West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Canterbury and West Coast
MATERNITY CARE

Maternity Quality & Safety Programme

Annual Report 2018 -19

(Cover photo: Duncan, Laura and baby Carter McKenzie)

The following people are acknowledged for their participation in compiling this report:

Anita Hyde – Maternity Services Consumer representative

Julie Bell - PA to Director of Nursing & Midwifery, WCDHB

Brittany Jenkins - Director of Nursing, West Coast DHB; Chair, CDHB & WCDHB Maternity Clinical Governance Committee

Norma Campbell – Director of Midwifery, West Coast & Canterbury DHBs

Sharyn Kenning – NIR/MVS Administrator

Kerri de Klerk – Ward Administrator, McBrearty Ward

Gloriavale Christian Community

Linda Monk - Midwifery Educator, WCDHB

Catarina Morais – Clinical Midwife Manager, West Coast DHB

Vicki Piner - Maternity Quality and Safety Programme Coordinator, WCDHB

Desma Reedy – Social Worker, Maternity Services

Meike Siebelink –Kawatiri Maternity Unit

Jenni Stephenson - Project Manager, Planning and Funding, WCDHB

Helen Turner – Kawatiri Maternity Unit

Ravi Vemulapalli - HoD, Obstetrics & Gynaecology, WCDHB

West Coast DHB Maternity Operations Group members

West Coast DHB Maternity Quality and Safety Group members

Planning and Funding staff, West Coast DHB

Canterbury DHB & West Coast DHB 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.

Thank you also to authors of the West Coast DHB Annual Plan 19/20.

Foreword

The West Coast District Health Board is pleased to present the Maternity Quality and Safety Programme Annual Report for 2018/19.

The West Coast has had a busy year again this year as we work towards the development of a Maternity strategy that will guide us for the next five years. A broad framework was presented to a Hui in February this year and we now continue to refine the outcomes of the feedback. This work along with the realignment of the West Coast health system beyond maternity has prompted much discussion about how we best meet the needs of our maternity population. The discussions have also developed into how maternity then sits alongside the other work happening particularly in the well child and mental health spaces.

Last year's report has been shared widely and has prompted more discussion about how we can continue to improve the maternity system for our mothers and their babies. The work that has been started in the previous year continues to evolve specifically in relation to the voices of the women and their whanau in our communities.

The maternity workforce continues to be a challenge for this small remote rural DHB. These discussions have sat alongside the wider discussions about rural generalism within our DHB and the challenges of a rural / remote rural DHB the length of the South Island. Equity of service provision and what equity means for our various populations has also been a frequent topic of discussion this year especially when we speak of the women who need to leave the Coast to have their baby (ies).

We continue to work closely with our colleagues in Canterbury DHB, but the problems are different and the discussions and solutions also vary. However, we appreciate that their external insight can be of assistance at times as can sharing with other rural DHBs. The sharing of the Guidelines work again this year in our Transalpine work continues to be an area that works well and ensures we get the intellectual resource we need to keep our guidelines up to date.

Education updates as well as support for the managers, our educator and others involved in maternity continue to be undertaken across the divide with an increasing confidence also in the use of Telehealth for some of our very little babies. We still need to continue to work out how we can use this better for women who may need to be seen by Fetal Maternal Medicine or the high risk obstetric clinics in Canterbury. Our O&G workforce now also has the support of a rural generalist this year. The intention is to take some of the more straightforward clinical load off our O&Gs and for the generalist to know they are still there in the background if needed. This is starting to bed in well, but getting O&G locums continues to be an area of fragility as is the midwifery workforce locums.

The Maternity Quality and Safety Programme continue to add significant value to our maternity system on the West Coast. The work started last year in reviewing the outcome data continues and is now a standing item in the Operational Group meetings in maternity. We are looking forward to the work programme of 2019/20 as well as the signing off of the strategy which can then influence that programme of work.

We are looking forward to the ongoing development and maturing of the consumer council across the whole of the West Coast to recognise the regional variations. We have an updated maternal mental health pathway which is now operationalised and needs to be reviewed both from the women's and health practitioners' perspectives.

Thank you very much to our MQSP Coordinator Vicki Piner, our Midwife Manager Catarina Morais (who has just gone on maternity leave as this report is being published), O&G lead Ravi Vermulapalli , Midwifery Educator Linda Monk, and all the midwives, nurses and allied health professionals who enthusiastically keep us all motivated and focused on improving our maternity services on system the West Coast. I hope you enjoy reading our report.

Norma Campbell
Director of Midwifery, West Coast and Canterbury DHBs

Canterbury and West Coast MATERNITY CARE

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Glossary

Caesarean section	An operative birth through an abdominal incision.
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.
Neonatal Death	Death of a baby within 28 days of life.
Nulliparous	Medical term for a woman who has never given birth; also applies to women who have given birth to a stillborn baby or a baby that did not survive outside the womb.
Parity	Number of previous births a woman has had.
Primiparous	A woman who has given birth once; multiparous is a woman who has given birth two or more times.
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).
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.
Tertiary facility	Refers to a hospital that can provide care for women with high-risk, complex pregnancies by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. Tertiary maternity care includes an on-site, level 3, neonatal service.
Weeks' gestation	The term used to describe how far along the pregnancy is. It is measured from the first day of the woman's last menstrual cycle to the current date.

PHOTO 1: CELEBRATING INTERNATIONAL MIDWIVES' DAY
(L-R: Linda, Harmony, Leigh, Dawn, Bridget, Kerri & Sandy)

Abbreviations

BFHI	Breast Feeding Hospital Initiative
CDHB	Canterbury District Health Board
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
MCGG	Maternity Clinical Governance Group
MIRG	Maternity Incident Review Group
MOG	Maternity Operations Group
MOH	Ministry of Health
MQSG	Maternity Quality & Safety Group
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
W&CH	Women's and Children's Health

Overview

Background

This is the seventh West Coast 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. They consist of three high-level strategic statements to guide the planning, funding, provision and monitoring of maternity services by the Ministry of Health, DHBs, 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.

Aims and Objectives

The West Coast DHB is committed to improving the quality and safety of maternity services for consumers.

The Canterbury DHB and West Coast DHB Maternity Services' aims and objectives are to:

- Provide woman-centred maternity care that meets the needs of the population;
- Continue to implement, review and establish as required, systems and processes to support the provision of quality and safe care;
- Take a whole of systems approach towards improving the health of women and children as guided by the Ministry of Health's goals and targets;
- Align the maternity workforce to meet the needs of the population;
- Align and strengthen regional links.

Purpose

The purpose of this report is to provide information about the West Coast DHB's:

- Improvements in relation to overall aims and objectives;
- Achievements against the quality improvement goals set for 2018/19;
- 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 2017 ;
- Response to consumer feedback and ongoing consumer involvement;
- Quality initiative goals for 2019/20.

Anita Hyde – Maternity Services Consumer

Kia ora, I'm a busy mum of a two and a five-year-old, who loves getting involved in this fantastic community we choose to live in. Alongside my role of Maternity Consumer Representative, I work part-time and am also on the Greymouth Parents Centre Committee, a trained Mum4Mum, and Secretary for the Greymouth Motorcycle Street Race. When I get a spare moment, crafting is my sanity saver!

Both of my children were born at Grey Hospital; however with my second being a little unwell we were under the care of Fetal Medicine at CDHB, and NICU once she was born.

This past year there have been some great opportunities to contribute the consumers' voice to help shape the maternity service moving forward. In February the Maternity Hui was held which brought together a wide range of health professionals, local service providers and consumers to discuss maternity services and beyond in the region. We were all encouraged to give our views and suggestions on developments that could be made and there were some great ideas put forward. My whanau's experience of having to travel at our own expense to Christchurch 5 times during my last pregnancy for scans, which could have been carried out locally, was shared with the group, and the suggestion to make telemedicine consultations more accessible was well received and I am pleased to see that it has been followed through to become part of next year's strategy.

A strong theme throughout the day was Maternal Mental Health and this reflects concerns in the community also. It has been great to see the development of the Maternal Mental Health pathway which is now in use. There is still work to be done in this area and I will continue to be vocal about this and the need for better post-pregnancy support and screening; however it is great to know that this is also a focus of the maternity team.

The coming year has more exciting changes for the maternity service, with the opening of the new hospital in Greymouth which will give whanau a much more private and comfortable place to be. Further development of the consumer groups will mean better representation for women in other communities and will hopefully give an even stronger consumer voice.

I'd like to thank the maternity team for involving me in their discussions, explaining the lingo and taking my suggestions openly. I'd also like to really thank the parents in our community who have shared with me their stories, giving me the confidence to speak up and represent them and put forward their concerns, ideas and praise.

Maternity Management & Admin Team 18/19

			
Norma Campbell Director of Midwifery, WCDHB & CHDHB	Brittany Jenkins Director of Nursing / Chair Maternity Governance Group	Catarina Morais Clinical Midwife Manager	Meike Seibelink Kawatiri Maternity Unit
			
Helen Turner Kawatiri Maternity Unit	Dr Ravi Vemulapalli Obstetrician & Gynaecologist HoD, Obstetrics	Dr Sherif Mehrez Obstetrician & Gynaecologist	Dr Vicki Robertson Obstetrician & Gynaecologist
			
Linda Monk Midwifery Educator	Kerri de Klerk Maternity Services Administrator	Vicki Piner MQSP Co-ordinator	Julie Bell PA to Director of Nursing WCDHB
			
Marianne Seibelink Kawatiri Administration Manager	Sharyn Kenning NIR/MVS Administrator / Data Collator		

1. West Coast Maternity Services

1.1 Vision and Values

The West Coast DHB's Maternity Vision and Values in the delivery of maternity services:

"Providing safe, high quality maternity care in partnership with West Coast women and their whānau."

Values:

- Respect
- Protection / Care
- Education / Learning
- Efficient / Resourceful
- Accountable / Accountability

For women, their partners and their wider whānau, there is a need to continue to transform our maternity services to ensure:

Equity of access and outcome for all West Coast women to our maternity system/services

- Active partnership with people and communities at all levels.

Women are supported to take greater responsibility for their own health whilst pregnant

- Supporting women's navigation of the maternity system, through communication that includes the use of accessible technology.
- Women understand the information they need to manage their care.

Women stay well when pregnant in their own homes and communities

- Integrating health services and making better connections with wider public services.
- Providing care closer to home.

Women or their babies who are unwell when pregnant receive timely and appropriate care

- Access for all women and babies to the appropriate level of service for care required.

PHOTO 2: CARTER & BABY TAYLOR MCKENZIE

1.2 Maternity Facilities

There are two facilities available to women living on the West Coast and most births are at the larger Grey Base Hospital. Kawatiri Maternity Unit is at Buller Hospital in Westport and is a primary unit. Christchurch Women's Hospital is the only tertiary facility for the West Coast and is located in Canterbury. They accept referrals from the West Coast and we work closely with their team when women and/or their babies are more complex and require that level of support at any point in their maternity journey.

West Coast DHB	
Primary	Kawatiri Maternity Unit at Buller Hospital, Westport
Secondary	McBrearty Ward at Grey Base Hospital, Greymouth
Tertiary	Christchurch Women's Hospital

The photo below depicts McBrearty Ward, Grey Base Hospital as it is at time of print. Maternity services staff eagerly await the completion of Te Nikau, Grey Base Hospital and the new maternity facility.

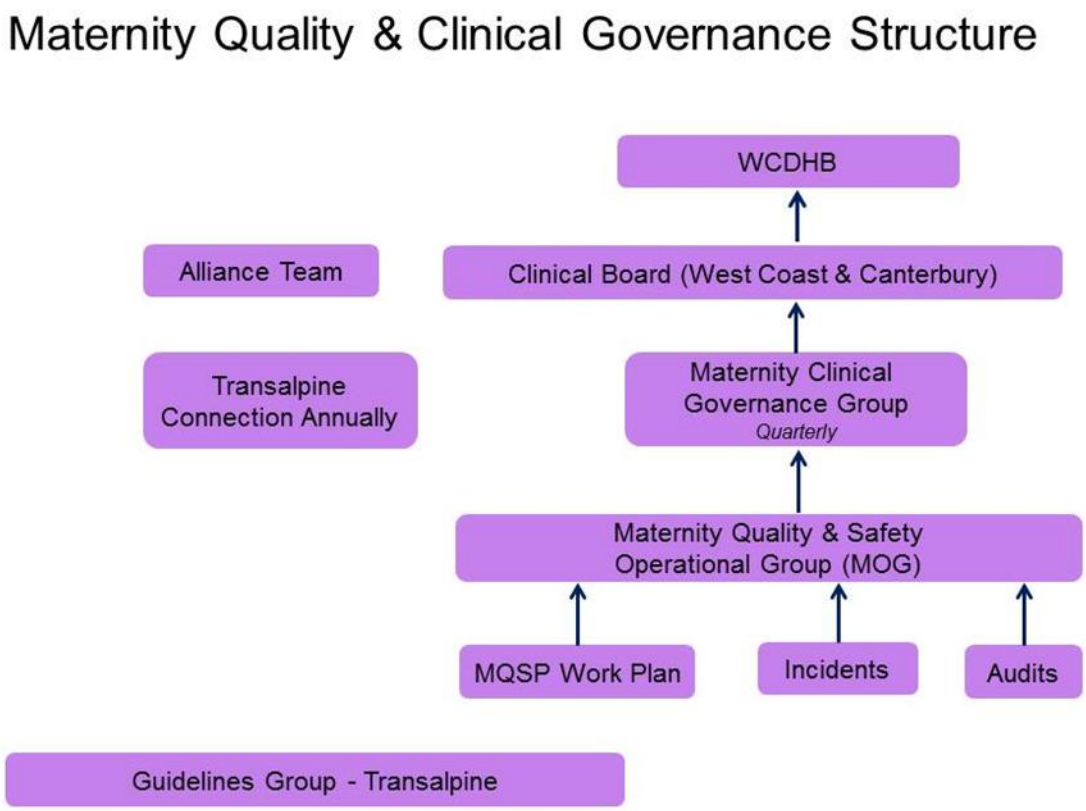
PHOTO 3: MCBREARTY WARD ENTRANCE

PHOTO 5: WHANAU FACILITY FOR PATIENT'S WHĀNAU, GREY BASE HOSPITAL

PHOTO 4: KAWATIRI MAIN ENTRANCE

2. Maternity Governance

The West Coast DHB Governance and reporting lines are illustrated below:



2.1 MQSP Programme

In 2015 each DHB's maternity service was requested by the MoH to self-audit and identify themselves within three tiers of performance:

1. Emerging
2. Established
3. Excelling

Meeting the requirements of each tier was based on the New Zealand Maternity Standards (2011) and the service specification for each tier prescribed by the MoH. During 2016 the West Coast DHB moved from an "emerging" tier to "established." When the MQSP was originally set up West Coast DHB was closely linked with Canterbury DHB and shared a MQSP Co-ordinator. In 2016 we recruited a West Coast MQSP Co-ordinator allowing us to focus on the areas of the MQSP that have relevance to our environment and women. However, we share a strong link and work closely with Canterbury DHB via our Trans Alpine relationship.

From 2017 we have continued to embed the MQSP into our maternity services and link our plan into the overall strategic goals and quality improvement programme for the West Coast DHB.

As part of our continued momentum and quality improvement we developed a Work Plan for the 2018/2019 year and we report against that in this report.

Collegial support is provided to the West Coast MQSP Co-ordinator via regular teleconferences and group emails with the national group. The environment is collaborative with learning and resources shared. MQSP Co-ordinators from across New Zealand meet in Wellington annually with the MoH to look at future direction.

South Island MQSP Co-ordinators keep in regular contact via teleconference and email. This support provides an opportunity to share resources, bounce ideas off each other and learn from each other.

PHOTO 6: SOUTH ISLAND MQSP COORDINATORS

(L-R) Samantha Bourke, Canterbury DHB; Vicki Piner, WCDHB; Heather LaDell, Southern DHB; Lois McTaggart, Nelson Marlborough DHB

2.2 West Coast DHB / Canterbury DHB "Transalpine" Relationship

Like many small DHBs, population numbers on the West Coast cannot support provision of a full range of specialist services requiring us to refer patients to larger centres with more specialised capacity. Since 2010, the West Coast DHB has shared executive and clinical services with the Canterbury DHB. This includes a joint Chief Executive and clinical directors, as well as shared public health and corporate service teams.

While the West Coast has always had informal clinical arrangements with the Canterbury DHB, the Transalpine model has allowed these to be formalised through clinically-led transalpine service pathways. This formal arrangement enables the West Coast DHB to develop the workforce and infrastructure needed to ensure we can meet the needs of our population.

The Transalpine approach is reflected in our shared governance model and relationship, whilst acknowledging the DHB's differences. West Coast and Canterbury DHBs 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 DHB provides to the West Coast DHB, so our women can access services as close as possible to where they live and provides us with the backup and support of a tertiary level service, who know and understand our environment, when required.

A cohort of CDHB clinicians regularly visit the West Coast providing cover when their West Coast peers are on leave and our clinicians have opportunities for working in Christchurch with their peers. This approach has brought down barriers, strengthening relationships and has given our Canterbury based clinicians a real understanding of the challenges we face in a rural environment; by working in our environment they fully understand it. We have so much to teach each other.

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.

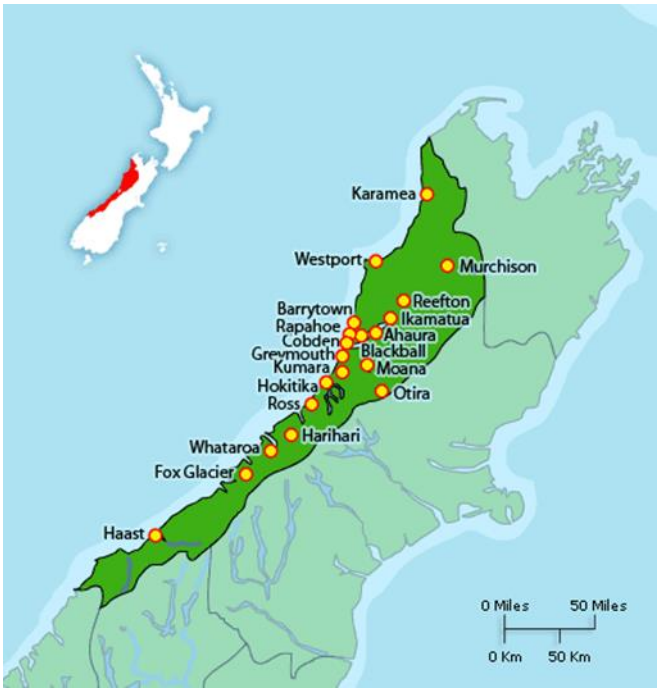
3. The West Coast DHB

The West Coast District Health Board (DHB) is one of twenty DHBs charged with improving, promoting and protecting the health and independence of our resident population.

We have the smallest population of any DHB in New Zealand with responsibility for 32,143 people; only 0.7% of the total New Zealand population (2013 Census). We employ 972 people (including casual staff) in our health service (663.65 FTE).

Although we are the smallest DHB by population we have the third largest geographical area, making the West Coast DHB the most sparsely populated DHB in the country with only 1.4 people per square kilometre. Our District extends from Karamea in the north to Jackson Bay in the south, and Otira in the East. It comprises three Territorial Local Authorities: Buller, Grey and Westland districts:

- **Grey District** has the largest population, with an estimated resident population of 13,371 people (less than 1% of New Zealand's population).
- **Buller District** has an estimated resident population of 10,473 people.
- **Westland District** has an estimated resident population of 8,307 people.



3.1 Our Population

The West Coast has a relatively static population with the DHB being responsible for 32,410 people in 2018/19; almost unchanged over the last 10 years. We have an older age structure and a higher proportion of people aged over 65 (19%) compared with the national average (16%).

Deprivation is an indicator of the need for health services and the West Coast has a lower mean personal annual income ($20,400) compare to the rest of New Zealand ($24,400). Higher proportions of our population receive unemployment benefit, or invalid benefits, have no educational qualifications and lack access to a motor vehicle or telephone.

Ethnicity is also a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others. There are currently 3,900 Māori living on the West Coast (12% of the population) and by 2026 that proportion will increase to 13%.

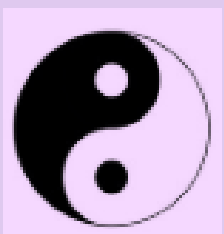
Our Māori population has a considerably different age structure with 41% of our Māori population being under 20 years of age, compared to 24% of the total West Coast population.

Our population is diverse

12%
Are Māori

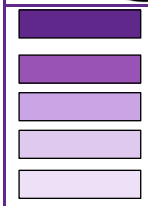
3.4%
Are Asian

1.2%
Are Pacific



Our population is becoming more diverse. By 2026, 13% of our population will be Māori.

3.2 Our Maternity Profile

Category	WCDHB – 2017 Data from MoH Data	
	Birth Rate	356 deliveries in 2017
	163 Babies born every day in New Zealand	30 babies per month were born to WCDHB mothers
	Maternal Age	Highest proportion of WCDHB mothers are in the 25-29 years bracket (35%)
	Maternal Ethnicity	23% Māori 72% European / other descent 4% Asian 1% Pacific
	Deprivation	Quintile 5 5% (Most Deprived) Quintile 4 47% Quintile 3 22% Quintile 2 19% Quintile 1 6% (Least Deprived)
	Birth by Facility Type	Grey Base Hospital (secondary) 73.4% Kawatiri Maternity Unit (primary) 5.6% Christchurch (Tertiary) 10.5% Home Birth 10.4%
	Parity	37.4% Nulliparous (1st time Mums) 62.6% Multiparous
	Body Mass Index	39.7% of WCDHB women were of a healthy weight
	Smoking at LMC First Registration	18.8% women were smoking at time of registration with their LMC
	Smoking 2 weeks postnatal	80.6% of women smoking at registration were smoking 2 weeks postnatal

3.3 Where our Mums live and birthed in 2018

WEST COAST DISTRICT HEALTH BOARD

MINISTRY OF HEALTH MANATŪ HAUORA

WCDHB Birthing Facility

Home birth

Canterbury DHB Tertiary Centre
(29 births during 2018)

Mother's Residence

Please note that there were births at Nelson and one in Auckland

4. Achievements against Priorities

4.1 West Coast DHB MQSP Work Plan 2018/19

The following table summarises achievement against the goals set for the 2018/19 year across the West Coast DHB.

- Indicates that the work has been completed and/or is in business as usual (BAU) phase
- Indicates that the work is in progress / underway and nearing completion
- Indicates that the work is in progress: about two thirds completed before embedding as BAU
- Indicates that there is still significant work required to achieve completion

		Progress Report	Status
		WCDHB MQSP Work Plan 2018/19	
1	Develop good communication systems for consumer representatives to provide input into the MQSP programme and maternity service delivery.	Our Maternity consumer attends our Maternity Operations Group meetings and Governance Group. Via our "roadshows" and Maternity Hui we have established a list of women who would like to be involved more in providing consumer feedback. There is intention to set up "consumer hubs" regionally, but more work to be done in this area.	
2	Audit and evaluate the use and effectiveness of the maternal mental health pathway	Completed – revised, updated Maternal Mental Health Pathway implemented in July 2019 (more detail provided in Quality Initiatives section).	
3	Workforce Development and Education: provide education to clinicians working in the maternity setting so they are proficient at screening and are aware of local services and pathways for: family violence, smoking, alcohol and other substance abuse, maternal mental health pathway.	All women identifying as smokers on registration are offered smoking cessation services and if they present to the ward throughout their pregnancy the offer is made again. LMCs screen for family violence at the time of booking and revisit this during the pregnancy journey (when the woman is alone). Revised Maternal Mental Health pathway provided to all clinicians working in maternity services and outside agencies working with women and their whānau. All core midwifery staff and LMCs are provided with FSEP training on an annual basis. Bi-cultural training for staff working in maternity services is an area that requires further work and has been identified in the Draft Maternity Strategy.	
4	Identify women with modifiable high risk factors for perinatal related death and work individually and collectively to address these; diabetes, healthy BMI, accurate height and weight measurement in pregnancy, antenatal recognition of fetal growth restriction.	GROW charts are used antenatally to identify any fetal growth restriction and action plans are put in place. Introduced individualised GROW charts to take into account ethnicity, weight and height of the women.	

		Progress Report	Status
5	Early detection of women with high BMI at time of booking with their LMC; early referral for women identified with high BMI, continued monitoring of BMI throughout pregnancy.	All women with a BMI of >=35 are referred to the Obstetric Clinic and Nutritionists. Close watch is kept on their BMI throughout pregnancy (weighed at every appointment).	
6	Embed activities outlined in the West Coast SUDI prevention plan in the Maternity Quality Safety Programme	The SUDI prevention plan is embedded within maternity; we monitor and report on safe sleep audits and have worked with the South Island Co-ordinator to increase pēpi pod numbers. We also extended the smoking cessation incentivised period to four months post birth to encourage those mums returning to smoking post birth to remain smoke free.	
7	Establish Māori by Māori for Māori PPE to meet the needs of our Māori and Pacific women.	A contract for the provision of Māori for Māori PPE has been signed with our Māori provider. Looking at how this type of PPE is delivered in Canterbury. We expect to start delivering this programme within the 19/20 year.	
8	Promote and support women breastfeeding; continued implementation of the Breastfeeding priority plan and retention of BFHI status.	Over the past twelve months we have employed a lactation consultant, provide on line breastfeeding training to the multidisciplinary maternity team, and have retained BFHI status at both our primary and secondary facilities.	
9	Continued review of NZ Clinical Indicators: ongoing interrogation of data to identify trends for targeted education and action	We are working towards implementing a VBAC clinic and hope to offer these during the 2019/2020 year. Currently during pregnancy women experiencing previous c/section are offered VBAC advice (Obstetrician sees them between 20 – 24 weeks). Regular reporting against indicators to our Maternity Operations Group.	
10	Support and increase use of primary birthing facilities and home birth for low risk women	During 2018 we had 26 births in the Primary facility (up 8 from 2017). Home birth figures were up by 3 against 2017 numbers, but there were fewer births in the Gloriavale community.	
11	Develop wider understanding of transportation challenges faced on the West Coast for our mothers and pēpi.	Much work to be done in this area; brochures need to be developed. We also need to further explore more use of telehealth and back to back appointments for women requiring more than one type of specialist intervention.	

4.2 MoH Projects and the MQSP Programme

As part of the annual reporting to the Ministry of Health and the MQSP we were required to report progress on:

- A local Project that met MoH MQSP Criteria
- Two National Projects meeting MoH MQSP Criteria
- Five NMMG Priorities
- Five PMMRC Priorities
- Two MWWG Recommendations

Local Project – Maternal Mental Health Pathway

Audit, Evaluate the use and effectiveness of the Maternal Mental Health (MMH) Pathway

As a local project we chose to work on our Maternal Mental Health Pathway and this was a huge area of focus for us during the 18/19 financial year. This project is listed in more detail in Section 7 under Quality Initiatives.

National Project 1: Consumer Involvement

Encourage, monitor and increase consumer involvement in MQSP Programme and Maternity Service Delivery

Although there is still much work to do, during 2018 we have endeavoured to hear the voice of consumers more clearly. Our maternity consumer representative started attending Maternity Operations Group meetings; she has been bringing the voice of the consumer to maternity policies, procedures and audits.

From the roadshows at the end of 2018 we met with women who identified as being interested in providing a consumer voice to our work. We invited these women to the Maternity Hui held February this year and invite them to provide feedback on our work e.g. feedback on the MMH Pathway.

We have increased the use of social media - Facebook to get key messages out to our women and to invite them to provide feedback, to promote our maternity services and as a point of contact where women can go with queries related to maternity issues.

During the next year we intend to establish three / four regional "hubs" where consumers in those areas will be the voice of their specific region. We will specifically engage with these groups when we are in planning stages for maternity related initiatives. The use of video technologies will be beneficial in reducing the need for our consumers to travel to centres for meetings.

National Project 2: Māori for Māori PPE

Establish Māori for Māori PPE to meet the needs of our Māori and Pacific Women

Hapu Wananga
Recently a small roopu travelled to Christchurch hosted by Te Puawaitanga to gather ideas for the delivery of a Kaupapa Māori Hapu Wananga programme to be designed and delivered through Poutini Waiora (local Māori provider). Te Puawaitanga ki Otautahi have been very open with sharing their programme and resources with us and have offered continued support as we move closer towards developing hapu Wananga for our whānau on Te Tai Poutini. Our local programme will be funded through SUDI funding; this will allow more flexibility to deliver a Kaupapa Maori holistic programme.

Gina Beal, Mama and Pépi kaimahi for Poutini Waiora is now developing local resources, securing a location for the delivery and managing the logistics before we hold our first Wananga.

4.3 Addressing NMMG Priorities

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 2018 /19 periods below.

Workforce

As a small team servicing the needs of women across a largely rural environment we need to look at inventive ways we can support our workforce. During March we held a meeting with staff to connect with them and to get their perspective on the impact on such a small workforce of LMCs and employed midwives leaving the West Coast. That discussion presented an opportunity to brainstorm and discuss suggestions that could help alleviate some of the stress staff face when we are not fully staffed. One of the suggestions we have trialled during our staffing shortage is supporting the unit with an RN (1 FTE) who has obstetric training and works under the direction of a Core midwife. We continue to actively recruit midwives and we are in active discussions across the South Island as well looking at how we can provide care close to women in such a rural DHB.

WCDHB Midwife Sustainability Package

The West Coast DHB provides a Sustainability Package for community based LMCs:

- LMC Education is provided and paid for by the DHB – the same as we provide for our Core Midwives;
- Free use of clinics in the rural areas where women can see their LMCs: Grey Base Link 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 DHB vehicles for travel;
- The Package is renewed every twelve months.

As a small DHB we could lose 2-3 women per month transferring to Tertiary care that has the potential to impact significantly on the LMC's income, so we offer support via this package.

Rural Midwifery Workforce Workshop

PHOTO 7: CELEBRATING MIDWIVES' DAY

Concerns around the ongoing sustainability of the rural midwifery workforce prompted the holding of a rural midwifery workforce workshop held in Christchurch during June 2019. South Island DHB midwifery leaders in partnership with the South Island Alliance brought together 44 key stakeholders from across the South Island to develop and prioritise an action plan to sustain the current rural midwifery workforce and recruit the future workforce. The workshop provided participants with the opportunity to discuss the challenges facing midwifery services, to hear how other areas had addressed some of their issues and to look at ways of working together to support the recruitment and retention of our midwifery workforce.

As a small rural DHB our small staffing numbers mean that even small changes in the numbers of midwifery numbers can have a dramatic impact. We work closely with our community based LMCs meeting regularly to address issues as they arise.

Place of birth – Encourage Primary Births

The West Coast DHB has only one primary birthing facility for West Coast women – Kawatiri Maternity Unit located at Buller Hospital provides primary birthing facilities for women with healthy uncomplicated pregnancies. Numbers of births at the unit, although low relative to the rest of New Zealand, are showing an increasing trend. During 2018 we had 26 births at the facility, up 8 from 2017. The majority of Buller women who birth at the Secondary facility at Grey Base Hospital return to Buller to have their post natal care provided at Kawatiri. We had 10 home births for the year, which is an increase of 3 from 2017 numbers. The number of Gloriavale women birthing at home was less for the 2018 year (21 vs 26).

"The amazing team of midwives at Kawatiri go above and beyond to make sure you are cared for and treat you as a person not just a number."

Feedback from woman having postnatal care at Kawatiri
January 2019

PHOTO 8: KAWATIRI POSTNATAL ROOM

Kawatiri has a fully equipped birthing room with birth pool option and promotes active birth whilst having all emergency equipment required. A large lounge area is available for use by family and whānau of labouring and postnatal women. The unit has two large postnatal rooms for women and their partners to stay either post birth at Kawatiri, or as a transfer from secondary care services in Greymouth. Postnatal care is carried out by midwives and Foote Ward nursing staff.

PHOTO 9: KAWATIRI BIRTHING ROOM

PHOTO 10: KAWATIRI LOUNGE

Audit of IOL and C/section rates

PHOTO 11: BABY ZEKE WITH DAD ADAM AND MUM ANNIE WELLS

We monitor our IOL and C/section rates and report these through to the Maternity Operations Group on a monthly basis which is attended by our consumer representative. Indications for IOL / C/sections are reviewed and discussed to identify what could have done differently. During 2018 we implemented measuring estimated blood loss (EBL) to improve our reporting of post-partum haemorrhage.

Maternal Mental Health

Our Maternal Mental Health pathway was a key focus and a project that we concentrated on for the 2018 / 19 year. ***This is reported in more detail in the quality initiative section of this report.***

Access to Post-Partum Contraception

We are currently offering our women LARC which includes IUCDs, implants and Deprovera injections. Up to early 2017 women could access LARC via Family Planning in a clinic located within Grey Base Hospital. With Family Planning withdrawing the clinic from the West Coast this has meant women have had to go back to their GP and not all GP practices offer this service. To address this lack of suitably trained staff to provide LARC insertion we are rolled out training across the West Coast within our primary facilities.

From 1st July 2017, the West Coast PHO increased their free contraception consultations from the age of 22 to the age of 25 which means more women can now access this free contraception. Women who quality for a community services card over the age of 25 can access funding via WINZ. We do not currently have any provision within our Gynae services to offer LARC free to any women not meeting these criteria.

4.4 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.

Reduce preterm birth and neonatal mortality

WCDHB has 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 4 months post natal.

The WCDHB has a policy to identify preterm labour with a process for appropriate transfer to the right place. Women presenting in labour less than 36 weeks gestation are transferred to the tertiary unit, if it is safe to do so. WCHDB has a policy to identify preterm labour early and arrange for appropriate transfer. There is a guideline for rural nursing and primary birthing unit on assessing women presenting with symptoms of pre-term labour.

PHOTO 12: ALEX WILLIAM BLANCHFIELD

Improve care for mothers under 20 years of age

We know that there is more we can be doing in this area and we have made contact with Mums under 20 years of age on our consumer group. Working closely with our community based LMCs and NGOs we aim to identify ur young mothers so we can provide additional support for them and follow up on their care. All young mums are referred to the maternity social worker who then takes their case to our inter-disciplinary safety meeting to ensure these mums are receiving adequate care and support.

DHBs observe skin to skin and identify risk of SUDI

As a small DHB we work well as a small team with the specialties supporting maternity services. Our theatre team is very supportive of skin to skin contact as soon as possible following birth. An audit was conducted to determine the success rate of initiating skin to skin contact post-delivery by caesarean section to identify factors promoting / hindering initiation for skin to skin contact in the operating room. This audit is still being written up, but essentially it identifies that careful placing of monitoring equipment utilised by the anaesthetic team to ensure stability of the mother is required to facilitate safe skin to skin.

The breastfeeding record used at our facilities has been updated to identify and collect skin to skin initiation, when it occurred and if delayed the reason for delay.

Our stock of pēpi pods was increased in 2018, in line with the SUDI prevention plan. WCDHB carry out regular safe sleep audits of our birth ward conducted by our safe sleep Co-ordinator. She discusses safe sleep with all of the women. If during the safe sleep discussion it becomes apparent that the mother does not have a safe sleep space for baby/pēpi we will gift the woman a pēpi pod to take home to ensure all mothers are able to provide a safe sleep space for their baby/pēpi.

4.5 Addressing MMWG 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.

Early recognition and treatment of sepsis

Early recognition and treatment of sepsis is included in regular training and education sessions for multidisciplinary teams. We have guidelines in place that span transalpine services. One of our senior consultants presented a case study on early recognition of sepsis in the maternity setting to the multidisciplinary teams which was open to all health professionals working in maternity care. This presentation was supported by one of our physicians presenting education on sepsis recognition and treatment.

Establish septic bundle kits

Establish septic bundle kits to address human factor components, such as stress in high acuity settings within the next 18 months. The WCDHB use the Six Sepsis guideline which is embedded in our emergency department – point of entry for all women prior to going up to the maternity ward. One of the scenarios practiced in our last PROMPT training was the use of the sepsis bundle.

Consider establishing sepsis clinical pathways

Consider establishing clinical pathways across primary and secondary /tertiary care to enable earlier recognition and treatment, while waiting for nationally consistent guidelines to be developed. Via our Transalpine relationship the WCDHB shares a policy on the early recognition and treatment of puerperal sepsis.

PHOTO 13 CHARN AND MILLI

5. Clinical Indicators Analysis

The Ministry of Health's data New Zealand Maternity Clinical Indicators (2017) was published this year. The analysis below shows the DHB's performance and position in relation to both the indicators and national averages. Percentage figures are from either the "DHB of Domicile" set or the "Facility of Birth" as indicted and are based on standard primiparae only (rather than all women giving birth / all deliveries).

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 19% of all births in the WCDHB. This group aged 20-34 years, uncomplicated singleton pregnancy, full term, cephalic presentation represent the lease complex situations in which intervention rates would be expected to be low, and can be compared between institutions.

Analysis of Individual Indicators for West Coast during 2017

Indicator No.	Title	2016 WCDHB Rate (n)	2017 WCDHB Rate (n)	Change from 2016	Higher or lower than national average	National Average 2017
1	Registration with an LMC in the first trimester of pregnancy	79.2% (248)	80.2% (284)	▲ +1%	▲	72.3%
We continue to promote early registration with an LMC via posters in GP practices, links to Find Your Midwife on the WCDHB maternity pages and consistent messages via social media.						
2	Standard primiparae who have a spontaneous vaginal birth	76.2% (32)	63.3% (31)	▼ -12.9%	▼	65.1%
Low numbers impact on our statistics; however we are within the national figures. Improvement in data collection means more accurate identification of standard primiparae and this number is reducing.						
3	Standard primiparae who undergo an instrumental vaginal birth	7.1% (3)	12.2% (6)	▲ +5.1%	▼	16.3%
Again low numbers have an impact. There is no significant variance; within the national average.						
4	Standard primiparae who undergo caesarean section	23.3% (7/30)	21.1% (8/38)	▼ -2.2%	▲	21.0%
Within the national average. We routinely audit all caesarean sections and discuss the cases.						
5	Standard primiparae who undergo induction of labour	10.0% (3)	5.3% (2)	▼ -4.7%	▼	8.8%
Rates remain stable. We review all induction of labour indications annually and do not find any inductions without indication.						
6	Standard primiparae with an intact lower genital tract (no 1st – 4th degree tear or episiotomy)	21.7% (5)	23.3% (7)	▲ +1.6%	▼	19.0%
WCDHB is slightly higher than the national average. LMCs/midwives attend perineal care workshops contributing to improvement in these numbers.						
7	Standard primiparae undergoing episiotomy and no 3rd or 4th degree perineal tear	13.0% (3)	23.3% (7)	▲ +10.3%	▼	30.0%

Indicator No.	Title	2016 WCDHB Rate (n)	2017 WCDHB Rate (n)	Change from 2016	Higher or lower than national average	National Average 2017
Numbers are consistent with instrumental deliveries.						
8	Standard primiparae sustaining a 3rd or 4th degree perineal tear and no episiotomy	4.4% (1)	3.3% (1)	▼ -1.1%	▼	4.2%
Numbers remain stable.						
9	Standard primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear	0	0			2.1%
We have no women within this group.						
10	Total number of women having a general anaesthetic for caesarean section	6.7% (5)	8.3% (7)	▲ +1.6%	▲	8.2%
General anaesthetics are used only when birth needs to be imminent; the baby is distressed and there is no time for epidural or spinal pain relief or there are other reasons we need to move to GA. The unit policy is for regional anaesthetic for a section unless it is clinically contraindicated or the clinical situation dictates the need for general anaesthetic.						
11	Women requiring a blood transfusion with caesarean section	4.0% (3)	6.0% (5)	▲ +2.0%	▲	3.1%
Noted slight changes in need for blood transfusion with increased PPH during C/section. Introduced policy to give regular tranexamic acid for emergency c/sections and C/sections for women with higher BMIs.						
12	Women requiring a blood transfusion with vaginal birth	2.8% (4)	3.0% (5)	▲ +0.2%	▼	2.4%
In line with slight increases in PPH; some due to prolonged labours.						
13	Diagnosis of eclampsia at birth admission	N = 0	N = 0			
14	Women having a peripartum hysterectomy	N = 0	N = 0			
15	Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period	N = 0	N = 0			
We have no women meeting the criteria for indicators 13, 14 and 15.						
16	Maternal tobacco use during postnatal period	18.3% (56)	17.8% (60)	▼ -0.5%	▲	10.5%
Continuing education programmes. Have extended the smoking cessation incentivisation programme period to 4 months post birth.						
17	Preterm birth (under 37 weeks gestation)	0.47% (1)	4.3% (11)	▲ +3.83%	▼	8.4%

Indicator No.	Title	2016 WCDHB Rate (n)	2017 WCDHB Rate (n)	Change from 2016	Higher or lower than national average	National Average 2017
We had two deliveries under 32 weeks; 9 deliveries for gestation of 32-36 weeks. This increase is due to women coming late to labour.						
18	Small babies at term (37-42 weeks' gestation)	1.4% (4)	2.5% (8)	▲ +1.1%	▼	2.9%
In line with the national average.						
19	Small babies at term born at 40-42 weeks' gestation	0	75% (3/4)	▲ +37.3%	▲	30.4%
We are reviewing data to review those that are less than the 10th percentile identified at booking time and monitored with growth checks.						
20	Babies born at 37+ weeks' gestation requiring respiratory support	0	0.41% (1)	▲ +0.41%	▼	2.2%
One baby met this criterion during the period.						

6. West Coast DHB Maternity Data

The data in this section is from local Maternity data sources and compares 2016 and 2017 in comparison with increase or decrease noted. Data here is counted in terms of all "deliveries" in a DHB facility (as opposed to a count of exclusively standard primiparae as used by the New Zealand Maternity Clinical Indicators.

Gestation at Delivery	2016		2017		Trend
	Number	%	Number	%	
Extremely preterm (<28 weeks)	0	0	1	0.4	▲
Very preterm (28-31 weeks)30	0	0	0	0	
Moderately preterm (32-33 weeks)	0	0	0	0	
Later preterm (34-36 weeks)	2	0.9	9	3.6	▲
Term (37-41 weeks)	211	97.2	236	95.2	▼
Prolonged (>42 weeks)	4	1.8	2	0.8	▼

Type of Labour	2016		2017		Trend
	Number	%	Number	%	
Spontaneous	115	53	157	63.3	▲
Induction	38	17.5	50	20.2	▲
Artificial Rupture of Membranes	13	6	5	2.0	▼
Augmented	26	12	8	3.2	▼
Did not labour	25	11.5	28	11.3	▼

Method of Delivery	2016		2017		Trend
	Number	%	Number	%	
Elective Caesarean	26	12	34	13.7	▲
Vaginal	112	51.6	137	55.2	▲
Vaginal Water Birth	15	6.9	12	4.8	▼
Kiwi Cup	5	2.3	5	2.0	▼
Ventouse	0	0	0	0	
Forceps	8	3.7	12	4.8	▲
Emergency Caesarean	46	21.2	48	19.4	▼
VBAC	3	1.4	0	0	

Breech	2016		2017		Trend
	Number	%	Number	%	
No	214	98.6	241	97.2	▼
Yes	3	1.4	7	2.8	▲

Anaesthetic	2016		2017		Trend
	Number	%	Number	%	
None	110	50.7	137	55.2	▲
Local	7	3.2	9	3.6	▲
Epidural	26	12	28	11.3	▼
Spinal/Epidural	69	31.8	66	26.6	▼
General	4	1.8	5	2.0	▲

Perineum	20.16		2017		Trend
	Number	%	Number	%	
Intact	63	29	62	25.0	
1st Degree tear	36	16.6	48	19.4	
2nd Degree tear	27	12.4	27	10.9	
3rd or 4th Degree tear	3	1.4	7	2.8	
Episiotomy	16	7.4	24	9.7	
N/A	72	33.2	80	32.3	

Post-Partum Haemorrhage	2016		2017		Trend
	Number	%	Number	%	
No	188	86.6	208	83.9	
Yes	29	13.4	40	16.1	

Blood Loss Amount	2016		2017		Trend
	Number	%	Number	%	
>1500mL	4	1.8	10	4.0	
<1000mL	198	91.2	230	92.7	
≥1000mL ≤1500mL	15	6.9	8	3.2	

Admitted to Neonatal Intensive Care	2016		2017		Trend
	Number	%	Number	%	
No	217	100	246	99.2	
Yes	0	0	2	0.8	

Neonatal Outcomes	2016		2017		Trend
	Number	%	Number	%	
Well Neonates	216	99.5%	247	99.6	
Neonatal Deaths	2	0.9	1	0.4	

Stillbirth	2016		2017		Trend
	Number	%	Number	%	
No	215	99.1	248	100	
Yes	1	0.4	0	0	

Small for gestational age	2016		2017		Trend
	Number	%	Number	%	
No	212	97.7	244	98.4	
Yes	5	2.3	4	1.6	

Feeding Method	2016		2017		Trend
	Number	%	Number	%	
Bottle	7	3.2	2	0.8	
Breast	200	92.2	245	98.8	

7. Quality Improvement

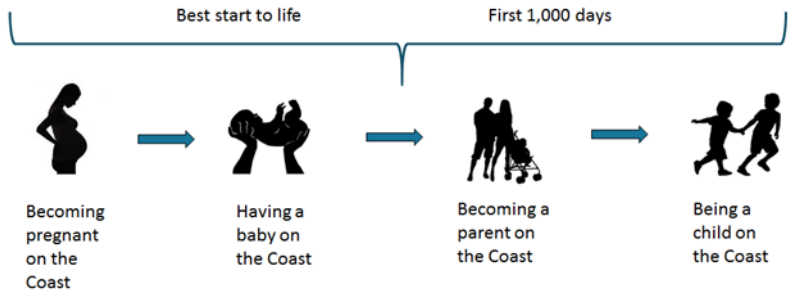
7.1 West Coast Maternity Strategy

In February 2019 the West Coast DHB hosted a co-design workshop to which a wide range of organisations and stakeholders were invited in order to review the current maternity journey from pre-conception through to parenthood and early childhood. In attendance were representatives from West Coast DHB Maternity Service, Canterbury DHB Maternity Services, Community Lead Maternity Carers (LMC), Plunket, Poutini Waiora, Māori Health, West Coast Primary Health Organisation (PHO), Paediatrics, Social Work, general practice, Violence Intervention Programme, Rural Medicine Specialist, Oranga Tamariki, Ministry of Social Development, Public Health Nursing, Sexual Health nursing, Community & Public Health and a good number of recent consumers and their babies.

PHOTO 14: MATERNITY HUI

The group were asked to identify what is working well as well as where are the opportunities for strengthening connections and developing improvements and the feedback was grouped into four life stages; becoming pregnant (thinking about being in the best position possible for a healthy pregnancy), having a baby (accessing maternity services and birthing on the Coast), becoming parents (making the transition as well prepared as possible) and becoming a child (looking at the hand over from maternity services to services such as Paediatrics and the Well Child Tamariki Ora (WCTO) programme.

The feedback from this session has formed the basis of our strategy; each of these life stages is interlinked with success at each point reliant on well laid foundations. Life course health outcomes for a baby born today are affected by; the health and wellbeing of their mother before she conceives; their time in-utero and childhood.



The overarching feedback from our workshops to date has been the need to connect maternity with the wider system but also, within maternity, to reduce siloes and welcome input from other agencies not in health. One of our key issues is poverty and the impact this has on the child, the woman and the pregnancy.

The draft strategy has been developed around four pillars of work to cover time from before a woman becomes pregnant to encourage her to be living a lifestyle that ensures she has good health and wellbeing, how we use our maternity services, and where these are located, as well as linking into the first 1,000 days (conception until a child is about 2 years old) and best start t life, so that whānau/family can provide the best for their child to thrive.

The four strategic themes are:

- Becoming pregnant on the West Coast
- Having a baby/pēpi on the West Coast
- Becoming a parent on the West Coast
- Becoming a child on the West Coast

In June 2018, the WCDHB Board gave their endorsement to share the draft West Coast Maternity Strategy more widely for feedback. In

PHOTO 15: BECKY & BABY GEORGE

sharing this we specifically acknowledge that there are gaps and areas that we haven't covered as fully as we'd like, notably addressing equity issues for Māori and other cultures needs to be better described. We have had initial meetings with our Māori women and plan to hold three Hui across the West Coast before November to discuss the draft strategy with our Māori population to ensure we the strategy is addressing their needs.

7.2 Maternal Mental Health Pathway (MMH)

During the 2018/19 financial year a major focus for maternity services was the audit of the West Coast maternity MMH and it was a quality improvement project undertaken using the Quality Improvement methodology.

The first stage of the project was to audit the existing MMH pathway, its use and effectiveness. The previous pathway was adapted from another's DHB's pathway for the West Coast environment; it had multiple flows and although it had relevant detail and pathways on it, it was not simple to follow. It also had the acute presentation of the woman at the top of the flow as the entry point. Maternity services needed to change that so that women who required low / medium levels of maternal mental health support could be offered that support before they got to the crisis stage.

A stocktake of the all health organisations and NGOs on the West Coast providing maternal mental health support was undertake. A database of WC based MMH providers was created which formed basis of the updated MMH referral pathway. To complete the quality cycle it is important to be able to measure if the changes you are making are an improvement, so data was required to form a baseline to determine if the updated pathway is making a positive different.

The Maternity Booking Form needed to be amended to ensure capture, at the earliest possible point, at booking with the LMC, treatment for current/past mental health condition, or family history of mental health treatment as these can be predictors of potential future MMH support being required. Working with the LMCS the project team updated the booking form to capture this data and also did other refinements to the form at the LMCs' request.

We are now collecting contemporaneous (current and ongoing collection at time) data indicating a woman's MMH state and whether she has been referred for support and has accepted this support. This provides us with an opportunity to check back as to how many of these referrals are being picked up. Interestingly the data is confirming the project team's theory that areas of higher deprivation correlate to higher incidence of MMH support being required. This may assist in future planning for where MMH support services are located to match the need. However, low numbers on the Coast require the monitoring of this data.

The updated MMH Pathway went through much iteration with feedback incorporated from a wide range of health professionals working with woman during their perinatal journey, consumers and NGOs before the final MMH was approved and went into use April 2019. The final pathway consists of one page, back to back, colour coded to indicate the level of support required for the woman. It also indicates the referral required at each level; self, health professional, whānau and on the flip side of the pathway the providers of each level match the colour coding as to level of support. This document has been provided to all LMCs, has been shared on our *website*, on Facebook, with all of the MMH providers and other agencies e.g. Police, WINZ, St John. It is attached as an addendum to this report.

The document has been put on the West Coast DHB document control list and will be updated annually to ensure details are current and correct.

7.3 Post-partum beds

Our operational nurse manager led a project to replace outdated beds, and we were able to get 5 new electric beds. Women are now able to find themselves the most comfortable position without calling the midwife to manually change the bed position.

PHOTO 16: POST-PARTUM BED

7.4 Improved data collection

We have a maternity data collection group that has been working really hard to make sure that the data collected is the most accurate. We meet regularly to analyse the data and since we started this group we have been able to achieve the following quality improvement initiatives:

1) Measure blood lost instead of estimating it;
2) Changed booking form to collect more data and make it easier to use and interpret;
3) Initiated a project to set up a birth after C section clinic (BAC) to be done by a core midwife.

Data we collect is shared with the Maternity Operations Group and provides us with the ability to identify trends.

7.5 Improved WCDHB Internal Website - Intranet

After analysing and discussing Safety1st (incident management system) incidents where access to our maternity and neonatal policies was not a straightforward process, we improved access to our policies under health areas and departments. An extensive piece of work was also carried out to ensure that our maternity policies could be easily accessed through health pathways (system used by general practitioners).

As part of the transalpine model of care we can access Canterbury DHB's maternity policies and procedures directly from within our local intranet.

7.6 Baby Friendly Hospital Initiative Accreditation

During 2018 both McBrearty Ward at Grey Base Hospital and Kawatiri maternity Unit at Buller Hospital proudly renewed their BFHI accreditation once again. During the process of achieving the accreditation we identified an area that could be improved:

- **Breastfeeding training** for all of our multidisciplinary team could be better organized and better documented. To address this, we initiated contact with an online training company, called Step2 Education and in 2019 we were able to provide access to breastfeeding online training to all of our staff members. Step 2 Education retains a database of staff completing the training.

7.7 Skin to skin

Our BFHI Audit also identified that the multidisciplinary team would benefit from more education about the importance and benefits of skin to skin, particularly in theatre, when babies are born by C/section.

The training brought the theatre team on board and now theatre staff are invested in promoting and protecting skin to skin in theatre and also in the recovery room. In order to do not disturb skin to skin a scale was located in theatre, so baby can be weighed immediately after C/section and have uninterrupted skin to skin, at least for the first hour of life.

7.8 Sterilisation of artificial feeding equipment

We were determined to change the way we sterilised the artificial feeding equipment for our babies. After many discussions and research we decided to move from using steriliser tablets to using a steam steriliser; much safer, kinder for the environment and on mother and baby.

7.9 Tongue Tie release pathway

We have now a solid and efficient tongue tie release pathway. Our lactation consultants do the diagnosis and support with breastfeeding, while two of our general surgeons do the tongue tie release if indicated. This has helped reduce unnecessary tongue tie releases and has also meant that babies can have this service provided closer to home.

7.10 Maternity Road shows

The Clinical Midwife Manager, Maternity Quality Co-ordinator and Director of Midwifery travelled to Westport, Reefton, Hokitika, Franz Josef and Greymouth late 2018 to actively listen to feedback from our West Coast mums about maternity care and services. We value the honesty of the women we speak to in telling us of their experiences of the services we provide.

The request for more breastfeeding support was mentioned by mums attending our roadshows and was a theme. An outcome of this was to formally support the position of Lactation Consultant. McBrearty Ward now has a Lactation Consultant working one day per week (Thursdays) holding appointments at McBrearty ward and also going out into the community for a couple of hours.

Initially we were aiming to take the lactation consultant services to the community and worked together with BIG (Breastfeeding Initiative Group) to put this project in place, however attendance was poor and we needed to revisit the project and find a more sustainable way to deliver lactation consultant support and advice.

7.11 Maternity Incident Review

Initially the incidents that occurred in the maternity setting were discussed at a general incident review meeting, with managers from various departments and services present. Despite being interesting, we looked at how we could make this work better. We trialled having an initial maternity incident review meeting with the Clinical Manager Midwife, Maternity Quality co-ordinator and Head of Obstetrics to discuss and review all the incidents looking for quality improvement opportunities.

Following this initial meeting if there is learning and relevance of the incident/s occurring within the maternity setting for the wider DHB multi-disciplinary teams we will share the results of our initial review with the wider team. This new format has been working well.

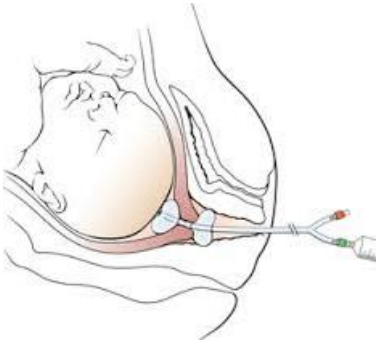
Initial review of incidents allows us to respond quickly to those more serious events that benefit from a staff Debrief and discussion of the timeline of events. Debriefs not only provide support for the staff involved in serious events, they also allows us as team to highlight how things could have been managed in a better way. We share our findings and recommendations with our maternity team in a constructive way.

7.12 Emergency C/section Review

All Emergency C/sections are reviewed and discussed and the clinical indication determined for each C/section. This discussion allows us to reflect on practice, provides an opportunity for learning, and creates great constructive discussions and reflections about our practice for all members of the maternity services team.

7.13 Cooks Balloon - IOL

An outcome of one of the maternity services discussion session was the introduction of the "Cooks Balloon" as an induction of labour method.



The Cooks Balloon is a non-drugs method that thins and opens the cervix (entrance of the uterus) in a mechanical way. We are offering it as a choice to all women, that for some reason require an induction of labour, and we recommend it for women that had a previous C/section or are at higher risk during pregnancy.

Since introducing this method for IOL, we have already achieved successful results for women that went through induction of labour and had a beautiful vaginal birth, after a previous C/section.

7.14 Consumer input into Maternity Operations

Consumer input on maternity services and care provided – We have now our consumer rep Anita attending the MOG meeting, and her feedback has been essential and very valuable. It's great to have the voice of the consumer at our meetings to keep our focus on our women in the decisions we make. We've been working on how to get more meaningful feedback from our Mums.

7.15 West Coast Smokefree Pregnancy and Newborn Incentives Programme

This Programme incentivises women and their partners to be smokefree during the pregnancy by providing them with grocery vouchers at various stages of being registered on the programme and also post birth. We know it is difficult for women to give up smoking if their partner continues to smoke, so early on partners were included in the programme.

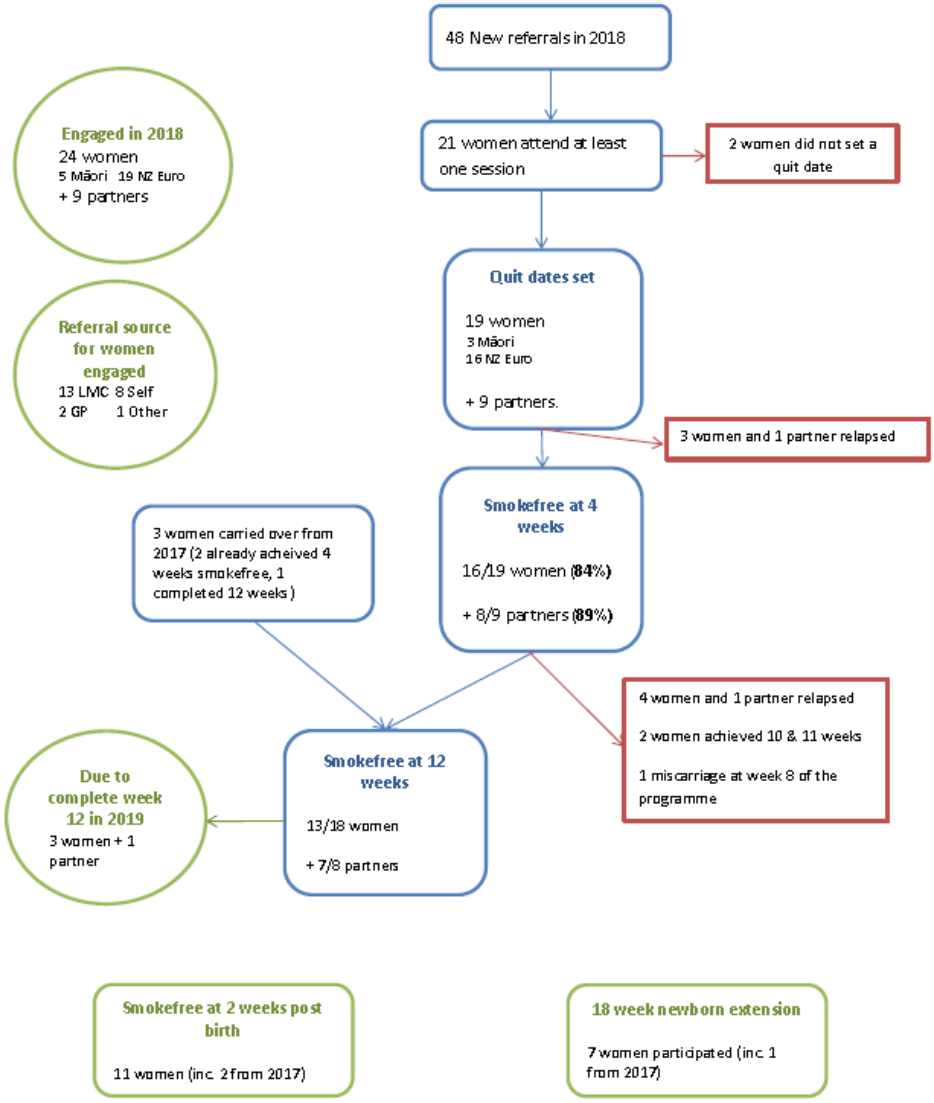
Initially the incentivisation programme finished at 2 weeks post birth, however we were aware that some women were taking up smoking again at this point. In an effort to redress this and in line with our West Coast

SUDI Prevention Plan we extended the period of incentivisation in July 2018 to 18 weeks post birth, for the woman and her partner. Smokefree tracking forms are included as an Addendum.

Programme Uptake during 2018

There were 48 referrals to the programme during 2018:

- 24 women and 9 partners were involved with the programme during 2018.
- The 18-week newborn extension phase was available for mothers from July onwards (and was extended to include partners from February 2019).
- 19 women and 9 partners set quit dates during the year; 16 of the 19 women and 8 of the 9 partners were abstinent at 4 weeks.
- 13 women and 7 partners completed the 12-week programme during the year, with a further 3 women and 1 partner going through to 2019.
- For the 12 week programme, the 'weeks of achievable abstinence' rate was 83% for the women and 84% for partners.
- 11 women received a 2-weeks post-birth $50 voucher. 7 women participated in the 18-week newborn extension phase (available from July onwards).



[1] For Health Target reports Q3&4 2017/18 and Q1&2 2018/19 there were 32 women who reported smoking when registering with an LMC

8. Introducing Our People / Our Team

Catarina Morais – Clinical Midwifery Manager

As a clinical manager midwife I have the privilege to work with an exceptional multidisciplinary team, that very often place themselves outside of their comfort zone to provide an excellence of care to our families, women and babies. It has been exciting to get to know the strong and resilient community of our stunning West Coast.

Being Clinical Manager for West Coast maternity services has been a very interesting and rewording experience. Despite doing a management role I have been able to do clinical work whenever needed and on Christmas Day 2018 I had the opportunity to be the lead midwife at a very magical homebirth in Hokitika.

Being a small team inserted in such a strong community has the advantage of implementing change in a faster and effective way. It didn't take me long to know everybody, their roles and it is lovely to be able to address everybody by their names. It is so much nicer to be able to have constructive discussions face to face, instead of facing a train of emails.

We certainly had a busy year with plenty of changes, improvements, training and learning experiences, passionate discussions and team effort. As a large DHB family we did share difficult and happy moments, always supporting each other. The West Coast became my home and the place where I am about to became a mother.

Projects and achievements for 2018

Countdown donations 2018

With the support from Countdown, during 2018 we were able to purchase:

- **Neonatal resuscitation trolley** – having a neonatal resuscitation trolley made the team more effective and efficient on responding to neonatal emergencies. All the material needed in a neonatal emergency situation can be found easily in the neonatal trolley.
- **Transcutaneous Bilirubinometer** - allows staff to check the bilirubin levels (jaundice) without the need to collect blood from the baby, so less invasive and distressing for both baby/pēpi and mother.
- **New baby cots** – we were able to replace old bassinets that were infection control unsafe.
- **Birthing stool** –new birthing stool allows women in labour to adopt many positions and can also be used in the birthing pool.
- **2x suturing stools** – we were able to replace the old metal suturing stools with 2 new, very comfortable and easily adjustable stools.
- **Camera and printer** – with this we are able to provide memories for parents who have unfortunately lost their babies. We can now take and print photos of the baby and give it to the parents before discharge.

Thanks Countdown!!!

PHOTO 19: RESUS TROLLEY

PHOTO 20: BIRTHING STOOL

PHOTO 17: STERILISER

PHOTO 21: MEMORIES KIT: PRINTER AND CAMERA

PHOTO 18: SUTURING STOOLS

Countdown "Wish List" for 2019

The following items are on our wish list for 2019 countdown funding:

- **ISTAT machine** – if, during labour or at birth a baby shows signs of distress we collect blood from the umbilical cord and send it to the laboratory or ED departments to be tested. When we do this procedure the ideal is to have the cord blood processed and the blood results as soon as possible. With this ISTAT machine we will be able to test the cord blood at the bedside and have the results immediately. If results show that a baby was distressed we contact the neonatal team and discuss the best management of care for that baby, giving treatment or transfer to a tertiary centre as soon as possible.

- **Birthing couch + birthing matt + ottoman** – this will allow women to mobilise and be more active during labour, increasing the chance of achieving a vaginal delivery.

Thanks to our Wonderful Community

PHOTO 22: THANKS "STITCHES"

During the course of the year we received gifts of beautiful knitting that we can provide to the Mums coming into McBrearty ward. Pictured below is some of the beautiful knitting we received. Thank you!!

PHOTO 24: THANKS KOTTAGE KNITTERS

PHOTO 23: THANKS CAROL MCALPINE

Linda Monk – Midwifery Educator

Education Provided in 2018

In 2018 we welcomed our new Maternity manager Catarina Morais. Catarina came to us originally from Portugal, but had been working in a number of different countries including the UK, Switzerland France and then Auckland City hospital & Middlemore hospital.

Newborn Life Support Courses - NLS

Kicking off the year I continued to run our Newborn Life Support Courses every 1st Tuesday of the month. This is a three hour update course. We cover resuscitation of the newborn in the first minutes of life, practice airway management, ventilation and chest compressions and practice different scenarios that may be encountered with new-borns.

Over the year 50 people attend the NLS course. All new RMO's attend this course as part of their orientation to the WCDHB. Registered nurses from various wards across the hospital including Parfitt (Paediatric) and the Emergency Department also attended. It is good to see that this is still a popular course and well received by those attending. Some of the feedback received:

"Great update on the resuscitaire."
"How to use Neopuff and ventilation skills helpful"

Feedback from 2018 NLS Course Participants

Maternity Case Review

Senior Midwife, Denise Stacey co-ordinated Maternity case reviews throughout the year; reviewing interesting cases from previous months. All core and community based midwives and senior consultants are invited to case review which was well attended by most of the LMC midwives, core midwives, student midwives and our two RMOs. Brisk discussions were held regarding women's outcomes, what could we have done better and what would we change.

Journal Club

Journal Club was held regularly throughout the year (dependent on ward occupancy). Topics covered included:

- Individual risks of stillbirth at advanced maternal age; a literature review of evidence.
- Effects of Cryotherapy on relief of perineal pain after vaginal childbirth with episiotomy - A randomised and controlled clinical trial.
- Singleton breech presentation at term.
- A prospective cohort study of freestanding midwife led primary maternity units in NZ Clinical outcomes

Emergency Skills Day

As an approved education provider for the New Zealand Midwifery council Linda held 3 combined Emergency skills day in 2018 as part of the compulsory recertification for all midwives to attend annually to keep their practising certificate current.

The midwives enjoy getting together with other midwives in a non- threatening environment, practicing new and old skills and they come away with a greater awareness for recognising emergency situations and acting on them. The emphasis for this year was on teamwork. This meant focusing on clear communication, clear roles, shared decision making and working together. Having a team leader who can organise the team delegate tasks

and responsibilities, make changes during the emergency and step back and see the whole picture (helicopter view) is an important part of a great team work as well.

Helicopter Safety Training

Annual helicopter Safety training update for midwives was held 22nd March. In the morning was a 2 hour course for new midwives and the afternoon session was a one hour refresher for previous attendees. But, alas as in the line of duty the helicopter got called out on an emergency and the afternoon session was not able to go ahead.

IOL Guideline Update

In March we updated the Induction of Labour guideline and had a visit from the Pharmaco Rep that distributes Cervidil (one option we use for ripening the cervix in an induction). We also had a demonstration about the Foetal Pillow. This is inserted into the vagina and blown up to elevate the foetal head during caesarean section. This can help reduce foetal morbidity.

Loss and Grief Workshop

On Friday 13th April West Coast Maternity services held a workshop on Loss and Grief. This workshop was aimed at health professionals, both clinical and non-clinical who deal with pregnancy and post natal loss and grief in their working environment. This was held at the St John Ambulance Headquarters. Around 40 people attended the workshop throughout the day, with attendees from a wide range of organisations attending including: Plunket, Poutini Waiora, community based Lead Maternity Carers, EAP, Family Start, Gloriavale Christian Community, West Coast PHO and West Coast DHB staff representatives from the following specialities: public health, surgical ward, theatre, paediatrics, maternity, quality, social work, mental health.

Dr Vicki Culling, Loss and Grief Consultant was the keynote speaker. Her first daughter was stillborn at 10 days overdue – an experience which led her to utilise her skills in supporting bereaved parents and families and educating health professionals. Vicki has worked actively at both the national and local levels of Sands.

Vicki was a founding member of the national Perinatal and Maternal Mortality Review Committee (PMMRC) set up in 2005 and charged with collecting data on perinatal and maternal mortality and morbidity in NZ. She has been involved with the International Stillbirth Alliance (ISA) from 2005-2011. Vicki is currently a member of the HQSC's Consumer Network, and a member of the Ministry of Health's Maternal Fetal Medicine Governance Board. She also works as a lay reviewer with the Medical Council of NZ and the Dental Council of NZ. We were also fortunate in our other speakers and topics covered included:

- Perinatal Maternal Mortality Review - Di Leishman, PMMRC Rep, CDHB / Denise Stacey, PMMRC Rep, WCHDHB
- Maori Culture with respect to Loss & Grief - Gary Coghlan, Manager Maori Health
- Other Cultures / ethnicities and considerations to Loss & Grief - Vicki Culling, Loss & Grief Consultant
- SANDS - Melanie Tarant, SANDS Grey/Westland
- Maternal Mental Health and Loss / Grief - Jose Timmerman, Social Worker, Community Mental Health
- Maternity Services Social Worker – My Role; Desma Reedy, Maternity Services Social Worker
- Loss & Grief: the role of the Undertaker - David Neame, Westland Funeral Services

Below are some of the comments from the Evaluation forms filled out by the participants. These have been collated by Vicki Piner our MQ&S Co-ordinator.

A sample of workshop Attendees comments on what they would now do differently, after attending the Workshop:

- Allow more time to patients to talk and listen
- Ask the parents more as to what they want

- Be more confident in offering support
- Bring increased mindfulness to client's loss
- empathy, empathy, empathy
- I will never say "at least" or "on the bright side"
- Listen, be empathetic, proceed slowly, gently ask again
- More aware of Maori Culture
- Remember to celebrate anniversaries with women and talk with them again about their babies
- Use the name of the baby who is no longer present

Sample comments on what Workshop Attendees enjoyed the most

- The fact that many of the speakers shared their personal stories
- Listening to all the different journeys that the speakers have been on
- The openness and sharing of people's personal experiences
- A reminder to bring relevance and acceptance to work with all clients
- The wonderful information and presenters
- Story telling / experiences
- Thought provoking with some statistics. Personal.
- Stats - interesting. This was the first time I heard from a funeral director's view; that was great

PHOTO 25: CELEBRATING SAFE SLEEP DAY

All attendees felt that the content and presentation was informative.

Foetal Surveillance Education Programme (FSEP)

On the 24th April we held a full day FSEP (Foetal Surveillance Education Programme). This is run by RANZCOG and was facilitated by Issy Eadie a midwife working for RANZCOG. This was attended by 18 Midwives and our two O&G consultants and topics for this course included

- Fetal physiology,
- CTG Interpretation& management
- Maternal monitoring and the complete picture

The midwives value this course because it is something they do frequently in their role so it is important to be able to correctly interpret CTG's.

Breastfeeding Study Day

We connected via video connection into a Breastfeeding Study day run by Carole Bartle at Christchurch Women's Hospital. A total of 6 midwives attended and this is part of our ongoing Breastfeeding Education. Topics Included

- Donor mil & Milk Sharing
- New Research and Contemporary News
- Focus on Step $ Skin to Skin
- "the Code" Formula & Bottles

STABLE Workshop

On the 23rd & 24th May Maggie Meeks and Bronwyn Dixon, Neonatologists from Christchurch Women's NICU ran our annual STABLE (Post resuscitation/ Pre transport Stabilization Care of sick Infants) Workshop. This was held in Westport at Kawatiri Ward with 17 Participants; a mixture of midwives, RMOs, Registered nurses and Medical students. With this knowledge and skills we are able to make the journey of the sick neonate to CWH NICU as smooth as possible.

Sitting Comfortably & Let's Consider Perineal Trauma

Another workshop attended via video conferencing from Christchurch was "Sitting Comfortably & Lets Consider Perineal trauma." We had 8 midwife attendees.

Turaunga Kaupapa – Cultural aspects of Breastfeeding

Robyne Bryant facilitated a Turaunga Kaupapa talk on Cultural Aspects of Breastfeeding. This is a compulsory component of our BFHI (Baby Friendly Hospital Initiative) and was part of our education to maintain this status in our facility. All maternity staff attended this. The talk was available on video so those unable to attend on the day were able to watch it at a time convenient to them.

PHOTO 26: MILLIE TUPUNA WAIPOURI

Baby Friendly Hospital Initiative

We underwent audit to retain BFHI status on 15th August by the accreditors. We were again successful in retaining our baby friendly unit status until review on 1st August 2022. Credit must be given to the hard work put in by or lactation consultants and the enthusiasm of the staff to always better our breastfeeding rates.

Professional Obstetric Multi-Professional Training (PROMPT)

Our popular PROMPT (Professional Obstetric Multi-Professional Training) workshops were held in June and September this year. The PROMPT team continue to put together a fun filled day of lectures and emergency scenarios for the participants. These include midwives, RMO'S and registered nurses.

Video Conferencing with Neonatal Team at CDHB

We updated the midwives skills on using the Parfitt (paediatric ward) video conferencing unit in McBrearty Ward for when we have a sick baby that requires consultation with the tertiary based neonatal team. This was as a follow up from recommendation of incident review, thus closing the quality loop.

Power to Protect

On July 24th we held "The Power to Protect" (formerly Shaken Baby prevention Programme) - Kati Wilson was the presenter. She talked about abusive head trauma in shaken babies and the power to protect for one hour. She then held a workshop for attendees to have the knowledge to provide the shaken baby prevention programme in their own department, practice or organisation. In McBrearty we provide the opportunity for all women and their partners post-natally to watch the video and give them information about Shaken Baby prevention.

There were some alarming statistics to come ou.t Abusive head trauma is the leading cause of head injury in under 2 year olds. Approximately 20 babies a year are diagnosed (these are the ones that present to hospital) with Shaken baby syndrome. 1in 5 who present to hospital will die.

Safe Sleep Workshops

At the end of August we held a number of Safe Sleep workshops, one in Westport and two in Greymouth. Dr Nick Baker, Nelson Paediatrician conducted these workshops. They were informative, interactive and he discussed all the latest statistics around SUDI and safe sleeping.

Sample feedback from participants included:

- More information to give parents, possibly frame questions? Discussion differently.
- I will be able to include all the information to my clients to support their choices and decisions around safe sleeping
- I can use this knowledge in my work with families, their babies and young children.
- Learning lots of new information around risk factors and infant survival rates.
- Better knowledge of specific risk factors and what to look for in terms of safe sleep space.

Regular use of equipment practice

We received a new B450 monitor from Countdown funds to use on our neonates who need stabilization prior to transport or just increased monitoring. This monitor is mounted on the newborn resuscitaire in our NICU. Our staff learned how to use all the various equipment that goes with this monitor and how it should be applied to a baby.

To be able to better care for our sick babies, we also had some training in the use of the ISTAT machine. By using the ISTAT machine in our ward we can have instant results for blood tests on our sick babies and initiate the appropriate care sooner.

Barbara Roberts, Newborn Hearing Screener

Universal Newborn Hearing Screening Early Intervention Programme

Newborn hearing screening has been offered to all babies since December 2009 (10 years in December. There are two screeners providing this service at the moment,. However another screener was trained at the end of last year to support the team. During June,

In June I had a catch-up with Gurjoat Yraich (head audiologist Christchurch Hospital), re getting the screening results on Health Connect South so all DHBs and Canterbury Audiology have access to them. All the data forms for this year have been loaded onto the South Island wide clinical system now. Sometimes a baby is born in another DHB and transfers back to the West Coast to be screened. With the results on HCS the other DHBs can see screening results if need be.

A small number of babies were referred to Audiology last year. One baby was profoundly deaf and now has cochlear implants and others have required hearing aids. Parents are always very grateful the diagnosis and treatment has been made early in the baby's life.

Denise Stacey, PMMRC Rep

Perinatal and Maternal Mortality Review Committee Representative

I am a core midwife at Grey Base 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 DHB's 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 also do Maternal Case reviews monthly if able for our midwives, LMC's and Obstetrician's. Looking at interesting cases and looking 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-judgemental way

PHOTO 27: SAFE SLEEP DISPLAY

Janette Greaney, Safe Sleep Co-ordinator

Safe Sleep Co-ordinator

As part of my role, I ensure that all women birthing in our maternity unit have had a discussion regarding safe sleep practices for their babies/pēpi prior to their discharge home. I check that they have woollen blankets and a suitable sleeping space e.g. bassinette for their baby to sleep in at home. I discuss the risks of bed sharing, smoking, the benefits of breastfeeding and assess the risk factor for that baby. If needed a pēpi pod is provided to the mother.

Once safe sleep has been discussed a safe sleep audit form is completed. The data from these forms is collated and provided to the South Island Alliance. The Co-ordinator maintains our stock of pēpi pods and gifts approximately 4 per month to families.

Bev Sinnott, Lactation Consultant

International Board Certified Lactation Consultant (IBCLC)

My name is Bev Sinnott and I am an International Board Certified Lactation Consultant (IBCLC). As an IBCLC I provide expert breastfeeding and lactation care, promote changes that support breastfeeding and help reduce the risks of not breastfeeding. I advocate for breastfeeding as the norm for babies and toddlers.

My role is also to function and contribute as a member of the maternal-child health team. I provide care in a variety of settings, while making appropriate referrals to other health professionals and community support resources. Working together with mothers, families, policymakers and society, I am also the BFHI Coordinator for the WCDHB where I maintain, evaluate and lead the ongoing development of the Baby Friendly Hospital Initiative (BFHI) to meet BFHI accreditation and certification requirements.

Job satisfaction as an IBCLC? As the old saying goes:

"If you love what you do, you'll never work a day in your life."

Helen Turner, Kawatiri Unit Manager

Kawatiri maternity unit provides primary maternity services for pregnant women who live in the remote rural Buller region. Approximately 60% of these women live in Westport leaving around 40% of women who live between Karamea and Springs Junction, an area covering 7,953km^2.

During the period of 1st July 2018- 30th June 2019 - 28 women in Buller were planning to birth at the primary unit with the remainder choosing to birth in Greymouth, Nelson or Christchurch for either personal or medical reasons. During this period we had 18 births at Kawatiri Maternity unit, 3 of who were first time mothers, we had 2 transfers in labour to Greymouth and 9 women chose to transfer to Kawatiri for their postnatal care.

At Kawatiri Maternity facility LMC midwives hold their daily antenatal clinics and obstetric clinics are held once a month. The facility also offers free whooping cough and flu vaccinations, cervical screening, monthly physiotherapy classes, monthly Babes in Arms breastfeeding support group and Plunket antenatal classes.

Since November 2018 the Kawatiri clinical midwife has been attending monthly Obstetric clinics at the Kawatiri maternity facility. Held within the familiar and family-friendly setting for women and having a midwife in attendance assists with a women-centred care approach, facilitates the effective transfer of information and assists in gaining the informed consent of women attending.

Education

Education completed by Buller midwives during 2018/2019 includes:

- Emergency skills workshop as a requirement for the New Zealand register of midwives;
- Fire safety training;
- Safe sleep education;
- Breastfeeding education and the Buller Birthing Practice LMC midwife also completed the 'Broken Sleep' online breastfeeding conference.

PHOTO 29: MEIKE & HELEN

Baby Friendly Hospital Initiative

In 2018 Kawatiri maternity unit achieved the Breastfeeding Friendly Hospital Initiative status for the fourth year running. We were presented with a certificate and kōhatu award for our commitment in keeping this standard and we celebrated this achievement with women and their babies from our community.

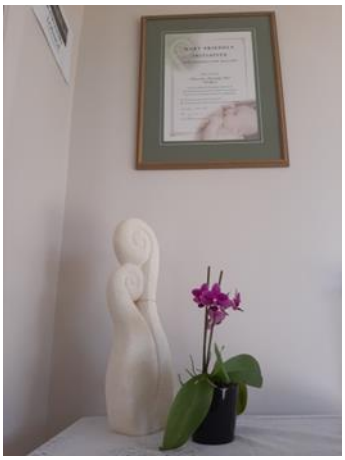


PHOTO 28: KOHATU

Certification Audit

In February 2019 Kawatiri maternity unit was audited by the Ministry Of Health. The auditors were very pleased with our unit and reminded us to ensure that separate mother and baby notes are maintained. Following this a quality initiative was enacted to ensure that inpatient neonates have their own set of clinic notes that are to be completed by midwives and Foote ward (hospital) nursing staff. These notes are then sent onto clinical coding for a separate file to be created to ensure each child's medical records include birth information.

Improved Data Collection

Other quality initiatives include updating booking spreadsheets to ensure that all women are connected with women's health and antenatal education programmes; keeping a record of when and why artificial 'ready to feed' formula is used within the facility; and a 'birth care' checklist to ensure that quality and safety standards are maintained when the role of Kawatiri midwife is delegated.

PHOTO 30: GRACE DELILAH JEFFERIES 13/4/19

Feedback from women who use our facility is very positive, they enjoy the quiet and relaxed atmosphere, spacious rooms and use of the lounge and kitchen for when family/whanau visit.

A big thank you to Voice for Life Westport and other dedicated knitters who have provided us with knitted hats and booties over the past year, our mother and babies greatly appreciate these gifts.
Grace Delilah Jefferies. Born 13.04.19

June 2019 has seen Helen Turner take on the Management of Primary Maternity Services. Helen has been an LMC in the Buller region for the past 3 years and has taken over from Mieke Siebelink who is now ready to focus on providing LMC services in Buller.

PHOTO 32: ELOQUENCE TURNER & RITA MCGAVESTON

Helen Turner gave birth to a baby girl at her home in Buller in early April this year. Helen and baby Eloquence, who is usually snuggled up close in a baby wrap, have been providing clinical midwifery care for Kawatiri and back-up care for LMC Mieke Siebelink.

Eloquence is pictured here helping her mum complete a postnatal assessment on baby Rita McGaveston.

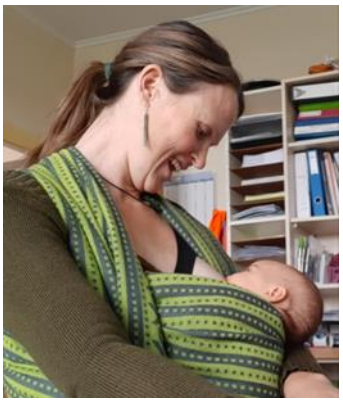


PHOTO 31: HELEN & BABY ELOQUENCE

9. Maternity Services Focus 2019/20

9.1 Maternity Strategy

During late 2019 we are undertaking further consultation with our Māori community, both consumers and workforce, regarding the West Coast Maternity Strategy. The purpose of this further work is to ensure our kaitiaki and wahine Māori feel connected to the strategy and are comfortable that it sets the direction for reducing the health inequalities that exist within maternity care for this community.

9.2 Consumer Engagement

Maternity Services Feedback Form

Over time the response rate to our maternity services feedback form has declined from around 35% to 17%. To increase the feedback provided by our women we spoke to women to identify what was impacting on them providing feedback and when and how they would prefer to provide feedback on our services. Contact was made via Facebook, emails (to our consumer group) and interviews conducted with women on the wards and out in the community. Overwhelmingly women would prefer to either complete a feedback survey whilst in the ward ("while we're there we might as well provide feedback we've got time before we go home") or to do it later online.

During the 2019/20 the Feedback form is being changed to a more simplistic format that can be done online or by hardcopy with core questions:

- What was the most important issue to the woman/her whānau
- What were the best things about her care? *(What should we continue to do)*
- How could we improve the service we provided?

Consumer Regional "Hubs"

During the maternity roadshows of 2019, we identified groups of women interested in becoming part of regional maternity consumer hubs. We're exploring this more during 2019/20 with the idea of going to our women in each of the regions with specific issues / initiatives we'd like their feedback on. This is still in the early stages, however we're clear we need the voice of our consumer more in our planning.

We want more of our young, Māori women to be informed, engaged and part of our maternity services planning. We know if we get it right for Māori we get it right for everyone, so as part of the setting of the regional consumer hubs, we will be engaging with our Māori women / whanu.

9.3 Move to new Maternity Facility

During 2020 we'll be moving to the new maternity facility at Te Nikau, Grey Base Hospital. We're very excited as we have a beautiful space in the new hospital. The following photos show almost complete maternity facilities as at the time of printing (September 2019), however please be aware that there are no furnishings in these rooms as yet.

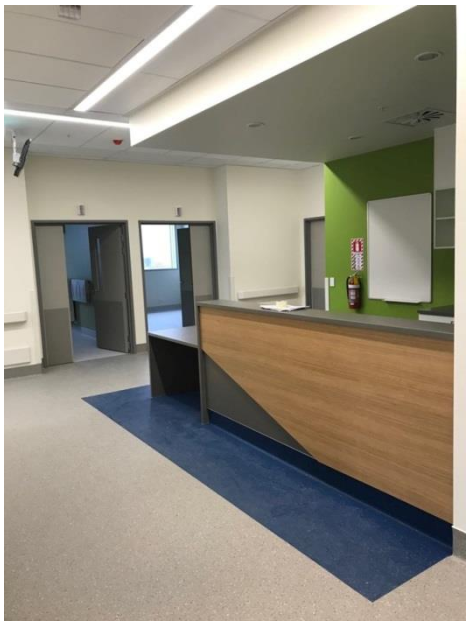


PHOTO 33: RECEPTION AREA

PHOTO 35: BIRTHING ROOM

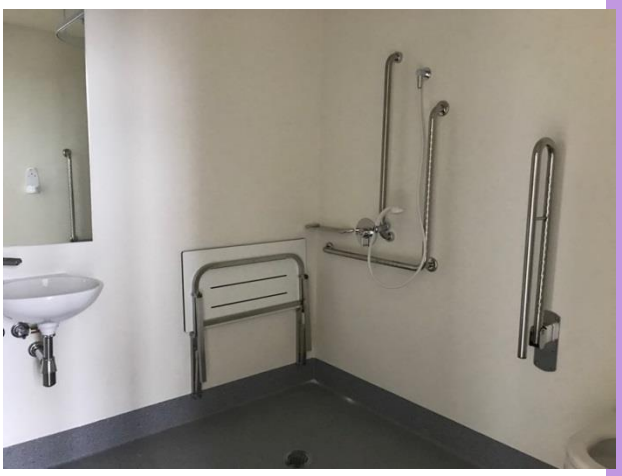
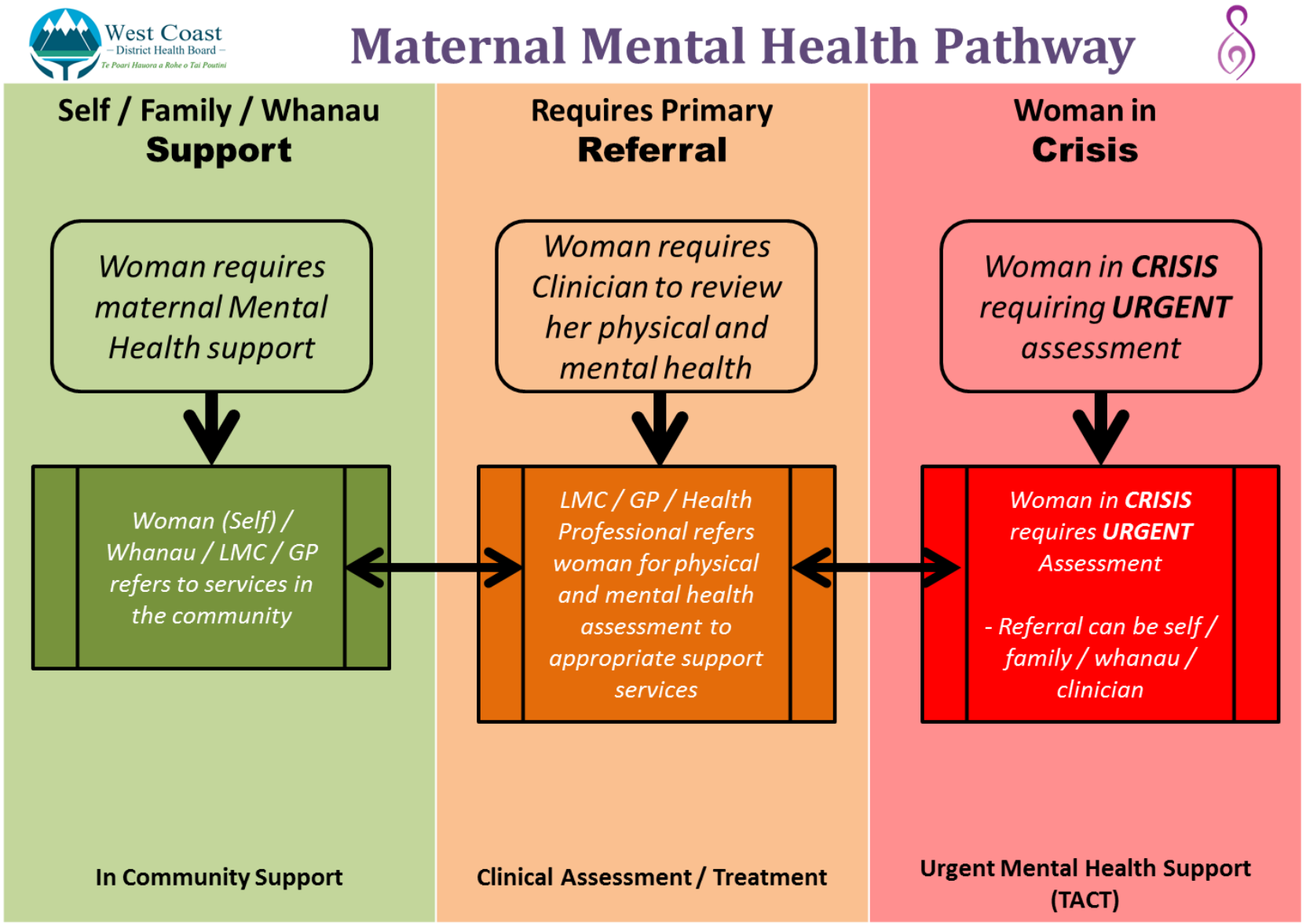


PHOTO 34: ENSUITE

PHOTO 36: ROOM WITH A VIEW

Addendums

Addendum 1: Mental Health Pathway



Services / Support available listed on back of this page

Maternal Mental Health Pathway – Services / Support available for Pregnant / Postnatal Woman

Support — In Community SUPPORT

General Practitioner (GP)		Coast wide	Clinical review, diagnosis, risk assessment and referral to other agencies e.g. PHO for counselling.
Emerge Aotearoa	(0800) 000 029	Coast wide	Community based support service that promotes recovery and community involvement for people experiencing mental health issue or addiction.
Infant and Toddler Specialists	(03) 768-4914	Buller, Grey, Hoki	Provide clinical infant mental health interventions in the social, emotional and cognitive wellbeing of the baby / toddler within the context of a caregiving relationship.
PACT West Coast	(03) 768 6660	Buller, Grey, Westland	Mental Health and addiction support for parents / caregivers.
Poutini Waiora	(0800) 333 170	Buller, Grey, Westland	Counselling; alcohol and other drugs, Mama and Pepi; promoting bonding for newborn babies up to 2 years age.
Sands - Melanie Tarrant www.sands.org.nz	(027) 752 8289	Coast wide	Support for those experiencing pregnancy, baby or infant loss and support for pregnant mums after experiencing loss.
Cornerstone Family Support	(03) 768 4290	Coast wide	Home visits or at private whanau rooms; education, information, liaison with WCDHB mental health services and other appropriate permissions e.g. family start.
Family Start	(03) 768 6568 Press "2"	Coast wide	Intensive home visiting parenting support that focuses on the parent-child relationship and child development from pregnancy until 3 years of age; also supporting families to access welfare, health, education and other necessary services.
Homebuilders West Coast Trust Wpt: (03) 788 8065 Grey:	(03) 768 6665	Grey & Westport Offices	Home based support service for families / whanau facing difficulties, needing support and / or wanting to make changes in their lives; counselling, parenting programmes. Support for families.
Potikohua Trust (No. 37)	(03) 789 6000	Buller	Provide drop-in support and services to women and their families including private counselling, seminars and events.
Presbyterian Support	(03) 768 7158	Buller, Grey, Hoki	Single parent benefit administration, services where violence is a factor in the relationship.

Phone support available 24 hours / 7 days a week

Healthline (0800) 611 116 Free advice and information from a registered nurse — Plunketline (0800) 933 922 Free Parenting support

Referral — Clinical Assessment / Treatment – *requires* REFERRAL

General Practitioner (GP)		Coast wide	Clinical review, diagnosis, risk assessment and referral to other agencies e.g. PHO for counselling.
West Coast PHO	(03) 768 6182	Grey & Westport offices	Brief Intervention Counselling during pregnancy and the postnatal period **(requires GP referral).**
Adult Mental Health Teams		**Buller (03) 788 9234**	**Greymouth (03) 769 7805** **Hokitika (03) 756 9700**
In-Hospital Support: x2924 social worker		Grey Base Hospital **For Inpatients Only**	Provide advice and support about the appropriate course of action. Provide referral to other agencies.
Sth Island Mothers & Babies Service **(03) 337 7708** ***Christchurch based Inpatient service & Consultation***		***Requires Referral from WC MH Services***	Consultation with WC MHS and Inpatient treatment where appropriate. Available for GP phone consultation (after referring to Perinatal Mental Illness in Community HealthPathways).

CRISIS — URGENT mental health support for woman in CRISIS

Triage, Assessment, Crisis, Treatment (TACT) **(0800) 757 678**	Coast wide	Based in Greymouth, but providing Coast wide support, TACT operates from 8 am until 9.30 pm every day. On call staff available after hours for crises **OR** present to A&E for mental health assessment.

Authorised by: West Coast Maternity Services — Review due: June 2020

Addendum 2: MQSP Work Plan for 2019 / 2020

Initiative / Priority		Action	Expected Outcome	Measure
1	Encourage, increase and monitor involvement of consumer members in WCDHB's MQSP	Improve communication systems for consumer representatives to provide input into the MQSP programme and maternity services delivery	• Establish regional Maternity Consumer "Hubs" with members representing West Coast regions – four regional hubs (Grey, Buller, South Westland, Reefton) • The hubs are established by involving Tangata whenua at the outset to ensure that the way their meetings are held is inclusive to all • Consumers are representative of our birthing population age • Increasing Consumer representation on Maternity Operations Group including participation by Tangata whenua • Visit Gloriavale at least once annually • Utilise social media as a forum for consumer voice to both distribute and provide information two way • Refine the maternity feedback form in a variety of mediums so it is easier for women to provide feedback	• Four regional hubs established by quarter 3 (end of March 2020) • Māori are represented in each of the four regional hubs by February 2020 • Quarterly meetings held from March 2020 with all consumer groups facilitated from a different West Coast venue within the community supported by Video Conference (4 meetings per year held regionally) • Increased understanding by community about accessing services • Increased rate of feedback from women and their whanau(above 30% response rate)
2	Maternity Strategy		• Involvement of Tangata whenua to ensure the strategy addresses equity issues • Further development of the strategy to ensure rurality equity issues have been addressed • Strategy ensures women and their whanau on the West Coast access maternity services easily	Hui held in three parts of the West Coast as part of consultation for the strategy by December 2020 Maternity Strategy finalised
3	Workforce Development and Education	Provide education to all clinicians working in the maternity setting so they are proficient at screening women and are aware of local services and pathways for: • Family Violence • Smoking • Alcohol and other substance abuse • Maternal Mental Health Pathway Cultural Competency education provided to Workforce Multi-disciplinary FSEP provided by the DHB	• All health professionals in the maternity setting are able to screen for family violence, smoking, alcohol and other substance abuse effectively. • Health professionals and the communities are familiar with referral process and how they can access these services • Māori Health Team to encourage all LMCs to participate in the Takarangi Cultural Competency Framework and aligning it to the Turanga Kaupapa 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	Audit provides evidence: • That at least 70% pregnant women accessing maternity services are asked questions about family violence • Audit identifies appropriate referral for women indicating exposure to FV • 90% of pregnant women identifying as smokers upon registration are offered brief advice and support to quit smoking • Referral numbers to Smokefree Pregnancy and Newborn Incentive Programme indicates increase in referral (48 referrals in 2018) numbers • Women report that the services and staff they

Initiative / Priority		Action	Expected Outcome	Measure
		for all clinical staff working within maternity services and facilitated for all community based access holders Newborn Life Support and emergency skills education through PROMPT run regularly across the West Coast Education that responds to improvements noted through quality assurance activities, review of our data and outcomes and review of any sentinel events across maternity Create a workforce plan for high quality maternity care in our rural setting	appropriate to their setting. Fetal surveillance training includes: • Risk assessment for mothers and babies throughout pregnancy as well as intrapartum • Support and promote professional judgment, interdisciplinary conversations and reflective practice • Identify key stakeholders to support the development of a South Island Maternity Workforce Plan to support undergraduate education and workforce planning to better meet the future demands of our population. • Further development and refinement of the Rural generalist model and how it works in maternity • Recruitment and retention of both midwives and obstetrician permanent staff. • Maternity locums secured for the workforce across the West Coast	encountered when pregnant acknowledged and respected cultural differences that exist in our communities At least one session on cultural competency per year is delivered to staff working in maternity services 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 Conduct an audit of our workforce to try and determine staffing over next 5 years in regards to planning for retirement etc Work with the South island Alliance in regard to education of more midwives Continue to work on the West Coast and across the Coast to develop rural generalist model with understanding and skills to assist in maternity across the rural / remote rural areas
4	Identify women with modifiable high risk factors for perinatal related death and work individually and collectively to address these	Review and update educational and promotional material including online resources to promote: • Uptake of peri-conceptual folate • Pre-pregnancy care for known medical diseases such as diabetes • Healthy BMI pre and during pregnancy • Access to antenatal care • Accurate height and weight measurement in pregnancy • Antenatal recognition of fetal growth restriction • Identify women with previous uterine surgery prior to ultrasound (NMMG) • Identify women who have had preterm babies and/or pre-eclampsia previously • Indian women	• Women and Health professionals have access to and are accessing online resources • Review the health information resources provided to women in early pregnancy with a view to replacing the Bounty Packs. • Discussions when working with the consumer groups in all our hubs in regard to how best to share this information across our community • Information is up to date and accessible in appropriate formats (paper / electronic) • Information / engagement is appropriate for women of priority ethnicities e.g. Māori, Pacific, Indian. • Appropriate referrals to tertiary provider for women identified as at high risk and specifically utilising technology for these ongoing discussions so women feel supported not only by the West Coast services but also the tertiary centre • Communication between DHBs provides for seamless	Review of referrals to tertiary sector indicate that they are timely and appropriate and that referrals are early in the pregnancy • Hits on Website / Facebook and feedback from consumer groups indicates women are accessing information • Audit of women with previous uterine surgery indicates appropriate management throughout their pregnancy • Facilitate closer working relationships with NGOs for staff working within maternity services to engage our priority ethnicities • Engagement with women who we know can have poorer maternity outcomes for themselves and their babies are engaged in our maternity system and

Initiative / Priority		Action	Expected Outcome	Measure
		Women are encouraged and supported to live smokefree	follow up of WC women referred to tertiary provider on their return to the Coast in the hub and spoke model • Women with previous uterine surgery are identified (higher risk of abnormal placentation) for placenta placement check • Women with previous pre-term birth/s are identified, monitored and referred as well as supported in the subsequent pregnancy. • Work with the Healthy West Coast workstream of the West Coast Alliance to monitor the provision of smokefree advice to key groups (by ethnicity), namely: • Hospitalised smokers • Smokers enrolled with the PHO • Pregnant women • Households with a new baby • People diagnosed with Diabetes	understand how to access that care early and why- consumer forum survey Following 20 week scan any women who have a placenta which looks like it is abnormally situated or developed has a referral Women who have had preterm births are contacted and seen early in the next pregnancy
5	Early detection of women with high BMI at time of booking with their LMC	Women are encouraged and supported to achieve healthy weight before they become pregnant by community information that starts in our High schools Early referral to clinics for women identified as high BMI Continued monitoring of BMI throughout pregnancy	• Work with the Healthy West Coast workstream to ensure resources are available to continue to provide integrated nutrition support across the system including primary care and early childhood settings • Women identified as having high BMI during pregnancy have some explanantyion about weight gain in pregnancy being less than women who do not have a high BMI • Ensure their HbA1C is normal and that they have GDM screening at 24 weeks with more support if need be for GDM • Women with a BMI > 40 are referred to an anaesthetist for discussion around pain management • Information around risks associated with high BMI during pregnancy is communicated to women	• Audit referrals to show that women with BMI higher than 35 are referred appropriately for monitoring and management • Active engagement of women in healthy lifestyle programmes (e.g. Green Prescription) • All women with a BMI >40 are referred to anaesthetist for analgesia assessment pre 30 weeks gestation
6	Link West Coast SUDI Prevention Plan to the MQSP	Embed activities outlined in the West Coast SUDI prevention plan in the Maternity Quality Safety Programme	• Contribute to the development of Kaupapa Māori Pregnancy & Parenting Education programme • Provision of Safe Sleep devices • Large community discussion about safe sleep, stop smoking to protect pépi etc. • Actively promote increased stop-smoking support (from 2 weeks post birth up to 16 weeks post birth) for women during the antenatal and postnatal periods actively promoted	• PPE with Te Ao Māori and Tikanga aspects woven through developed and at least one course held by June 2020 • Maintenance of our stock of Pēpi-pods • % babies living in smokefree home increases (65.2% (44.0% for Māori) in 17/18) • Provide at least one SUDI education session facilitated by a subject matter expert (SME) to workforce per calendar year

Initiative / Priority		Action	Expected Outcome	Measure
			• Data about babies living in a smokefree home and their outcomes vs those who do not and their admissions for hospitalisation potentially so community understand importance • Support and encourage Workforce Education – engagement of Subject Matter Expert (SME) to provide education to maternity service providers • Increase in the supply of wahakura for our mums	
7	Establish Maori by Māori for Māori PPE to meet the needs of our Māori and Pacific women	Build on the work carried out throughout 2019 and establish the Māori for Māori PPE programme	• Māori and Pacifica consumers provide advice and feedback into PPE programme development • At least two Māori for Māori PPE programmes are delivered within the 19/20 year	• Increased attendance and positive feedback from Maori and Pacifica women attending PPE (2018/19 - Maori 4%, Pacific 0%)
8	Promote and support women breastfeeding	Continued implementation of the Breastfeeding priority plan Community information about mama to mama support when breastfeeding Importance for breast health of breastfeeding Impact on baby's health if they are breastfed Continue to promote annual Breastfeeding education to staff working in the maternity setting Work with LMCs to increase referral rates to breastfeeding support services if needed. Mama for Mama groups	• Mothers are supported to continue to breastfeed to 12 months post birth in line with MOH recommendations • Referral to lactation consultants for mothers as required • Information provided on FB / Website for mothers requiring further support • Continue to train Mum4Mum peer supporters across the Coast • Increase the provision of breastfeeding support and advice in the community • Active referrals from LMCs to breastfeeding support services • The West Coast Breastfeeding Interest Group continues to work and promote breastfeeding in the community	• 95% of babies on the West Coast are exclusively or fully breastfed on discharge from their LMC Care (Qtr 4 Total result = 86%; Maori: 73%) • 70% of babies on the West Coast are breastfed to 3 months post birth (Qtr 4 Total result = 70%; Maori: 60%) • 100% Core Midwives meeting education requirements for BFHI Accreditation • An increase in referrals from LMCs to Breastfeeding support services

9	Continue to review NZ Clinical indicators. Monitor and respond to DHB's variation	Ongoing interrogation of birth data identifies trends that provide for targeted education and action, by ethnicity
		Reviewing all our clinical outcomes and not just the Standard Primip as on the west Coast this is a very small subset and want to ensure equity across populations not only by ethnicity but also geographical locality
			• Data is used to evaluate the effectiveness of previous actions and future plan actions
			• Monthly meetings to review data
			• Monthly review of unusual outcomes
			• Data analysis identifies trends / patterns for NZ Māori women and birth outcomes for NZ Māori babies
			• Identify birth outcomes for NZ Māori babies
			• Set up VBAC clinic so women with previous C/s are seen by the O&G and Senior Midwife to ensure informed consent for second C/s or trial VBAC
				• Evidence of direct correlation between clinical indicator and relevant quality improvement initiatives and/or changes in practice i.e. improvement can be monitored
				• Quality initiatives address identified trends for NZ Māori women and NZ Māori babies
				• Quarterly report on birth outcomes by ethnicity for all West Coast births
				• VBAC rates increase following implementation of VBAC clinic post March 2020
				• Monitor and report, regularly to MOG:
				  ○ C/section rate
				  ○ IOL

Initiative / Priority		Action	Expected Outcome	Measure
				○ PPH ○ Trends
10	Support and increase use of primary birthing facilities and home birth for low risk women	Promotional material / information reviewed and distributed Primary facility and home birth promoted via Facebook and good news stories	• Increase in number of women choosing to birth or have post natal care in DHB primary birthing facility in Buller • Increase in number of women choosing to home birth on the West Coast • Ensuring our maternity facility on the west Coast maintains a normal birth focus as the only available facility as well as quality secondary care	• Bed occupation and birth location indicates continued usage of primary birthing unit (2018: 26 births in West Coast primary facility) as birth location choice • Increase in number of home births (2018: 27 home births; 5 home, 22 Gloriavale)
11	Develop a wider understanding of the transportation challenges faced on the West Coast for our mothers and Pēpi	Explore opportunities for delivery of obstetric and fetal medicine clinics via Telehealth	• Work with the Fetal Medicine specialists and Obstetricians to scope and implement a trial Telemedicine clinic • Improved information around realistic transportation timeframes • Identify strategies to mitigate some of the transportation issues e.g. co-booking of related appointments to alleviate unnecessary travel, holding outreach clinics to eliminate travel, VC meetings instead of travel • Identify support in the community for women and their families/whānau who do require travel and make this information available • Identify sources of financial support for Mums and their whanau when requiring travel outside of the West Coast	• Patient information brochure for Mums and families / whānau • Updated travel information online and in printed format for women and their families / whānau • Provide care close to home when needed • Recognise the pressures on LMC workforce to achieve this in a rural DHB and need to adapt how care is provided specifically using telehealth
12	Establish a process for the management of women who are experiencing fetal loss	Development of a process for the management of miscarriage for the new Te Nikau Grey Hospital environment Close working relationship with SANDS locally Ensuring network of support for whanau experiencing fetal loss regardless of gestation	• Process meets the needs of our women in a clinically safe and viable way • Staff know the process and follow it	• Women are managed appropriately and their feedback indicates they feel that their needs and preferences have been considered

Addendum 3: Smokefree Incentivisation Programme

smokefree AOTEAROA NEW ZEALAND 2025

Living Smokefree

Your name		Quit date	
Support person		Phone	

Working towards a smokefree pregnancy

Week	CO Reading	Smokefree Reward	Tick when reached
1		**Collect** your $50 voucher	○
2		Earn $25 towards your next voucher	○
3		**Collect** your $50 voucher	○
4		Earn $25 towards your next voucher	○
5		Earn $25 towards your next voucher	○
6		**Collect** your $75 Voucher	○
7		Earn $25 towards your next voucher	○
8		**Collect** your $50 Voucher	○
10		Earn $25 towards your next voucher	○
12		**Collect** your $50 Voucher	○
2 weeks post-birth		**Collect** your $50 Voucher	○

Keep going to keep baby healthy & safe

Week	CO Reading	Smokefree Reward	Tick when reached
Baby at 5 weeks		**Collect** your $50 voucher	○
Baby at 8 weeks		**Collect your** $50 voucher	○
Baby at 11 weeks		**Collect your** $50 voucher	○
Baby at 14 weeks		**Collect your** $50 voucher	○
Baby at 18 weeks		**Collect your** $50 voucher	○

Quit now!

Give your baby the best start in life

Healthy West Coast
Te Hauora o Tatou – The Health of Us All

Supporting Living Smokefree

Partner Form

Your name		Quit date	
Support person		Phone	

Working towards a smokefree pregnancy

Week	CO Reading	Smokefree Reward	Tick when reached
1		**Collect** your $25 voucher	○
2		Earn $25 towards your next voucher	○
3		**Collect** your $50 voucher	○
4 - 5		Earn $25 towards your next voucher	○
6		**Collect** your $50 voucher	○
8		**Collect** your $25 voucher	○
10		Earn $25 towards your next voucher	○
12		**Collect** your $50 voucher	○

Keep going to keep baby healthy & safe

Week	CO Reading	Smokefree Reward	Tick when reached
Baby at 2 weeks		**Collect** your $50 voucher	○
Baby at 5 weeks		**Collect your** $50 voucher	○
Baby at 8 weeks		**Collect your** $50 voucher	○
Baby at 11 weeks		**Collect your** $50 voucher	○
Baby at 14 weeks		**Collect your** $50 voucher	○
Baby at 18 weeks		**Collect your** $50 voucher	○

Quit now!

Give your baby the best start in life

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