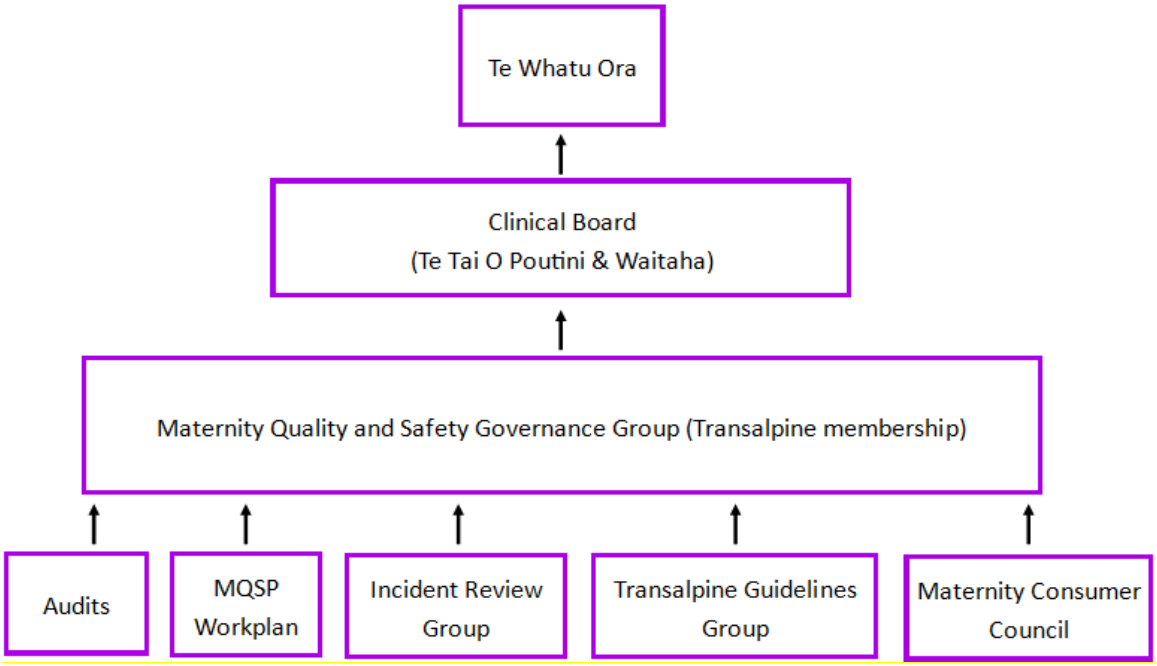
Birth room in Te Rau Kawakawa – image kindly donated by local Westport photographer Ezra Hopkins

Te Nīkau Hospital and Health Centre



Maternity Governance

Reporting lines and governance outlined below:



Midwives undertaking the Pink Ribbon walk to raise funds for Breast Cancer

Our People/Team in 2023

			
Norma Campbell Director of Midwifery, Te Tai o Poutini and Waitaha	Dawn Kremers Midwife Manager	Maegan Cameron Consumer Representative	Biddy Molloy LMC Liaison
			
Dr Jane Fielder-Transalpine Obstetrician & Gynaecologist	Dr Reuben Hoyte Obstetrician & Gynaecologist	Dr Ravi Vemulapalli Obstetrician & Gynaecologist	Sandy Goile Midwifery Educator & Clinical Coach
			
Dr Brendan Marshall Rural Hospital Generalist	Dr Alan Furniss Rural Hospital Generalist	Dr Sara Gordon Rural Hospital Generalist	Charlotte Binks Lactation Consultant
			
Rana Kamo Obstetric & Diabetes Clinic Midwife	Mary Sullivan Newborn Hearing Screener	Kerri de Klerk Maternity Services Administrator	Natalya Vitali MQSP Coordinator

Transalpine Partnership

Like all small rural health services, population numbers on the West Coast means we rely on close relationships with clinical colleagues in larger centres and networks in order to provide our population the full range of specialist services. One of the key aims of the recent health reforms is to drive more consistent service delivery across districts in Aotearoa. In many ways the West Coast and Canterbury are 'ahead of the game' having worked in this way for over a decade.

Since 2010, the West Coast has shared executive and clinical services with Canterbury. This included a joint Chief Executive and clinical directors, as well as shared public health and corporate service teams. Our transalpine model is increasingly recognised as the type of network that ensures clinical teams in both smaller and larger centres support each other to optimise outcomes for whānau and community.

The Transalpine approach in maternity is reflected in a number of ways:

- We share a Director of Midwifery.
- The shared service and clinical partnership arrangements that have been developed are embedded in the West Coast Maternity Quality Safety Programme.
- Canterbury and West Coast share opportunities for education, policy and procedure review and case review.
- West Coast and Canterbury, through the Guidelines Group, regularly review and develop policy and procedure to ensure consistency, particularly in an environment where clinicians work between both environments. This Transalpine approach to service provision has allowed better planning for the assistance and services Canterbury provides to the West Coast, whānau can access services as close as possible to where they live.
- We have the backup and support of a tertiary level service, who know and understand our environment, when required.
- Canterbury clinicians, including RMOs, regularly visit the West Coast providing cover when their West Coast peers are on leave and obstetricians, rural generalists and midwives have opportunities for working in Christchurch Women's Hospital to update experience with their peers. This approach has brought down barriers, strengthening relationships and has given our Canterbury based clinicians a real understanding of the challenges faced in a rural environment; by working in our environment they fully understand it. We hope that with the new operating model for Hospital and Specialist Services we will be able to continue to work like this and, also widen it across Te Waipounamu.

The content in this report demonstrates the collaboration between professional disciplines, managers and consumers and it should therefore serve as a useful resource for a range of stakeholders including the NMMG, local clinicians, planners and funders as well as consumers.

Transalpine Obstetrics and Gynaecology (O & G) Service

Te Tai o Poutini is now into its fifth year of supporting a rurally designed model of maternity service delivery.

Otherwise known as the 'Rural Generalist Model', it is actually a 'mixed model' of obstetric service delivery essential in supporting safe obstetric service delivery. This model also exists in

large parts of Canada, Australia and in many rural states of the USA, in which generalist practitioners who work in primary care but with the skills to manage complex intra partum and post-partum obstetric care, work alongside specialist obstetricians and gynaecologists. Their link into community settings is key to facilitate long term relationship building with community and whānau.

Rural Generalism

Approximately 200-250 babies are born on the West Coast each year; around 80-100 of these will be via caesarean section. In the past, Te Tai o Poutini has struggled to recruit and retain qualified obstetric and gynaecological subspecialists, relying heavily on expensive locum cover, contributing to a lack of continuity of care for our women. Multiple reports spoke to concerns about the long-term viability of the service. Feedback from community, (at the time district health) board, senior managers and clinical teams at the coal face indicated a need to do things differently - to support a sustainable, skilled workforce that provided safe and appropriate care to its small, remote, and sparsely located population.

Rural Generalism encompasses a broad skill set. On the West Coast, Rural Generalist consultants work across GP, Emergency, Medical and Surgical services and have versatile skills. Te Nīkau Greymouth Hospital is unique having three permanent Rural Generalist consultants with an advanced women's health skill set - Dr Brendan Marshall, Dr Sara Gordon and Dr Alan Furniss, are rural hospital specialists with additional surgical skills in obstetrics and gynaecology. Brendan and Sara were the first (and at this point are the only) doctors to complete the advanced training in Aotearoa, NZ. Both Sara and Brendan completed their training at Christchurch Women's Hospital, which delivers >6000 babies per year. Brendan is also currently the interim Chief Medical Officer for Te Tai o Poutini, West Coast.

While the rural generalist obstetric training programme is relatively new to New Zealand, awareness is slowly spreading, Dr Marshall says. "This qualification is used extensively in Australia, and no other centre in New Zealand has been accredited to deliver the advanced training before Christchurch was in 2018. It means secondary care specialists are involved in the care of expectant mothers living rurally on the Coast and work alongside primary care clinicians and obstetricians to ensure continuity of services - this reduces the chance of families having to travel to Christchurch for essential maternity services. That said, there will always be certain situations where we recommend delivery or procedures at a tertiary centre, for example where we anticipate higher risk or specific complications or NICU resources are required. Importantly, the reasons and criteria for these situations must be the same no matter who is providing the care. This is one of the key benefits for rural generalism. It matches your service specifications to what a small rural centre can safely support."

Governance

Key to this model has been formal clinical governance arrangements with Waitaha which sees all clinicians complete their training, credentialing, and ongoing skill maintenance at the larger centre. Dr Jane Fielder, with close support from her clinical director Dr Emma Jackson, has been visiting the coast monthly to provide service and ensure MCNZ collegial supervision is provided for our rural generalists. In the last two years Fiona Bach has joined the team to provide coast women access to specialist uro-gynaecology input. Brendan and Fiona were both on the organising committee for this years RANZCOG ASM which was held in Wellington. All of this strengthens the links and supports already in place between the two O & G departments. The departments already share a Director of Midwifery, all guidelines and referral pathways and are supported by the transalpine neonatal and paediatric service.

The model is embedded now and has been vital in ensuring the coast is able to keep a small maternity service running 24/7 with surgical birthing access, despite the challenges seen around the country for many larger units in doing this. At the same time, it has ensured the team have access to their leave – vital for any health workforce. Ongoing quality work will ensure the teams on both side of the alps work collectively to address any quality and safety issues that may arise. It will also help give assurance to other units who are interested in exploring this model.

As rural generalists are also credentialed to work in ED and primary care as well as obstetrics, the workforce is flexible and able to respond to the needs of the community it serves. This has provided some stability to the workforce more broadly which was the key reason this model was introduced. This has also meant much more continuity for staff and our community, in both hospital but importantly primary care settings.

Multidisciplinary simulation training of a Christmas maternity case in the Emergency Department

Training

Equally important, this has meant the coast is becoming a 'rural training hub' for health professionals. This can only happen when there is a stable senior group of clinicians to provide this training. Many of the rural generalists work across disciplines and inter-professionally (for example supporting nurse practitioner prescribers) to ensure access to training in rural settings is maintained. They love the chance to work alongside midwifery students, so they too become aware of the scope of the medical professionals.

The coast recently became the first centre in NZ to be accredited for Australian College of Rural and Remote Training (ACRRM). This was in large part due to success of rural generalists supporting obstetric service provision. ACRRM trains more than 200 rural generalists a year and there is hope even if 1 or 2 come to NZ and fall in love with the 'wild west coast' they may stay.

Another key component of the training model is that it allows O & G Registrars (specialist trainees) to experience the challenges of rural service delivery first hand. Unfortunately, specialty medical training is increasingly based in large urban hospitals. Opportunities to travel to more rural (and even regional locations) are limited. The integration of Christchurch clinicians into the service means registrars can accompany Dr Jane Fielder and Dr Fiona Bach on their visits to the West Coast to do clinics and operating lists. This improves the understanding of the registrars as to what the working environment is on the West Coast regarding rurality, resources

and support needs from tertiary services. The aim is to improve communication between colleagues on both sides of the Alps, assist with continuity and may encourage some to work rurally in the future.

The O and G Medical team now has 6 specialist doctors available for the acute roster (when it traditionally relied on 2). This team is made up of 3 rural generalists with special scope in procedural obstetrics, 2 O and G specialists based on the Coast and one transalpine O and G visiting regularly for clinical work and ongoing supervision and credentialing for the rural generalists. This has also provided some sustainability of the transalpine model as one of those trainees, Dr Ben MacLaughlin will join the team as a Transalpine visiting O and G in 2025.

Midwife Manager - Dawn Kremers

Another interesting year in Te Nikau Maternity. COVID was still doing it's rounds with challenges filling rosters due to staff illness.

Our lovely new birthing suite at Te Rau Kawakawa opened in May 2023. We celebrated with an open day and morning tea for hapū māmā and consumers to encourage Buller whānau to use the new birthing facility. Big thanks to the Maternity Consumer council who choose the mural for behind the birthing pool and are working on encouraging the Buller women to use the new facility.

We had our first return to practice midwife working with us, as well as two Midwifery first year of practice midwives. One was from Waitaha and the other the West Coast.

In November we had a good delegation of midwives attend the New Zealand College of Midwives Conference in Christchurch. This was a very informative and enjoyed by all that attended. We also had four of our midwives participate in the Pink Ribbon Walk around Hagley park, Christchurch to raise money for Breast Cancer.

Our new Educator Sandy Goile is full steam ahead with education which is well attended by all staff in and outside Te Whatu Ora. Sandy ensures the education sessions are interesting and at times fun to attend. Sandy also runs workshops for the South Westland rural nurse specialists and staff at Te Rau Kawakawa.

The introduction of a bubble CPAP machine has been welcomed by all who have access to it, including our maternity team and the Rural generalist and ED staff. Ongoing training and updates are delivered routinely by our Midwifery Educator. The bubble CPAP reduces the workload on our staff while waiting for the transfer team for our unwell babies. We have also introduced Manaaki Mats and with some generous funding from our local SANDS support have seen the purchase of a freezer for this. The Manaaki mats are for use for pregnancy loss, stillbirth and all other deaths. With the use of this whānau have the opportunity to take their pēpi home.

Our LMC workforce works tirelessly to support our Māmā through their pregnancy journey. We continue to advertise for LMC's to move to the coast with some incentives for this. We have three midwifery students currently in their second year who we support as much as required. They are both from the West Coast so once graduated will take up midwifery roles here.

A big thanks to our amazing team of midwives, both core and LMC's.

Practicing with our new bubble CPAP device

Midwifery Educator/Clinical coach - Sandy Goile

My role is that of midwifery educator and clinical coach which I have been in since February 2022. My role as educator is combined with the clinical coach role which has been created nationwide to support clinical practice, provide additional support to colleagues, as well as acting in a supervisory capacity for new graduate midwives and 'return to practice midwives.'

As clinical coach, I am available to support midwives' and student midwives on placement with clinical practice and additional support. In 2023 we had two local second year student midwives. In 2023 we had one return to practice midwife. We also had two new graduate midwives who I supported through the orientation and MFYP (My First Year of Practice) process. They operated 'trans-alpine' both spending three months each in Te Nikau and Waitaha/Canterbury.

I have helped run several sessions on skills such as Sterile Water Injections for pain relief, as well as training in operating the new Glucometer and iStat machine. I have also trained staff in the use of the Bubble CPAP machine which we obtained in November 2023. This enables us to offer hands free breathing support to babies prior to transfer to a NICU.

We held several education days over 2023:

Emergency skills refresher days for midwives

Recertification of Emergency Skills Workshops for midwives continued with two of these workshops held in Te Nikau throughout the year. This workshop includes:

- Newborn Life Support skills and scenarios
- Maternal collapse and CPR
- Resuscitation of baby and child

We also practice skills including shoulder dystocia, cord prolapse and post-partum haemorrhage. The workshops also provided a forum for the introduction and discussion around the latest developments and protocols in maternity care such as maternal sepsis.

PROMPT (Practical Obstetric Multi-Professional Training)

We held two PROMPT courses at Te Nikau. Run over a full day, this is a multi-professional course in the practical management of obstetric emergencies and teamwork. This great course is offered worldwide and includes lectures, skill stations and scenarios. We had great attendance 16 attendees at each of the days. Attendees included midwives, SMOs, RMIP students, Rural generalists, duty nurse managers, flight paramedics, nurses, and anaesthetists.

Newborn Life Support

Throughout the year I delivered three Newborn Life Support courses (Advanced). This is a full day course and includes the fundamental skills of resuscitation, scenarios and a knowledge and skill assessment. This course is aimed at any health professional that is involved with births who may be expected to manage resuscitation of a newborn. These well attended by midwives, nurses, Duty nurse managers, RMO's, and paramedics.

I also held Newborn Life support half day refresher courses at Te Nikau. This three-hour course requires pre reading and has a quiz component, lectures, and practical skills. This assist staff improve their skills and refresh their knowledge in providing neonatal resuscitation.

STABLE

We were able to hold a STABLE course in late August. This programme provides general guidelines for the assessment and stabilisation of sick infants in the post-resuscitation, pre-transport stabilisation period. Usually held once a year, the course was delivered face to face by neonatologists Maggie Meeks and Bronwyn Dixon over two days. Midwives, doctors, and nurses that attend gain important education about neonatal stabilisation and the ability to provide a standard of care and comprehensive team approach to improve the infant's stability, safety, and outcome. We had 18 participants attend this great day.

Perineal repair

In July, we welcomed midwifery educator Rhonda Robertson, from Waitaha/Canterbury to deliver a perineal care and repair workshop. This was a very informative and interactive workshop which was well attended by 13 midwives. We were given up to date information on perineal care and had a great time practicing our skills on chicken breasts.

PADA

In March we hosted a one-day professional development workshop for those supporting whānau in pregnancy, childbirth and early parenthood including Midwives, GP's, Psychologists, Counsellors, Social Workers, and NGO's. We were able to explore the issues, hear about research, best practice and network with others.

Summary

In 2024, I plan to bring additional education to the West Coast such, Documentation. I plan to develop and provide orientation education to staff at the new Te Rau Kawakawa unit in Buller when it opens next year. I will also continue with regular Case reviews. We will continue to join the Christchurch Women's Hospital PMMRC meetings every Tuesday via TEAMS. I will continue to support any midwifery students that join us for clinical placements.

Overall, it has been a very successful year with being able to provide a significant amount of education throughout the year. I continue to enjoy my role and look forward to adding more education in the future.

Midwives practicing Newborn Life Support during an Emergency Skills Day

Perinatal and Maternal Mortality Review Committee Representative - Denise Stacey

I am a core midwife at Te Nīkau Hospital; I am also the local coordinator for the Perinatal and Maternal Mortality Review Committee (PMMRC). The PMMRC is an independent committee that reviews the deaths of babies and mothers in New Zealand. The PMMRC has also been reporting on data related to babies with moderate to severe Neonatal Encephalopathy – NE since 2010.

My role as the local coordinator for the PMMRC is that of collecting all data from the stillbirths, neonatal and maternal deaths as well as collecting data from any babies born with moderate to severe NE. I send this data to the PMMRC where it is collated.

From the data collected the PMMRC then makes recommendation for all the Maternity Units to improve outcomes for mothers and babies.

I am also a resource person for the midwives who are dealing with a stillbirth, neonatal death or maternal death.

I present the monthly Maternal Case reviews for our midwives, LMC's and Obstetrician's. These are examined using the HQSC maternal morbidity review toolkit looking at interesting cases and at ways we could to improve the care and outcomes for our mothers and babies. These cases are anonymous and are presented in a non-judgmental way.

Lactation Consultant - Charlotte Binks

I'm Charlotte, one of the core midwives working on the Te Nikau Maternity ward, a International Board-Certified Lactation Consultant (IBCLC) and BFHI Co-ordinator for Te Nikau Hospital.

The lactation consultant's role is to protect and promote breastfeeding, and to support women/wāhine/whānau to make the best choices for them; as decided by them. I aim to do this by collaborating with colleagues (core midwives/lead maternity carers (LMC's)/GP's/breastfeeding advocates) to ensure comprehensive support is available to women and by focusing on education for both staff and women.

My role as BFHI coordinator is to ensure the Te Nīkau Hospital service meets the criteria of the BFHI, which is line with the WHO/UNICEF global standards. This ensures us as a service: meet a standard for exclusive breastfeeding rates on discharge from inpatient care, are meeting the standards of the Ten Steps to Successful Breastfeeding and are in line with "The Code". Te Nīkau Hospital is currently reaccredited as a Baby Friendly service following an audit in 2022, and we continue to work towards our accreditation needs for the next audit in 2026.

I currently see women antenatally and postnatally for consultations as needed. Referrals are sent in by LMC's, GP's and PHO health workers. In addition, I have started running an antenatal breastfeeding group workshop for women and whānau to attend in the third trimester. I regularly run sessions which have been well attended and well received.

With the support of PHO Breastfeeding Advocate Erin Turley and Midwifery Educator Sandy Goile we held a breastfeeding education day for Maternity staff and primary health providers in May 2023. This session focused on the revised mastitis protocol and updates in clinical breastfeeding support.

Looking forward I hope to continue finding new ways to support women and their whānau on the Coast, whether it be in the lactation consultant role or as a core midwife on the ward.

Newborn Hearing Screening Programme – Mary Sullivan

The UNHSEIP team screened 233 babies born to West Coast families during 2023. Most babies are screened on the maternity unit prior to discharge and the remaining are screened in outpatient clinics held as required at Te Nikau, Te Rau Kawakawa and Gloriavale.

Two babies were referred to Christchurch for audiology assessment and one for hearing surveillance.

Our equipment was updated in April to the easiScreen in line with the national requirements and problems with transferring data to the screening unit were finally resolved. The service was audited and met all requirements.

GAP (Growth Assessment Protocol) – Tanya Parsons

We introduced GAP and customised Grow Charts (GROW) in 2021 as standard for every pregnancy. All practitioners (midwives and doctors) are trained in their use and follow the antenatal screening and risk assessment pathways for women according to the SGA and FGR Clinical Practice Guideline. GROW upgraded from paper charts to on-line electronic charts from the end of November 2023, which has improved access from different practice locations.

As GAP champion in 2023 I have attended monthly on-line meetings with the New Zealand GAP Lead Educator and attended the 2023 NZ Action on Pre-eclampsia and SGA Study Day in Auckland.

I undertake regular audit of GAP as an ongoing quality surveillance.

Audit results. For the year ended 30 September 2023 there were only 13 babies born on the West Coast who were SGA (Small for Gestational Age), which equates to 7% of all West Coast births for those 12 months (National Rate of SGA babies born was 14.2%). Of those 13 babies, 11 were either suspected or known to be small antenatally from either serial fundal height measurement and/or ultrasound and managed accordingly.

2023 saw an improvement in identification of SGA or FGR babies. In 2022, 62% of SGA babies born were suspected and/or detected antenatally and managed accordingly; in 2023 this improved to 85% of SGA babies born being suspected and/or detected antenatally and managed accordingly.

Obstetric and Diabetes in Pregnancy Clinic – Rana Kamo

Obstetric clinics are held weekly in Greymouth and monthly as needed in Westport. In 2023 we increased the use of telehealth for appropriate cases to allow greater access. The Diabetes in Pregnancy Clinic runs concurrently with the Obstetric clinic to maximise the benefit of travel for those who live remotely. In 2023 there were 26 women were cared for through this service, with weekly contact with the DIP team via email, phone and in person visits. Feedback has been very appreciative of having a more streamlined service and reducing the frequency of in person visits required to manage this pregnancy complication.

Kia Jade Campbell born in the new Te Rau Kawakawa unit on 3/12/23

MQSP Programme

MoH Projects (as per Service Agreement)

Local Project: Growing Up Well on the West Coast

This project was embeded in the in the First 1000 Days work, and due to community demand resulted in 20 hui being held across the Coast to collect feedback. This has since been analysed with the following themes for materntiy:

• Concerns on access to rural maternity services and increased costs to whānau when needing to access maternity healthcare

• Significant differences between breastfeeding experiences, with conflicting advice and limited support

• Whānau want more voice within maternity services.

• Identified successes in maternity and early years healthcare space, when closer to main centres/hospital areas (rather than rural areas)

All findings have been pulled into the Localities Programme and the work of Takiwā Poutini, a three-year pilot project to improve health and wellbeing outcomes for all, particularly focused on Māori, Pacific peoples and people who experience disability. Information about their work can be found here: https://www.takiwapoutini.nz/

National Project 1: Implementation of NOC/NEWS as per national roll out

The NOC/NEWS has been developed to assist with early recognition of clinical deterioration of infants who are at risk with the aim of improving outcomes for these infants. This chart is a vital signs chart developed nationally to standardise the initial assessment and care of all newborns in New Zealand. It also provides a single view of clinical information and assist in recognising trends, which may indicate a baby's condition has deviated from the norm.

We rolled out NOC/NEWS in June 2020 and it was relatively uncomplicated, being readily accepted by staff. As we were already using an Early Warning Score (EWS) we were essentially moving from one EWS to another. Regular audits show good consistent use in Te Nīkau.

National Project 2: NE Taskforce

We introduced the Growth Assessment Protocol (GAP) and training for all maternity staff and LMC's in late October 2021. All pregnancies generate a GROW chart with every baby having a customised Birth Centile generated to inform care pathways. This has led to an increase in the number of pregnancies identified as requiring closer monitoring with ultrasounds for growth, resulting in more babies having closer monitoring via the NOC/NEWS of their transition over the first twenty-four hours of life. Current outcomes are reported above.

Celebrating International Midwives Day

Addressing NMMG Recommendations

The National Maternity Monitoring Group (NMMG) was established by the Ministry of Health in 2012 as part of the Maternity Quality Initiative. NMMG oversees the New Zealand maternity system and provides strategic advice to the Ministry of Health for improvement. We report against their national areas of focus for our West Coast population during the 2023 period below.

1. Encouraging low risk women to birth at home or in a primary facility

Te Tai o Poutini has sustainability agreements with community based LMCs to ensure women have them available on the Coast as an option and as valued members of our maternity team:

- LMC Education is provided free of cost by Te Nikau – the LMCs are invited to all education that is also offered to employed colleagues with much of it being multidisciplinary;
- Free use of clinics in the rural areas where women can see their LMCs: Te Nīkau clinic, Hokitika Health Centre and other rural clinics;
- Extra Sustainability Package paid quarterly. LMCs provide up to the 3rd trimester and full postnatal care, so if a woman transfers out to the tertiary sector the birth fee would be lost. However, this package pays a proportion of that fee based on where the woman lives; rural / semi-rural and remote if the woman births elsewhere;
- If travelling – LMCs can often access Pool vehicles for travel and in some areas, Hospital accommodation;
- The Package is reviewed and renewed every twelve months with input from LMCs.

We were also excited with the opening of the new integrated family health centre Te Rau Kawakawa in Westport in late May 2023 with a dedicated primary birthing space. Once planning and procedures were put in place we welcomed the first baby in October 2023.

2. Equitable access to post-partum contraception, including regular audit

We offer our women LARC (Long Acting Reversible Contraception) which includes IUCDs, implants and Depo-provera injections. This service is being offered by the Rural Generalist Doctors, as inpatients or outpatients from the maternity ward in Te Nikau.

The next stage of this project is to develop and implement a tracking system to identify gaps in the offer and uptake of LARCs in the postnatal population.

3. Equitable access to primary mental health services, maternal mental health referral and treatment pathway

The Maternal Mental Health Pathway is updated yearly to reflect the changes in personnel and contact details, this pathway is available to the public via our website, and a sticker version is included inside the front cover of every Well Child Tamariki Ora book provided to every baby. This also provides information about accessing breastfeeding support and information about PURPLE crying.

We have identified a pathway for referral to Brief Intervention Counselling provided by West Coast PHO for LMCs who can negate a GP visit and referral for the women; this works for the bulk of GP practices - which are DHB owned and removes a barrier for women who previously would have required a GP visit for referral.

4. Ongoing audit and review of MEWS and Trigger Tool

MEWS was rolled out in 2019 and the ongoing audit of use reports to the Deteriorating Patient Committee. Cases are discussed at Maternity Incident Review Group meetings, and at case reviews as appropriate.

Addressing PMMRC Recommendations

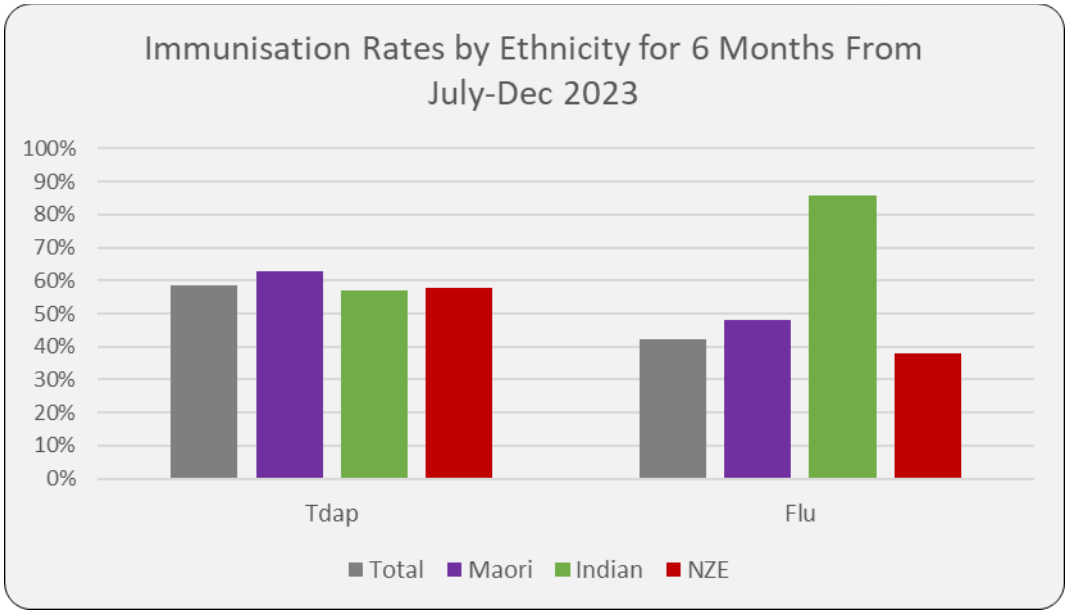
The Maternal Morbidity Working Group (MMWG) was established in May 2016 under the umbrella of the Perinatal and Maternal Mortality Review Committee (PMMRC). The MMWG's role is to review and report on maternal morbidity, and to develop quality improvement initiatives to reduce maternal morbidity and improve maternal outcomes. In its 2016-2017Annual Report, the MMWG recommended the prioritisation of a national guideline for the management of sepsis in pregnancy within the next three years. We report progress against their recommendations below.

1. Reduce preterm birth and neonatal mortality

2. Monitor key maternity indicators by ethnicity to identify variations in outcomes and improve areas where there are differences in outcome

HAPŪ MĀMĀ VACCINATION PROJECT

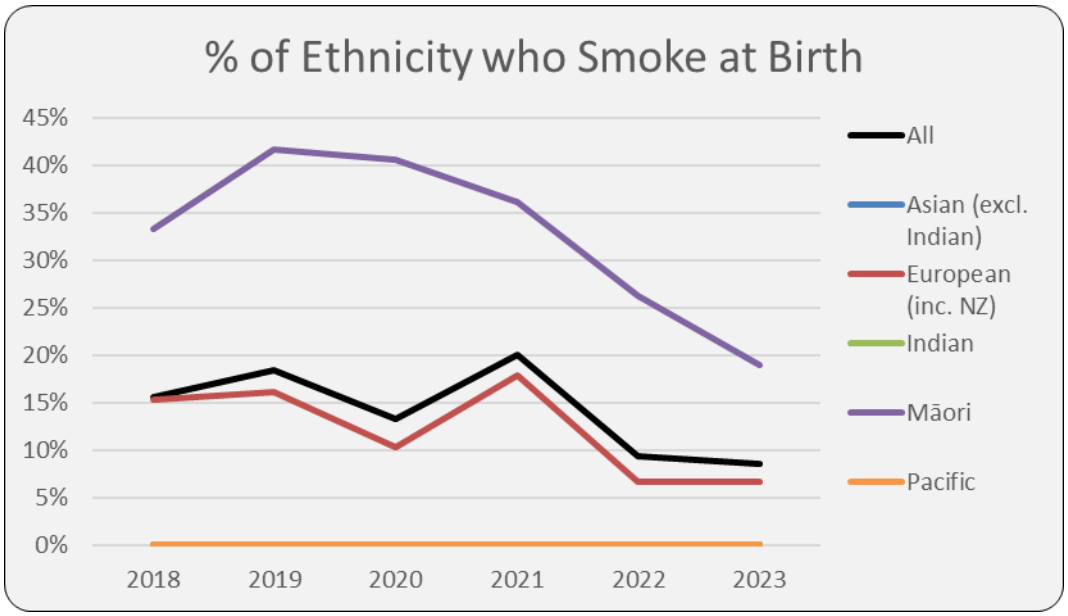
Our big project for 2023 was aimed at improving immunisation during pregnancy. Working collaboratively with the Population Health team, planning cumulated in launching a drop-in immunisation service during the national Immunisation Week, and then from the Maternity Ward in Te Nikau from June Promoted through LMCs and targeted text messaging at 16 weeks, vaccination is promoted at the time of attendance for the routine anatomy scan, or any other time families are in Greymouth during business hours. Having only one ultrasound location on the West Coast allowed us target timing of messaging and appeal to harder to reach populations through co-location at the maternity unit. Identifying midwife champions within the maternity ward allowed this service to be run though drop-ins as well as by appointment, reaching a larger demographic.



Unfortunately we were unable to determine baseline vaccination rates due to coding errors within the NIR from vaccinating pharmacy sites, and not being able to filter data for vaccines given during pregnancy. Despite this we feel that we have made a large positive impact on the vaccination rate post introduction. For the six months from July-December 2023 61% of pregnancies has received a Boostrix immunisation (whooping cough), and 40% had received the influenza immunisation. In addition to this we gave 9 MMR immunisations during the postnatal period to those whose antenatal testing indicated would benefit.

SMOKE CHANGE

In 2023 wāhine Māori represented 21% of women accessing our services but were over represented in our stats for smokers during pregnancy. Following a 2021 review of the smoke ceasation pathway and referral uptake with the PHO, we have obserced significant decrease in the smoking rates at time of birth. Changes we made included updates to referral form and changing to opt-out referrals. These changes have resulted in a positive change as seen below, but unfortunately only 18% of women smoking at time of registration were no longer smoking at birth in 2023 indicating that there is still work to be done.



SAFE SLEEP PROGRAMME

We have an active SUDI prevention plan with cross sectorial membership and a very engaged SUDI working group. The group has increased the period of incentivisation for smoking cessation provided to Mums and partners to 6 months post-natal. All babies who are Māori are offered a wahakura as a taonga. When wahakura are unavailable Pēpi Pods are also offered to whānau as part of reinforcing safe sleep messages. These safe sleep spaces are offered to all families of at-risk babies, with education and follow-up provided.

3. Co-design models of care to meet the needs of Indian women &
4. Co-design models of care to meet the needs of women <20 years

These groups are targeted as priority populations for membership of the Maternity Consumer Council with several members having been young mums. Recruiting Indian members is ongoing.

5. Interdisciplinary fetal surveillance education for all clinicians involved with intrapartum care

All clinicians working within maternity have access to attending the Fetal Surveillance Education Programme (FSEP) offered by RANZCOG, which is mandatory for employed staff. Those not able to attend face to face FSEP complete the online education package.

6. Cultural competency workshops for all Maternity Service staff

All clinicians attend mandatory bi-cultural treaty workshop training. The West Coast Māori Health Unit provide cultural support and training as and when required. Attendance is monitored through staff performance appraisal processes.

7. Implementation of HQSC maternal morbidity review toolkit and SAC rating (maternal and NE case review)

The system for reporting the HQSC maternal morbidity review is embedded in the maternity setting and regular incident review takes place with a focus on quality activity and systems. Our Maternity Incident Review Group includes representatives from all disciplines involved in the maternity journey, as well as consumer representation and members that sit across the transalpine partnership. Recommendations and learnings from these reviews are presented at staff meetings and build into multidisciplinary education days outlined under the education section above.

We have a 'trigger list' of events and conditions that staff must complete an incident report on, in addition to any other events that staff believe warrant further investigation. Incidents classed as SAC 3 or SAC 4 are reviewed at MIRG following initial investigation, with all SAC 1 & 2 events being managed and reviewed by the Hospital wide Serious Incident Review Committee.

Addressing MMWG Recommendations

1. Implementation of hypertension guideline

With the recent publication of the National Hypertension Guideline, we plan work across Te Wai Pounamu services in 2023 to ensure this national guideline is implemented across the South Island, albeit with localised contact details etc during the operationalising of it.

2. Use of the Health Equity Assessment Toolkit (HEAT) to assess services for the impact of health equity

HEAT is used when reviewing policies and is being imbedded within the wider Quality team. COVID-19.

3. Establish a pathway for women with identified placental implantation abnormalities

As with all complex pregnancies, women with placental implantation abnormalities are initially reviewed through our antenatal clinic with consultation with our transalpine partners in Christchurch. Plans of management and ongoing assessment are made following that consultation. These women are recommended to birth in the Tertiary unit at Christchurch Women's Hospital, and will usually be supported to relocate during pregnancy for this ongoing care and monitoring (gestation of this plan to relocate dependant on severity of implantation abnormality).

4. Establish septic bundle kits to address human factor components such as stress in high acuity settings

We decided not to create 'Sepsis Boxes' due to very low numbers and relatively short expiry dates on medications and clinical supplies. However as below we have ensured that the whole team has been trained to access what is required and include sepsis in simulation exercises and compulsory education days.

5. Establish clinical pathways across primary and secondary/tertiary care to enable earlier recognition and treatment of sepsis

We are adopting the Sepsis policy from Waitaha – Canterbury, with posters displayed in clinical areas in Maternity and the Emergency Department. Education on the Sepsis bundle is embedded within PROMPT and Midwifery Emergency Skills workshops to increase clinician's awareness to suspect and treat sepsis.

Midwives Sandy and Robyne Manning the stand at the NZCOM Midwives Conference 2023

Outcome Analysis

The Ministry of Health's New Zealand Maternity Clinical Indicators Data for 2022 are the most recent available. The analysis below shows our performance and position in relation to both the indicators and national averages and are based on standard primiparae only (rather than all women giving birth / all deliveries). We have based our data on "Area of Domicile."

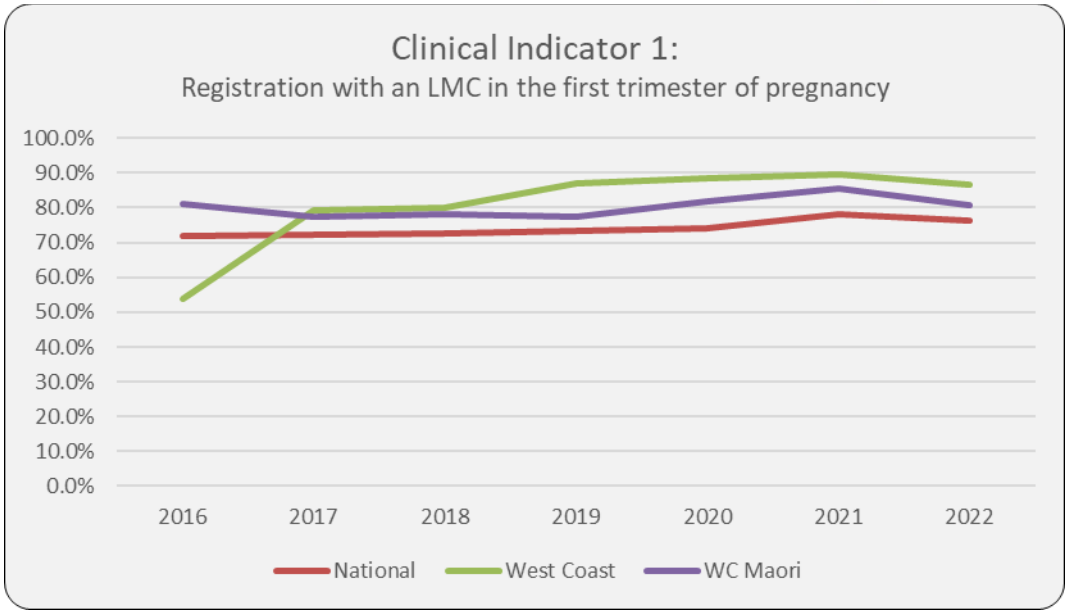
National Data

The purpose of these indicators is to increase the visibility and quality of maternity services and to highlight areas where quality improvements could be made. The data largely refers to "standard primiparae" who make up approximately 13% of all births from the West Coast, with inclusion criteria outlined below. This group represents the least complex situations and in which intervention rates would be expected to be low, which can be compared between institutions. Due to the very small sample size for the West Coast we are also presenting data using the Robson scoring criteria introduced by the World Health Organisation to enable a standardised international comparison.

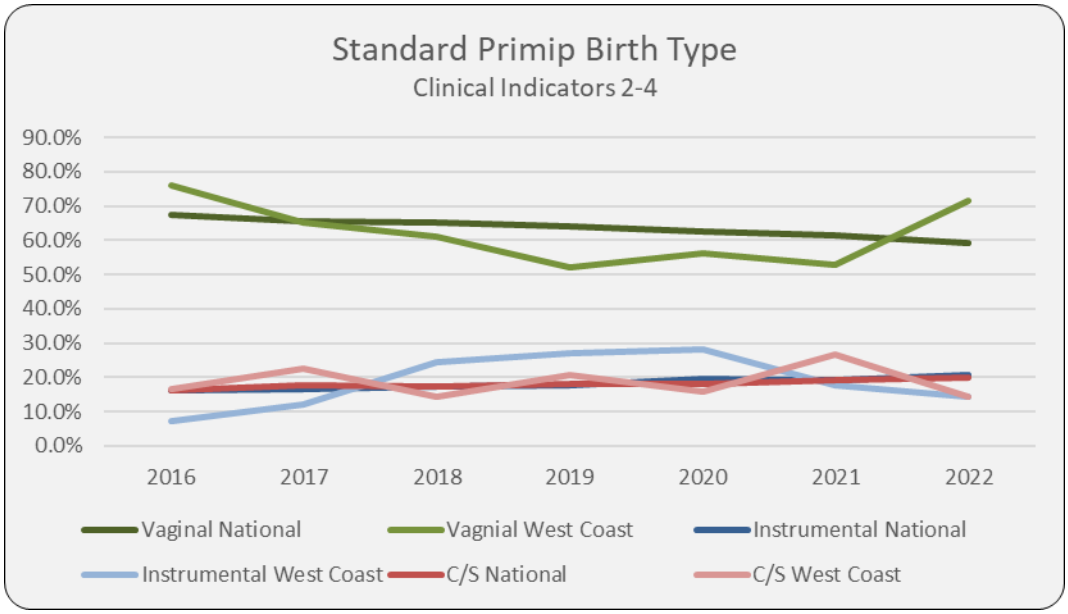
Standard primiparae: a group of pregnant people considered to be clinically comparable and expected to require low levels of obstetric intervention. This report defines standard primiparae as pregnant people recorded in MAT who meet all of the following criteria:

- gave birth at a maternity facility or had a home birth[1]
- are aged between 20 and 34 years (inclusive) at birth
- are pregnant with a single baby presenting in labour in cephalic position
- have no known prior pregnancy of 20 weeks and over gestation
- give birth to a live or stillborn baby at term gestation: between 37 and 41 weeks inclusive (based on gestational age recorded for the baby and exclusion criteria)
- have no recorded obstetric complications in the present pregnancy that are indications for specific obstetric interventions.

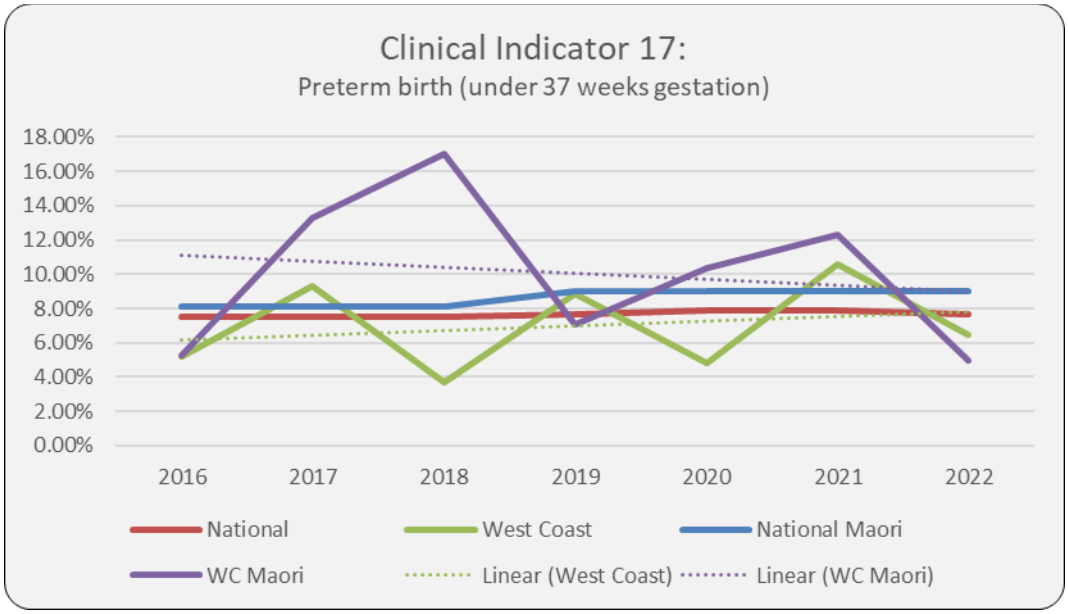
Note that low numbers meeting requirement for 'standard primip' dropping from 49 in 2020 to 30 in 2022, with only % not absolute numbers now available to view. Due to the extreme statistical fluctuations caused by very small numbers across all the indicators we are only reporting on Clinical Indicators 1, 2, 3, 4, & 17. Clinical Indicator 16 – Smoking Rates is not able to be reported on as this information has not been published nationally due to a legislative requirement to report on this indicator was removed from November 2021. Smoking data is presented above under Monitor Key Outcomes.



The change in registration in 2016 reflects a change in the operation model of maternity care across the West Coast. In 2022 for the 7th consecutive year since this change the West Coast has the highest rate of Māori registrations in the first trimester.



As is demonstrated by the graph above, the West Coast consistently follows national trends for birth type for Standard Primips.



Since the model of care change in 2016 the preterm birth rate for Māori Whānau is slowly decreasing but more work needs to be done to remove the inequity observed.

Robson Criteria

The World Health Organisation endorsed Robson classification, also known as the 10-group classification, is a system used to categorise women into groups based on five obstetric characteristics: Parity, single/multiple pregnancy, any previous CS, onset of labour, gestational age, and fetal presentation. More information can be found at: https://www.who.int/publications/i/item/9789241513197

At this stage this data is only available through **local Maternity data sources** and compares 2019 through to 2023. Data here is counted in terms of all "births" in a West Coast Maternity Facility (as opposed to a count of exclusively standard primiparae as used by the New Zealand Maternity Clinical Indicators). Because of this all homebirths and births that occurred to West Coast resident families outside of our local facilities are excluded.

In this report we are presenting data on the following five Robson Groups:

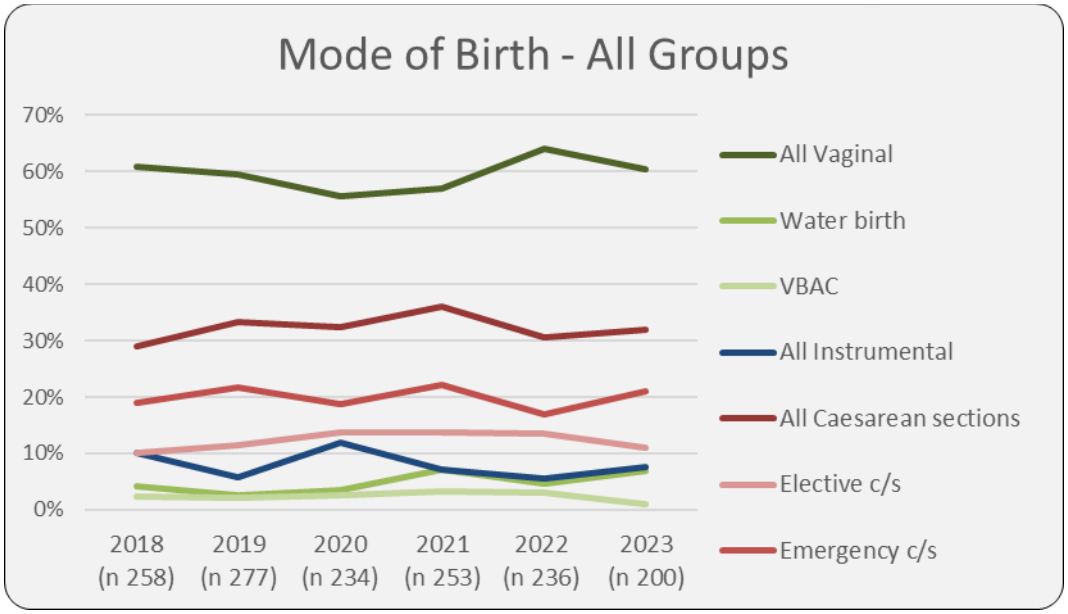
Group 1 – Primip in spontaneous labour at term with a single cephalic baby

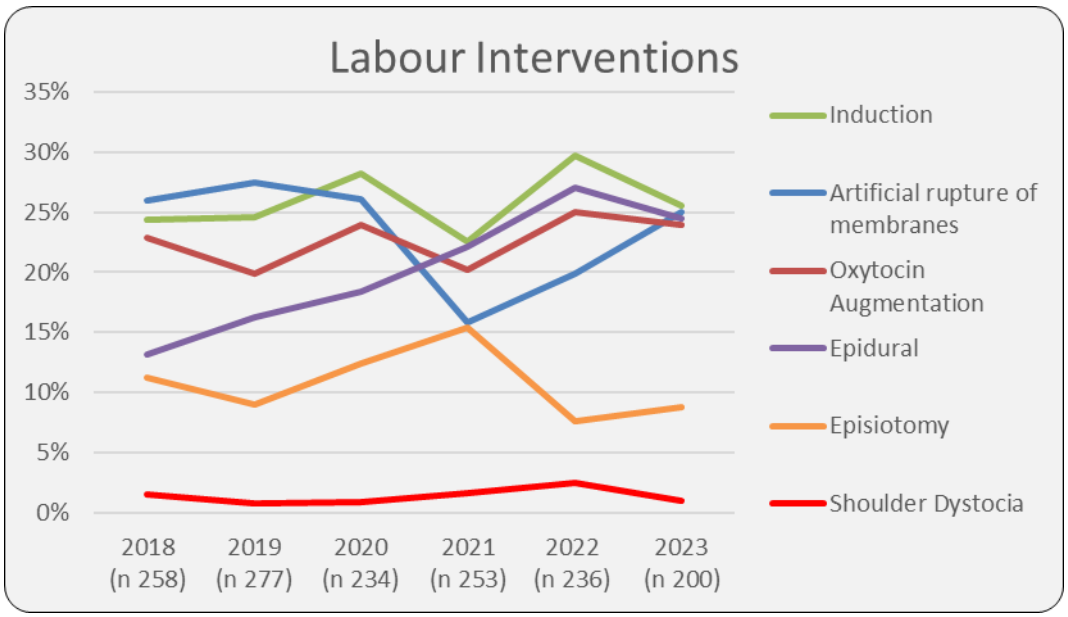
Group 2a – Primip at term with a single cephalic baby with an induced labour

Group 3 – Multip woman at term with a single cephalic baby with no previous c/s in spontaneous labour

Group 4a – Multip at term with a single cephalic baby with no previous c/s with an induced labour

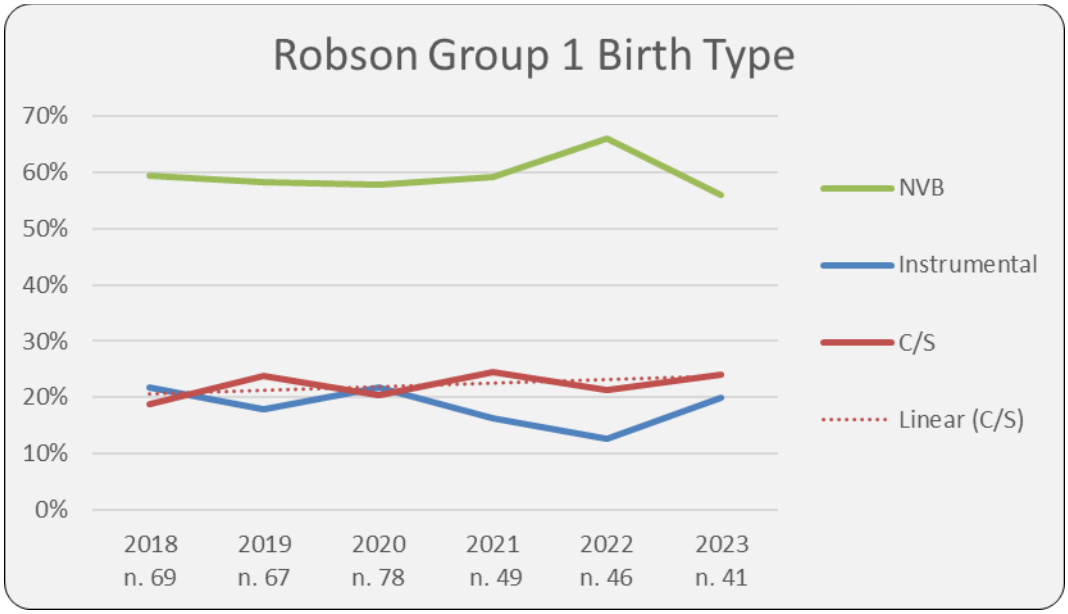
Group 5.1 – Multip at term with a single cephalic baby with one previous c/s

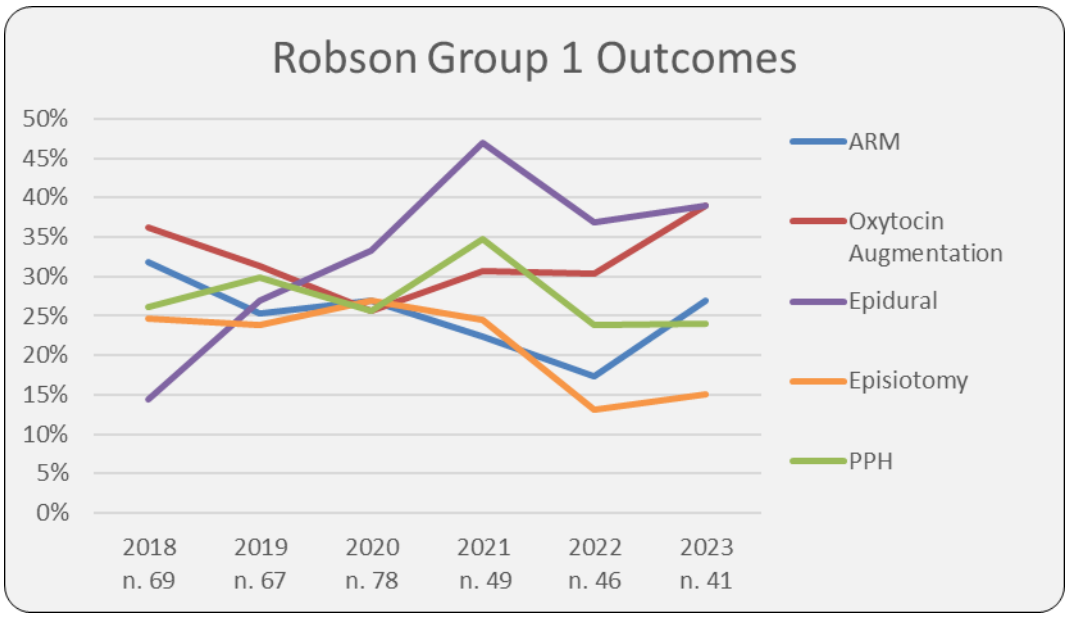




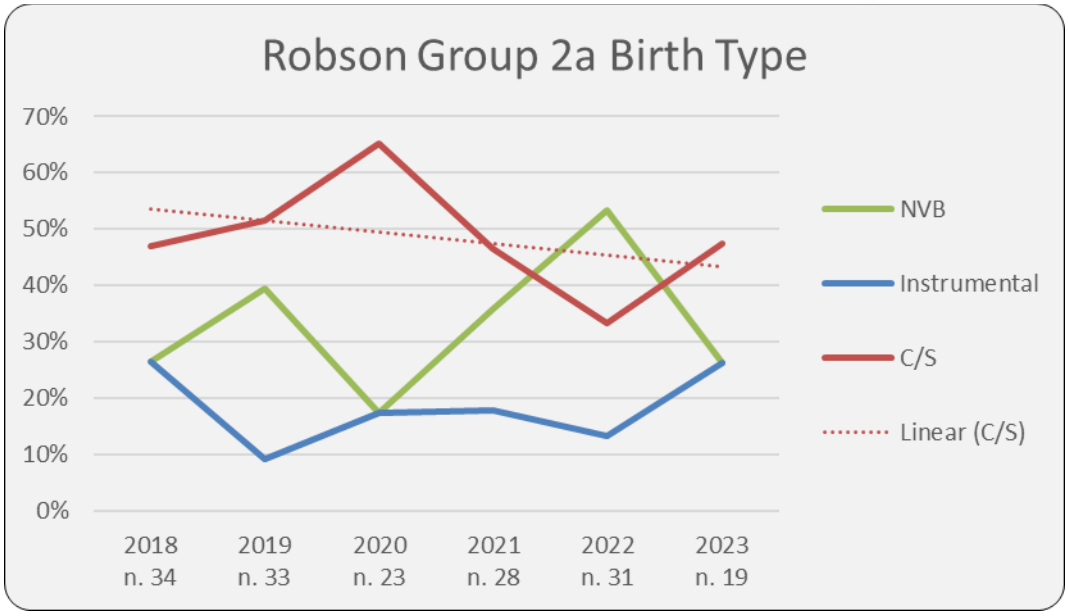
Our overall rates for mode of birth have remained relatively steady since 2018, with the fluctuations seen in the C/S rates attributed to planned electives having spontaneous labour and their births being categorised as emergency C/S due to their acuity changing.

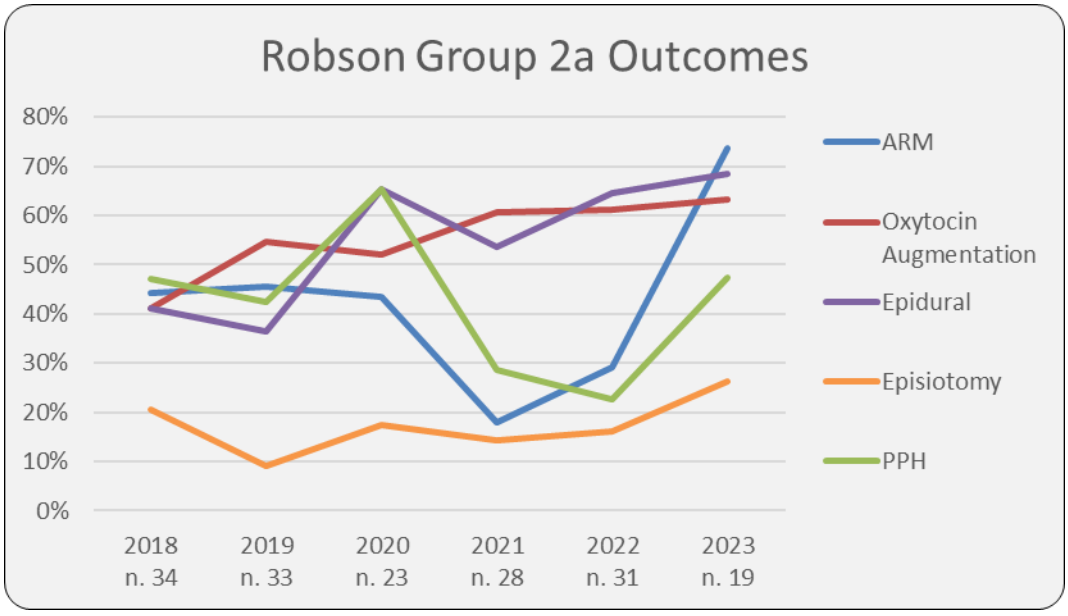
The rapid increase in epidural rates seen over the preceding four years appears to be stabilising around to one in four labours. Other intervention rates appear to be fairly steady, with the exception of episiotomy which is closely tied to instrumental birth rates.





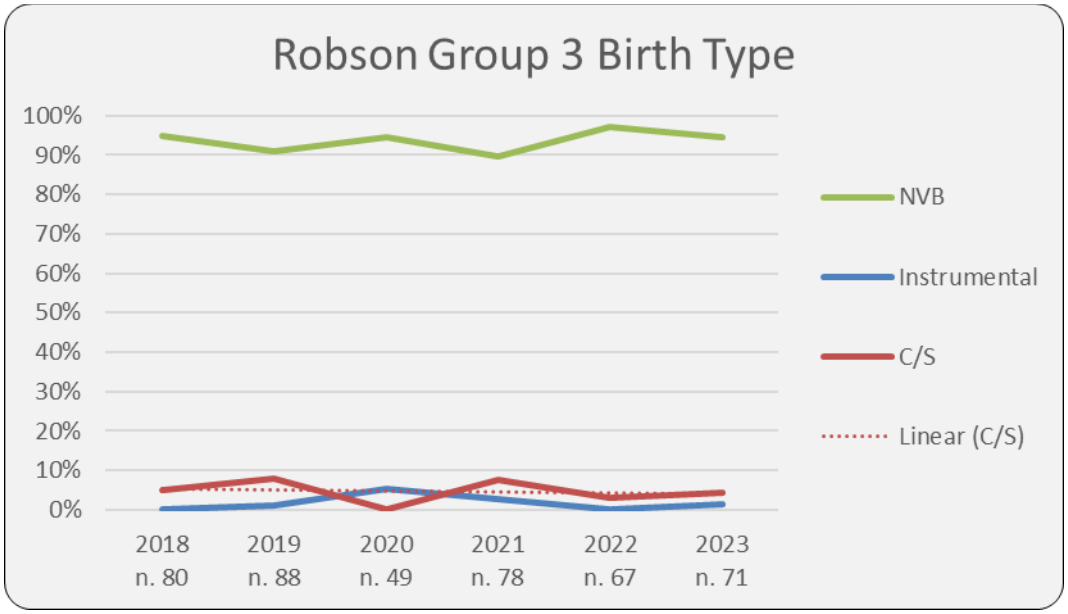
Robson Group 1 comprises of those having their first baby at term, in spontaneous labour with baby presenting head down. While annual numbers are relatively small, trend lines indicate where outcomes are changing. The most significant observable change across the last six years is the increasing epidural rate. Interestingly other interventions and the C/S rates does not seem to be following the same trend for this group despite substantial international evidence that epidural use can cause a cascade of intervention.

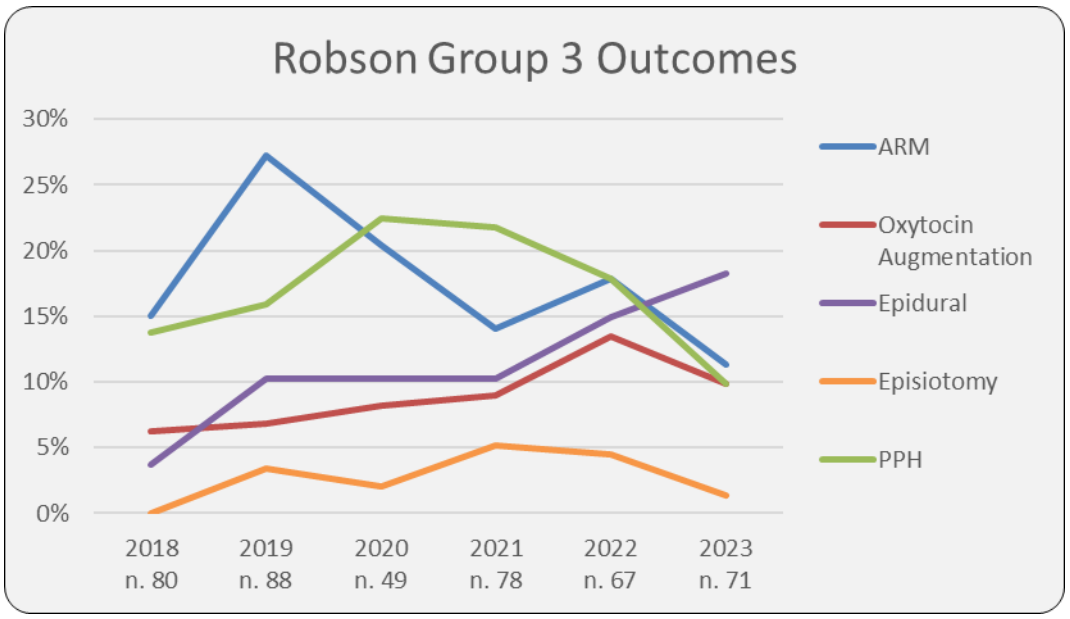




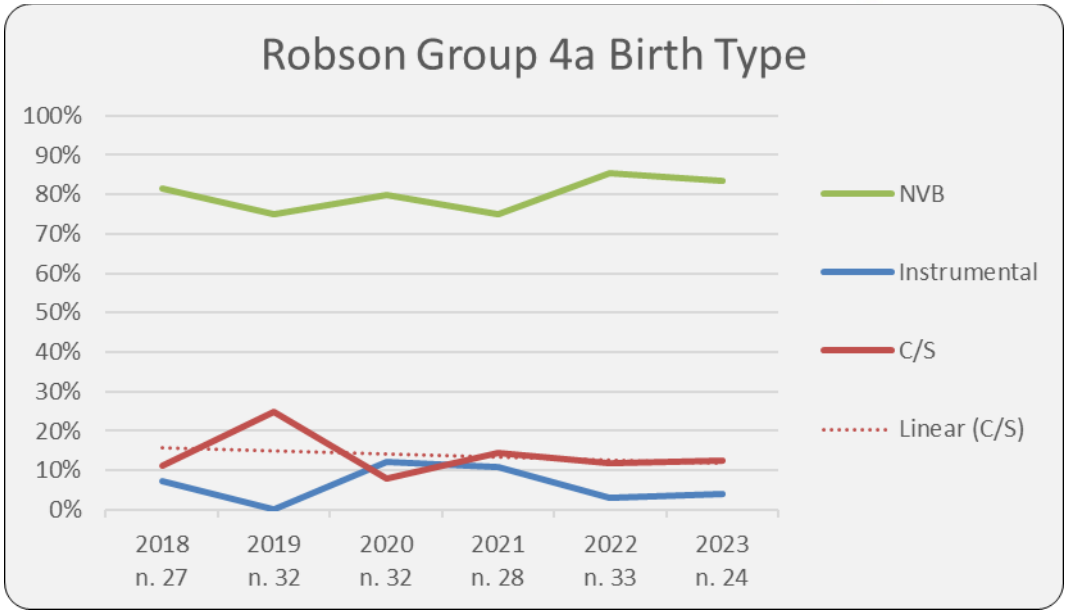
Robson Group 2a comprises the same requirements as Group 1 with the exception that these labours were induced rather than spontaneous. Part way through 2020 we changed the method we use to induce labour to using small regular doses or oral misoprostol. Since this change we are starting to see a trend of lowering the C/S rate, however low numbers mean that we will have to wait a couple more years to see if this does eventuate.

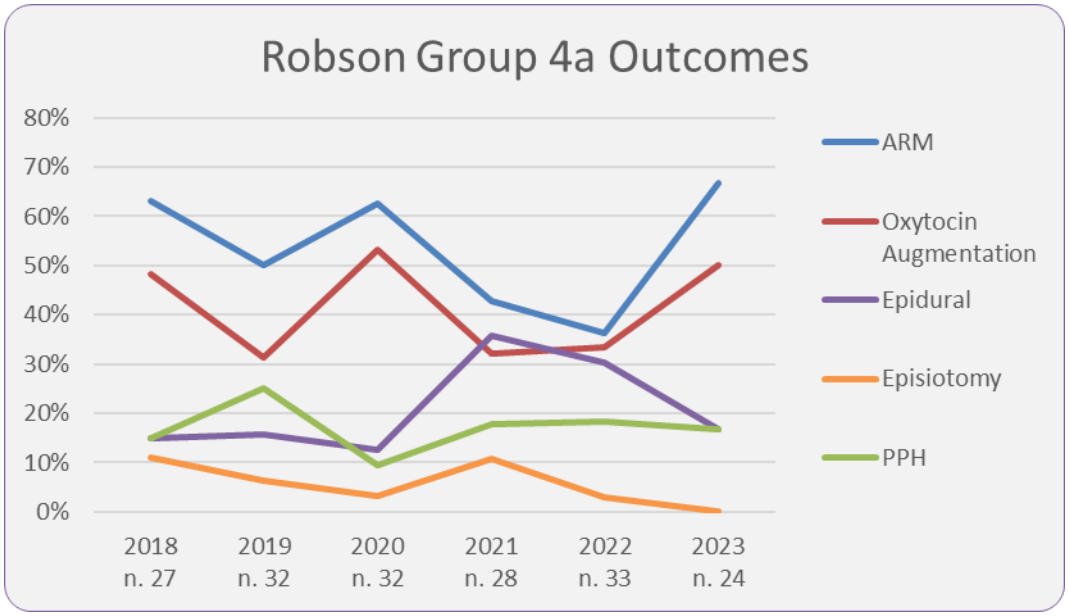
On intruducing misoprostol as a principle method of induction there was some concern that this could increase the PPH rate but we have not observed this to be the case, rather it appears that the trend is moving in the opposite direction. Again we see an increasing epidural rate, this time closely linked with the oxytocin augmentation rate as would be expected.



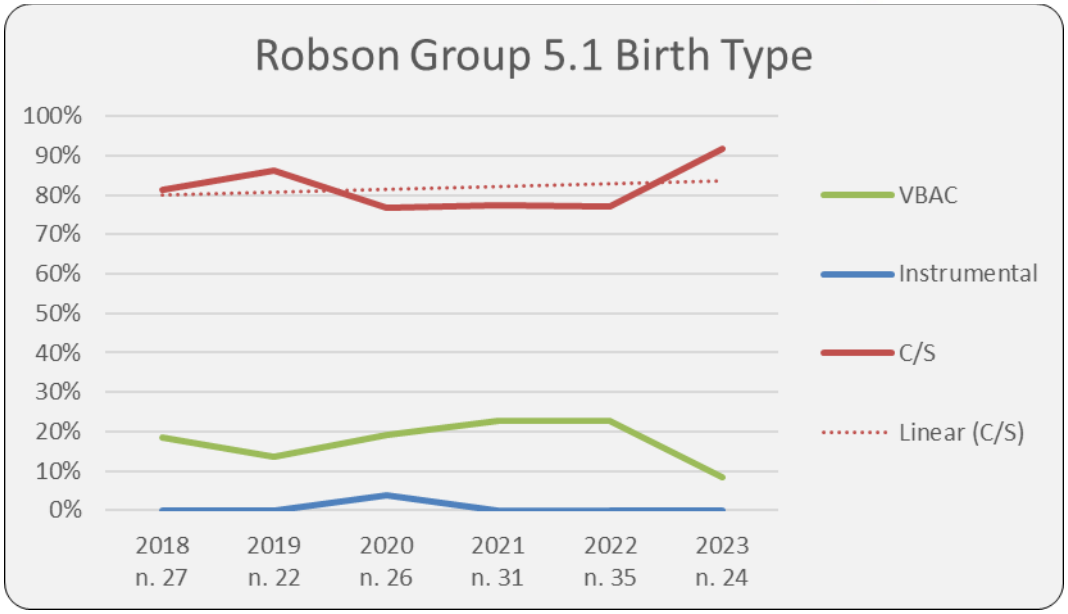


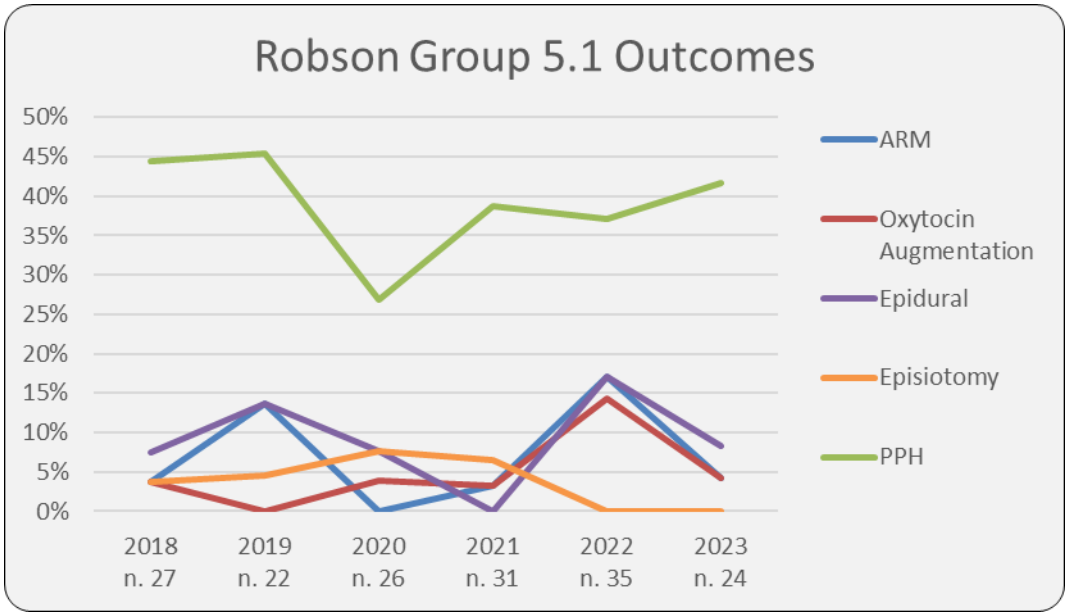
Robson Group 3 are our multiparous group that are at term with a single cephalic baby in spontaneous labour, and who have not had a previous c/s. Rates as outcomes for this group continue to be steady, with a noticeably increasing epidural rate.





Robson Group 4 are the multiparous group that are at term with a single cephalic baby who have not had a previous c/s, but have their labour induced. While numbers are low, birth type and intervention rates remain steady with the usual fluctuations expected in a small sample size.

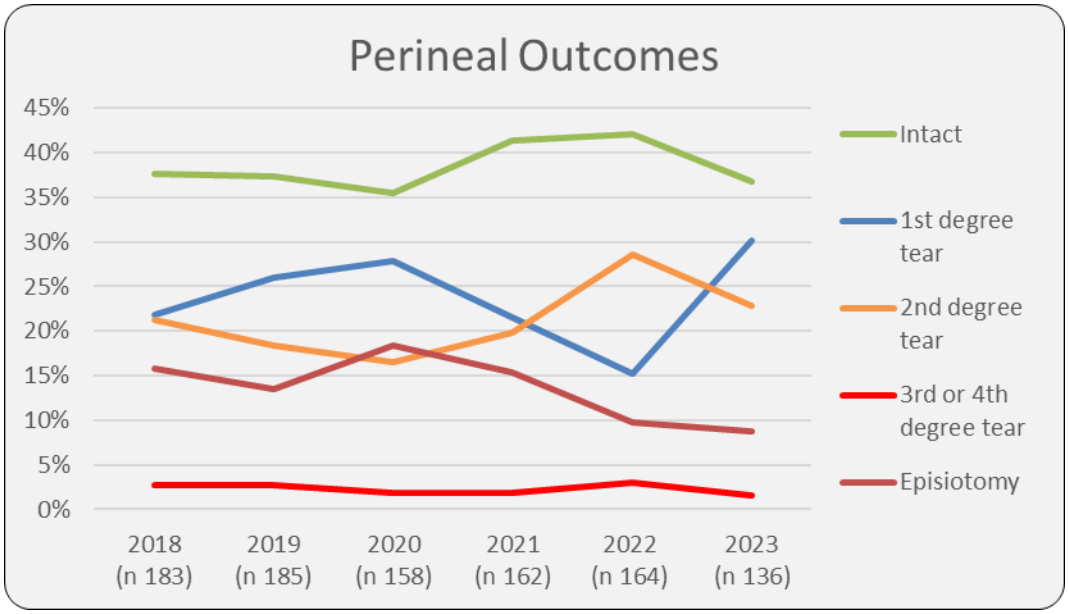




Robson Group 5.1 are those multiparous women who are at term with a cephalic baby having had one previous c/s. Those who have had a c/s are reviewed in our obstetric clinic and given the choice of having a repeat elective or planned c/s, or to labour and attempt a normal birth. In 2023 we saw a reduction in the VBAC rate, however this could be due to normal statistical variation.

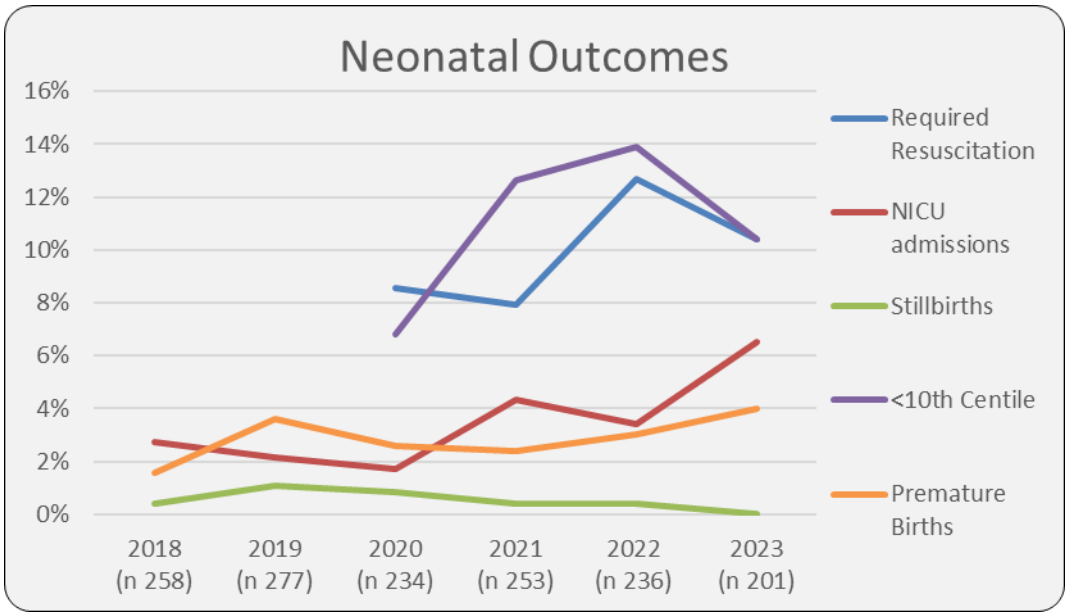
Perineal Outcomes

For this measure births by caesarean section have been excluded in order to only view rates for women who birthed their babies vaginally either assisted or unassisted.



The decline in episiotomies observed over the previous three years coincides with the move to Te Nīkau came with access to warmers for perineal compresses during the second stage, with no apparent increase in the rate of severe tears.

Neonatal Outcomes



In 2023 we had an increase in preterm births in our facilities driven by the acuity of the clinical situations preventing transfer. As presented earlier in clinical indicator 17 our overall year to year preterm birth rate is remaining steady.

The primary reason for transfer to NICU is respiratory, followed by a suspicion of sepsis. In late November 2023 we purchased a Bubble CPAP machine to assist the stabilisation and treatment of respiratory conditions prior to transfer.

Feeding Method on Discharge

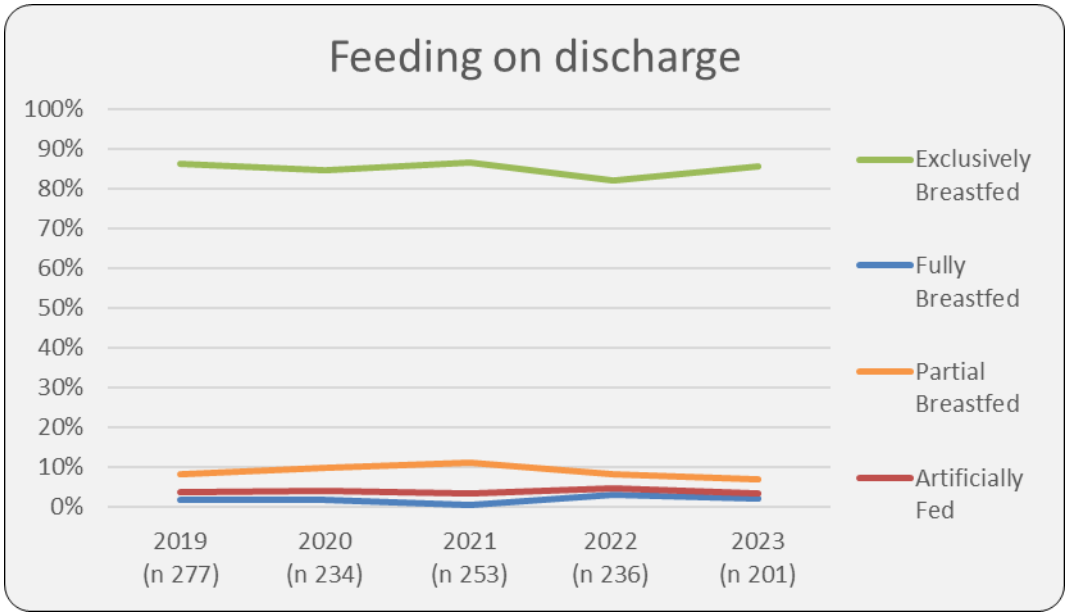
The method of feeding on discharge is based on the breastfeeding definitions used by the Ministry of Health and are as follows:

Exclusive breastfeeding: The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breastmilk, from the breast or expressed, and prescribed medicines have been given from birth.

Fully breastfeeding: The infant has taken breastmilk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.

Partial breastfeeding: The infant has taken some breastmilk and some infant formula or other solid food in the past 48 hours.

Artificial feeding: The infant has had no breastmilk but has had alternative liquid such as infant formula with or without solid food in the past 48 hours.



With the introduction of pasteurised donor breastmilk in 2022 we see an increase in the number rate of fully breastfed babies with a corresponding decrease in partially breastfed babies. Prior to this we had a fairly regular supply of non-pasteurised donor breastmilk. Although our exclusive breastfeeding rate fluctuates, babies who are artificially fed remain stable.

Feedback & Consumer Engagement

Maternity Consumer Council

Our Maternity Consumer Council met seven times in 2023 to discuss issues and ideas for service improvement, and consulted on a range of hospital initiatives and consumer information materials, as well as undertook projects that were important to them. While attendance at meetings varies due to many members having small babies, there is an active Facebook group where ideas and projects are discussed.

The main projects for 2023 were:

- Postnatal Kai ideas flyer

- Wellchild options poster and sticker for Wellchild books
- Started projects on flyer of available birth aids and how to use them, a list for LMCs with
- Selecting a mural for birth room in Te Rau Kawakawa – image kindly donated by local Westport photographer Ezra Hopkins

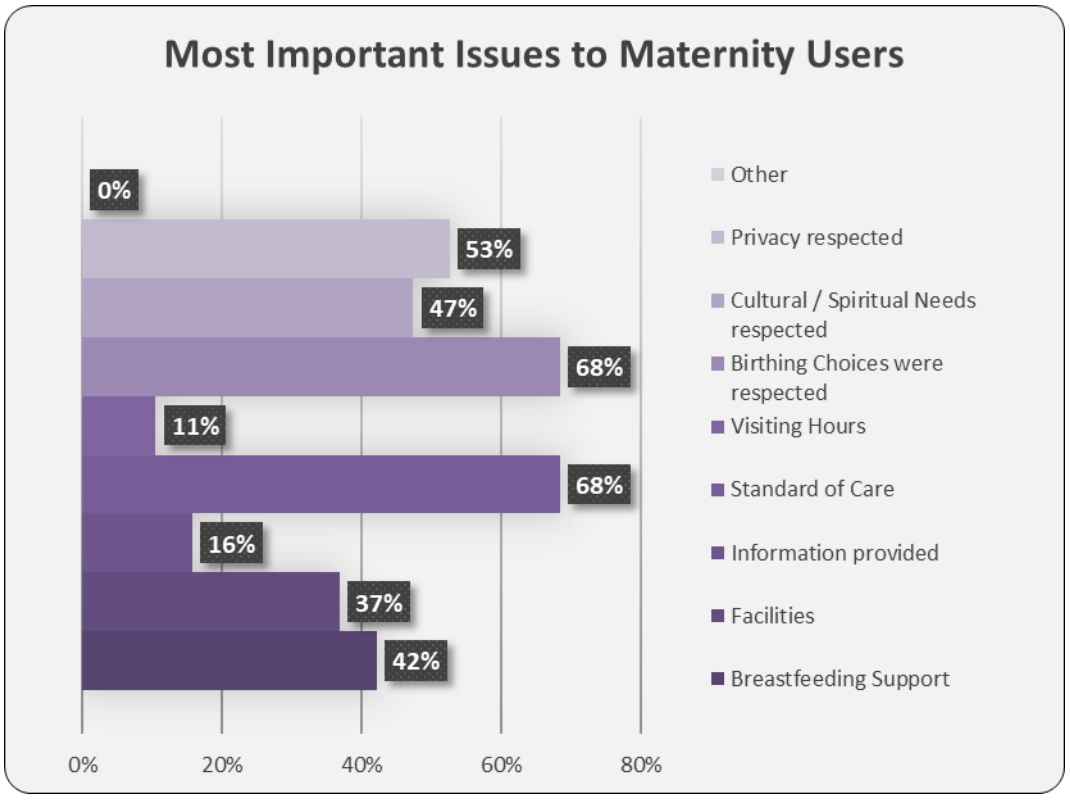
The Maternity Consumer Council also provides a forum for feedback for the community and allows open discussion on feedback themes and resulting actions to filter back to the community.

- Access to services i.e. obstetric clinics in remote areas, antenatal class frequency and locations, improvements to parent parking
- Inequity caused by criteria to qualify for the National Travel Assistance Scheme (NTAS) for those medically needing to travel to Christchurch for care and/or birth
- Access to breastfeeding support once discharged from the Hospital

In response to these concerns we have increased the awareness of telehealth availability for LMC referrers, improved access to obstetric clinics in Westport, and improved the signage for parent parks at Te Nikau. We have invited speakers to the meetings from hospital services and the PHO to clarify and address access and inequity concerns for support and are working with the NTAS coordinator and our finance department to assist those who need to travel out of district for care.

Feedback

We also gather feedback via a consumer survey which can be completed via an iPad on the ward or posted/given to staff following discharge. This is also available for completion on the public website. We also have a dedicated email address for emails that is advertised in consumer information and via the website. We also gather feedback from the many cards and thank-you notes given to the ward and LMCs.



Best things:

- The level of care was outstanding our every wish was met. Dad was included/welcomed; breastfeeding support was consistent; we felt very comfortable; all staff were caring and invested
- We were well informed during the whole process of induction, birth and postpartum/breastfeeding. Every single one of your staff were so lovely, we felt really well looked after and could ask questions easily and they were always respected and answered.

How we could improve:

- Ensure partner's meals are provided if partner staying because we live in Westport
- Just air conditioning in the rooms, room 1 was HOT

As a result of this feedback we have ensured that:

- Fans are available for use and our staff are recommending the blinds are pulled down during summer as we have no air conditioning or thermostat control
- LMCs discuss the ability to purchase partner meals at the café during birth planning and have reminded our staff to offer this to all partners who are staying.

Quality Improvement

Maternity Incident Review Group

Our Maternity Incident Review Group includes representatives from all disciplines involved in the maternity journey, as well as consumer representation and members that sit across the transalpine partnership. Recommendations and learnings from these reviews are presented at staff meetings and build into multidisciplinary education days outlined under the education section above.

We have a trigger list of events and conditions that staff must complete an incident repot on, in addition to any other events that staff believe warrant further investigation. Incidents classed as SAC 3 or SAC 4 are reviewed at MIRG following initial investigation, with all SAC 1 & 2 events being managed and reviewed by the Hospital wide Serious Incident Review Committee.

Findings from the review of cases are presented at staff meetings and education sessions, with adjustments to policies and procedures made as required. An example of this is to run dedicated simulations in Theatre as well as on the Maternity Ward.

Other Quality Improvement Groups

Other involvement in quality groups and projects across the West Coast include the Immunisation Advisory Group, Quality Improvement Forum, Medication Safety, Prescribing Governance Group, Patient Deterioration Working Group, Policy and Procedure Review, Form and Booklet Review

Te Tai o Poutini MQSP Work Plan for 2024 – 2025

The following table sets out the Work Plan for the West Coast Maternity Quality and Safety Programme for 2024-2025, based on the projects directed by the Te Whatu Ora and reported quarterly. This Work Plan will be expanded with the development of a Te Tai o Poutini Maternity Strategy once updated priorities from interest groups are released, and we have the report from the 'Growing up well on the West Coast' project.

Ministry of Health MQSP Projects				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
1	National	Implementation of NEWS/NOC as per national roll out	• All staff working within maternity services or with our pregnant women are trained in the use of NEWS and are using the tool appropriately. • Annual refresher training available for current and new staff using the tool, incorporated within compulsory education sessions.	• Random audit to indicate compliance in using the tool and appropriate escalation when tool indicates action. • Exception reports to Te Whatu Ora via MQSP Programme.
2	National	NE Taskforce projects	• Head circumference measured in NEWS/NOC screening to monitor an early warning sign for NE • Growth Assessment Protocol (GAP) used to monitor fetal growth throughout pregnancy and early referral any identified risk factors • GAP education is provided on at least bi-annual basis to all maternity carers both internal and external to the WC team.	• Audit of medical charts to indicate appropriate use of GAP tool and follow up referrals being made • Ensure that baseline data (broken down into ethnicity) identifies hapū māmā who will require additional scans due to increased risk factors and audit of these māmā indicates referrals were made and scans provided. Review maternity booking form to identify this information. Collected through GAP programme • Conversations and information with māmā requiring additional scans is culturally appropriate.

Ministry of Health MQSP Projects				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
3	NMMG Recs 2019 MQSP (1)	Improvements to work place culture and safe staffing	• Staff working within the Te Nikau Maternity Unit are oriented to and familiar with the environment • Full implementation of the CCDM programme to ensure staffing levels are managed within safe staffing guidelines and management aware of and act on any variation to staffing levels • Staff training in the use of submitting Safe Staffing Form in Safety1st • Regular staff meetings which include community based LMCs to identify any issues that require a collaborative approach to resolution. • Foster Transalpine relationships at all levels of the Maternity System • Expand support roles to maternity	• Policies, procedures and information packages are updated to reflect the Te Nikau environment and Trans Alpine model of care • Safe Staffing escalation plan used when appropriate • CCDM Co-ordinator reviews Safe Staffing incidents on Safety1st and feeds back to CMM Maternity. • Monthly meetings across the different staffing disciplines to ensure timely and appropriate action to identified workplace culture issues. • Utilise opportunities for WC staff to upskill by shadowing counterparts in Canterbury maternity specialist areas • Statements of Accountability produced for new maternity positions: Maternity Care Assistants and Kaiawhina
4	NMMG Recs (2)	Encouraging low-risk women to birth at home or in a primary facility	• Promotional material / information reviewed and distributed • Primary facility and home birth promoted via Facebook and good news stories • Ensuring the Maternity Facilities on the West Coast maintain a normal birth focus, with easy access to quality secondary care	• Increase in number of women choosing to birth or have post-natal care in Te Rau Kawakawa • Sustain or increase number of women choosing to home birth on the West Coast
5	NMMG Recs (3)	Cultural competency workshops for all Maternity Service staff	• Māori Health Team to encourage all LMCs and Core facility staff to participate in the Takarangi Cultural Competency Framework and aligning it to the Turanga Kaupapa	• At least one session on cultural competency per year is delivered to staff working in maternity services • All maternity services staff meet WC cultural competency training requirements

Ministry of Health MQSP Projects				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
			• Ensure our maternity services provide care in a culturally appropriate way including the use of te reo in signage and conversations • Maternity Services identify cultural education appropriate to their setting.	• See an increase in the use of Te Reo across communications both written and verbal • Support a WC Cultural Working Group to develop a programme of work aimed at improving the cultural competency of the maternity workforce
6	NMMG Recs (4)	Access to post-partum contraception, including regular audit	• Establish a working group to review post-partum contraception access and availability • Informational resources identify how to access post-partum contraception	• Increased numbers of women accessing post-partum contraception • Post-partum contraception is to be discussed with all women prior to discharge from maternity unit
7	NMMG Recs (5)	Equitable access to primary mental health services	• Maternal Mental Health (MMH) Pathway is reviewed, and updated information is current • Work with the WC PHO to capture number of referrals to MH services in primary sector • Liaise with PHO to determine number of women accessing MH services via GP or self-referral • Liaise with LMCs to ensure appropriate data capture, referral and follow up to MH services	• Audit of women who indicated current MH issue on their booking form identifies all were offered access to MH services • All women with identified MH issue at booking are screened using EDPS or other recognised maternal mental health screening tool • Yearly review of MMH pathway
8	PMMRC Recs relevant to MQSP (1)	Reduce preterm birth and neonatal mortality	• Appropriate identification of high-risk pregnancies is made at booking • Identify whānau who smoke and ensure appropriate advice and referral to cessation services occurs. • Appropriate referrals to secondary and tertiary provider for pregnancies identified as at high risk, including utilising	• Review of referrals to obstetric services to indicate that they are timely and appropriate and that referrals occur early in the pregnancy • Audit of women with previous uterine surgery to identify appropriate management throughout their pregnancy

Ministry of Health MQSP Projects				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
			technology for these ongoing discussions to increase equity of access to services • Communication between WC and Christchurch provides for seamless follow up of WC women referred to tertiary provider on their return to the Coast in the hub and spoke model • Universal implementation of GAP to identify and monitor other high-risk pregnancies.	• Facilitate closer working relationships with NGOs for staff working within maternity services to engage our priority populations • Ensure appropriate referrals made for pregnancies with abnormal placentation • Women with previous preterm births have early referral in subsequent pregnancies for management plan
9	PMMRC Recs (2)	Co-design models of care to meet the needs of Indian women	• Meet with Indian women and their families to identify any barriers to accessing maternity care • Consumer Council meeting regularly	• Strategies developed ensure equitable access to services • Demonstrate at least one episode / engagement with these target groups • At least one representative of these women on our Maternity Consumer Council.
10	PMMRC Recs (3)	Co-design models of care to meet the needs of women <20 years of age	• Provide a forum for women <20 years where they can communicate any specific issues facing them in pregnancy and access to care and support. • Review alternative ways of provision of information to this cohort of women (increased use of technology)	
11	PMMRC Recs (4)	Interdisciplinary fetal surveillance education for all clinicians involved with intrapartum care	• Multi-disciplinary FSEP provided by Te Nikau Hospital for all clinical staff working within maternity services and facilitated for all community-based access holders	• Education is available each year either face to face, or online with a target of 100% core midwifery staff meeting the requirements of FSEP and all community based LMC midwives offered training
12	PMMRC Recs (5)	Implementation of HQSC maternity morbidity review toolkit and SAC rating (Maternal and NE Case review)	• Continued use of the HQSC Maternity SAC rating tables to capture incidents within Safety1st that match this list. • All LMCs and Maternity staff are aware of the "Trigger List" and record incidents this matching this list in Safety1st	• Review of all Maternity incidents recorded within Safety1st and escalation for RCA investigation if warranted.

Ministry of Health MQSP Projects				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
13	MWWG (subgroup of PMMRC) (1)	Implementation of Hypertension guideline, with a review / restock of medication to ensure easy availability in acute care settings	• Work with South Island counterparts to create overarching policy	• Guideline implemented
14	MWWG (2)	Continued audit of MEWS charts / implementation	• Continued business as usual	• Random audit of MEWS charts to indicate appropriate use and if required opportunities for further education which are followed up
15	MWWG (3)	Use of the Health Equity Assessment Tool (the HEAT) to assess services for the impact of health equity	• Use HEAT tool in guiding of any maternity related strategies, policies, guidelines • Staff education on HEAT tool	• HEAT Tool used as a guiding document for new policies and procedures.
16	MWWG (4)	Establish a clinical pathway for women with identified placental implantation abnormalities	• Trans Alpine working group to develop pathway for women with identified placental implantation abnormalities	• Pathway easily accessible for staff working within the maternity setting
17	MWWG (5)	Establish septic bundle kits to address human factor components, such as stress in high-acuity settings	• All staff working within the maternity setting can locate the Sepsis Clinical Pathway across primary / secondary / tertiary sectors • Sepsis pathway taught during annual update sessions	• Sepsis pathway implemented • Education sessions run prior to implementing sepsis bundle and pathway
18	MWWG (6)	Establish clinical pathways across primary and secondary/tertiary care to enable earlier		

Ministry of Health MQSP Projects				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
		recognition and treatment of sepsis		
19	Local Project	Maternity Consumer Council	• Increased consumer consultation on quality initiatives, policies, procedures, and patient information • Membership reflective of population accessing maternity services • At least one consumer driven project achieved per year	• Consumer Council meeting regularly feeding into Maternity Quality and Safety Governance Group • Consumer driven project implemented
20	Maintaining Competence	Ongoing Education	• All maternity staff to meet professional and organisational requirements for ongoing education • New education added as specified	• Ongoing education: GAP, PROMPT, Emergency Skills, STABLE, FSEP, NLS, BFHI requirements, Cultural Competency
21	National	Pulse Oximetry Screening	• National Pulse Oximetry Screening Guideline fully implemented • All newborns are offered pulse oximetry screening in the first 24 hours of life to screen for congenital heart disease	• Ongoing audit as per national guideline • National reporting once reporting framework implemented