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 2020

(Cover photo: Ava and Millie Dwyer, DOB: 6 March 2020)

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

Anita Hyde – Maternity Services Consumer representative
Jane Fielder - Transalpine Obstetrician & Gynaecologist
Julie Bell - PA to Director of Nursing & Midwifery, WCDHB
Brittany Jenkins - Director of Nursing, WCDHB;
Norma Campbell – Director of Midwifery, West Coast & Canterbury DHBs
Kerri de Klerk – Maternity Unit Administrator, WCDHB
Gloriavale Christian Community
Natalia Mendoza - Core midwife, WCDHB
Linda Monk - Midwifery Educator, WCDHB
Dawn Kremers – Clinical Midwife Manager, WCDHB
Vicki Piner - Maternity Quality and Safety Programme Coordinator, WCDHB
Barbara Roberts – Hearing Screener, WCDHB
Lou Reubens – Community LMC
Bev Sinnott – Lactation Consultant, WCDHB
Jenni Stephenson - Project Manager, Planning and Funding, WCDHB
Chantelle Taege – Core Midwife, WCHDB
Helen Turner – Kawatiri Maternity Unit
Ravi Vemulapalli – Senior Clinician, Obstetrics & Gynaecology, WCDHB
West Coast DHB Maternity Operations 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 20/21.

Disclaimer
While every effort is made to ensure the accuracy of the information contained in this report, West Coast District Health Board cannot guarantee the integrity of the information or data supplied.

Foreword

The West Coast District Health Board is pleased to present the Maternity Quality and Safety Programme Annual Report for 2020.

The West Coast has had a busy year again this year as we completed the Maternity Strategy and agreed with the Board to use it as a platform to guide not only the first 1,000 days, but we have also initiated the programme called Growing Up Well on the West Coast. We have a project group with wide representation across our community and have commenced hui around different communities on the West Coast, so we can improve our maternity and other systems for whanau.

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 mamas and their pepī. 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. We are placing a strong focus on equity particularly paying attention to the remoteness and distances needed to travel for many of our hapū wāhine and their whānau.

The maternity workforce has improved this year with both midwifery and medical appointments. The impact of our rural generalist model is that we are not only attracting but retaining a medical workforce and for midwives the door is also open to work alongside our rural nurse practitioners to both assist each other as both groups visit whanau in the community. There is also a stronger transalpine working relationship developing not only with midwifery, but now with the O&G department at Christchurch Women's. As in previous years our guidelines and referral pathways are transalpine but are reflective of the West Coast perspective with input from the Coast. This helps the maintenance of standards of care across both DHBs in maternity whilst utilising the capacity that is available in Canterbury.

We moved to oral Misoprostol as the active induction of labour agent in this year and we discuss this also in this report.

We were delighted to welcome Dawn Kremers into the role of Charge Midwife Manager permanently this year. She had covered for Catarina Morais (previous CMM) for her maternity leave and then applied for the role when it was advertised.

Education updates as well as support for the managers, our educator and others involved in maternity continue to be undertaken across the Coast with an increasing confidence also in the use of Telehealth for some of the urgent treatments for our very little babies. We do 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, but this is also improving and on everyone's radars.

The Maternity Quality and Safety Programme continues to add significant value to our maternity system on the West Coast. We now have data we can rely upon and regularly review it in the Operational Group meetings in maternity. We are looking forward to the work programme of 2020/21 as well as a more settled year, we hope, with no more pandemic challenges as we had in 2020.

We are also looking forward to the ongoing development and maturing of the consumer council which has been established for the whole of the West Coast and their input into maternity with members who are maternity consumers is valued as we endeavour 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 Dawn Kremers, O&G lead Ravi Vermulapalli , Midwifery Educator Linda Monk, our transalpine obstetrician Jane Fielder and rural generalists Brendan Marshall and Alan Furniss, as well as all the midwives (core and LMC) , nurses and allied health professionals who enthusiastically keep us all motivated and focused on improving our maternity services on 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

Anita Hyde – Maternity Consumer

Kia ora, I'm a busy mum of a four and a seven-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 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.

The past year started well with plans for a coastwide consumer network to be developed and the scheduling of a national maternity consumer forum, but unfortunately as with many things this was put on hold due to COVID. The consumer forum has since been transferred to an online meet, and it has been valuable in hearing from others how they are operating and the progress they are making in getting the consumer voice integrated into all levels of DHB decision making. I look forward to strengthening the connection with consumer reps in Canterbury, particularly Kaikoura who face similar challenges with rurality as we do.

Our local network is still a work in progress, but in addition to having a more geographically diverse group, it has also been identified that representation from different ethnicities is needed. I am looking forward to supporting these new consumers to bring forward their ideas on how we can make the service accessible and welcoming to all West Coast parents.

The shift into Te Nīkau Hospital in July was long awaited, but the maternity team has done a fantastic job of ensuring the needs of our whānau have been met. The new birthing rooms and ward are clean, calm and spacious to give privacy or support as needed. As always with new buildings, it has been an adjustment with new processes and challenges to work out, but it is great to see that the maternity team are committed to ensuring the pathway for people using the service is as simple as possible.

Here's to less disruption in 2021, so we can put plans into action, utilise the learnings around the use of technology that came from lockdown, and focus on our main priority – our West Coast Whānau.

Nga mihi nui,

Anita Hyde

Table of Contents

Glossary

Caesarean section	An operative birth through an abdominal incision.
Core LMC	A secondary services-based core lead maternity carer.
Episiotomy	An incision of the perineal tissue surrounding the vagina to facilitate or expedite birth.
Gravida	Number of pregnancies a woman has had.
Maternity facilities	A maternity facility is a place that women attend, or are resident in, for the primary purpose of receiving maternity care, usually during labour and birth. It may be classed as primary, secondary or tertiary depending on the availability of specialist services (Ministry of Health 2012). This section describes women giving birth at a maternity facility.
LMC	Lead Maternity Carer; usually a community-based midwife who will provide each woman with continuity of midwifery care throughout pregnancy, labour and birth and the postnatal period, within a partnership model of care from the time she registers with the LMC to six weeks post-partum.
Multiparous	A woman who has given birth one or more times.
Neonatal Death	Death of a baby within 28 days of life.
Nulliparous	Medical term for a woman who hasn't given birth to a child; also applies to women who have had a miscarriage, stillbirth or elective abortion, but has never given birth to a live baby.
Parity	The number of previous pregnancies that resulted in live births or stillbirths (counting twins or multiple births as one).
Primiparous	A woman who has not given birth.
Post-Partum	Means "after the birth" and refers to the period after the woman has birthed.
Primary facility	Refers to a maternity unit that provides care for women expected to experience normal birth with care provision from midwives. It is usually community-based and specifically for women assessed as being at low risk of complications for labour and birth care. Access to specialist secondary maternity services and care will require transfer to a secondary/tertiary facility. Primary facilities do not provide epidural analgesia or operative birth services. Birthing units are considered to be primary facilities. Primary maternity facilities provide inpatient services for labour and birth and the immediate postnatal period.
Postpartum Haemorrhage	Excessive bleeding after birth that causes a woman to become unwell.
Primary Maternity Services	Primary maternity services are provided to women and their babies for an uncomplicated pregnancy, labour and birth, and postnatal period. They are based on continuity of care. The majority of these maternity services are provided by Lead Maternity Carers (LMCs).
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.

AVEY ARMSTRONG - DOB: 6TH JANUARY 2020

Abbreviations

BFHI	Baby Friendly 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

1. Overview

1.1 Background

BRIAR DASH - BORN 9 APRIL 2020

This is the eighth 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.

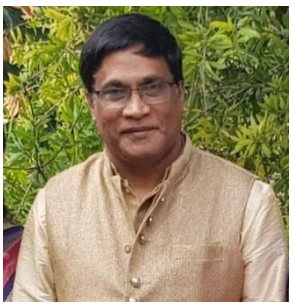
1.2 Purpose

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

- Improvements made in relation to overall aims and objectives;
- Achievements against the quality improvement goals set for 2019/2020;
- 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 2018;
- Response to consumer feedback and ongoing consumer involvement;
- Quality initiative goals for 2021.

BELLY CAST - OFFERED AT KAWATIRI

2. Maternity Team 2020

			
Norma Campbell Director of Midwifery, WCDHB & CHDHB	Dawn Kremers Clinical Midwife Manager	Anita Hyde Consumer	Mary McGrane Liaison Midwife
			
Helen Turner Kawatiri Maternity Unit	Dr Ravi Vemulapalli Obstetrician & Gynaecologist HoD, Obstetrics	Dr Jane Fielder Obstetrician & Gynaecologist	Dr Reuben Hoyte Obstetrician & Gynaecologist
			
Dr Brendan Marshall Rural Hospital Generalist	Dr Alan Furniss Rural Hospital Generalist	Linda Monk Midwifery Educator	Natalia Mendoza BAC Clinic Midwife
			
Bev Sinnott, Lactation Consultant	Barbara Roberts Newborn Hearing Screener	Kerri de Klerk Maternity Services Administrator	Vicki Piner MQSP Co-ordinator

3. West Coast Maternity Services

The West Coast DHB's Maternity Strategic Framework identifies our vision and values for West Coast maternity services.

3.1 Our Vision

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

BRIAR DASH

3.2 Our Values

Mana Taurite

Equity

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

Whanaungatanga

Everyone belongs

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

Manaakitanga

Respect for all

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

Tino rangatiratanga

Empowering whānau

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

Oranga tonutanga

Health and wellbeing

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

Aroha

Love and empathy

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

3.3 Maternity Facilities

There are two facilities available to women living on the West Coast and most births are at the larger Te Nīkau Hospital and Health Centre. 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	Maternity Unit at Te Nīkau Hospital & Health Centre, Greymouth
Tertiary	Christchurch Women's Hospital

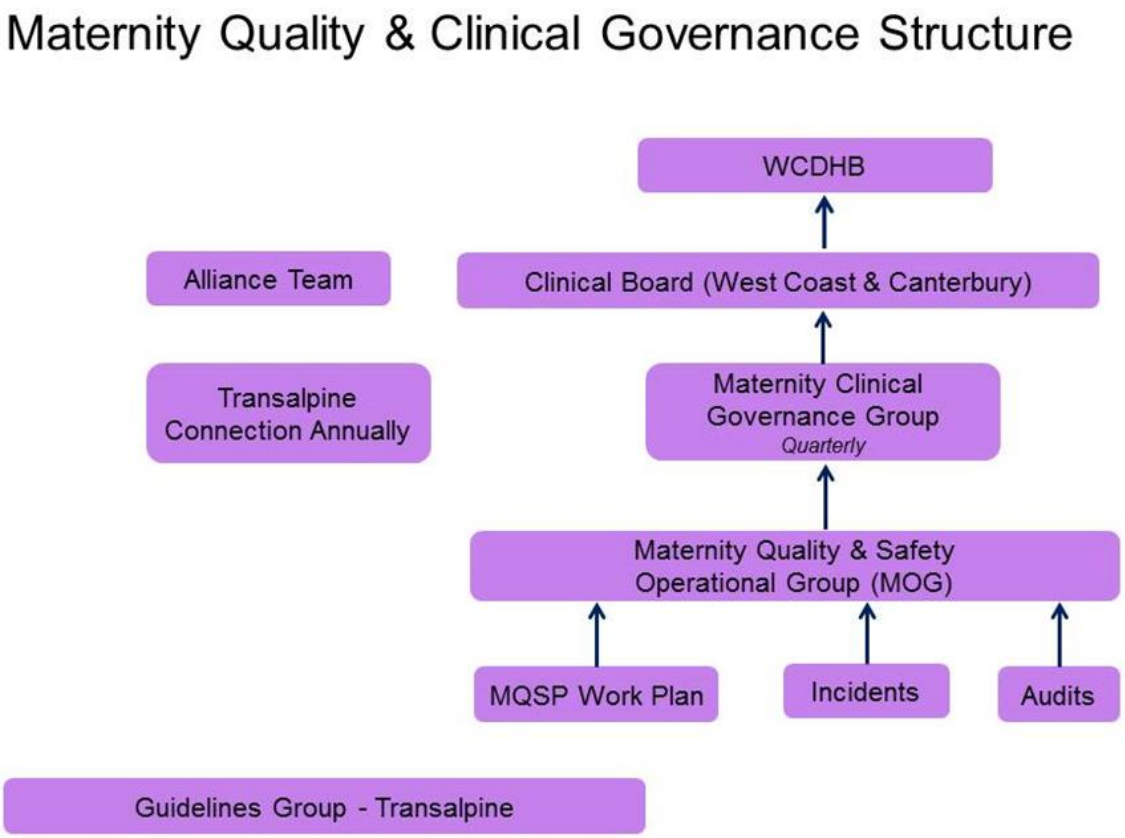
TE NĪKAU HOSPITAL & HEALTH CENTRE

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

KAWATIRI MATERNITY UNIT, BULLER

4. Maternity Governance

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



4.1 MQSP Programme

Meeting the requirements of the Maternity Quality Safety Programme (MQSP) is 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." West Coast DHB share a strong link and work closely with Canterbury DHB via our Transalpine relationship.

We continue to embed the MQSP into our maternity services and link our annual work 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 2019/2020 year and we report against that in this report. We are now in a "business as usual phase" for MQSP.

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 virtually with the Ministry of Health team regularly throughout the year but attempts to meet in person during 2020 were thwarted by COVID-19.

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

DISPLAY FOR MIDWIVES DAY 2020

4.2 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.

More detail on how this Transalpine model for obstetrics and gynaecology is contained further in this report (Section 8).

5. 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 31,575 people; only 0.7% of the total New Zealand population (2018 Census). We employ approximately 1,100 staff (including casual staff) in our health service (705 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.

We have the smallest population of any New Zealand DHB with the third largest geographical area

It comprises three Territorial Local Authorities: Buller, Grey and Westland districts:

- **Grey District** has the largest population, with an estimated resident population of 13,344 people.
- **Buller District** has an estimated resident population of 9,591people.
- **Westland District** has an estimated resident population of 8,640 people.

5.1 Our Population

The West Coast is a diverse society with a large and growing indigenous Māori population. There are a range of other cultures, including Asian and Filipino populations. The proportion of New Zealand European/Pākehā living on the Coast is reducing.

The West Coast has a relatively static population with the DHB being responsible for 32,410[2] people in 2020/2021; almost unchanged over the last 10 years. We have an older age structure and a higher proportion of people aged over 65 (20%) compared with the national average (16%).

Our community is changing:

Our population is becoming more diverse. By 2025, 13.4% of our population will be Māori.

New Zealand officially recognises three languages (English, Te Reo Māori and New Zealand Sign Language). Almost one-fifth of the population is multilingual (with one in five multilingual speakers having Te Reo as one of their languages). On the West Coast English is spoken by 92% of people with te reo the next most common language at 1.8%. New Zealand Sign Language is used by less than one percent of people.

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

On the West Coast there are also a large number of Māori who whakapapa (ancestry) to iwi in other parts of Aotearoa. Irrespective of where they reside, many Māori hold strong connections and sense of belonging to their tūrangawaewae (ancestral lands) and marae, and their ability to access and participate in Te Ao Māori (Māori world view). These familial and cultural connections provide a strong and enduring sense of identity and are prerequisites to good health. There is a need to support some Māori to learn their whakapapa and develop these connections.

The Asian population is very broad, comprising ethnic groups from Afghanistan to Japan. On the West Coast 3.6% of our population identify as Asian. The largest groups are Indian, Chinese and the grouping of South East Asian.

Pacific peoples on the West Coast are diverse; there are over 16 distinct Pacific ethnic groups with different languages and culture in New Zealand. The main groups of Pacific peoples in our region are Samoan, Tongan, Cook Island Māori, and Fijian.

There is a small but growing Middle Eastern, Latin American, and African (MELAA) population of nearly 0.5% within the West Coast's population.

European New Zealanders are people of European descent, including British and Irish, and people indirectly of European descent, including North Americans, South Africans, and Australians. In the 2013 census, at least 74% of the New Zealand population identified with one or more European ethnicity.

[2] Source: Stats NZ – 2020 Population Estimates

Deprivation is an indicator of the need for health services and the West Coast has a lower mean personal annual income ($26,400[3]) compare to the rest of New Zealand ($31,800). 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. The 2018 NZ Census reported there were 3,900 Māori living on the West Coast (12% of the population). NZ Stats estimate that 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

Our population is becoming more diverse. It is estimated that by 2026, 13% of our population will be Māori.

12%
Are Māori

3.4%
Are Asian

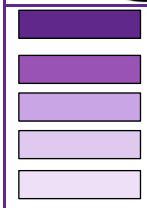
1.5%
Are Pacific

SPENCER DANIEL COOK - DOB: 07012020

[3] Source: NZ Census 2018

5.2 Our Maternity Profile

(Source: MOH Qlik Hub)

Category	WCDHB – 2020 Data from MoH Data	
	Birth Rate	291 Babies born in 2020
	160 Babies born every day in New Zealand	24 babies per month were born to West Coast mothers
	Maternal Age	Highest proportion of West Coast mothers are in the 25-29 years bracket (33%)
	Maternal Ethnicity	19% Māori 74% European / other descent 6% Asian 1% Pacific Peoples
	Deprivation	Quintile 5 6% (Most Deprived) Quintile 4 43% Quintile 3 24% Quintile 2 22% Quintile 1 5% (Least Deprived)
	Birth by Facility Type	Grey Base Hospital (secondary) 78% Kawatiri Maternity Unit (primary) 2% Christchurch (Tertiary) 9% Home Birth 11%
	Parity	34% Nulliparous (1st time Mums) 66% Multiparous
	Body Mass Index	60% of West Coast women are considered overweight or obese
	Smoking at LMC First Registration	14% of West Coast women were smoking at time of registration with their LMC
	Smoking 2 weeks postnatal	40% of women who were smoking at registration with their LMC were no longer smoking 2 weeks postnatal 60% of women smoking at registration were smoking 2 weeks postnatal

5.3 Where our Mums live and birthed in 2020

WEST COAST DISTRICT HEALTH BOARD

MINISTRY OF HEALTH
MANATŪ HAUORA

296 births

221 McBrearty Ward / Te Nīkau Maternity Unit

7 Kawatiri Primary Maternity Unit

25 Canterbury DHB Tertiary Centre

Gloriavale Community

Mother's Hometown

41 Homebirths: **23** at Gloriavale
2 Births at Nelson Hospital

6. Achievements against Priorities

6.1 West Coast DHB MQSP Work Plan 2019/20

The following table summarises achievement against the goals set for the 2019/20 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			
WCDHB MQSP Work Plan 2019/2020			Status
1	Encourage, increase and monitor involvement of consumer members in WCDHB's MQSP	Our Maternity consumer attends Maternity Operations group meetings. However, we do need to increase our consumer group and had planned to engage interested members during our annual "road trips" and hui on the maternity strategies when meeting with the community. However, COVID-19, moving to a new hospital and the fact that the MQSP Co-ordinator had a long period of sick leave meant we did not achieve this goal. are going out to engage with our communities as part of the Growing Up Well on the West Coast – a project looking at the journey from the time of pre-pregnancy to at least the first 1,000 days. We will be using this opportunity to promote MQSP and engage and recruit additional Consumer members. We have an informal group of consumers who provide feedback on ideas / information prior to being implemented. We consulted this group prior to updating information leaflets we needed to refine, and they were influential in improving that information to make it more understood.	
2	Develop maternity strategy; further development of the strategy to address equity issues, rurality and ease of access to services for our women.	Hui that were planned did not occur due to the reasons noted above (COVID-19 levels, hospital move and key personnel sick leave), however these issues will be explored further when we go out to engage with our community as part of the Growing Up Well on the West Coast project. We are mindful of ensuring we get feedback and representation from our key ethnic groups; Māori, Pacifica and Indian women.	

3	Workforce Development and Education: provide education to all clinicians working in the maternity setting to ensure that they are aware of local services and pathways for family violence, smoking, alcohol and other substance abuse, maternal mental health pathway. Cultural competency training offered to maternity staff. Multi-disciplinary FSEP provided to core midwives and LMCs. Create a workforce plan for high quality care in our rural setting.	All women identifying as smokers at registration are offered smoking cessation service and if they present to the ward during their pregnancy the offer is made again. During 2020 at the time of first registration 58 of our women indicated they were smokers; of these 31 (53%) accepted referral to smoking cessation services and 20 (34%) declined. For 2021 we have moved to a different model; all women smoking at registration (and at periods throughout their pregnancy) will be informed that they will be referred to smoking cessation services unless they opt out. LMCs screen for family violence at time of booking and throughout the pregnancy journey (when woman is alone). Core midwives and LMCs refer women to the fortnightly multi agency/disciplinary meetings where plans are made to keep the women and their babies/Pepī safe during pregnancy and postnatally. For any admissions to our facilities women are again screened for family violence. The revised Maternal Mental Health Pathway was operationalised during 2020 (details being checked, reviewed and updated during 2021). Key contact information has been made into a sticker which is included every in Tamariki Ora handbook all new Mums are given. During 2020 we had two midwives attend Takurangi Cultural training. The MQSP Co-ordinator attended HEAT training. Core midwifery staff and LMCs provided with FSEP training on annual basis. The West Coast has addressed some of the issues faced in recruiting and retaining suitably qualified maternity specialists by strengthening the Transalpine Model of O&G Services (more in Section 8) and the Rural Hospital Generalist model.	
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.	Women with one previous c/section are referred to the BAC clinic to discuss their delivery options before seeing the Obstetrician if needed. Our figure for VBAC increased slightly from 2019 (2%) to 2020 (3%). We commenced the process of updating information leaflets provided to women to ensure they are still relevant and align across the Transalpine maternity service; this work is ongoing.	

	Women are encouraged and supported to live smokefree.	Social media was utilised more throughout 2019-2020 to promote health messages and information for our women and was instrumental during COVID-19 lockdown to keep our staff / community updated in a constantly changing maternity environment. All health professionals working within the maternity setting (including community based LMCs) have access to the WCDHB intranet and resources e.g. health pathways, guidelines, forms, policies and procedures.	
5	Early detection of women with high BMI at time of booking with their LMC. Early referral to clinics for women identified with high BMI. Ensure HbA1C is normal and that they have GDM screening at 24 weeks with more support if needed for GDM.	All women with a BMI of >=35 are referred to the Obstetric Clinic and nutritionists. Close watch is kept on their BMI throughout pregnancy (regular weighs at appointments). GDM Screening pathway was updated during 2020. Women who need it are seen regularly by the Diabetes Clinical Nurse Manager (CNM) and managed in conjunction with the Obstetrician. Regular scans for growth are carried out throughout the pregnancy. Women with a BMI >=35 are referred to an anaesthetist for discussion around pain management during labour.	
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	We increased our stock of wahakura (by 10) and maintain our stock of Pepī pods. All women birthing in our facility are provided with Safe Sleep education and if needed, supported by the provision of wahakura or pepi pods. LMCs and Wellchild providers can access these stocks for their women. The SUDI plan has been embedded into the WCDHB annual maternity plan. We continued to support and encourage smoking cessation and extended the smoking cessation incentivisation programme to the smoking partners of our women in an effort to increase the number of smokefree homes.	
7	Establish Māori by Māori for Māori Pregnancy & Parenting Education (PPE)	The WCDHB continue to support and promote Māori for Māori PPE; two hapūtanga were held by Poutini	

	to meet the needs of our Māori and Pacific women	Waiora (local Māori health promoter) during 2020 with more planned for 2021.	
8	Promote and support women breastfeeding. Core midwives meet educational requirements for BFHI. Increased referrals from LMCs to breastfeeding services	The rate of women exclusively breastfeeding at two weeks post birth increased slightly from 83% (18/19) to 84% (2019/2020), however there is more work to do in this area. 100% of our Core Midwives meet educational requirements for BFHI Accreditation. The numbers of referrals from LMCs to Breastfeeding support services reduced during 2020. We are meeting with LMCs to determine reasons for this and to look at how we support increasing referrals.	
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. Monthly meetings to review data, incidents, look for trends. Set up BAC clinic.	Maternity Operations Group meet and review data in a multi-disciplinary setting (includes consumer input, community based LMC, theatre staff, etc,). C/section and IOLs rates and outcomes are reviewed and audited regularly. Maternity services have a "trigger list" requiring submission of an incident form for any event that matches the NZ clinical indicators or is not optimum for our women/babies. Incidents are reviewed bi-monthly to identify opportunities for quality improvement. BAC clinic set up (more info in Item. 4)	
10	Support and increase use of primary birthing facilities and home birth for low risk women includes exploring opportunities for delivery of obstetric and fetal medicine via Telehealth	WCDHB continues to support women to have informed choice around intended place of birth. We continue to support the primary birthing facility in Buller and offer this as a choice for women where it is clinically safe to do so. Homebirth numbers increased from 28 (8%) in the 2019 calendar year to 32 (11%) in the 2020 calendar year. However, the number of births in the primary facility decreased (down to 2% from 5% of total births). Upon noticing this trend, we contacted the women who had uncomplicated births at the secondary facility to birth to determine the reasons for place of birth choice. Women informed us that they were aware of the need to travel should they need a higher level of care and had mitigated that by choosing secondary care for the level of security it provides. We are also aware that as a result of media and discussions in the communities, it appears Buller women have lost some confidence in the primary birthing unit. However, as a DHB we can help build this up. The current unit, although clean and welcoming, is old and outdated as part of an aged hospital. There is a new Hospital and Integrated	

		Family Health Centre being built in Buller and we expect that once built, women will choose this newer facility for their birth and/or postnatal care.	
11	Develop a wider understanding of the transportation challenges faced on the West Coast for our mothers and Pēpi	The Transalpine O&G is part of a working group looking at how transportation issues can be mitigated by the use of technology in delivering consultations, etc. Where possible, we have been scheduling obstetric appointments to coincide with other appointments (e.g. ultrasounds) for women living outside the Grey region to reduce their need to travel. Our Rural Nurse Specialists support our community based LMCs to assist with postnatal care – providing this care closer to home for the women. We are looking at how we can increase the use of telehealth to lessen travel.	
12	Establish a process for the management of women who are experiencing fetal loss Develop a process for the management of miscarriage for the new Te Nīkau Hospital.	WCDHB has a fetal loss package for women. Maternity services staff know this process and follow it. The Early Pregnancy Assessment Service procedure has been updated to reflect the new environment and changed model of care (rural hospital generalists).	

STAFF AT CORE MIDWIFE PADDY O'CONNELL'S RETIREMENT

7. 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:

- One Local Project
- Two National Projects meeting MoH MQSP Criteria
- Three1. NMMG Priorities
- Five PMMRC Priorities
- Six MWWG Recommendations

7.1 Local Project: Growing Up Well on the West Coast

During 2020 the Growing Up Well on the West Coast (GUWOTWC) project was launched.

It has grown out of the Maternity Strategy consultation, undertaken in 2019, which identified a need to reshape our early years, health and social services in ways that are rooted in the desires Coast communities have for Coast kids to grow well, rather than structured around funding contracts and historical service provision. The aim of the project is to engage with our communities to co-design process that will shape the way the DHB delivers and supports other agencies to provide health and support to newborn pepī/babies, tamariki/infants, rangatahi/youth and their whanau/families up and down the West Coast.

This reflects our acknowledgement that our communities are the same, but different and therefore how we achieve equity needs to be the same, but different also. The programme is also grounded within the Prime Minister's Child and Youth Wellbeing Strategy (2017) which aims to support

… New Zealand to be a place where all children and young people are loved, confident, happy and healthy, and are empowered to reach their full potential. (DPMC, 2019)

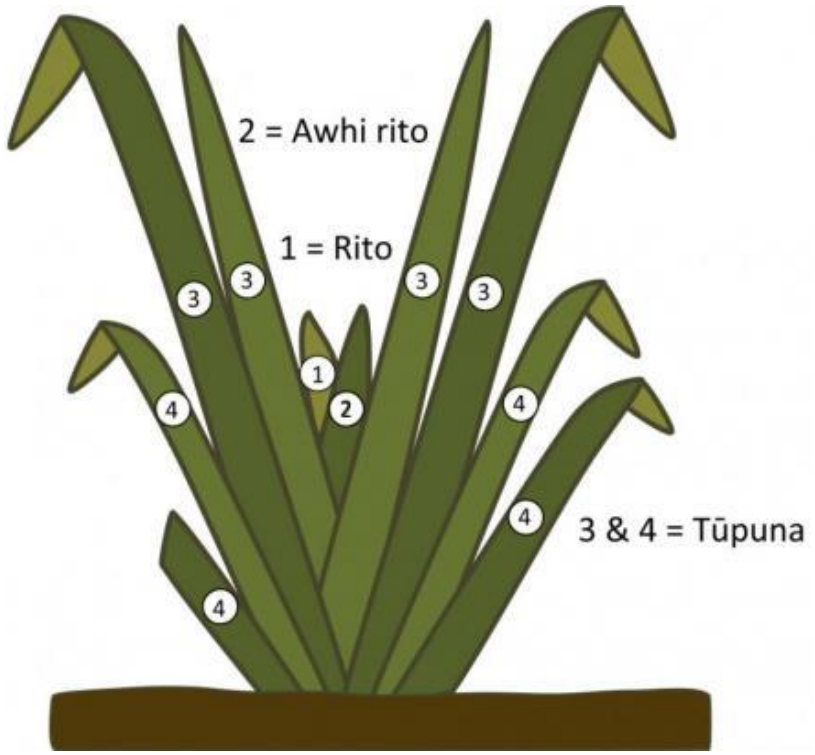
It was agreed that a community development styled consultation process would be undertaken, utilising the Te Rito o te Harakeke model and that conversations are invited across the district, free flowing and community determined.

The research components of the programme aim to capture the consultation journey, narratives and outcomes as well as to measure quantitatively and qualitatively the impacts of changes made, via a Rural Early Years Strategy, once developed from the consultation.

This research will also set out the parameters of a longitudinal study, measuring access and health outcome changes resulting from the strategy implementation with a particular focused on those areas of existing inequity. This will then inform future applications for research funding.

Engagement Hui are supported by a Stakeholder group of multi-disciplinary / multi-agencies representative of our community. We are mindful of ensuring that we hear the voices of our target groups, specifically using the Appreciative Model of Inquiry in the shaping and design of models of care to meet our communities' needs.

Te Rito o te Harakeke model



Te rito o te harakeke refers to the central shoot of a flax bush. This visual model is commonly used to represent the concept of Māori whānau (a child surrounded by love and support).

1 = Rito/baby
2 = Awhi rito/parents

Hutia te rito o te harakeke,	If you pluck out the centre shoot of the flax,
Kei whea te korimako e kō?	Where will the bellbird sing?
Ka rere ki uta, ka rere ki tai.	It will fly inland, it will fly seawards.
Kī mai koe ki au,	If you ask me,
he aha te mea nui i te ao?	What is the most important thing in the world?
Māku e kī atu,	I will reply,
He tangata, he tangata, he tangata!	People, people, people!

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

We rolled out NEWS/NOC in June 2020. The NEWS has been developed to assist with early recognition of clinical deterioration of infants who are at risk with the aim of improving outcomes for these infants. This chart is a vital signs chart developed nationally to standardise the initial assessment and care of all newborns in New Zealand. It will also provide a single view of clinical information and assist in recognising trends, which may indicate a baby's condition has deviated from the norm.

Rolling out the NOC/NEWS was relatively uncomplicated, and it was readily accepted by staff as we were already using an Early Warning Score (EWS) and essentially moved from one EWS to another.

7.3 National Project 2: NE Taskforce Project

The trigger tool is in place and incidents reported against this tool are reviewed at Maternity Incident Review Group. The Health Quality Safety Commission (HQSC) Maternity Severity Assessment Code rating is used by Maternity staff. Incidents are reported via Safety1st (South Island wide incident reporting database) with incidents confirmed as SAC1/SAC2 referred to Serious Incident Review Committee (WCDHB clinical leads) for reporting to HQSC and subsequent RCA review.

7.4 Addressing NMMG Recommendations

The National Maternity Monitoring Group (NMMG) was established by the Ministry of Health in 2012 as part of the Maternity Quality Initiative. NMMG oversees the New Zealand maternity system and provides strategic advice to the Ministry of Health for improvement. We report against their national areas of focus for our West Coast population during the 2018 /19 periods below.

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

The West Coast DHB has sustainability agreements with community based LMCs to ensure women have choice:

- LMC Education is provided and paid for by the DHB – the same provided to our Core Midwives;
- Free use of clinics in the rural areas where women can see their LMCs: Te Nīkau clinic, Hokitika Health Centre and other rural clinics;
- Extra Sustainability Package paid quarterly. LMCs provide up to the 3rd trimester and full postnatal care, so if a woman transfers out to the tertiary sector the birth fee would be lost. However, this package pays a proportion of that fee based on where the woman lives; rural / semi-rural and remote if the woman births elsewhere;
- If travelling – LMCs can often access DHB vehicles for travel and in some areas, DHB accommodation;
- The Package is reviewed and renewed every twelve months.

MAE WALKER BORN AT HOME 07/01/20

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.

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 are low relative to the rest of New Zealand. A number of Buller women who birth at the Secondary facility based in Greymouth return to Buller to have their post-natal care provided at Kawatiri.

Best about my care at Kawatiri:

"Being able to rest and recover in a peaceful, relaxing environment where the rest of my children and partner could come and go as they wish."

Feedback from a woman birthing at Kawatiri

Kawatiri has a fully equipped birthing room and promotes active birth whilst having all emergency equipment required.

KAWATIRI ANTENATAL ROOM

The unit has a postnatal room 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.

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

We offer our women LARC (Long Acting Reversible Contraception) 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. GPs are being supported to provide LARCs in primary care.

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 currently have provision within our Gynae services to offer LARC free to women if required. We are also moving to an electronic discharge summary allowing us to better capture contraception data for future planning.

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

The WCDHB reviewed our Maternal Mental Health (MMH) Pathway during 2019 and operationalised it then. Early in 2020 we created a sticker version of the MMH Pathway which is now included inside the front cover of every Well Child Tamariki Ora book provided to new mums. Our mums told us that the things that cause them anguish include breastfeeding and understanding their baby's cries, so we included links to breastfeeding support and information about PURPLE crying (Addendum 1).

As part of the introduction of the MMH Pathway, the LMC registration form was updated to capture, at time of booking, history of mental health treatment for the woman and / or her family. This section was added to the booking form:

MENTAL HEALTH	
History of MH treatment? ☐ N/A ☐ Self ☐ Family If yes, please provide details	Current MH treatment? ☐ Yes ☐ No If yes, please note treatment and provider *(e.g. counselling, medication)* .....
EPDS Screening done? ☐ Yes ☐ No Score	Referral offered? ☐ Yes ☐ Accepted ☐ Declined

This data is being collected and allows us to check if Edinburgh Postnatal Depression Score (EPDS) is being completed and whether or not the woman is being referred, and that referral is being accepted by the woman. The data is telling us that approximately one in three woman has a previous/current or family history of a mental health condition.

4. Ongoing audit and review of MEWS and Trigger Tool

Staff retrospectively collect this data for MoH and send it through per quarter. We know that staff use this tool within the maternity unit, however we need to audit other areas of our organisation; e.g. primary unit and emergency department. We are currently exploring the best way to ensure we capture this data to carry out audit.

7.5 Addressing PMMRC Recommendations

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

1. Reduce preterm birth and neonatal mortality

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. All babies who are Māori are given a wahakura as a taonga. Pepī pods are also offered to whanau as part of reinforcing safe sleep messages.

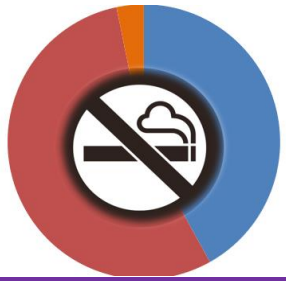
The WCDHB has a policy to identify preterm labour with a process for appropriate transfer to the right place. Women presenting in labour less than 36 weeks gestation are transferred to the tertiary unit, if it is safe to do so. There is a guideline for rural nursing and primary birthing unit on assessing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

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

Whilst our standard primip data is not available to us in a way that allows us to break it down easily by ethnicity, collecting our own data means we are able to review it with an equity lens. Labour and birth data, broken down by ethnicity and other demographics is reported monthly to our Maternity

Our Maori Mums who smoke:

Are more likely to be aged between 26 and 30 years of age and have more than one pepi



Operations Group to highlight any identified emerging trends. For example, we know that our Māori mums are more likely to be smokers aged between 26 and 30 years of age, that our Indian women are an increasing birthing population, and that they generally have babies of smaller birthweight. We also know that Māori wāhine do not engage with an LMC within the first 12 weeks of pregnancy. As a DHB we acknowledge that we have work to do to address equity issues on the West Coast and this is a key focus in our Work Plan moving forward.

3. Co-design models of care to meet the needs of Indian women

&

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

We have work to do in both of these areas and this work is wrapped up within the Growing Up Well on the West Coast project and the First 1,000 Days. We are capturing the demographic data of the women we engage with to ensure we are hearing the voices of those we need to hear. As part of

these projects our aim is to identify regional consumer groups with membership representative of our priority groups; women of Māori, Pacifica, Indian ethnicities and those women under the age of 20 years.

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

Ongoing education of all staff working within the maternity setting is provided via one mandatory FSEP Workshop (face to face bi-annually). Our last mandatory workshop was held February 2020 and our next face to face workshop is scheduled for early 2021. Clinicians working within the maternity setting will complete mandatory online training throughout 2021.

6. Cultural competency workshops for all Maternity Service staff

Two of our maternity staff have attended Takurangi training and we expect the number of attendees to increase as time goes on.

All clinicians attend mandatory bi-cultural treaty workshop training. The WCDHB Māori Health Unit provide cultural support and training as and when required.

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

The system for reporting the HQSC maternal morbidity review is embedded in the maternity setting and regular incident review takes place with a focus on quality activity and systems. WCDHB also carry out case review in conjunction with our Transalpine peers in Canterbury.

7.6 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.

1. Implementation of hypertension guideline

Hypertension Guidelines have been implemented across the Transalpine (across CDHB and WCDHB) region. Women diagnosed with hypertension are referred early to the Obstetrician. Medication checks / audits ensure that medications are reconciled and restocked as required. These are checked by the Pharmacy Manager at least weekly.

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

During 2020 the MQSP Co-ordinator attended HEAT training delivered by the Māori Health team based within the West Coast DHB. This tool is being used to critique our project work to ensure we

are addressing potential equity issues. We expect more of our maternity services staff to complete this training during 2021.

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

This is part of our Trans Alpine work; working with our tertiary Trans Alpine partner, women are able to access services in Canterbury via referral.

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

The WCDHB use the Six Sepsis guideline which is embedded in our emergency department – point of entry for all women (unplanned admissions) prior to going up to the maternity ward. Although we have not fully established a septic bundle kit; this work is captured within our "Deteriorating Patient" work group across the DHB.

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

Early recognition and treatment of sepsis is included in regular training and education sessions for multidisciplinary teams e.g. Midwives emergency Skills day, PROMPT. 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.

MIDWIVES OUTSIDE THE OLD MCBREARTY WARD CELEBRATING SAFE SLEEP DAY

8. 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). We have based our data on "DHB of Domicile."

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 17% of all births in the WCDHB. This group aged 20-34 years, uncomplicated singleton pregnancy, full term, cephalic presentation represents the least complex situations and in which intervention rates would be expected to be low, which can be compared between institutions.

Analysis of Individual Indicators for West Coast during 2018

Indicator No.	Title	2017 WCDHB Rate (n)	2018 WCDHB Rate (n)	Change from 2017	Higher or lower than national average	National Average 2018
1	Registration with an LMC in the first trimester of pregnancy	80.3% (286)	81.1% (264)	▲ +0.9%	▲	72.7%
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. This is a significant improvement (>80%) compared to 2014 when we changed our model of midwifery care.						
2	Standard primiparae who have a spontaneous vaginal birth	65.3% (32)	61.2% (30)	▼ -12.9%	▼	64.7%
Low numbers impact on our statistics; however, we are within the national figures. Remains stable.						
3	Standard primiparae who undergo an instrumental vaginal birth	12.2% (6)	24.5% (12)	▲ +12.3%	▲	17.0%
This increase in instrumental births is offset by the lower number of caesarean sections.						
4	Standard primiparae who undergo caesarean section	22.4% (11/49)	14.3% (7/49)	▼ -8.1%	▼	17.2%
We routinely audit all caesarean sections and discuss the cases. This decrease in this figure correlates to increased number of instrumental births.						
5	Standard primiparae who undergo induction of labour	8.2% (4)	6.1% (3)	▼ -2.1%	▼	7.8%
Rates remain stable and within national levels. 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)	28.9% (11)	26.2% (11)	▼ -2.7%	▼	26.5%

WCDHB sits almost at the national average. No significant change in our rate.						
7	Standard primiparae undergoing episiotomy and no 3rd or 4th degree perineal tear	23.7% (9)	26.2% (11)	▲ +2.5%	▲	24.6%
Slight increase; however relates to only two cases; impact of low numbers.						
8	Standard primiparae sustaining a 3rd or 4th degree perineal tear and no episiotomy	2.6% (1)	2.4% (1)	▼ -0.2%	▼	4.5%
Numbers remain stable. More perineal care and identifying the risk of tear earlier; providing episiotomy prior to tear may have contributed to slight reduction in numbers.						
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	9.0% (9)	4.4% (4)	▼ -4.6%	▼	8.5%
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 unless it is clinically contraindicated or the clinical situation dictates the need for general anaesthetic.						
11	Women requiring a blood transfusion with caesarean section	6.0% (6)	4.4% (4)	▼ -1.6%	▲	3.0%
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. Tranexamic Acid is part of our surgical safety checklist.						
12	Women requiring a blood transfusion with vaginal birth	2.7% (4)	2.5% (5)	▼ -0.2%	▲	2.1%
WCDHB sits within the national average.						
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	17.7% (60)	13.4% (42)	▼ -4.3%	▲	9.4%

We have extended the smoking cessation incentivisation programme period to 4 months post birth and included partners. Changes introduced in 2021 will see all women smoking at registration being referred to smoking cessation unless they opt out. We expect to see this have an impact in the future as it has in other DHBs.						
17	Preterm birth (under 37 weeks gestation)	9.2% (33)	3.7% (12)	▼ -5.5%	▼	7.5%
We had no babies born under 34 weeks during this period.						
18	Small babies at term (37-42 weeks' gestation)	2.5% (8)	2.6% (8)	▲ +0.1%	▼	3.1%
19	Small babies at term born at 40-42 weeks' gestation	37.5% (3/8)	50.0% (4/8)	▲ +12.5%	▲	29.9%
We are reviewing our data to determine whether these low birthweight babies have been diagnosed during pregnancy and appropriately managed.						
20	Babies born at 37+ weeks' gestation requiring respiratory support	0.6% (2)	1.3% (4)	▲ +0.7%	▼	2.1%
WCDHB sits below the national average for this indicator.						

9. West Coast DHB Maternity Data

The data in this section is from **local Maternity data sources** and compares 2019 and 2020 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	2019		2020		Trend
	Number	%	Number	%	
Extremely preterm (<28 weeks)	3	1%	0	0%	
Very preterm (28-31 weeks)30	2	1%	0	0%	
Moderately preterm (32-33 weeks)	2	1%	2	1%	No Change
Later preterm (34-36 weeks)	3	1%	4	2%	
Term (37-41 weeks)	266	96%	220	96%	No Change
Prolonged (>42 weeks)	1	0%	4	2%	

Type of Labour	2019		2020		Trend
	Number	%	Number	%	
Spontaneous	178	64%	132	57%	
Induction	32	12%	31	13%	
Artificial Rupture of Membranes	11	4%	15	7%	
Augmented	28	10%	21	9%	
Did not labour	28	10%	31	13%	

Method of Delivery	2019		2020		Trend
	Number	%	Number	%	
Elective Caesarean	32	12%	30	13%	
Vaginal	156	56%	115	50%	
Vaginal Water Birth	7	3%	8	3%	No Change
Kiwi Cup	11	4%	8	3%	
Ventouse	0	0%	3	1%	
Forceps	5	2%	16	7%	
Emergency Caesarean	60	22%	44	19%	
VBAC	6	2%	6	3%	

Breech at Delivery?	2019		2020		Trend
	Number	%	Number	%	
No	263	95%	223	97%	
Yes	14	5%	7	3%	

Anaesthetic	2019		2020		Trend
	Number	%	Number	%	
None	146	53%	120	52%	
Local	13	5%	6	3%	
Epidural	46	17%	41	18%	
Spinal/Epidural	71	26%	61	27%	
General	1	0%	2	1%	

Perineum	2019		2020		Trend
	Number	%	Number	%	
Intact	73	26%	60	26%	No change
1st Degree tear	48	17%	44	19%	
2nd Degree tear	34	12%	26	11%	
3rd or 4th Degree tear	5	2%	2	1%	
Episiotomy	25	9%	28	12%	
N/A	92	33%	70	30%	

Post-Partum Haemorrhage	2019		2020		Trend
	Number	%	Number	%	
No	201	73%	180	78%	
Yes	76	27%	50	22%	

Blood Loss Amount	2019		2020		Trend
	Number	%	Number	%	
>1500mL	5	2%	6	3%	
<1000mL	257	93%	212	92%	
≥1000mL ≤1500mL	15	5%	12	5%	No change

Neonatal Outcomes	2019		2020		Trend
	Number	%	Number	%	
Well Neonates	273	99%	227	99%	No Change
Neonatal admissions	5	2%	5	2%	No Change
Stillbirth	3	1%	2	1%	No Change
Small for Gestational Age	3	1%	9	4%	

Feeding Method	2019		2020		Trend
	Number	%	Number	%	
Bottle	8	3%	7	3%	No Change
Breast	265	96%	218	96%	No Change
Mixed	4	1%	3	1%	No Change

10. Our "Transalpine" Model

10.1 Transalpine Obstetrics and Gynaecology Service

Dr Jane Fielder, Transalpine O&G Specialist

Dr Reuben Hoyte, O&G Specialist

Dr Ravi Vemulapalli, O&G Specialist

Dr Brendan Marshall, Rural Hospital Generalist

Dr Alan Furniss, Rural Hospital Generalist

The last twelve months has seen the evolution of the transalpine Obstetrics and Gynaecology service. Dr Brendan Marshall and Dr Alan Furniss, Rural Hospital Medical Specialists with special scope in procedural obstetrics commenced acute Obstetric call after credentialing at Christchurch Women's Hospital. This is to provide obstetric on call cover and support the service. Further to this change Dr Jane Fielder started work as the Transalpine O and G specialist after an initial 2-week secondment in July, followed by a week a month on the West Coast from September.

Jane's role as Transalpine O and G is partly composed of clinical work on the West Coast, but also to provide support and training to the Rural Hospital Medical Specialists. It then culminated with the departments becoming "Transalpine" at the end of 2020 and Dr Emma Jackson taking on the role of Clinical Director of the Transalpine O and G department. This is strengthening the links and supports already in place between the two O and G departments. The departments already share a Director of Midwifery, all guidelines and referral pathways and are supported by the transalpine neonatal and paediatric service.

The future of the O and G service will continue to evolve over the next twelve months. A second permanent Obstetrician Gynaecologist, Dr Rueben Hoyte has just been employed in addition to Dr Ravi Vemulapalli who has been leading the service on his own for nearly twelve months prior to thesechanges. This second Obstetrician and Gynaecologist will, in addition to their West coast role

have a small component of their time working at Christchurch Women's Hospital on a regular basis to maintain and advance skills and to continue to improve the working relations of the two departments.

In addition, the rural generalists also spend time at Christchurch Women's Hospital with ongoing skill maintenance and credentialing. These changes mean the medical service on the West Coast for the first time in a long while is well staffed with 4 specialists on the acute roster and 4 gynaecologists available for clinics. This has also provided some reassurance to our midwifery workforce and women. Having this model should provide consistent and sustainable medical staffing for the maternity service for the future. The Rural generalist model also applies to midwifery.

10.2 Rural Hospital Generalism – an integral part of West Coast Maternity Services

Approximately 230 babies are born on the West Coast each year; around 80 of these will be via caesarean section. In the past, the West Coast DHB (WCDHB) has struggled to recruit and retain suitably qualified obstetric and gynaecological specialists relying heavily on expensive locum cover contributing to a lack of continuity of care for our women. WCDHB needed to do things differently to create a sustainable, skilled workforce that provided safe and appropriate care to its small, remote and sparsely located population. We needed a new model of care.

Enter Dr Brendan Marshall. In 2018 we welcomed Greymouth based GP and Rural Hospital Specialist Dr Marshall to maternity services upon his completion of the Advanced Diploma of Obstetrics.

Brendan moved to the West Coast with his family in 2013, to a role involving general practice, emergency medicine, anaesthetics and supporting paediatrics and orthopaedics after hours. GP and Rural Generalist Dr Marshall was the first person to complete the Advanced Diploma of Obstetrics through a New Zealand accredited provider. He originally completed his medical training in Australia and finished his Advanced Diploma at Christchurch Women's Hospital. He began training prior to moving to the Coast, and in 2018 continued his training through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to meet Australasian standards and further support the sustainability of West Coast maternity services.

The West Coast DHB, Health Workforce New Zealand and the South Island Workforce Development Hub (part of the South Island Alliance of DHBs) supported his diploma based at Christchurch Women's Hospital. Brendan is a crucial link in the Maternity Services Transalpine model of care linking secondary based clinicians at Te Nīkau Hospital &Health Centre to their colleagues based in the closest tertiary centre, Christchurch Women's Hospital.

Dr Marshall advocates for the Rural Generalist programme jointly run by the Australian College of Rural and Remote Medicine and the Royal Australian College of GPs. In this programme, junior doctors can

opt for post-graduate training in one or more specialties, for example, anaesthetics, emergency medicine and obstetrics in addition to completing the components. Brendan chose obstetrics and became the first GP to complete an Advanced Diploma of Obstetrics through a New Zealand accredited provider.

Brendan is credentialed to perform caesareans, but not complex gynaecological surgery. Training and oversight is rigorous. The Advanced Diploma is overseen by the Obstetrics and Gynaecology Specialist College who sign off on the Diploma putting in clear boundaries on what a clinician can and cannot do. Doctors are required to keep logbooks and competence is regularly assessed by senior colleagues requiring Brendan to regularly visit Christchurch Women's Hospital to work under Canterbury DHB specialists to ensure his skills are up to scratch and he is providing safe care.

"The training programme is relatively new to New Zealand, many doctors know little about it":

Dr Brendan Marshall on the Advanced Diploma of Obstetrics

Dr Marshall points out that patient safety stats for rural generalists are good - and studies done on similar programmes overseas largely bear that out. In Canada, a study comparing caesareans provided by rural GPs with those of specialists concluded that rural GPs performed the operation with "an acceptable degree of safety". And in Nova Scotia, rural hospitals fewer than 100 deliveries a year performed by rural generalists had the lowest complication and death rates in the province.

The training programme is relatively new to New Zealand, many doctors know little about it, Marshall says.

"This qualification is used extensively in Australia, and no other centre in New Zealand has been accredited to deliver the diploma before. It means GPs are again involved in the care of expectant mothers living rurally on the Coast and helping the obstetricians based in Greymouth to ensure families don't have to travel to Christchurch for certain services. As a team, we provide essential obstetric services such as caesarean sections, assisted deliveries, and more advanced ultrasound skills on weekends. This model is all about collaboration with permanent obstetricians and midwives to support a more sustainable way of thinking, so that ultimately, obstetricians, midwives, rural nurses and rural doctors can work better together."

11. The impact of COVID-19

At 13:30 hrs on23rd March 2020 Prime Minister Jacinda Adern moved New Zealand into Alert Level 3 effective immediately. Then two days later at 23:59 hrs on 25th March 2020, the nation went into Alert Level 4 and the went into self-isolation.

Working closely with our Transalpine partner Canterbury DHB, we prepared for these events by updating our policies and procedures in response to changing COVID-19 alert levels.

Women, staff and our communities were kept up to date with how this would impact on birthing and labour and visiting hours via our Maternity Services Facebook page. Visitors were reduced during this time to only one support person being allowed to accompany the woman. Staff were trained in the donning and doffing of personal protective equipment and we were fortunate to have good supplies available for staff.

When we returned to Alert Level 2, we again worked with our Transalpine colleagues to develop a survey to determine what the impact of Alert Levels 3 and 4 had on our women birthing during this period – this survey is attached (Addendum 2). This form was provided to our women with postage paid on the last page, so they could simply fold and mail.

During the COVID-19 lockdown period, there were 19 women who birthed at our facilities and 1 woman who came in for postnatal care (birthed at roadside). Of these 8 responded to our survey asking how we did during lockdown (40%).

None of women who responded to the survey birthed at home.

Our respondents

Ethnicity	Māori	NZ European	Pacifica	Asian
Responses	2	4	1	1
	25%	50%	13%	13%
20-29 yrs	2	1	1	0
30-39 yrs	0	3	0	1

Post Natal Care

Mother			Postnatal Care Location	
Age Group	Primips	Multips	Home	Greymouth Maternity
				
Responses	3	5	2	6
	38%	63%	25%	75%
20-29 yrs	2	2	0	4
30-39 yrs	1	3	2	2

None of our respondents had a planned C/Section or had planned a birth at a DHB unit and changed that to a homebirth.

Were you affected by your support person not being able to visit during your stay after your baby/pepi was born? If so, How?

Response	#	More detail – if supplied
Yes	4 50%	• I decided to go home as soon as possible after my baby was born because I knew my husband couldn't visit. • I left hospital asap. I have a toddler at home who also needs her mother. If their father and our toddler could visit I would of stayed longer for more help especially with latching
No	4 50%	• No as we went home immediately after the birth • No, my husband was allowed to stay with me the whole time

Did COVID-19 change how long you stayed in hospital after baby/pepi was born? If Yes, at request of hospital?		
Response	#	More detail – if supplied
Yes	5 63%	• We went home straight away, this was our choice • I left because the support wasn't there for me. • It was my choice to return home. Being my second baby and knowing my husband would help, I felt it was a better choice for my family. • My choice to stay one night • My choice.
No	3 37%	• No, we were allowed to stay until I had established breastfeeding and was comfortable going home.

How well supported did you feel in hospital after you had your baby without the presence of visitors e.g. rest, readiness for going home?		
Response	#	More detail – if supplied
Well Supported	5 50%	• Very well supported • Very well, the hospital midwives/nurses/lactation consultant were great • Great. In the few hours I was there post birth the midwives were fabulous and very helpful in facilitating my prompt discharge • Felt well supported, was a short stay and partner was there • Very well supported
Not well supported	2 25%	• Not very well. I felt alone in the hospital and there was no support to help with latching • Not particularly, felt like i had more support from staff after my first born a couple years ago.

How did you find your stay in terms of support for breastfeeding?		
Response	#	More detail – if supplied
Well Supported	4 50%	• Very good support • Pretty good, but different midwives had different ideas. I felt best after I saw lactation consultant nurse on second to last day and she really made the difference. • No issues • Very good • Very well supported
Not well supported	2 25%	• No support • Again, I felt like I had more support and guidance after my first born than this time during lock down
N/A / Blank	2	• I formula fed from birth, so this did not apply to me

If applicable, how did this compare to your previous stay after having a baby / pepi?		
Response	#	More detail – if supplied
Applicable	4 50%	• Last time I stayed 3 nights as my baby needed to be monitored • Was much shorter, midwives left me to it but helped if I asked. First baby the midwives were more hands on • I felt very alone this time. The only time the ward midwives would come check if everything was ok was if I called for them or obs had to be taken otherwise I was completely alone with my new-born • About the same
N/A / Blank	4 - 50%	

How did you feel about your LMC not being able to visit?

- The after care of the midwives and nurses on the wards was amazing and Jenn especially went above and beyond to make sure my wife was comfortable after the birth as she had had a spinal block and I wasn't allowed to stay due to the Covid restrictions. I wasn't made to feel that I had to leave straight away and they were happy for me to stay and spend time with my wife and new baby for a little. Throughout the night Jenn checked on my wife and baby and helped with the breastfeeding. When I returned the following morning one of the nurses informed me she had ordered me a lunch (very tasty) and I was able to spend some valuable time with my new family. During this time, we were visited by both Reuben and also the Anaesthetist who checked to ensure my wife was recovering well and she was discharged the following day.
- I was able to see her the day after my c section before level 4 started, after that she text and called me which was awesome
- I was very unsettled, I had no contact what so ever
- My midwife visited at home
- It would have been good to have her visit but understandable. She was very supportive via phone
- My midwife is great to communicate with over phone. Would of been nice if she was able to take baby's obs and reassure me that she was ok
- Ok. She was still able to support me via phone

What was best about your care during your hospital stay over this time?

- The care and support provided by the whole team at Grey Base including Rana LMC
- That the nurses understood what a weird time it was. I just felt well cared for by the midwives
- During and after the birth I found the staff to be cheerful, helpful, and understanding that this was a possibly stressful experience. They handled themselves impeccably and I appreciate them putting themselves in harm's way to ensure women and babies are safe and supported during their birth.
- A quiet ward
- I got to see someone outside of my bubble
- The midwives on the ward were lovely and made me feel very safe

Are there ways in which your care could have been improved during your stay in hospital?

Response	#	Comments – if supplied
No	4 50%	• Nothing that really stands out • I was happy with the care provided
Yes	4 50%	• I feel if the supper was there it would have been better • More support for breastfeeding • Having my partner there would have been nice
Blank	1	

What was the effect for you and your whanau by having to stay in your bubble at home? Any comments about not having visitors at home due to lockdown?

- It helped us get better rest and we were well supported by our LMC. However, we also felt a little isolated and would've liked to see friends during this time.
- It was hard, emotionally and physically. My husband had to be back at work the day after we got home so I was on my own with baby for a few hours. That was difficult physically. Mentally I'm heartbroken at everything that was missed out on. Meeting people, photos, early bonding with family etc. My grandad passed away and not being able to be close with family was hard.
- It affected me a lot as my family live elsewhere and we're not able to be there to support me
- Loved it to be honest. It was precious family time and a relief not to have to host people all the time
- Hard not have family support but positive for bonding and breastfeeding on demand
- It's hard. With a new baby you can feel isolated and overwhelmed when you have support of friends and family, without that support it's even harder. As great as technology is with communication there is things it cannot do. Sometimes all you need is someone to come make a cuppa and hold the baby for a while, it gets stressful for mum and the rest of the family being stuck at home with no support. I think the prime minster has already forgotten what it's like having a new born
- It's been nice and quiet so I've been able to get lots of rest. We have two other children (3 total)

12. Quality Improvement

12.1 Induction of Labour - Misoprostol

We continue to audit our inductions of labour to identify trends. We introduced Misoprostol as our induction of labour active ingredient for ripening the cervix and are auditing its effectiveness in the induction of labour process. Our women are appreciating this less invasive method of IOL.

12.2 Fetal Pillow

The fetal pillow is a disposable soft silicone balloon that is designed to elevate an impacted fetal head out from the pelvis during a second stage caesarean section making the delivery safer, easier and less traumatic for the mother and baby.

At the West Coast DHB we started using the fetal pillow for women in advanced labour with the head deep in the pelvis to reduce the risk of fetal injury during c/section. Staff have noticed the improved safety for the baby and are now familiar with the equipment.

12.3 Maternity Incident Review Group

The WCDHB has a "trigger list" to guide the reporting of maternity incidents. The trigger list includes incidents that match the clinical indicators list e.g. PPH and other types of incidents that are less than optimum for Mothers and their babies/pepi. Maternity incidents are reviewed to provide feedback to the submitters and to identify opportunities for continued quality improvement.

12.4 Forms updated with consumer input

We met with a group of our Mums during 2020 and worked with them to update our forms;

- Nuchal Translucency Screening Consent
- Iron Infusion form

to make them more easily understood by our women. This group also had input into the design of the Maternal Mental Health Stickers that have been placed inside all Wellchild Tamariki Ora books.

12.5 LMC Registration Data

There is a wealth of data collected on the LMC Booking Form that helps inform us of where we need to focus our efforts. We already collect data around the maternal mental health of the woman and have recently added the BMI and smoking status of the woman; if she is a smoker/vaper, how many per day, whether it was discussed with the woman and if the woman accepted referral to smoke change. We have made a change already in that woman who are smoking at time of registration will be informed that they will be referred for smoking cessation advice; they will have to opt out of the process, rather than have to opt in which was the case. We expect to see this change reflected in more woman taking up the smoking incentivisation programme.

We are interested in smoking status at registration and BMI as it will help inform us of the implications the Growth Acceptance Protocol will have on radiology services and referrals to the tertiary provider for higher BMI women.

12.6 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.

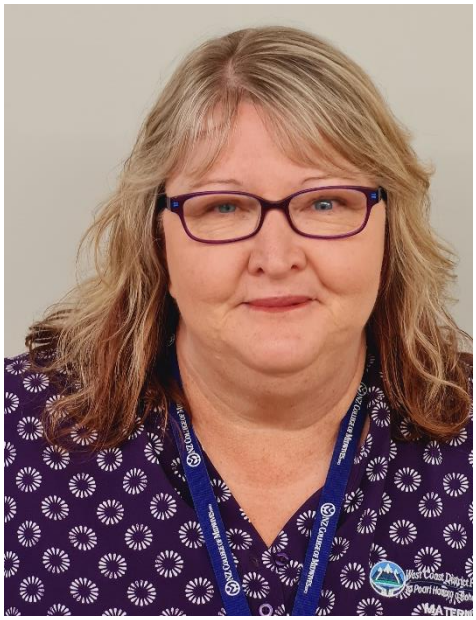
12.7 Consumer & Community LMC input into Maternity Operations

Our consumer representative Anita attends the MOG (Maternity Operations Group) meeting, and her feedback has been essential and very valuable to ensure that we are mindful of how the decisions we make impact on our consumers. We appreciated hearing the voice of the consumer at our meetings to keep our focus on our women. We're also mindful of the fact that our community based LMCs work closely with our teams and we have a Liaison LMC that links community and core LMCs.

As a small rural workforce, it's crucial that any decisions we make that could impact on our community based LMCs are discussed with them and that we keep them informed. Likewise, they keep us updated on any issues they face so we can all work together to ensure women continue to receive the best possible care.

MATERNITY STAFF IN THEIR XMAS SCRUBS

13. Our People / Our Team



Dawn Kremers – Clinical Midwifery Manager

This is a new role for me. I moved from Canterbury to the West Coast in 2015 and worked as a Lead Maternity Carer (LMC) based in the community. I have 20+ years' experience as an independent midwife working alongside and supporting many amazing women and their whānau throughout this time.

My role also took me to South Westland to support the women living there, which allowed me to work alongside the Rural Nurse Specialists with the added bonus of driving through some beautiful scenery, which you never tire of seeing.

I was offered the opportunity to take on the role of Clinical Midwifery Manager (CMM) to cover parental leave in 2019 and I'm glad that I did. I love working as part of a larger team and linking the community with the secondary health service. This is now a permanent role, which I have taken on at full speed ahead!

Our maternity unit staff are an amazing team, working alongside other health professionals, including LMCs providing exceptional maternity care and support to our West Coast mothers and families/whānau. Our region is long and includes Buller, Reefton and South Westland. I feel very privileged to be a part of this team.

As CMM I have faced some big challenges in 2020; firstly, with COVID-19 which changed so many lives. Maternity services continued to provide quality care as women were still having babies during the lockdown period. However, we did need to tighten up on our isolation procedures and staff were trained in the use of personal protective equipment (PPE). Everyone coped well under the circumstances and kept themselves and their families/whānau safe. I am very proud of the way our team rose to the challenges COVID-19 delivered and how they continued to provide excellent care and support to our women and their families/whānau. Close liaison with community based LMCs meant we were able to keep a close eye on our new mums and babies/pepi.

PATSY, PADDY AND LORRAINE FAREWELL MCBREARTY WARD

The second, and more exciting challenge I faced, was the move from our old McBrearty Ward at Grey Base Hospital to our lovely new Maternity Unit in Te Nīkau Hospital and Health Centre. "Dumping the junk" from the old McBrearty Ward was an interesting exercise in self-control, but also a good opportunity to have a clean out. The move itself took place on the 29th July 2020 and went smoothly. Old and new staff who worked / had worked in McBrearty Ward gathered to farewell the ward. It was a great opportunity to catch up.

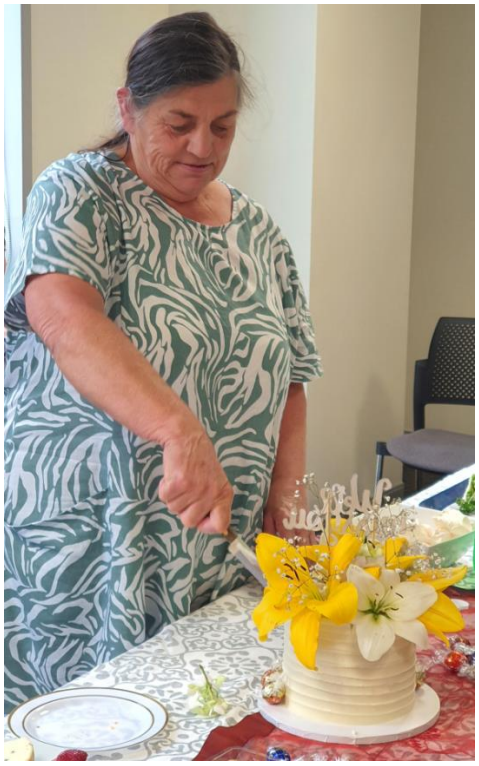
We had our last baby in McBrearty the afternoon before we moved, and the first baby born was born in the Maternity Unit, Te Nīkau Hospital on the 1st August. Staff have settled in quickly to the new environment.

Our new Maternity Ward

We had a visit by Rt Hon Jacinda Adern, Prime Minister when she visited Greymouth to officially open Te Nīkau Hospital and Health Centre. She was really impressed with our new facilities, especially our birthing rooms with the scenic murals behind the birthing pools.

Women coming to birth at Te Nīkau have the luxury of their own private room with en suite and their partner has been catered for in terms of pull out beds meaning new families can bond in those first initial hours. Our women love the new unit and feedback has been very favourable. It is a great environment in which to work and safer in terms of security that our old ward.

STAFF SHOW RT HON JACINDA ADERN ONE OF THE NEW BIRTHING ROOMS



JEANETTE CUTS THE RETIREMENT CAKE

Unfortunately, sadly we said goodbye to two of our amazing long-term staff members to retirement. We wish both Paddy and Jeanette a well-deserved rest and wish them well for their new challenges in the future. Both of these fabulous women had given 50+ years to nursing and midwifery on the West Coast and have delivered, literally a couple of generations of some families. Both will be missed by staff and the families they have served during their long tenure with the DHB.

I look forward to further challenges and what this new role has in store.

Dawn Kremers
Clinical Midwifery Manager

SOME OF THE "OLD GUARD" CAME TO WISH PADDY WELL IN HER RETIREMENT

Countdown Donations

Countdown once again supported us to purchase the following items for our Maternity ward. We have appreciated the financial support from Countdown, without this we wouldn't of been able to purchase some of the items we now use in Maternity. Sadly, 2019 was the last year of this support.

- Birthing Couch, birthing mats and ottomans
- Birthing room murals behind the pools
- 2 x Infrared thermometers

COUNTDOWN STAFF AND THE MAYORESSS PRESENT THE CHEQUE

1 BIRTHING RM 2

BIRTHING RM 1

BIRTHING COUCH

Linda Monk – Midwifery Educator

Education Provided in 2020

What a year!

Well what can I say? I started the year with a hiss and a roar with a lot of education planned for this year. Although COVID-19 did cause many postponements I managed to fit most of our ongoing education in for the year.

An advantage of only providing education to small groups meant I was able to provide most of the planned education, however unfortunately COVID-19 meant we were unable to deliver the Breastfeeding Workshop.

Emergency Skills Workshops for Midwives

Recertification of Emergency Skills Workshops for midwives continued with three of these workshops held throughout the year. The workshop includes:

- New born Life Support skills and scenarios
- Pregnant woman collapse
- Resuscitation of baby and child

We practice skills including shoulder dystocia, cord prolapse and post-partum haemorrhage. The workshop also provided a forum for a great discussion about the events happening in New Zealand and around the world with COVID-19. We were able to discuss and demonstrate PPE in these groups and talk about how this would affect our ability to provide quality care to our mothers, babies and their whanau.

Rural Generalists in the Maternity Service

Rural Hospital Specialist, Dr Brendan Marshall provided a presentation about the role of Rural Generalists; how they practice and how this will be implemented into the maternity workforce on 14th February. It was well received by staff.

FSEP Workshop

It was a stroke of luck that I had booked our FSEP Workshop to take place early in 2020. We were able to hold this before the threat of COVID-19 became evident in New Zealand and we went into lockdown. This was well attended by staff working in maternity services. In total we had 17 midwives, 2 registered nurses and 2 senior clinicians attend; 21 maternity staff which is the bulk of our workforce.

Newborn Life Support

Throughout the year nine Newborn Life Support courses were delivered, seven in Greymouth and two in Kawatiri Maternity Unit, Buller Hospital. This 3-hour course requires pre-reading and has a quiz component followed with lectures and then practical skills on the day. This assists in helping staff improve their skills and refresh their knowledge in providing neonatal resuscitation.

Neonatal Skills Day

I delivered a short course "Neonatal Skills Day" for the midwives. This course covered various clinical skills including taking blood sugars and the treatment of hypoglycaemia in the Newborn, jaundice and the use of the phototherapy lights, how to take cord and capillary blood gases and use of the B450 monitor.

Moving to Te Nīkau

In June we began preparations for the move from McBrearty Ward, Grey Base Hospital into the new maternity unit, at Te Nīkau Hospital and Health Centre. Our old ward was outdated and not maintained, and all staff had been looking forward to the move to the new facility for a long time.

Orientations for the new hospital began first with an overall walk around of the new facility followed by individualised orientations with small groups within their own services and relevant part of the facilities. Fire training was conducted prior to this and was a prerequisite prior to all orientations. My role was to conduct orientations for all staff that would be using the maternity facility; including all midwives (community LMCs and Core LMCs), all Obstetricians and allied health services staff. Each of these staff were given an orientation package which included "treasure hunts" to find where equipment is stored, the use of emergency equipment, correct use of call bells and procedures, using patient call bells and tv remotes and using swipe cards to enter and exit the ward. All training had to be completed before staff could begin working shifts in the new facility.

Newborn Observation Chart / Newborn Early Warning Score

8th June saw us roll out the NOC/NEWS (Newborn Observation Chart/ Newborn Early Warning Score) in our maternity unit. The NEWS has been developed to assist with early recognition of clinical deterioration of infants who are at risk with the aim of improving outcomes for these infants. This chart is a vital signs chart developed nationally to standardise the initial assessment and care of all newborns in New Zealand. It will also provide a single view of clinical information and assist in recognising trends, which may indicate a baby's condition has deviated from the norm.

Helicopter Familiarisation Day

Helicopter Familiarisation training was held in October and was attended by the new midwives who had joined our team throughout the year. The paramedics staffing the helicopter were very informative and they allowed the midwives to lie on the stretcher to get the feel of what it would be like for a woman transferring in the helicopter. This lets our midwives put themselves in the woman's shoes and experience it for themselves.

MIDWIVES PRACTICE BEING A "PATIENT" INSIDE THE CHOPPER

Perinatal Anxiety and Depression Aotearoa (PADA) Seminar

In November we held our PADA (Perinatal Anxiety & Depression Aotearoa) seminar which had been postponed from April. More than 1 in every 10 women in New Zealand will develop a mental illness during pregnancy or within the first year after having a baby. These seminars provide professional development for those supporting families affected by mental illness related to pregnancy, childbirth and early parenthood. This seminar was well attended with over 30 multidisciplinary health professionals including midwives, rural nurse specialists, Plunket nurses and Poutini Waiora (local Māori health provider). Our speakers were Liora Noy a PADA Educator who talked about taking off the pressure, supporting mums with Breastfeeding and post-natal depression and maternal wellbeing. Peter Ashton and Robin Atkinson from Alcohol & Drug Services covered supporting clients with addictions during the perinatal period. Vicki Piner our Maternal Quality and Safety person presented the Maternal Health Pathway; our improved and easy to follow version which is currently being reviewed and updated as necessary. Patricia Hsu from the West Coast Primary Health Organisation talked about Brief Intervention Counselling services they provide for women and how attendees could access it for their women.

STABLE Course

Our STABLE Course was held mid-November. This programme provides general guidelines for the assessment and stabilisation of sick infants in the post resuscitation, pre-transport stabilisation period. Canterbury DHB based Neonatologists Maggie Meeks and Bronwyn Dixon travel to the West Coast to facilitate this course once a year. Midwives and doctors that attend gain important information about neonatal stabilisation and the ability to provide a uniform, standardised process of care and comprehensive team approach to improve the infant's overall stability, safety and outcome. This is a very popular course and was attended by 19 midwives and doctors.

Perinatal Pathology

National Perinatal Pathology Lead Educator Kay Jones flew from Auckland to bring us a workshop about "The Practicalities, the people and the Partnership." She talked about the work that goes on behind the

scenes when a baby dies and different aspects of care and responsibility for that baby during the process of post mortem and the returning the baby to whanau for burial.

Summary

Overall, even with the effects of the COVID-19 lockdowns we were able to provide a significant amount of education throughout the year.

We were very excited to move into the new hospital Te Nīkau and try out the new facilities and technology we had for delivering our education.

Thanks to my midwifery educator colleagues throughout New Zealand and my Workforce development team who help and inspire me throughout the year. Also, thanks to Dawn Kremers our Clinical Midwife Manager who keeps me on time and on track.

CLINICIANS AT THE PROMPT TRAINING

Barbara Roberts, Newborn Hearing Screener

Universal Newborn Hearing Screening Early Intervention Programme

BARBARA ONE OF THE TWO SCREENERS

The Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) recently celebrated its 10-year anniversary. The programme was announced by government in 2006, implementation began in 2007, and full national rollout was completed in August 2010. Around 95 percent of families now have newborn hearing screening testing for their babies.

Each year, it's estimated that between 135 and 170 babies are born in New Zealand with mild to profound permanent congenital hearing loss. Identifying hearing loss early means children can get the interventions they need as soon as possible, to help their language, learning and social development.

Data reported in the Deafness Notification Database indicates that since the start of the programme, there has been a significant shift in the age at which a hearing loss is identified, with more babies having their hearing loss identified before they are one year of age. In 2010, the average age hearing loss was identified was 14 months; compared with at five months in 2018."

The Ministry of Health and the Ministry of Education jointly oversee the delivery of the UNHSEIP. DHBs are the main providers of newborn hearing screening and follow-up audiology services. The Ministry of Health and Ministry of Education provide funding to support early intervention services for those babies who have a hearing loss identified through the programme.

There were quite a few challenges over the first half of 2020. COVID-19 Lockdown to Level 4 from March 26th to April 30th 2020 meant the screeners could only screen babies in the maternity unit before they were discharged. All hearing screening clinics were cancelled. Some babies were nearly three months old when we moved down to Level 3.

The National screening unit in Auckland required babies over 6 weeks of age be screened by Audiologists. Myself and my colleague, as West Coast screeners pointed out that meant West Coast parents would had to travel with their babies to Christchurch. Due to us both being experienced in screening babies 2-3 months old, the National Screening Unit allowed us to screen older babies. This allowed us to provide this service, here on the Coast and saved unnecessary travel for our West Coast parents. By the end of May 2020 all babies born between March and May 2020 had been screened except for one whose parent had declined screening.

Hearing screening clinics were resumed on April 30th. Each appointment was 45 minutes long to provide enough time between appointments. This also meant no one was left waiting in the waiting room; our parents appreciated this. To maintain distance and lessen potential contacts, we could only allow one parent / caregiver to accompany the baby at the screening.

At the end of July 2020, we moved into the new Te Nīkau Maternity Unit. No dedicated area had been allocated for the hearing screening programme. However, we are resourceful, so we have everything we need, including the paperwork and spare equipment, set up in a trolley that can be moved to where the clinics have been booked and are being held.

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

Bev Sinnott, Lactation Consultant

International Board-Certified Lactation Consultant (IBCLC)

My role consists of supporting LMCs, Core staff and women of the West Coast to support, protect and promote breastfeeding. I advocate for breastfeeding as the norm for babies and toddlers.

I facilitate breastfeeding support clinics from the maternity unit (by referral) and in the community (drop in) from the Plunket rooms (great parking) once a week on a Thursday. I am hoping to expand this role to other community groups in Greymouth this year.

My role liaises with paediatrics nurses, Plunket Nurses and PHO Breastfeeding Advocates.

I attended a CDHB ankyloglossia and BTAT scoring education session and access and assist with tongue tie releases here on the West Coast.

Maintaining all the breastfeeding equipment from breast pumps to feeding equipment, including antenatal expressing kits and advocate for continued safe improved feeding equipment keeps me busy.

During 2020 and continuing, I have adapted breastfeeding policies and guidelines from CWH to work within the WCDHB's unique environment and culture. As the BFHI Coordinator for the WCDHB I am responsible for maintaining, evaluating and leading the ongoing development of the BFHI to meet BFHI accreditation and certification requirements.

This year all breastfeeding policies and guidelines will need to be reviewed and updated by me in response to BFHI accreditation next year (BFHI is two yearly).

As a BFHI Educator along with Anna McInroe, we aim to deliver education study days twice yearly. During 2021 year we are running a Breastfeeding Education Clinical skills study day, covering the BFHI Ten Steps. I am enjoying putting the clinical skills tool together, a lot of hours in front of the computer though!

Te Nīkau Maternity staff are impressive at embracing all the ideas/initiatives I introduce/initiate; we work as a team seamlessly supporting each other and the women and babies in our care.

CELEBRATING WORLD PREMATURITY DAY WITH:
LINDA MONK (MIDWIFERY EDUCATOR)
ANTONY AND BABY MILLAR BURT BORN AT 36 WEEKS
MARY SULLIVAN (CORE MIDWIFE)
NATALIA MENDOZA (CORE MIDWIFE)

Helen Turner, Kawatiri Unit

The year 2020 has been a challenging one for the whole world and even in our remote rural West Coast region of New Zealand, many families and whānau have been affected by the impacts of Covid-19. Whilst the full force of the Covid-19 virus did not reach Buller, the impact of self-isolation affected everybody and increased anxiety within the community.

KAWATIRI ANTENATAL ROOM

As the winter months approached, many women's routine pregnancy care was required to be postponed due to their family illnesses, as the two midwives in Buller attempted to keep themselves and Buller women and babies safe. Remote rural midwifery care became adaptive, as women often felt safer staying at home and particularly away from hospital environments. Routine blood tests were taken by midwives to avoid unnecessary outings for women and this, along with the increase in phone calls and travel times, greatly increased the daily activities of the midwives. One story remains clear to mind when, during isolation, two very remote rural women met me half way in a secluded car park and antenatal care was provided wearing full PPE, in the back of the women's cars. Thankfully, albeit necessary, it was also found to be amusing for those involved, if only there had been someone to take a photo!

During the 2020 isolation period there were no babies born at the Kawatiri primary facility, the rates of women choosing to home birth during this time and in the months following increased for Buller, likely due to women re-addressing where they felt safest to birth. There was a small increase in pregnant women following the isolation period and Buller midwives appreciated the new bookings.

Overall, 2020 was a quiet year for pregnancies in Buller, with the lowered caseload impacting upon the birth rates for the Kawatiri primary facility. With only 7 women birthing at the facility during the year, investigations began to discover women's reasons for choice of birth place. Reflecting on the feedback gained and exploring impacts upon women's perceptions of childbirth will continue into 2021, in a attempt to align with national movements to support healthy women and babies to birth in New Zealand's primary birthing facilities.

KAWATIRI BIRTHING ROOM

The Kawatiri facility continues to offer support to maternity providers on the West Coast with the availability of midwifery and obstetric clinic spaces, consumables and health promotional information. The coming year will also see pregnancy and parenting education classes hosted by Plunket from Kawatiri. Creating a hub for maternity in Buller and helping reduce inequities to accessing maternity care.

KAWATIRI POSTNATAL ROOM

The facility purchased a new mat for the birthing suite and this has provided women with comfortable options for positioning during labour and birth, enhancing empowerment and well-being for birthing women in Buller. A new TENS machine increases women's options for pain relief and the environment supports the physiological hormone releases during labour, aided by new gadgets such as an aromatherapy diffuser and essential oils, a Bluetooth speaker and subdued lighting. We have a lovely postnatal room here at Kawatiri where partners are able to stay.

Buller women are also welcome to transfer back to the facility after birthing at Te Nīkau in Greymouth if they wish, where they can enjoy the remainder of their inpatient care whilst being closer to their family/whānau in Buller.

Steps towards the new Integrated Family Health Centre in Westport are underway and we eagerly await our exciting new birthing suite that plans to be a spacious room with a purpose-built birthing pool, similar to those in Te Nīkau, Greymouth.

Kawatiri wishes to give a big thank you to all the kind knitters in the community who donate newborn garments such as hats, booties, cardigans and even balls! They are much appreciated and well-loved by the families who use our facility here in Westport.

SOME OF THE LOVELY KNITTING KINDLY DONATED

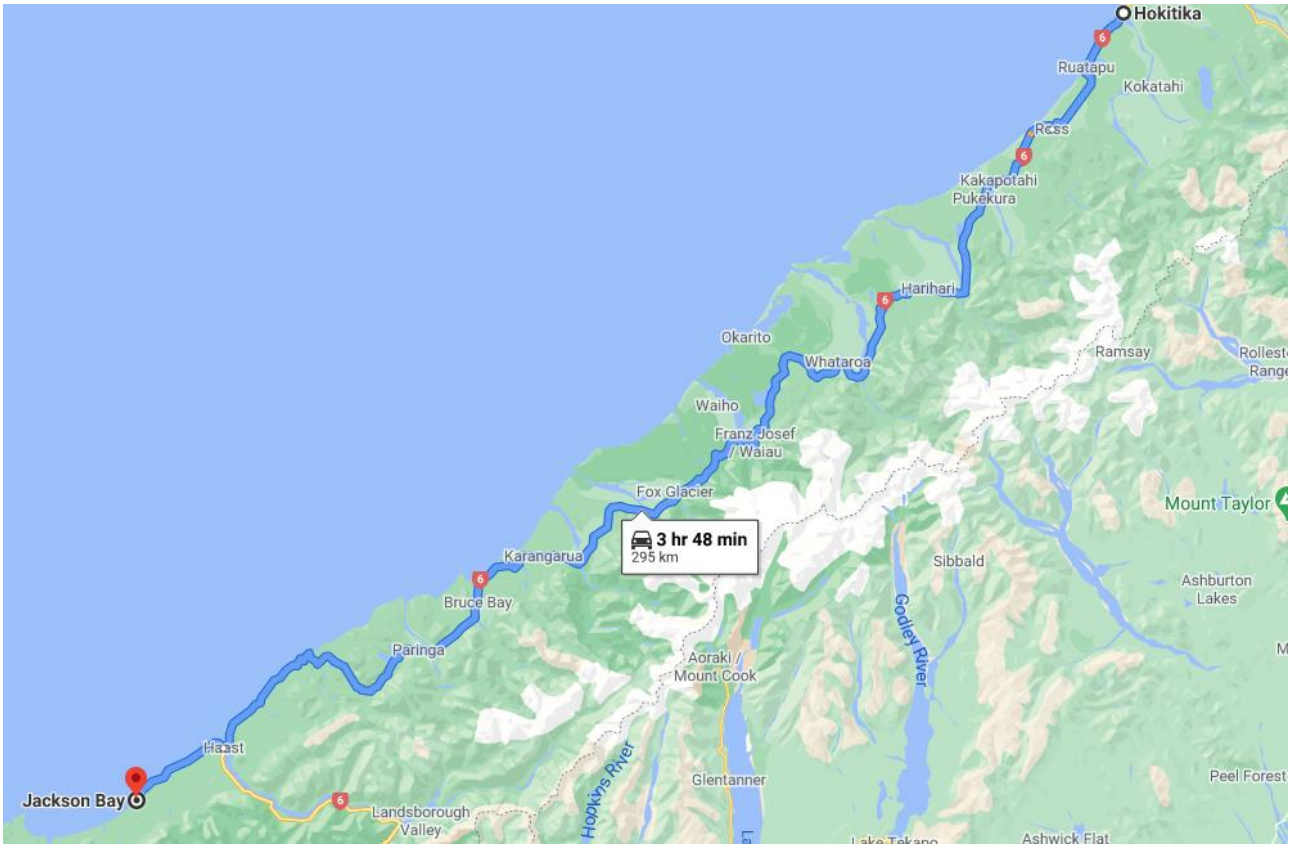
Lou Rubens

Rural Lead Maternity Carer, South Westland

LOU STOPS FOR A CUPPA

Hi, my name is Lou Rubens and I have the pleasure of being a rural Lead Maternity Carer serving the needs of our rural South Westland women. The area I cover stretches, geographically from Hokitika to Haast – approximately 295 km down the West Coast of the South Island.

Travelling this type of distance, in the rural, remote landscape requires me to think about all potential possibilities and what I might need to take with me in the car. I need to be prepared for whatever happens in terms of weather and road conditions. I always have on hand toilet paper, hand sanitiser, a blanket and sleeping bag (in winter), medication, first aid kit and 2 x phone car chargers.



There are many "dead spots" on the road south where mobile phone coverage is not available, so I make sure I let people know when I am heading south and when I expect to return. The area is so remote in places, that if you were to go off the road, you might not be discovered for some time. I am also considering purchasing an EPIRB (emergency locator beacon) as an additional safety measure, as this works on satellite and if I get into difficulty, it can be activated and I can be located quickly.

Although Google Maps suggests this journey is around 3 hrs and 48 minutes, in reality it can take much longer when weather and other road conditions hamper travel. There is only one road south and the famous wild West Coast weather can cause wind gusts, flooding, slips, bridge washouts and road works; all adding delays and contributing to more time on the road. Travel can definitely be challenging at times.

My typical week starts on Monday where I see local women or rural women who are up in Greymouth (for scans, etc.) in the Greymouth clinic. On Tuesday, I cover Hokitika and the surrounding district seeing the women living there.

"Why do I do it? I love getting to know the women. Rural women are real people and on a good day the scenery is breath taking"

Lou Rubens, Rural LMC

Wednesday is my "South Westland Day" and I start early. Today I will be on the road driving for at least six hours. I'm up early packed and on the road by 0700 hrs. After around 1 ½ hours driving, I will be in Hari Hari. seeing women who need an early appointment in their homes, as the majority of these women live on dairy farms and it is on my way south. After seeing these women, I carry on through to Franz Josef Township, around another hour's drive.

I see most of my women in the Franz Josef Clinic. However, if possible, I will do home visits and see some of the women at their home on my way south. Women living further south will generally drive up to the Franz Clinic for their appointments, coming from Whataroa, Fox Glacier and some as far south as Haast (2 hours' drive to Franz). These women think nothing of hopping in the car and driving huge distances and see it as part of their reality of living so remotely.

After my clinic finishes, I do home visits; sometimes involving further travel as far south as Haast and if it's getting late in the day and/or I have more clients to see the next day, I will stay in the DHB provided accommodation in Franz Josef township for the night. If it is only a day trip south and not too late in the day, I'll head back after seeing my postnatal women again seeing women on my way back that I wasn't able to see earlier.

Animals can be interesting in the rural setting. I have had llamas get loose and had to navigate them on the road and cattle and other livestock can hold up travel. So why do I do it? Well, for me I love getting to know the women. Rural women are real people. And on a good day the scenery can be breath-taking.

Living so remotely and so far from secondary based care means there are additional considerations for rural women. One of my women home birthed in Hari Hari; but she was a multip with a previous normal birth. Due to travel times we recommend that women living further south come up to Te Nīkau Hospital for their birth – we discuss when they might want to come up to Greymouth and whether they have

somewhere to stay in their early stages of labour. Some women will choose to come up to Greymouth a couple of weeks earlier than their EDD and stay in Grey with friends and family. The Whanau Facility at Greymouth can be booked, but as we know, babies do not arrive on a schedule, so a backup plan is required.

I love that the women are so flexible; they understand the complexities of living in a rural environment and are realistic in their expectations and travelling times. They are a hardy bunch of strong, independent women forged that way by the environment in which they live. It makes it a real pleasure to work with them and to be a part of their special journey through pregnancy and childbirth. Rural communities are small; all the women know each other and this comes with difficulties and benefits. They all know I am the one looking after all the pregnant and postnatal women; their friends, their sisters and themselves. What they lose in privacy is gained in security and strong relationships are formed. Travelling so often into their communities mean I have become part of these rural communities and I'm treated as a local. I feel that this makes the service I provide a much more personal service.

The biggest challenge I face is the travel and travel times especially for a woman who has higher needs or a baby that is not gaining weight. Sometimes I have had to travel huge distances to see women I needed to monitor, to turn around and come back and go south again the next day. What makes this all possible is the excellent support network provided by the rural nurse specialists, the Rural Generalists for Obstetrics; we all work in together and they will check in on the women and the rural nurse specialists provide well child services.

The sustainability package offered to my LMC practice makes the provision of services to South Westland rural women possible as well as the support provided by the West Coast DHB. Without this support, the service would not be viable and South Westland women would struggle to get care. The WCDHB provides the use of a vehicle, covers fuel for all home / clinic visits, and provides overnight accommodation in Franz Josef if needed. Just having the car and fuel provided alone makes the

"The sustainability package offered to my LMC practice makes the provision of services to South Westland rural women possible."

Lou Rubens, Rural LMC

difference to the viability of the service and makes the world of difference. Free access to DHB midwifery education also allows me and my colleagues to keep our skills up to date and relevant. Community based LMCs all have access to the internal WCDHB intranet and are kept up to date with all events occurring in maternity services making us feel an integral part of the small team providing maternity services for our West Coast women.

I love being part of a community where people know who you are. You may lose your anonymity, but you gain security and a feeling of belonging and community. I love the fact that there are no traffic lights and I enjoy the quieter pace of life. The scenery is gorgeous – it is such a nice place to be.

THE SOUTH WESTLAND STORK ANNOUNCES A NEW BIRTH

Chantelle Taege, Core Midwife

Trained on the Coast and Stayed on the Coast

At the start, I didn't really know why I wanted to be midwife, but as time goes on I see more reasons that prove the decision I made was the right one for me. I like being to be able to help women journey through their transition to motherhood. As a mother myself, I know the kinds of things that would have made a difference to me and what I can do as a midwife to help new mums.

I began my training on the West Coast doing my first-year health sciences at Tai Poutini Polytechnic in Greymouth. In second year of training I chose Ara in Christchurch as it had blended learning; I was able to stay in my home town, have my own tutor here and could do placements on the McBrearty Ward, working with our local community based LMCS. I travelled across to Christchurch for block learning with the other students. We also did hands on skills learning at Ara in their own clinical setting.

I chose Ara because I knew that I wanted to be a midwife on the West Coast. I wanted a programme that would give me the opportunity to be a midwife and to be practising working in the setting that I would work in later on once qualified. It provided me the chance to become familiar with the ward I would work in and to build relationships with the people I would be working with, both in the community and in the secondary service. It also meant that I could stay in my home town and as the mother of a young child this was really important to me. I was well prepared going into the training as I had attended Ara educational sessions. These sessions were detailed schedules of what the training would look like and what the expectations of students are.

It was hard being away from home, working long hours and being on call, however these are all day to day realities of life as a midwife and this part of the course really prepares you well, although it is challenging at the time.

I found the third year the most difficult as this is where you utilise all the theory, skills and learning you've been doing by putting it into practice working on placement with LMCs. I personally spent 13 weeks working with Christchurch based LMCs and came back to the Coast and did 14 weeks placement with the LMCs here, which I followed with a rural placement with the Gloriavale midwifes for 6 weeks. This last year gave me a good mix of working environments; working in Christchurch in the big busy hospital wards, in a city environment, then working in remote rural areas such as Gloriavale and with community LMCs.

Once qualified I chose to be a core midwife in the maternity ward. The reason I chose this is that I enjoy the structure and routine that core midwifery offers. I also get a really good mix of secondary care on the West Coast – being able to have the opportunity to be a part of everything that goes on. As a core midwife, I see such a variety of work and I get to utilise my knowledge and skills across a broad range of areas.

Core midwives are involved in transferring women to higher levels of care, for example at our closest tertiary hospital and it means we get to assist women to get to where they the need the best care. We

provide support in theatre, scrubbing in to receive the baby and work much closer with the consultants on a day to day basis. We're a small team on the West Coast and we all work in well together.

I feel the West Coast DHB provides a supportive environment. The opportunities provided by Ara working on the wards and with the LMCs, meant that when I finished my training I felt I'd already built relationships so from the get go I felt I was working into a more supportive environment. I was already familiar with the environment, knew the type of work we do here and knew key personnel. I felt like I slotted right into the maternity services team.

One of my memorable experiences was looking after a woman who had been induced. Her labour was coming fast and she had phoned her LMC. It was a speedy birth and I had the privilege of catching the baby before the LMC even arrived to the maternity unit. The moment that you catch a baby and bring that baby up to Mum is so special. It's that moment when Mum claps her eyes on her new born that is so special and what I love so much about being a midwife.

"You could see this moment a hundred times, but every time is as special as the first birth you've ever seen."

Chantelle Taege, Core Midwife

What I do miss being a core midwife is that as a community based LMC you are the key support person at the birth helping the woman to deliver her baby and welcoming it to the world. You could see this moment a hundred times, but every time is as special as the first birth you've ever seen.

The Challenges COVID provided

For me, when we went into Level 4 lockdown due to COVID-19 I found it wasn't was as challenging as I initially thought it would be. I think that is because we are a small team and we communicate really well. Protocols, plans and advice were constantly changing, and it was easier, being a smaller team, to be able to keep everyone up to date as we have such good communication networks.

The main feedback we got from our women during this time, was that they enjoyed the one on one time with just them and their baby. For us midwives that was nice to see. We felt that women left the ward more confident as mothers as they had uninterrupted time to focus on their babies, themselves and to establish good feeding and parenting routines. Restricted visiting made such a positive difference for so many of our women.

AVA AND MILLIE DWYER

Farewell – Paddy O'Connell

Midwife Patricia (Paddy) O'Connell retired after providing maternity services to Coasters for over 47 years. Midwife Mary McGrane provided the following (abridged) tribute to Paddy at her farewell afternoon tea on 23 September 2020.

Josephine Patricia O'Connell known as Patricia when times were tense, more commonly known to us as Paddy, was born in the original McBrearty Ward and raised in Runanga when 'coal was king'. Her dad was an underground miner while her mother and aunt trained and worked as Registered Nurses at Grey Base Hospital. Paddy's sister was also a nurse, so it was not surprising that Paddy trained to be a Registered Nurse before training as a Midwife.

PADDY CUTS THE RETIREMENT CAKE

It was midwifery where Paddy worked in both community and hospital settings which would dominate her working life. She worked as a Neonatal Nurse with Jock McLaughlin, Dr Paul Holt and others to care for babies born too early, too small, too big, pink babies that turned yellow and blue babies who wouldn't turn pink. All without the instant support of a tertiary Neonatal team.

Paddy supported families who were confronted with their babies having significant physical challenges when they were born. These days, antenatal scans prepare both parents and practitioners for such instances. She willingly jumped into the Bedford Road Ambulance to take a sick mother or neonate across the alps to Christchurch Hospital. Day or night, summer or winter with only the driver for company, a bag of "stuff" for any emergency en route and a basket of food from the kitchen for comfort. The notion of a retrieval team descending out of the sky was only a dream.

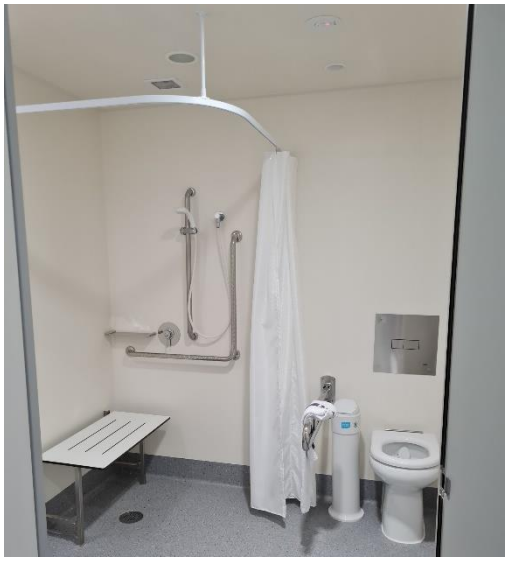
Paddy also worked as a Milk Room Nurse where, well before baby friendly hospital and donor milk became the norm, she made up jugs of milk formula. But more importantly, Paddy was a fantastic team player – the stuff of legends. She was diligent, thorough, persistent, doggedly determined and reliable beyond belief.

Paddy's retirement signals the end of an incredible era for Midwifery on the Coast. We express our heartfelt thanks to Paddy for her contribution to the West Coast health system and wish her well.

14. Welcome to Te Nīkau Maternity Unit

FRONT DESK

TYPICAL ROOM



EACH ROOM HAS ITS OWN EN SUITE

BIRTHING ROOM

NEONATAL ROOM

SHARED KITCHEN FOR WOMEN AND THEIR WHANAU

PUBLIC LOUNGE AREA

14.1 Our First Te Nīkau Pepī / Baby – Emily

Our new Maternity Unit opened on 29th July 2020, but we had to wait a couple of days for our first baby to born in the new Unit.

We welcomed the first baby born at Te Nīkau Maternity Unit on 1st August 2020.

Emily Evelyn Nicol is the beautiful baby of Josh and Dana.

Emily, Dana and Josh live in Westport and we were delighted that they were able to come down to Greymouth a few weeks later to officially celebrate Emily as our first Te Nīkau baby.

In this photo Josh, Dana and Emily stand in front of the birthing pool in the room where Emily was born.

15. Focus for 2021

Our focus for 2021 will be on the items on our Workplan as follows. These items will be reviewed using the Health Equity Assessment Tool to ensure solutions are equitable and address any inequities.

Ministry of Health MQSP Projects – reported Quarterly				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
1	National	Implementation of NEWS/NOC as per national roll out	*Rolled out the NEWS/NOC across all maternity settings on the West Coast* • All staff working within maternity services or with our pregnant women are trained in the use of NEWS and are using the tool appropriately. • Annual refresher training available for current and new staff using the tool.	• 100% compliance in using the tool. • Audit of tool usage indicates appropriate use
2	National	NE Taskforce projects	• Head circumference measured in NEWS/NOC screening to monitor an early warning sign for NE • Antenatal recognition of fetal growth restriction • Growth Assessment Protocol (GAP) used to monitor fetal growth throughout pregnancy and early referral any identified risk factors • GAP education is provided on at least bi-annual basis to all maternity carers both internal and external to the WCDHB.	• Audit of medical charts indicates appropriate use of GAP tool and follow up referrals are made, if indicated to the tertiary centre. • Data captured informs the Radiology requirements to meet the GAP guidelines
3	NMMG Recs 2019 MQSP (1)	Improvements to work place culture and safe staffing	• Staff working within the new Te Nīkau Maternity Unit are oriented to and familiar with the environment	• Policies, procedures and information packages are updated to reflect the Te Nīkau environment and Trans Alpine model of care

Ministry of Health MQSP Projects – reported Quarterly				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
			• Staffing levels are managed within safe staffing guidelines and management aware of and act on any variation to staffing levels • Staff training in the use of submitting Safe Staffing Form in Safety1st • Regular staff meetings which include community based LMCS to identify any issues that require a collaborative approach to resolution.	• Safe Staffing escalation plan used when appropriate • CCDM Co-ordinator reviews Safe Staffing incidents on Safety1st and feeds back to CMM Maternity. • Monthly meetings across the different staffing disciplines to ensure timely and appropriate action to identified workplace culture issues.
4	NMMG Recs (2)	Encouraging low-risk women to birth at home or in a primary facility	• Promotional material / information reviewed and distributed • Primary facility and home birth promoted via Facebook and good news stories • Ensuring our maternity facility on the west Coast maintains a normal birth focus as the only available facility as well as quality secondary care	• 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
5	NMMG Recs (3)	Cultural competency workshops for all Maternity Service staff	• 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 appropriate to their setting.	• At least one session on cultural competency per year is delivered to staff working in maternity services • All maternity services staff meet WCDHB cultural competency training requirements
6	NMMG Recs (4)	Access to post-partum contraception, including regular audit	• Establish a working group to review post-partum contraception	• Increased numbers of women access post-partum contraception

Ministry of Health MQSP Projects – reported Quarterly				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
			• Informational resources identify how to access post-partum contraception	• Post-partum contraception is offered to all high-risk women prior to discharge from maternity unit
7	NMMG Recs (5)	Equitable access to primary mental health services	• Maternal Mental Health Pathway is reviewed, and updated information is current • Work with the WCPHO to capture number of referrals to MH services in primary sector • Liaise with PHO to determine number of women accessing MH services via GP or self-referral • Liaise with LMCs to ensure appropriate data capture, referral and follow up to MH services	• Audit of women who indicated current MH issue on their booking form identifies all were offered access to MH services • All women with identified MH issue at booking are screened using EDPS or other recognised maternal mental health screening tool
8	PMMRC Recs relevant to MQSP (1)	Reduce preterm birth and neonatal mortality	• 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 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:	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 • Following 20 week scan any women who have a placenta which looks like it is

Ministry of Health MQSP Projects – reported Quarterly				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
			• Hospitalised smokers • Smokers enrolled with the PHO • Pregnant women • Households with a new baby • People diagnosed with Diabetes	abnormally situated or developed has a referral • Women who have had preterm births are referred early in the next pregnancy to a consultant for management plan
9	PMMRC Recs (2)	Co-design models of care to meet the needs of Indian women	• Meet with Indian women and their families to identify any barriers to accessing maternity care • Set up a maternity working group (some of this work will be captured in the Early Years project)	• Strategies developed ensure equitable access to services • Demonstrate at least one episode / engagement with these target groups • At least one representative of these women on our consumer groups.
10	PMMRC Recs (3)	Co-design models of care to meet the needs of women <20 years of age	• Provide a forum for women <20 years where they can communicate any specific issues facing them in pregnancy and access to care and support. • Review alternative ways of provision of information to this cohort of women (increased use of technology) • Links to Item 9. above	
11	PMMRC Recs (4)	Interdisciplinary fetal surveillance education for all clinicians involved with intrapartum care	Multi-disciplinary FSEP provided by the DHB for all clinical staff working within maternity services and facilitated for all community-based access holders 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.	• 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

Ministry of Health MQSP Projects – reported Quarterly				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
			• 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	
12	PMMRC Recs (5)	Implementation of HQSC maternity morbidity review toolkit and SAC rating (Maternal and NE Case review)	• Continued use of the HQSC Maternity SAC rating tables to capture incidents within Safety1st that match this list. • All LMCs are aware of the "Trigger List" and record incidents this matching this list in Safety1st	• Review of all Maternity incidents recorded within Safety1st and escalation for RCA investigation if warranted.
13	MWWG (subgroup of PMMRC) (1)	Implementation of Hypertension guideline, with a review / restock of medication to ensure easy availability in acute care settings	• Work with CDHB to develop Trans Alpine Pathway for Hypertension	• Trans Alpine Hypertension Guideline developed and in place by 1st July 2021
14	MWWG (2)	Continued audit of MEWS charts / implementation	• Continued business as usual	• Random audit of MEWS charts indicates appropriate use and if required opportunities for further education which are followed up
15	MWWG (3)	Use of the Health Equity Assessment Tool (the HEAT) to assess services for the impact of health equity	• Use HEAT tool in guiding of any maternity related strategies, policies, guidelines Staff education on HEAT tool	• HEAT Tool used as a guiding document for new policies and procedures.
16	MWWG (4)	Establish a clinical pathway for women with identified placental implantation abnormalities	• Trans Alpine working group to develop pathway for women with identified placental implantation abnormalities	• Pathway easily accessible for staff working within the maternity setting
17	MWWG (5)	Establish septic bundle kits to address human factor components, such as stress in high-acuity settings	• All staff working within the maternity setting are aware of the Septic bundle kids, their location and are using them appropriately	• Sepsis bundle kit established by end of 2021
18	MWWG (6)	Establish clinical pathways across primary and secondary/tertiary care to enable earlier recognition and treatment of sepsis	• All staff working within the maternity setting can locate the Sepsis clinical pathway / sepsis bundle across primary / secondary / tertiary sectors	• Septic bundle is accessible by December 2021

Ministry of Health MQSP Projects – reported Quarterly				
No.	**Driver**	**Project Title**	**Expected Outcome**	**Measure**
19	Local Project	Growing up Well on the West Coast project	• Project engages with women / whanau to capture the communities' needs for the period from conception to at least the first 3 years of life (first 1,000 days).	• Maternity Strategy for the delivery of services as an outcome of engagement • Consumer groups established across the Coast in "regional hubs" that are representative of our community

16. Addendums

Addendum 1: Maternal Mental Health Sticker

MATERNAL MENTAL HEALTH SUPORT AND ADVICE	
Often parents feel anxious or just need someone to talk to. Are you feeling down or a bit overwhelmed? Are you or someone you know feeling out of sorts or depressed? It's ok to feel this way. Reach out to any of the following for free advice and support:	
IN COMMUNITY SUPPORT	
PACT West Coast (03) 768 6660	Poutini Waiora (0800) 333 170
Cornerstone Family Support (03) 768 4290	Family Start (03) 768 6568, 2
Homebuilders West Coast - Grey: (03) 768 6665	Westport: (03) 788 8065
Potikohua Trust (No. 37)Westport: (03) 789 6000	
Text/ talk to a trained counsellor**1737** or **(0800) 1737 1737**	
Breastfeeding Advocates – Mum4Mum Support	
Erin Turley, Grey /Westland (027) 288 0392	Raewyn Johnson, Buller (027) 288 0269
Parenting / Health Support – available 24 / 7	
Healthline (0800) 611 116	Plunketline (0800) 933 922
URGENT SUPPORT FOR WOMAN IN CRISIS	
Triage, Assessment, Crisis Treatment (0800) 757 678	
For clinical treatment – see your GP / LMC for referral	

The Letters in **PURPLE** Stand for

The word ***Period*** means that the crying has a beginning and an end.

The period of "PURPLE crying" refers to a time period when some babies begin crying more and may be hard to settle. http://www.purplecrying.info

Addendum 2 COVID-19 Restrictions Survey

Canterbury and West Coast
MATERNITY CARE

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

How Did We Do During COVID-19 Restrictions?

During your stay with us after your birth we have aimed to provide a consistent level of quality care that meets your needs, despite these challenging and exceptional times.

We are really interested to hear about your experience with us and would appreciate you taking the time to answer this short survey. This will help inform our planning in case of another similar situation.

**To comment on an individual midwife, please provide feedback on the NZ College of Midwives website: https://www.midwife.org.nz/consumer-feedback.*

Where and when was postnatal care provided?

Please tick the ONE area you are providing feedback on

Canterbury: ☐ Ashburton ☐ Christchurch Women's ☐ St George's ☐ Rangiora ☐ Lincoln

West Coast: ☐ Greymouth ☐ Kawatiri

Home birth: ☐

About you

How old are you?

☐ 15-19 years ☐ 20-29 years ☐ 30-39 years ☐ 40+ years

Is this your first baby/pēpi?

☐ Yes ☐ No

Which ethnic group/s do you identify with?

Please tick the box or boxes which apply to you

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan
☐ Niuean ☐ Chinese ☐ Indian ☐ Other: .....

Were you affected by your support person not being able to visit during your stay after your baby / pēpi was born during the COVID-19 lockdown? If so how?

If you had a planned caesarean section at this time, had you planned to have your LMC present as well as your support person originally?

☐ Yes ☐ No
Comments:

For women who had planned to birth at one of the DHB units but then decided not to (choose to homebirth) can you please let us know what prompted you to make this change?

Did COVID-19 change how long you stayed in hospital after your baby/pēpi was born? If yes, was this your choice or at the request of the hospital?

How well supported did you feel in hospital after you had your baby/pēpi without the presence of visitors, eg. rest, readiness for going home?

How did you find your stay in terms of support for breastfeeding?

If applicable – how did this compare to your previous stay after having a baby/pēpi?

How did you feel about your LMC/Midwife not being able to visit during your inpatient postnatal stay? Were you contacted in other ways by the LMC, eg. phone?

What was best about your care during your hospital stay over this time?

Are there ways in which your care could have been improved during your stay in hospital?

What was the effect for you and your family/whānau by having to stay in your bubble at home? Have you any comment about not having visitors at home due to lockdown?

THANK YOU FOR COMPLETING THIS FORM

Please hand it to a staff member or fold and return by post

If you would like to be contacted to discuss anything further, please provide your details in the feedback form on the CDHB website (www.cdhb.health.nz – About Us, Feedback Form).