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

Canterbury and West Coast
MATERNITY CARE

Maternity Quality & Safety Programme

Annual Report 2021-2022

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Te Tai o Poutini Commissioning Team

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

Disclaimer

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

Foreword

Kia ora koutou

Te Whatu Ora Te Tai o Poutini is pleased to present the Maternity Quality and Safety Programme Annual Report for 2021/2022.

Despite the ongoing impact of COVID-19 and then the change to our health legislation to Pae Ora (Healthy futures Act on July 1, 2022) and the accompanying dissolving of the District Health Boards, we have continued to build on work from the past few years which had a focus of equity following the agreement on the Maternity Strategy for Te Tai o Poutini. We have been specifically increasing the work we do with the community and ensuring their voices are becoming louder and also working to reflect our Te Tiriti obligations in all that we do. Having the Strategy framework and now also having Te Pae Tata (the Interim New Zealand Health plan) with one of the Pou being Kahu Taurima (maternity and early years) means that the work we have done has a platform to continue as we realign our maternity systems nationally. In Te Tai o Poutini we understand that we need to meet the requirements of Pae Ora (Healthy Futures Act 2022) and Kahu Taurima and the expectations of both Te Aka Whai Ora and Te Whatu Ora.

Te Tai o Poutini is one of the first formed localities and at the time of writing the Locality Board now has all signatories to undertake the intentions of having such a vehicle within Health to finally address the social determinants and their impact on equity for health outcomes. This is particularly significant for Te Tai o Poutini as a remote rural part of Aotearoa within the region of Te Waipounamu. When we focus on the community and what they are telling us, then, as a system we are listening to their stories and can respond accordingly with an equity focus to provide a maternity service that works for them.

In the past, the focus for much of Maternity Quality and Safety work has rested within the hospital and specialist services part of health. Our Maternity Strategy required us to reorient ourselves and Te Pae Tata insists that we do, specifically relating to our obligations under Te Tiriti o Waitangi, and hear what whānau/ families are telling us. Our health system is now rearranged into Hospital and Specialist Services, Community and Public Health. Importantly, in time, we will identify the horizontal expectations that will link all of these pillars together.

Whilst this new health system has been occurring the Maternity Quality and Safety programme in Te Tai o Poutini has continued to operate within the work programme we agreed. We have continued to strengthen the Clinical Governance of this work and also the input from our whānau. In Te Tai o Poutini we have a whānau representative on our Maternity Quality Governance Group and have the intentions of developing a full Maternity Whānau Group in 2023. This was started and stopped throughout the past two years mainly due to a small workforce and COVID-19 thwarting our efforts. We continue to have most of the births in the past two years occurring at our new maternity unit within Te Nīkau.

The Buller District has struggled with midwifery cover as we lost all three of the midwives due to the vaccination mandate. This area is now recovering and with the opening of the new Integrated Health Centre in 2023, which has a maternity birthing space within it, things are now looking positive again in this community for local maternity care. We wish to thank all the locums and the local midwives- LMC and core who assisted to keep services in Buller maintained during that difficult time.

As with other areas we have noticed a rise in maternal mental health issues particularly anxiety and acknowledge that in the new world occupied by COVID-19 this has added to the already

burgeoning concerns our whānau have. Our local pathways continue to be updated and shared with our community.

Workforce has continued to be a challenge with sickness due to COVID-19 and other life issues that happen. With a small workforce, the impact is marked when there are several of the staff sick. We wish to thank all of the maternity team. It really is a team event in Te Tai o Poutini where everyone steps up and into shifts. Being LMC or core is only about how people are paid and where they work in this locality as they all rally around and are amazing support to each other. We now have local midwifery students who are being supported by their community and the wider maternity service to successfully get through their undergraduate education. These students have many additional challenges by living remote rural not least of which is their financial challenges. At the end of 2022 we recruited two graduates and we are now replicating the rural generalist model of support by having a joint Midwifery First Year of Practice Programme between Waitaha and Te Tai o Poutini. We also offer educational opportunities for all midwives who want to spend time at Christchurch Women's Hospital as part of their professional development. We continue to refine how this works.

The Rural Generalist (RG) model for our medical workforce has been tested during COVID-19 when locum doctors could no longer travel. The model allowed cover for Obstetrics and Gynaecology (O&G) as well as other parts of the hospital, showing how the flexibility of skills this qualification provides, and how the model works so well for a small rural centre. For Te Tai o Poutini we continued to have our RGs working, supported by our O&Gs both on the Coast and in Waitaha. The transalpine working relationship means that whilst the Coast has only around 250 births per annum we can keep many māmā close to home longer with input from the specialist service in Waitaha. The O&G from Waitaha, accompanied by a Registrar when possible, also spend time working on the Coast. This is valuable to improve communication between staff on both sides of the Alps and allows our registrars to see what it is like working in an isolated rural area. It will hopefully foster an interest in providing specialist services to rural areas in the future. In the last twelve months a second RGO has been trained at Christchurch Women's Hospital as well as a locum being credentialed prior to coming to work on the West Coast. These are important aspects to the safety of the RG Model in O and G. The RG model has allowed flexibility and sustainability as well as providing a safe service.

There are always things we could have done better during the pandemic, but we were all striving to do our best each day for women and their whānau. This was an especially challenging time. We linked frequently at this time with Waitaha especially in regard to maternity pathways and then how to adapt them to fit with the Te Nīkau facility.

Our quality frameworks and feedback from staff though the Safety 1st system, consumer feedback through satisfaction surveys and complaint processes and then our reviews at Incident Review meetings means we continue to work to ensure that the quality cycle is completed. We assist in the development of maternity guidelines with Waitaha and then adapt them to reflect how the evidence is operationalised within our community of practitioners.

We want to take this opportunity to thank everyone for all their mahi which at times has been above and beyond. The pride and professionalism shown by all is very much appreciated.

Thank you also to the members of our Community and all the NGOs we work with in Te Tai o Poutini who keep us on track with how we provide care. Big thanks to our MQSP Coordinator Vicki Roper who has now moved into a new role in the Locality and to Natalia Mendoza for picking up this role and moving it forward.

We hope you enjoy reading our report.

Norma Campbell
Executive Director of Midwifery & Gynaecology
Te Whatu Ora Te Tai o Poutini & Waitaha

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

Maegan Cameron – Maternity Consumer Representative

Kia ora koutou, Ko Maegan Cameron toku ingoa. I am a māmā of two boys aged 5 & 2 who were both born here on the Coast, and I am the Maternity Consumer Representative for Te Whatu Ora Te Tai o Poutini.

I was born and raised on the West Coast and have predominantly lived in the Hokitika area. I am immensely proud of my whakapapa and connection to Ngai Tahu, and am proudly supported by my whānau. I also work in the community as a Registered Social Worker, supporting parents of 0-5 year olds.

As a māmā of two young tamariki, I believe the voice and experiences of our mothers on the West Coast need, and deserve to be heard by the providers of our maternity service, and it is my passion to ensure a wide range of diverse voices are heard.

I was appointed to the role of Maternity Consumer Representative in June 2022, and it is my role to re-establish the Maternity Consumer Council, which has understandably been on hold due to COVID-19.

During December 2022, we visited several Playcentres on the West Coast and are looking to continue these visits during 2023. We hope to engage with people who may be interested in being involved with the Maternity Consumer Council, and to have this council re-established and meeting regularly throughout 2023. From this, the experiences, feedback and views of consumers will be directly provided to the Maternity Service here on the West Coast.

I look forward to connecting with maternity consumers within our community and I see a real opportunity to ensure voices of minorities are heard and experiences are used to bring about change into the future.

Nga mihi nui

Maegan

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Glossary

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

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

Abbreviations

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

Background

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

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

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

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

• All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

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

Purpose

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

• Improvements made in relation to overall aims and objectives;

• Achievements against the quality improvement goals set for 2021/2022;

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

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

• Response to consumer feedback and ongoing consumer involvement;

• Quality initiative goals for 2023.

Te Whatu Ora Te Tai O Poutini West Coast – Formally the West Coast District Health Board

The change from West Coast District Health Board to Te Whatu Ora occurred in July 2022. We do therefore mention both the DHB and also Te Whatu Ora Te Tai o Poutini as this is our locality as we move forward with the next year's programme of work. The West Coast District Health Board (DHB) was 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 by population we have the third largest geographical area, making Te Tai o Poutini the most sparsely populated Health locality in the country with only 1.4 people per square kilometre, and a seven-hour travel time by road from end to end.

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

- **Grey District** has the largest population, with an estimated resident population of 14,200 people.
- **Buller District** has an estimated resident population of 9,730 people.
- **Westland District** has an estimated resident population of 8,820 people.

We have the smallest population of any Te Whatu Ora Health locality with one of the largest geographical areas

Population

Te Tai o Poutini has a diverse population with a large and growing Māori population. There are a range of other ethnicities, including Indian and Filipino. The proportion of New Zealand European/Pākehā living on the Coast is reducing.

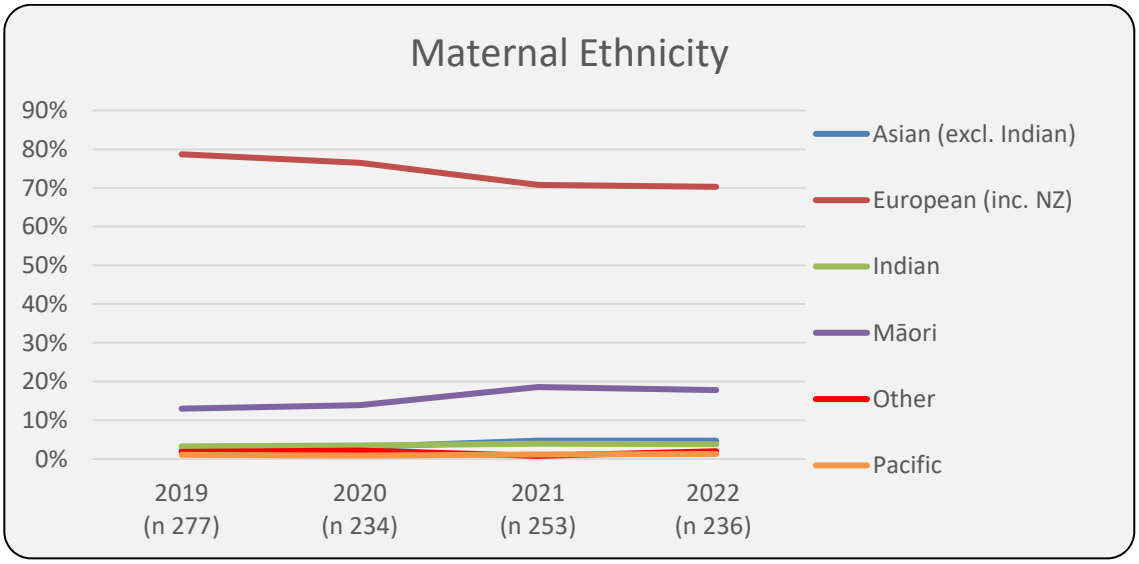
The population is relatively static with the Locality being responsible for 32,700[1] people in 2021/2022; almost unchanged over the last 10 years. We have an older demographic with a higher proportion of people aged over 65 (20%) compared with the national average (16%).

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

On the West Coast there are also many Māori who whakapapa to iwi in other parts of Aotearoa. Irrespective of where they reside, many Māori hold strong connections and sense of belonging to their tūrangawaewae and marae, and their ability to access and participate in Te Ao Māori (Māori world view). These familial and cultural connections provide a strong and enduring sense of identity and are prerequisites to good health. There is a need to increase support and understanding to better reflect these views in our health system in this locality, including and especially in maternity services. Around 41% of our Māori population are under 20 years of age, compared to 24% of the total West Coast population.

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

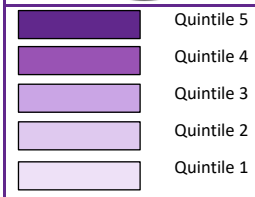
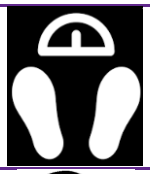
Pacific peoples on the West Coast are diverse. With the main groups being Samoan, Tongan, Cook Island Māori, and Fijian. There is a small but growing Middle Eastern, Latin American, and African (MELAA) population of nearly 0.5% within the West Coast's population.



Ethnicity is also a strong indicator of social determinants of health which impact on other health outcomes.

[1] Source: Stats NZ – 2022 Population Estimates

Maternity Profile

Category	Te Tai o Poutini – 2022 Data from Local Sources and Stats NZ	
	**Birth Rate**	303 babies born to West Coast families
	Estimated 4880 women of childbearing age (15-44) in 2022	Average of 27 babies per month were born to West Coast mothers
	**Maternal Age** National median 31 – 35% of births in 30-34 years age bracket	West Coast median 29 – 36% of mothers are in the 30-34 years age bracket
	**Maternal Ethnicity**	19% Māori 72% European / other descent 5% Asian (excluding Indian) 4% Indian 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**	Te Nīkau Hospital (secondary) 78% Kawatiri Maternity Unit (primary) 0% Christchurch (Tertiary) 9% Home Birth 11%
	**Parity**	35% Nulliparous (1st time Mums) 65% Multiparous
	**Body Mass Index**	49% of West Coast women are considered overweight or obese
	**Smoking at LMC First Registration**	9.8% of West Coast women were smoking at time of registration with their LMC
	**Smoking at time of birth**	5.5% of all West Coast women were smoking at time of birth 44% of women smoking at time of registration were no longer smoking at birth

Te Tai o Poutini Maternity Services

Our Vision

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

Our Values

Mana Taurite - *Equity*

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

Whānaungatanga -*Everyone belongs*

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

Manaakitanga - *Respect for all*

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

Tino rangatiratanga - *Empowering whānau*

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

Oranga tonutanga - *Health and wellbeing*

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

Aroha - *Love and empathy*

Without bias every person[2] is treated with love, compassion and empathy.

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

Maternity Facilities

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

Te Nīkau Hospital and Health Centre

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

Kawatiri Maternity Unit is at Buller Hospital in Westport and is a primary birthing unit, providing care for families with uncomplicated pregnancies. We are eagerly awaiting the opening of Te Rau Kawakawa, the new Integrated Family Health Centre in Westport (opening May 2023) which has a new purpose-built birthing space.

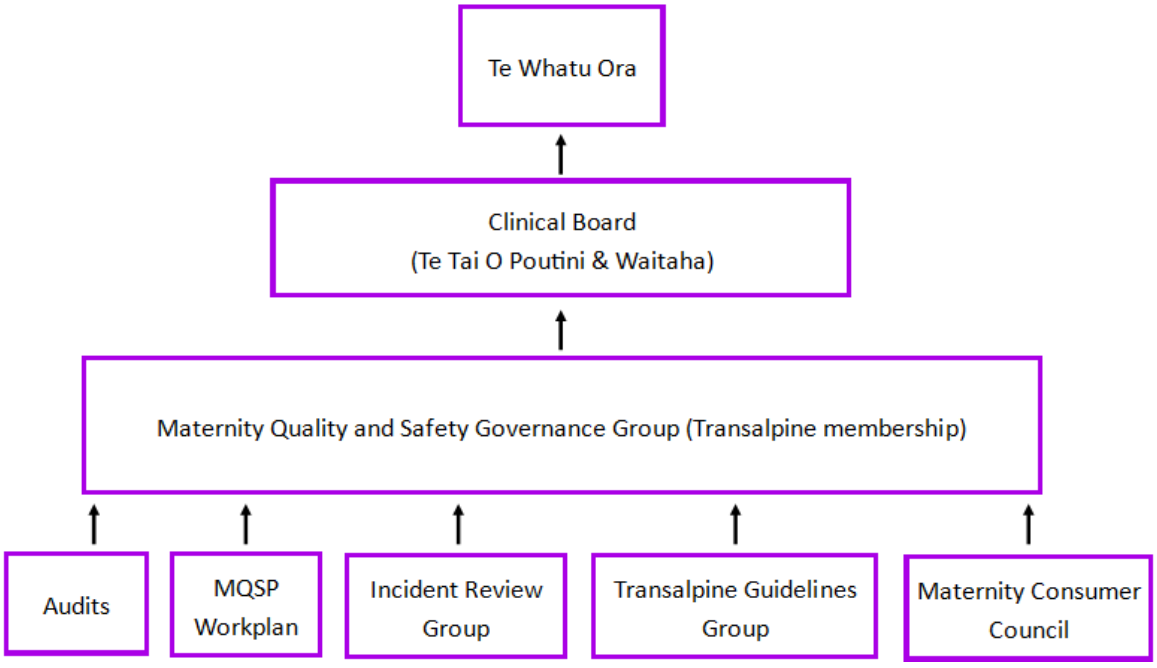
Entrance to Kawatiri Birthing Unit

The table below demonstrates the usage of our maternity facilities for all births to whānau registered domiciled on the West Coast (from Report on Maternity web tool)

Place of birth	Example	2018 WCDHB Rate (n)	2019 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2019	2020 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2020
Home	Home/Gloriavale	6.9 % (22)	7.6 % (26)	0.7%	4.1%	3.5%	11.6% (34)	4.0%	7.0%	4.6%
Primary	Kawatiri	9.1 % (29)	5.8 % (20)	-3.3%	-4.8%	10.6%	2.7% (8)	-3.7%	-7.0%	9.7%
Combined	Home & Primary	16.0%	13.4%	-2.6%	-0.7%	14.1%	14.3%	1.1%	0.0%	14.3%
We continue to have a strong homebirth community and are hoping to see the rate of women birthing in our Primary Maternity Unit in Westport increase once the new facility opens in 2023										
Secondary	Grey Base/Te Nīkau Hospital	74.1 % (237)	74.7 % (257)	0.6%		40.4%	77.1% (226)	2.4%		40.3%
Tertiary	Christchurch Woman's Hospital	10 % (32)	11.9 % (41)	1.9%		45.5%	8.5% (25)	-3.4%		45.4%
Combined	Secondary & Tertiary	84.1%	86.6%	2.5%	0.7%	85.9%	85.6%	-1.0%	-0.1%	85.7%
Birth rates in secondary and tertiary facilities continue to remain steady										

Maternity Governance

Reporting lines and governance outlined below:



Transalpine Partnership

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

From 2010- 2022, the West Coast shared executive and clinical services with Canterbury. This included a joint Chief Executive and clinical directors, as well as shared public health and corporate service teams. Our transalpine model is increasingly recognised as the type of network that ensures clinical teams in both smaller and larger centres support each other to optimise outcomes for whānau and community.

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

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

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

More detail about this Transalpine model and the role of Rural Generalists for obstetrics and gynaecology is contained further in this report.

Our People/Team

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

Transalpine Obstetrics and Gynaecology (O & G) Service

Since 2020 Te Tai o Poutini has had a unique 'mixed model' of obstetric service delivery that involves rural generalist obstetricians working alongside obstetricians to support obstetric services. This model is exactly what is utilised in similar size (and equally remote) obstetric units in Canada, Australia and certain states in the USA.

Key to this model has been formal governance arrangements with Waitaha which sees these clinicians complete their training, credentialing and ongoing up-skilling at the larger centre. Dr Jane Fielder, with close support from her clinical director Dr Emma Jackson, has been visiting the coast monthly to provide service and ensure MCNZ collegial supervision is provided for our rural generalists. Moreover, our rural generalists spend time at Christchurch Women's Hospital with ongoing skill maintenance and credentialing. This is strengthening the links and supports already in place between the two O & G departments. The departments already share a Director of Midwifery, all guidelines and referral pathways and are supported by the transalpine neonatal and paediatric service.

While any new service takes time to demonstrate benefits to Whānau and communities the two most telling benefits in the two years to date has been stabilisation of the SMO workforce and an ability to work through COVID-19 without requiring the fly in and out locums we relied on previously.

As rural generalists are also credentialed to work in ED and primary care locum use across all the hospital SMO locum workforce has fallen dramatically as has the need for locum use in obstetrics. Indeed, many have described the coast as the 'most stable obstetric workforce' in the South Island at present, having managed to release team members for planned leave, sabbaticals and ongoing training at a time when the strain of staffing rosters is really starting to show. This has also meant much more continuity for staff and our community, in both hospital but importantly primary care settings.

The newest member of the team is Dr Sara Gordon. This is significant as Sara is the first NZ graduate to complete the Adv. DRANZCOG (in NZ). Her role will further bolster the team with 6 specialist doctors now available for the acute roster. Moreover, Dr Reuben Hoyte and his whānau have now settled into the coast. While challenging through COVID-19 and staff shortages a key part of his role will be to continue working at Christchurch Women's Hospital on a regular basis to maintain and advance skills and to continue to improve the working relationship of the two services.

The last twelve months has also seen O & G Registrars (specialist trainees) accompany Dr Fielder on her West Coast visits to do clinics and operating lists. This improves the understanding of the registrars as to what the working environment is on the West Coast in regards to rurality, resources and support needs from tertiary services. The aim is to communication between colleagues on both sides of the Alps, assist with continuity and may encourage some to work rurally in the future.

Rural Generalism

Approximately 230-250 babies are born on the West Coast each year; around 80 of these will be via caesarean section. In the past, Te Tai o Poutini has struggled to recruit and retain qualified obstetric and gynaecological subspecialists, relying heavily on expensive locum cover, contributing to a lack of continuity of care for our women. Feedback from community, board

and clinical teams indicated a need to do things differently - to support a sustainable, skilled workforce that provided safe and appropriate care to its small, remote and sparsely located population. We needed a new model of care.

Rural Generalism encompasses a broad skill set in secondary care, with training and standards derived from tertiary care, delivered in a rural context. On the West Coast, Rural Generalist consultants work across GP, Emergency and Medical and Surgical services and have versatile skills. Te Nīkau Greymouth Hospital is unique in now having three permanent Rural Generalist consultants with an advanced women's health skill set - Dr Brendan Marshall, Dr Sara Gordon and Dr Alan Furniss, are rural hospital specialists with additional surgical skills in obstetrics and gynaecology. These types of specialists have provided services to international locations with similar rural context as the West Coast for many years – in Australasia they are known as "Rural Generalist Obstetricians".

For the West Coast rural model, Dr Brendan Marshall was the initial driver, believing this framework was what the West Coast needed to transform all of our services from being heavily dependent on locums, and also to provide teaching and training (pipeline) opportunities. The mantra for this is Right Clinicians; Right Skills; Right Places; Healthy Communities. Brendon was the first person to complete the Advanced Diploma of Obstetrics in New Zealand with accreditation via Christchurch Women's Hospital. He completed his original GP and ACCRM medical training in Australia and finished his advanced obstetrics training at Christchurch Women's Hospital in 2018, having been on the coast since 2013. Brendan was the first Australian GP to complete a Royal Australasian Obstetrics and Gynaecology (RANZCOG) Advanced Diploma of Obstetrics through a New Zealand accredited provider – Christchurch Women's Hospital.

"Te Aka Whai Ora and Te Whatu Ora are both keen to see the model utilised more widely across Aotearoa":

Dr Brendan Marshall on the Advanced Diploma of Obstetrics

The Te Tai o Poutini, Health Workforce New Zealand and the South Island Workforce Development Hub (part of the South Island Alliance of DHBs) supported his advanced training

based at Christchurch Women's Hospital. Dr Marshall is also the Clinical Director of Rural Services and a crucial link in the Maternity Services Transalpine model of care linking clinicians at Te Nīkau Hospital & Health Centre to their colleagues based at Christchurch Women's Hospital.

Dr Marshall advocates for the Australian Rural Generalist programme jointly run by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of GPs (RNZCGP). In Australia, the 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 Rural GP component.

Rural Generalists are credentialed to perform elective and emergency caesareans and acute gynaecological procedures (such as for miscarriage), but not complex gynaecological surgery. Training and oversight is rigorous. The RANZCOG Advanced Diploma curriculum is overseen by the Obstetrics and Gynaecology Specialist College, who put in clear boundaries on what a clinician can and cannot do. Rural Generalist Obstetricians (RGO's) are required to keep logbooks and competence is regularly assessed by senior O & G colleagues requiring the RGO's to visit Christchurch Women's Hospital to work under Canterbury specialists to ensure their skills are up to scratch and they are providing similar standards of safe care.

Dr Marshall notes that there is patient safety evidence, including published literature reviews on similar rural generalist programmes overseas demonstrating safety of this model of service provision in comparison with urban centres. 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". In Nova Scotia, rural hospitals with fewer than 100 deliveries a year performed by rural generalists had the lowest complication and death rates in the province. Brendon's dedication and expertise in the rural sector is well established and he completed a Master's Degree in 2022 focusing on rural generalism in a global context.

While the rural generalist obstetric training programme is relatively new to New Zealand, awareness is slowly spreading, Dr Marshall says. "This qualification is used extensively in Australia, and no other centre in New Zealand has been accredited to deliver the diploma before 2018". It means secondary care specialists are involved in the care of expectant mothers living rurally on the Coast and working alongside primary care clinicians and obstetricians to ensure continuity of services - to reduce the chance of families having to travel to Christchurch for essential maternity services. That said, there will always be certain situations where we recommend delivery or procedures at a tertiary centre, for example where we anticipate higher risk or specific complications or NICU resources are required.

For women with lower risk pregnancies, we have the resources to support the safest possible essential elective and emergency deliveries. As a team, we can provide antenatal assessment and care, caesarean section, assisted deliveries, early pregnancy and miscarriage care as well as specific pregnancy ultrasound services 7 days a week. The Rural Generalism model is about collaboration with obstetricians and midwives to support a more sustainable and progressive way of thinking, so that ultimately, obstetricians, midwives, rural nurses and rural doctors can use their wide range of skills to work efficiently together for all women and their whanau.

Dr Sara Gordon (FDRHMNZ, FRNZCGP) is a dual trained consultant in Rural Hospital Medicine and GP and is the first fully NZ trained rural specialist to undertake the RANZCOG Advanced Obstetric Diploma. Sara has joined the team this year following six months full time training at Christchurch Women's Hospital to consolidate her O & G skills and experience. She has been working alongside RANZCOG O & G specialists and similarly to O & G trainees is assessed against

the RANZCOG curriculum and Christchurch Women's in-hospital accreditation pathways. Sara successfully passed the RANZCOG Advanced exam in December and is now supported as an RGO on the O & G roster at Te Nīkau.

Dr Gordon along with Dr Marshall and Dr Furniss continue to have regular visits to Christchurch Women's for ongoing credentialing and experience as well as being supported by visiting specialists including Dr Fielder. Sara has expressed the training is rigorous and high intensity and emphasises the importance of the high quality tertiary centre training and maintenance of strong interprofessional links with our Christchurch colleagues.

"The quality of our maternity framework reflects the overall wellbeing of our medical system - supporting safe deliveries and a healthy start for babies is an essential service. Providing a high quality women's health service is paramount in supporting the overall health of communities" Dr Sara Gordon on the Advanced Diploma of Obstetrics.

Dr Alan Furniss is also an integral part of the RGO team with a wealth of experience in Rural Generalist roles in Australia, including obstetrics and governance.

Ashley Quigley born 1/08/2021 at home

Dawn Kremers – Midwife Manager

Well what a couple of years we have had in Te Nīkau Maternity. So many changes but we have all settled in well to the new facilities and in July 2022 we made the change to Te Whatu Ora.

COVID-19 has still had us on our toes and we have had our share of staff off due to this, it is becoming the new norm now for us all. COVID-19 brought about many challenges with our Buller midwifery workforce. Due to the vaccine mandate we lost our Buller LMC's which left no midwives to provide care for women in Buller. This was remedied employing locum midwives from around New Zealand. Fortunately, although initially it was unsettling for the Buller women when all their known midwives left, we now have one of our Grey midwives, LMC's Leigh Abernethy who has stepped into this role with the support postnatally of Mieke Sieblelink.

Buller had its share of challenges with two floods in July 2021 and February 2022. The hospital was relocated both times and the maternity unit was part of this. It was all hands on deck supporting the hapū women and new pēpi in the region. Women nearing their due date were

offered accommodation and transferred to Greymouth and were well supported during this stressful time. Great mahi with all involved.

We will welcome the opening of the lovely new birthing suite at Te Rau Kawakawa in May 2023 and are working on encouraging the Buller women to use the new facility. We are continually advertising to recruit midwives and hopefully it may entice them to relocate and enjoy all that the Buller region has to offer.

The last couple of years have brought us heartbreak and joy as we said good bye to some loved colleagues and welcomed new ones. Alana Attwood has joined our team as a core midwife, Alana comes to us from Ashburton. We said farewell to Bev Sinnott our IBCLC/ EN and Anna McInroe (RM) who both retired late 2022. Bev and Anna gave many years of service to Maternity. Very sadly we lost Barb Roberts who passed away in June 2021. Barb worked as an Enrolled Nurse in Maternity for many years, and later was the Newborn Hearing Screener along with Mary Sullivan. Barb is greatly missed and has left a large hole in our Maternity Team. We currently are working transalpine with two graduate midwives to provide them both with CWH experience and also Te Nīkau. We have a new graduate enrolled in the Midwifery First year of Practice programme (MFYP) working at Te Nīkau Maternity for 3 months and then they switch for the next three. We are hoping we will be able to have both settling on the Coast after they have done MFYP.

Staff past and present at the unveiling of a memorial for Barb Roberts

Our previous MQSP Co-ordinator, Vicky Roper, moved onto a new exciting position in 2021 and Natalia Mendoza (RM) stepped into her role. Natalia is working well in her position, also supporting the ward when needed.

Our Midwifery Educator Linda Monk has also retired and taken up the role of Kaiako for Te Pukenga, supporting our midwifery students on the West Coast. Excitingly we have three local students currently in their 2nd year of the Bachelor of Midwifery Programme. Sandy Goile who was previously an LMC has joined our team as Midwifery Educator/ Clinical Coach. Sandy has welcomed her new position full steam ahead.

We continue to offer our small workforce of LMC's who cover from Haast to Karamea a sustainability contract, this supports them financially to offset any income which may be missed with women needing to birth or be transferred to Christchurch. They are also offered the use of a hospital pool car when travelling great distances to see their West Coast Māmā's, as well as free education through Te Nīkau. The LMC's have stated the sustainability contract certainly helps financially.

Our amazing team of midwives here on the West Coast which includes both core and LMC's support each other in these stressful times. It is a pleasure to be part of this and look forward to the future and what it may hold. A big thanks to Norma Campbell (EDOM) for her ongoing support in my role.

Anna McInroe cutting her retirement cake & Linda Monk's retirement photo board

Sandy Goile - Midwifery Educator/Clinical coach

I commenced the role of midwifery educator/clinical coach on 28th February 2022, having been an LMC midwife on the West Coast for the previous eight years. I took over the role of midwifery educator from Linda Monk who retired at the end of 2021.

The role of educator has now been combined with the clinical coach role which has been created nationwide to support clinical practice, provide additional support to colleagues, as well as acting in a supervisory capacity for new graduate midwives and 'return to practice midwives.'

Since I have taken on the role of clinical coach, we have had no return to practice midwives or new graduate midwives, but I have been able to take the time to familiarise myself with the return to practice programme as well as develop an orientation package for all new midwives. In 2023 we will have two new graduate midwives starting at Te Nīkau and it will be my role to support them through the orientation process.

As clinical coach, I am available to support midwives' and student midwives on placement with clinical practice and additional support. I have run short sessions on skills such as cannulation, as well as training in operating the new iStat machine for point-of-care blood gas analysis.

As educator, there were challenges in getting staff to education days due to COVID-19 and staffing shortages. Despite the postponement of face to face education earlier in 2022, due to COVID-19, I still managed to deliver most of the planned education throughout the year.

Education provided in 2022

Emergency skills refresher days for midwives

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

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

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

PROMPT (Practical Obstetric Multi-Professional Training)

After a few cancellations and rescheduling we managed to hold 3 PROMPT courses over the year; two at Te Nīkau and one at Kawatiri Ward, Buller Hospital. Run over a full day, this is a multi-professional course in the practical management of obstetric emergencies and teamwork. This great course is offered worldwide and includes lectures, skill stations and scenarios. We had great attendance with 5 attendees in Buller, and 16 attendees at each of the Te Nīkau courses. Attendees included midwives, SMOs, RMIP students, Rural generalists, duty nurse managers, nurses and anaesthetists.

Participants at a PROMPT course in 2022

FSEP (Fetal Surveillance Education Program)

We ran a FSEP workshop in September which was well attended by staff working in maternity services. In total we had 19 midwives (4 from Nelson), one registered nurse and 2 senior clinicians attend.

Newborn Life Support

Throughout the year I delivered three Newborn Life support half day refresher courses, two in Greymouth and one in Buller Hospital. There were more planned but unfortunately with education on a hold for some parts of the year and stretched staffing levels in some areas these were cancelled. This three-hour course requires pre reading and has a quiz component, lectures and practical skills. This assist staff improve their skills and refresh their knowledge in providing neonatal resuscitation.

Midwives Emma and Alana practice Newborn Life Support

We also now offer the Newborn Life Support course (Advanced) and we held two of these throughout the year. This is a full day course and includes the fundamental skills of resuscitation, scenarios and a knowledge and skill assessment. This course is aimed at any health professional that is involved with births who may be expected to manage resuscitation of a newborn.

Treaty of Waitangi

In June we had Lee Tuki, Kaiwhakahaiere, present Te Tiriti o Waitangi workshop via NZCOM for midwives. This half day course was attended by 7 midwives and was relaxed, informative and very engaging. This workshop enabled the participants to reflect on equality and equity within our health and maternity service and explore ways to implement this knowledge in their practice.

STABLE

We were able to hold a STABLE course in November. This programme provides general guidelines for the assessment and stabilisation of sick infants in the post-resuscitation, pre-transport stabilisation period. Usually held once a year, this time, the course was delivered via TEAMS by neonatologists Maggie Meeks and Bronwyn Dixon on the first day and then face to

face by Maggie on the second day. Midwives, doctors and nurses that attend gain important education about neonatal stabilisation and the ability to provide a standard of care and comprehensive team approach to improve the infant's stability, safety and outcome. Usually a very popular course with large numbers attending, unfortunately we only had 8 attendees; 4 midwives, 3 doctors and 1 RMIP student doctor. This was due to COVID-19 and staffing issues.

Helicopter training

Helicopter familiarisation training was held in October with new and existing staff attending. The paramedic staff were very informative, and this is a great day to familiarise midwives with how to get in and out of a helicopter and what to expect when having to transfer a woman in a helicopter.

Summary

In 2023, I plan to bring additional education to the West Coast such as Spinning babies, Documentation, Perineal Repair and a Breastfeeding workshop. I will also continue with regular Journal Club for midwives and Case reviews. We will also join the Christchurch Women's Hospital PMMRC meetings every Tuesday via TEAMS. I will have new graduate midwives to work with as well as supporting any midwifery students that join us for clinical placements.

Overall, it has been a very successful year with being able to provide a significant amount of education throughout the year despite COVID-19 interruptions. I am enjoying my role immensely and look forward to adding varied education in the future. Thanks to my midwifery colleagues who have given their help and support in my first year in the role. Also, thanks to Dawn Kremers our Midwife Manager for her guidance, support and phenomenal singing.

West Coast midwives attend the Joan Donley Midwifery Research Forum 2022

Denise Stacey, Perinatal and Maternal Mortality Review Committee Representative

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

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

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

Charlotte Binks – International Board Certified Lactation Consultant

Hello! I am Charlotte, the new Te Nīkau employed lactation consultant and Baby Friendly Hospital Initiative (BFHI) coordinator, taking over from Bev Sinnott who retired in 2022.

I qualified as an International Board Certified Lactation Consultant (IBCLC) early on in 2022 and am enjoying learning more about the role and responsibilities involved. The new 0.2 FTE role fits in well with my role working 0.7 FTE as a core midwife on the maternity ward.

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

My role as BFHI coordinator is to ensure the Te Nīkau Hospital service meets the criteria of the BFHI, which is line with the WHO/UNICEF global standards. This ensures us as a service: meet a standard for exclusive breastfeeding rates on discharge from inpatient care, are meeting the standards of the Ten Steps to Successful Breastfeeding, and are in line with "The Code". Te Nīkau Hospital has been reaccredited as a Baby Friendly service following an audit in 2022. Huge thanks to all Maternity staff and importantly, Bev Sinnott, for all the hard work during this audit process!

In October 2022, I attended the BFHI coordinators meeting held at Manatū Hauora Ministry of Health in Wellington. This was a great opportunity to meet other BFHI coordinators and get a feel for the responsibilities involved. The attendees were given updates from Te Whatu Ora National Office and an overview of the previous audit process. It was also an opportunity for

coordinators and New Zealand Breastfeeding Alliance (NZBA) members to share their own work and research.

Since starting out in this role, I have started up a weekly lactation clinic on a Wednesday, which lead maternity (LMC) midwives are able to refer women to ante and postnatally. In addition, I am finalising resources for an antenatal breastfeeding group workshop for women and whānau to attend in the third trimester. I plan to run a session every two months from March this year.

There is to be a Breastfeeding education day set up for Maternity staff and primary health providers in May; with the support of PHO Breastfeeding Advocate Erin Turley and Midwifery Educator Sandy Goile. This session with focus on the revised mastitis protocol and updates in clinical breastfeeding support.

Thank you all Maternity staff and LMC midwives for your support while I transition into this role and I look forward to finding new ways to support women and their whānau on the Coast!

Newborn Hearing Screening Programme – Mary Sullivan

The Newborn Hearing screening programme took a massive hit with the loss of Barbara Roberts who instigated and coordinated the programme from the very beginning. It has been a big learning curve for us getting to grips with the administrative side of the programme but the service has continued uninterrupted.

A new screener trained at the end of 2021 and so our service is now fully staffed again and we screen most babies in the maternity ward prior to discharge. We are also screening babies at Gloriavale and in Westport at clinics held approximately once every three months or as required.

Rana Kamo – Obstetric and Gestational Diabetes Clinic Midwife

In 2021 I moved to core midwifery after having spent 15 years as LMC (Lead Maternity Carer) in the community both in Christchurch and West Coast. Although I loved working with women and their whānau within their home environments, for a period of time, the COVID-19 epidemic altered the way in which LMCs could deliver our service. I found the early days of COVID-19 very isolating as an LMC as a result of reduced contact with not only women but also our practice partners, the core midwives and obstetric teams. It was during this time I realized how much I needed the support network of midwives to make my career not only enjoyable but also sustainable. This prompted my move to core midwifery on the Maternity Ward. Although I enjoy the work I do on the ward, I was given the opportunity to assist with the weekly Obstetric Antenatal Clinic every Thursday and this is a role I enjoy very much. I am able to utilize my LMC knowledge and see the perspectives of both women and LMCs when arranging care. I really enjoy having some continuity of care with the clinic women as I also then get to see those women on the ward for their labour, birth and postnatal care, which fulfils the LMC pull that I sometimes still get.

During 2022, I was able to expand my Antenatal clinic role to also set up the Diabetes in Pregnancy Team. This was done in association with Debbie Noonan (dietician) and the Diabetes Team here on the West Coast to provide a pregnancy specific service and where possible keep otherwise well healthy women within the primary care sector of midwifery and dieticians. This continues to be a work in progress. I can access support as needed from Rural Generalists and

Obstetricians or when further intervention is needed I am able to consult with or refer to the Diabetes Nurse Specialist or Diabetes Physician. We are able to provide a dynamic approach to care which can be individualised to suit the woman. Again, I really enjoy the continuity of care aspect of caring for these women and can align the Gestational Diabetes care alongside care for other pre-existing conditions to ensure women get timely and appropriate care. Where possible I try and ensure appointments, scans and testing is done in an efficient manner particularly when women are having to travel from Westport or South Westland to access care. Although this is a new initiative for the West Coast, it has been very well received with women highlighting the dynamic approach to care being of benefit, for example utilising different forms of communication tools such as email, text and telehealth conference calling. For me, this role is also not constricted to only clinic days and I am able to work within my shifts to support women after hours and on weekends via phone or on the ward, meeting women where they are at and being able to work their care around what's happening for them.

As part of taking up this role as Diabetes team midwife I completed the diabetes in pregnancy paper at Otago Polytechnic and also spent time in Christchurch with the CWH diabetes team and found this learning invaluable.

Chantelle Taege - Safe Sleep Programme

As part of my role as a safe sleep coordinator, I ensure that all women birthing in our maternity unit have had a discussion regarding safe sleep practices/pēpi prior to their discharge home and provide education around the risks of bed sharing, smoking and the benefits of breastfeeding. During their stay on the unit all women have had a discussion around safe sleeping at home such as sleep locations, type of sleep device they will use and safe settling and sleeping away from home. All mothers/babies are assessed and if any risks are identified a pēpi pod is offered and are available for use on the ward. As a part of the role of the safe sleep coordinator I carry out audits which ensure discussions around safe sleeping practices have taken place and ensure that documentation and clear pathways for staff when discussing safe sleep and all mandatory training for staff is completed.

Leigh Abernethy – South Westland Lead Maternity Carer Midwife

As the LMC covering the areas ranging from Greymouth to Haast, I was already facing the challenge of covering the largest geographical area of any midwife in New Zealand – but then COVID-19 hit, and this remote rural, coast traversing midwife had to up her game.

When covering such a large area of land, preparing for a day in clinic can be compared to packing for weekend trip away. Who knows what I'll need? What I'll be faced with? What situations may arise?
As the midwife covering SWL, I have access to all of the health centres between Te Nīkau Hospital and Haast but my clinics are predominantly held in the Health Centre in Franz Josef. This is quite centrally located for most SWL whānau but it is also a 1 hour a 40-minute drive away from home – 2 hours and 10 minutes from Te Nīkau hospital.

Leigh with Rosa Hancock DOB 18/04/22

SWL is notorious for being bombarded with adverse weather and in July 2022, I was caught out. The West Coast was hit by some frantic wind and rain, causing a tree to fall on some power lines, into some roads and thus, trapping me in SWL. I remember the phone call I received from the Midwifery Manager who informed me that I would be there for the night. And this is the night that I realised that an overnight bag needed to be included in my midwifery kit in the back of the car!
With a call to an expectant Māmā to make plans for an impromptu home birth, if needed, settling some nerves of the local rural nurses and a call to my partner to say that I wouldn't be coming home; I made my way to the local Four Square for dinner and supplies and made myself comfortable in my motel room. And whilst a night in a motel room sounds like bliss for most, this was my first night away from my 19-month-old daughter. Although I think I may have been more upset than she was!

The weather plays a significant role in my role as the SWL LMC because there are times when roads are closed leaving hapū māmā stranded in the south. There has been a time where we have had to relocate a group of māmā after a devastating road wash out, flying them in a helicopter up to Greymouth, to live in motels and await the arrival of their pēpi! And in small communities such as those in SWL, occasions like that become the talk of the town!

Towns such as Franz and Fox for example, are thriving tourist areas for the West Coast. Filled with helicopter tours, kayaking adventures, retreats and hostels, these towns are run by local whānau who, during COVID-19, were hit hard. I have been covering SWL since 2019 and in that time, I have come to know these communities and watch them grow but what I have also done, is watch their struggles and hardships that COVID-19 brought to them. I watched these thriving towns, slowly wilt away. Doors closed. Lights off. Businesses gone… the community more than halved because of COVID-19; and the hardships of the locals was evident, adding an extra strain to those welcoming new life into the world. There was no training for me as a midwife for how

to support these SWL whānau.
No advice on what to say…

When Aotearoa went into lockdown, we were advised, as midwives, to discontinue our midwifery clinics and perform antenatal home visits. This is where it got interesting.
Home visits to expectant māmā and new babies whose homes span a distance of more than 300km made me realise that I probably needed to get my helicopter license.
On the plus side, travel was faster than normal as I was often the only car on the road.
The downside – nowhere to stop to eat, drink or pee!

Even after driving it a thousand times, I still find the drive to SWL so picturesque, no matter the weather, and after driving it so frequently, I now find the drive to be an absolute breeze.
But for a māmā in labour, those winding roads and varied speed limits, add a whole new challenge!
At Te Nīkau, we have plans in place for those whānau who need to travel such vast distances. The whānau house and transitional cottages. Without these, we'd be lost. This fantastic resource allows whānau to travel up to Grey when needed and await events. It gives women, (and their LMC) reassurance in knowing that they can be nearby, without having to be admitted to the maternity ward. For a lot of families in SWL, they have no options for childcare and no extended family nearby so childcare becomes a huge worry. In most cases, women birth alone whilst their partners care for their older children in the whānau house/hospital accommodation. It's heart-breaking to watch a woman labour alone. In these instances, the rapport that I have developed with the women enable me to support them both emotionally and physically during their birthing journey. And it's why I try my best to capture photographs for them too!

Being the LMC for SWL is not without it's challenges and it definitely requires a level of creativity to do the job. Saying that, I love my long drives, being a part of these wonderful communities, watching them grow and having interesting stories to be able to tell my grandchildren!

The South Westland Stork announces a new birth

Being a remote rural midwife is unique as is the sustainability package that LMC midwives on the West Coast are offered from Te Whatu Ora – to try and retain midwives and the care that they provide, LMCs are awarded a Sustainability contract. What this contract offers is: the use of hospital vehicles to enable us to drive up and down the coast as needed; free education supplied by the hospital, allowing us to keep our skills and knowledge up-to-date; the use of clinic spaces along the coast, free of charge and additional travel fees.

I love being the SWL LMC and not even a pandemic could change that.

Leigh Abernethy
LMC Midwife

Christine Sinclair – Student Midwife

My name is Christine Sinclair and I graduated as a registered midwife at the end of 2022 after completing my degree programme through ARA, Canterbury. I was born in Whangarei, schooled in Auckland, trained as a Registered Nurse in Wellington, and have spent part of the last four years based in Christchurch. I have travelled a lot and worked extensively in remote communities in Australia, particularly in the Northern Territory. I have been a West Coast resident since 2008 when I moved to Haast to undertake a Rural Nurse Specialist position.

I know for sure now that living and working "rural and remote" is my happy place. I undertook my midwifery training to try to address some of the inequity that I noticed women face when pregnant and during the postnatal period in these environments. Also, to address the gaps that existed in my professional knowledge base- plus I love a challenge. Midwifery training and the West Coast certainly provides plenty of these.

I have been grateful to have had my aspirations supported by the Te Nīkau hospital team including the LMC midwives, who have consistently provided a friendly, welcoming environment as well as providing excellent professional preceptorship during my placements as a student.

Having accommodation in Greymouth provided during placements and receiving a Rural study grant in my third year, helped towards the financial burdens that student midwives face during their training. All students undertake placements away from "home" without any formal financial assistance towards the associated costs. I would love to see this change for future students in order to support and grow the workforce.

A blended study programme with both face- to face and online learning is also helpful to allow rural students to continue to live in their own communities and I hope to see this flexibility

continue to grow. A strong workforce is imperative to supporting this also, as it is a big ask for midwives who are already under pressure to be asked to also support their junior colleagues.

Going forward for this year I will be staying in Christchurch to work as a Core Midwife in the busy tertiary environment of Christchurch Women's Hospital/ Waipapa and then transferring to Te Nīkau later in the year. This is a new approach that myself and another new graduate midwife have requested, and it is a great example of how the Transalpine Christchurch/ West Coast alliance can working together to create links between the regional and rural centres.

Continuity of care is an integral aspect of midwifery philosophy and a large part of being a nurse in a small community. You have the privilege of being able to provide whole of life care. I hope to return to South Westland once I have consolidated my midwifery knowledge through my first year of practice programme and somehow combine my skill sets to create a job that provides both a professional and personal life balance. However, if COVID-19 times have taught me anything it is that flexibility and adaptability are key. You just never quite know what is around the next bend in the road.

MQSP Programme

Achievements against Priorities (Work plan 21/22)

With the COVID-19 pandemic's changing alert levels, changing recommendations, and general disruption to normal operations there was a refocus to providing clinical care and developing response plans and work flows. Many of the projects planned and started before the pandemic stalled as focus was turned to meeting the ever-changing demand of the pandemic response.

The MQSP Workplan during this time was reduced to the MoH projects outlined below, with more of the quality work restarting during 2022 as outlined in the Quality Improvement section.

Theodora Quigley born 26/12/2022 at Te Nīkau

MoH Projects (as per Quarterly Report)

Local Project: Growing Up Well on the West Coast

This work came through the First 1000 Days work and was approved by the Board to commence in 2020. COVID-19 occurred which delayed the start of the hui. These hui were led by one of our local whānau leads Eli Maniawa from Whare Manaaki and also our then MQSP Coordinator Vicky Roper. We decided we would undertake 12 hui as a Steering Group but this soon became a response to the demands of our community to over 20 hui.

The collation of the feedback was also then stalled due to COVID-19 but this has now been extracted with some of it noting improvements to maternity and the rest providing valuable information for growing up well right through to teenage years. The Maternity data will now inform the 2023 work plan to target the areas that women told us needed work. This has commenced.

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

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

We rolled out NOC/NEWS in June 2020 and it was relatively uncomplicated, being readily accepted by staff. As we were already using an Early Warning Score (EWS) we were essentially moving from one EWS to another. There have been two up-dates to the layout of the chart which have enabled greater ease of use. Regular audits show good consistent use in Te Nīkau.

National Project 2: NE Taskforce

We introduced the Growth Assessment Protocol (GAP) and training for all maternity staff and LMC's in late October 2021. All pregnancies generate a GROW chart with every baby having a customised Birth Centile generated to inform care pathways. This has led to an increase in the number of pregnancies identified as requiring closer monitoring with ultrasounds for growth, and a doubling of the number of babies identified as being small for gestational age from 7% in 2020 to 14% in 2022, resulting in more babies having closer monitoring via the NOC/NEWS of their transition over the first twenty-four hours of life.

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 2021 & 2022 periods below.

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

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

- LMC Education is provided and paid for by the DHB – the LMCs are invited to all education that is also offered to employed colleagues with much of it being multidisciplinary;
- Free use of clinics in the rural areas where women can see their LMCs: Te Nīkau clinic, Hokitika Health Centre and other rural clinics;

- Extra Sustainability Package paid quarterly. LMCs provide up to the 3rd trimester and full postnatal care, so if a woman transfers out to the tertiary sector the birth fee would be lost. However, this package pays a proportion of that fee based on where the woman lives; rural / semi-rural and remote if the woman births elsewhere;
- If travelling – LMCs can often access DHB vehicles for travel and in some areas, DHB accommodation;
- The Package is reviewed and renewed every twelve months with input from LMCs.

Pia Droeher labouring at home, daughter Margo looking on with views of Franz Joseph Glacier

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

We offer our women LARC (Long Acting Reversible Contraception) which includes IUCDs, implants and Depo-provera injections. This work has commenced, and we are linking with Waitaha Canterbury in relation to the insertion and removal of LARCs. This is being driven by the Clinical leads, northern, southern and central region work streams and is being monitored by primary care. All LMCs are aware they can refer directly to a Rural Generalist doctor for insertion on the ward or as an outpatient. In addition to our obstetric and RG team, two core staff have started training to insert Jadelles, training will continue in 2023.

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

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

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

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

4. Ongoing audit and review of MEWS and Trigger Tool

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

Addressing PMMRC Recommendations

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

1. Reduce preterm birth and neonatal mortality

Our introduction of GAP outlined above and our work towards reducing the rates of smoking in pregnancy outlined under Projects below contribute to our work in this area. We have a localised policy to identify preterm labour with a process for appropriate transfer to appropriate service, including a guideline for rural nursing and our primary birthing unit on assessing women presenting with symptoms of pre-term labour. Women presenting in labour less than 37 weeks gestation are transferred to the tertiary unit, if it is safe to do so

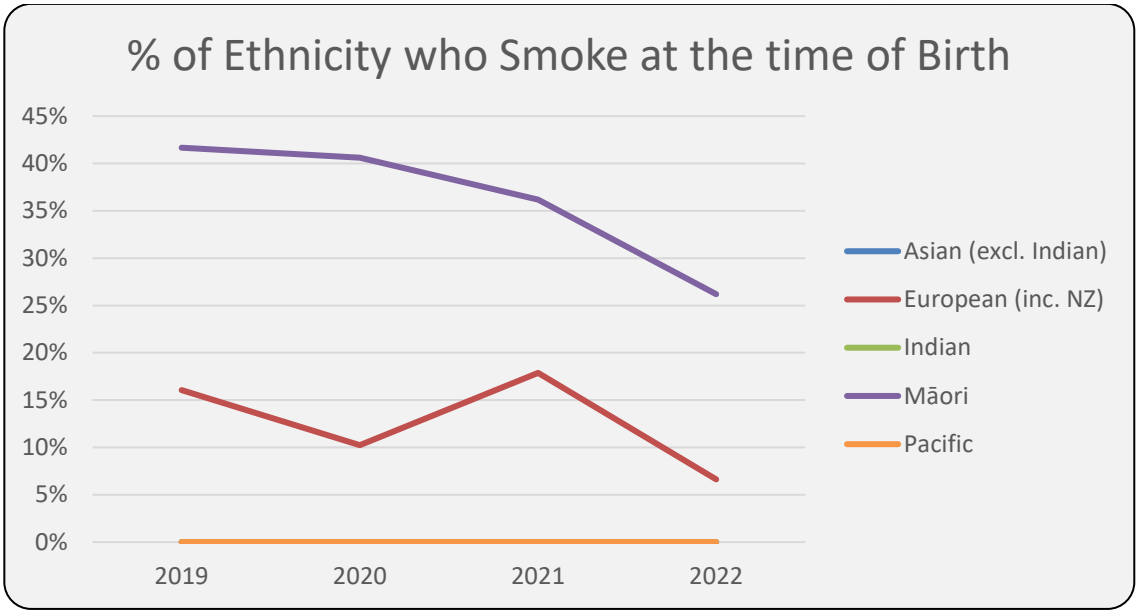
We have an active SUDI prevention plan with cross sectorial membership and a very engaged SUDI working group. The group has increased the period of incentivisation for smoking cessation provided to Mums and partners to 4 months post-natal. All babies who are Māori are offered a wahakura as a taonga. When wahakura are unavailable Pēpi pods are also offered to whānau as part of reinforcing safe sleep messages. These safe sleep spaces are offered to all families of at-risk babies, with education and follow-up provided.

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

Our main area for focus in this area has been our work on the Smoke Change programme outlined below.

SMOKE CHANGE

In 2021 and 2022 wāhine Māori represented just under 20% of women accessing our services but were over represented in our stats for smokers during pregnancy. During 21/22 we undertook a review of the smoke ceasation pathway and referral uptake with the PHO, resulting in a significant decrease in the smoking rates at time of birth. Changes we made included updates to referral form and changing to opt-out referrals. These changes have resulted in a positive change as seen below, as well as seeing 44% of women smoking at time of registration were no longer smoking at birth in 2022.



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

Recommendation 3 and 4 are wrapped up within the Growing Up Well project and with establishment of the Maternity Consumer Council regional hubs across the West Coast. There were very few pregnant women <20 years (3 in 2022), so we are looking at targeting women <25 years as well as Indian women. Recruitment for the Maternity Consumer Council has started with visits to playcentres, and other areas where new parents gather.

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

All clinicians working within maternity have access to attending the Fetal Surveillance Education Programme (FSEP) offered by RANZCOG, which is mandatory for employed staff. While COVID-19 disruption forced some in person sessions to be cancelled, this education continued to be available and promoted online. In September 2022 87% of midwives (core and LMC) attended face to face FSEP. Those not able to attend face to face FSEP complete the online education package.

6. Cultural competency workshops for all Maternity Service staff

All clinicians attend mandatory bi-cultural treaty workshop training. The West Coast Māori Health Unit provide cultural support and training as and when required. While this training was interrupted by restrictions due to COVID-19, there were two workshops on cultural competency presented in the second half of 2022.

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

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

staff meetings and build into multidisciplinary education days outlined under the education section above.

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

Addressing MMWG Recommendations

1. Implementation of hypertension guideline

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

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

HEAT is used when reviewing policies, awaiting further training opportunities as these were postponed due to COVID-19. We are also working to include Māori in how services are provided and looking to the operational model when it comes as well as the Locality work to advance this in 2023.

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

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

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

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

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

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

Clinical Indicator Analysis

The Ministry of Health's New Zealand Maternity Clinical Indicators Data for 2020 is the most recent available. The analysis below shows the DHB's performance and position in relation to both the indicators and national averages and are based on standard primiparae only (rather than all women giving birth / all deliveries). We have based our data on "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 13% 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. For future reports we will be presenting this data using the Robson scoring criteria introduced by the World Health Organisation to enable a standardised international comparison.

It is important to note that the data supplied for these clinical indicators is only sourced from births within maternity facilities, and as such excluded all women who birth at home. In 2020 the Report on Maternity web tool gives our homebirth rate as 11.6%. Homebirths are not recommended for women with antenatal complications and therefore a large percentage of our uncomplicated women are not included in the indicators below. It is also of note that the number of West Coast domiciled women who meet the criteria for 'Standard Primiparae' is falling, with 48 in 2019 and only 32 in 2020. Any conclusions drawn from this data should therefore be read with caution.

Indicator no.	Title	2018 WCDHB Rate (n)	2019 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2019	2020 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2020
1	Registration with an LMC in the first trimester of pregnancy	80.7 % (259)	87 .1% (297)	6.4% Increase	19.1% Above	68%	88.7% (293)	1.6% Increase	14.1% Above	74.1%
Registration for Māori Women is slightly lower at 85% but is still well above the national average.										
2	Standard primiparae who have a spontaneous vaginal birth	61.2% (30)	52.1% (25)	9.1% Decrease	12% Below	64.10%	53.1% (17)	1.0% Similar	9.0% Below	62.1%
3	Standard primiparae who undergo an instrumental vaginal birth	24.5% (12)	27.1% (13)	2.6% Similar	9.6% Above	17.50%	28.1% (9)	1.0% Similar	8.9% Above	19.2%
4	Standard primiparae who undergo caesarean section	14.3% (7/49)	20.8% (10)	6.5% Increase	2.6% Similar	18.20%	12.5% (4)	8.3% Decrease	5.1% Below	17.6%
See Graph below for birth type trend since change in model of care.										
5	Standard primiparae who undergo induction of labour	6.1% (3)	4.2% (2)	1.9% Similar	4.2% Below	8.40%	6.2% (2)	2.0% Similar	3.0% Below	9.2%
We continue to have a lower than national average rate of induction for standard primiparae.										

Indicator no.	Title	2018 WCDHB Rate (n)	2019 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2019	2020 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2020
6	Standard primiparae with an intact lower genital tract (no 1st – 4th degree tear or episiotomy)	26.2% (11)	13.2% (5)	13% Decrease	11.7% Below	24.90%	42.9% (12)	29.7% Increase	16.2% Above	26.7%
7	Standard primiparae undergoing episiotomy and no 3rd or 4th degree perineal tear	26.2% (11)	34.2% (13)	8% Increase	8.4% Above	25.80%	32.1% (9)	2.1% Decrease	6.0% Above	26.10%
8	Standard primiparae sustaining a 3rd or 4th degree perineal tear and no episiotomy	2.4% (1)	2.6% (1)	0.2% Similar	2.1% Below	4.70%	3.6% (1)	1.0% Similar	0.7% Similar	4.30%
9	Standard primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear	0 (0)	0 (0)	No Change	2.0% Below	2.00%	3.6% (1)	3.6% Increase	1.5% Similar	2.10%
Rates of intact perineums had been steadily declining since 2010 but we saw a sharp increase in rates in 2020 following our move to Te Nīkau and access to warmers for perineal compresses.										
10	Total number of women having a general anaesthetic for caesarean section	4.4% (4)	0.9% (1)	3.5% Decrease	8.1% Below	9.00%	4.5% (4/89)	3.6% Increase	3.3% Below	7.80%
With small numbers one case can result in a large change in local rates but we continue to be below the national average. Every case of a general anaesthetic is reviewed to identify areas for improvement.										
11	Women requiring a blood transfusion with caesarean section	4.4% (4)	3.5% (4)	0.9% Similar	0.4% Similar	3.10%	3.4% (3)	0.1% Similar	0.0% Same	3.4%
12	Women requiring a blood transfusion with vaginal birth	2.5% (5)	1.3% (3)	1.20%	0.80%	2.10%	3.4% (7)	2.2% Increase	1.0% Similar	2.4%
With small numbers one case can result in a large change in local rates but we continue to follow the national average, again all cases are reviewed.										
13	Diagnosis of eclampsia at birth admission	0 (0)	0 (0)	No Change	0.03% Below	0.03%	0 (0)	No Change	0.03% Below	0.03%
14	Women having a peripartum hysterectomy	0 (0)	0 (0)	No Change	0.05% Below	0.05%	0 (0)	No Change	0.04% Below	0.04%
15	Women admitted to ICU and requiring ventilation during the	0 (0)	0 (0)	No Change	0.02% Below	0.02%	0 (0)	No Change	0.03% Below	0.03%

Indicator no.	Title	2018 WCDHB Rate (n)	2019 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2019	2020 WCDHB Rate (n)	Change in WCDHB Rate	WCDHB vs. National Trend	National Average 2020
	pregnancy or postnatal period									
All rare outcomes with no women meeting these criteria.										
16	Maternal tobacco use during postnatal period	13.4% (42)	11.5% (38)	1.9% Decrease	3.1% Above	8.40%	10.5% (30)	1.0% Decrease	1.9% Above	8.60%
We are continuing to make steady progress to bring the down the rate of women who smoke while during the maternity episode, more detailed analysis was provided above under MoH Projects.										
17	Preterm birth (under 37 weeks gestation)	3.7 % (12)	8.9 % (31)	5.2% Higher	1.2% Similar	7.7%	5.6% (16)	3.3% Decrease	2.3% Below	7.90%
Numbers have fluctuated around an average of 7.2% for the previous five years, similar to the national average.										
18	Small babies at term (37-42 weeks' gestation)	2.6% (8)	1.6% (5)	1% Decrease	1.6% Below	3.20%	2.6% (7)	1.0% Increase	0.4% Similar	3.00%
19	Small babies at term born at 40-42 weeks' gestation	50% (4/8)	40% (2)	10% Decrease	12.1% Above	27.90%	28.6% (2)	11.4% Decrease	1.0% Similar	29.60%
We continue to follow the national average, expecting rates to sharply increase with the introduction of customised growth charts identifying more babies meeting these criteria. This can be seen in our own data below.										
20	Babies born at 37+ weeks' gestation requiring respiratory support	1.3% (4)	0.6% (2)	0.7% Decrease	2% Below	2.60%	0.7% (2)	0.1% Similar	2.0% Below	2.70%
We continue to have fewer babies requiring respiratory support than the national average.										

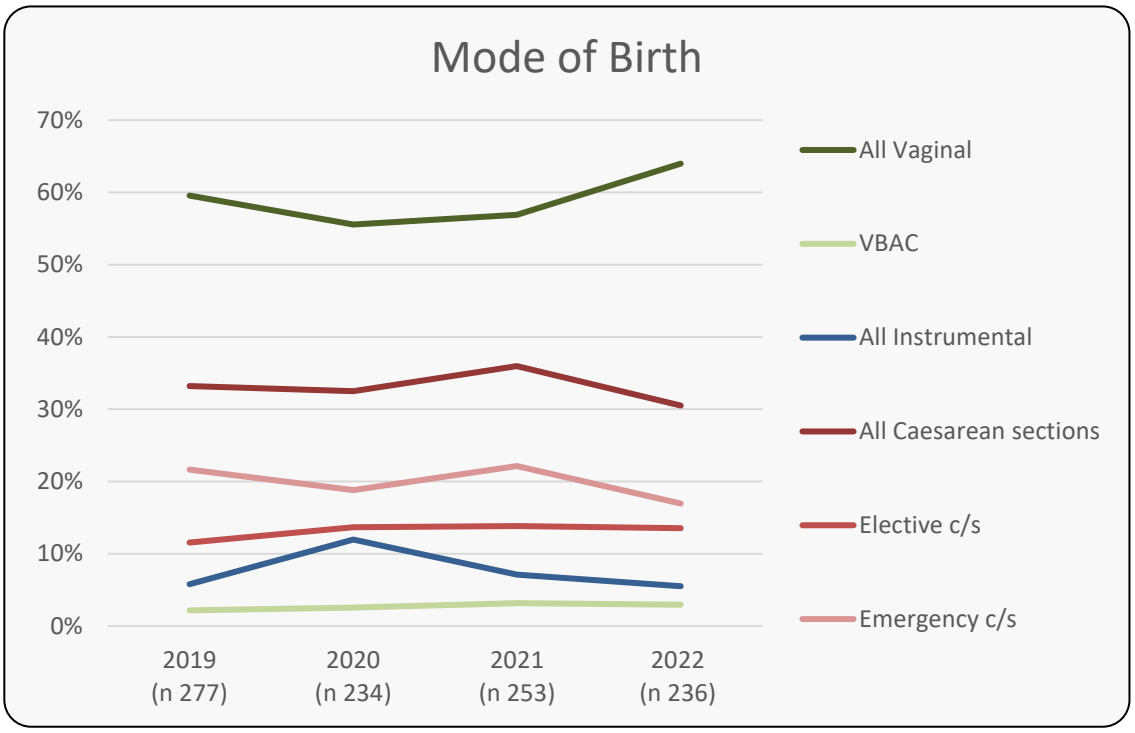
Midwifery Educator Sandy Goile models a Christmas Scrub top bringing cheer to the ward

WCDHB Maternity Data

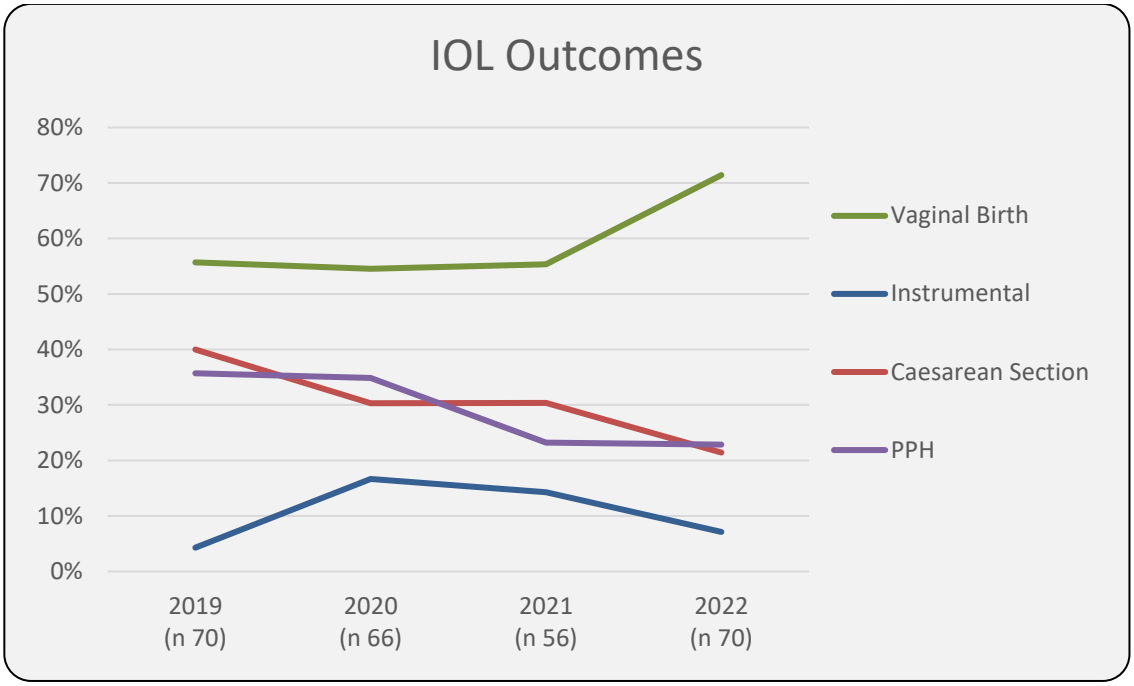
Outcomes

The data in this section is from **local Maternity data sources** and compares 2019 through to 2022. Data here is counted in terms of all "births" in a DHB facility (as opposed to a count of exclusively standard primiparae as used by the New Zealand Maternity Clinical Indicators). Because of this all homebirths and births that occurred to West Coast resident families outside of our local facilities are excluded.

Mode of Birth

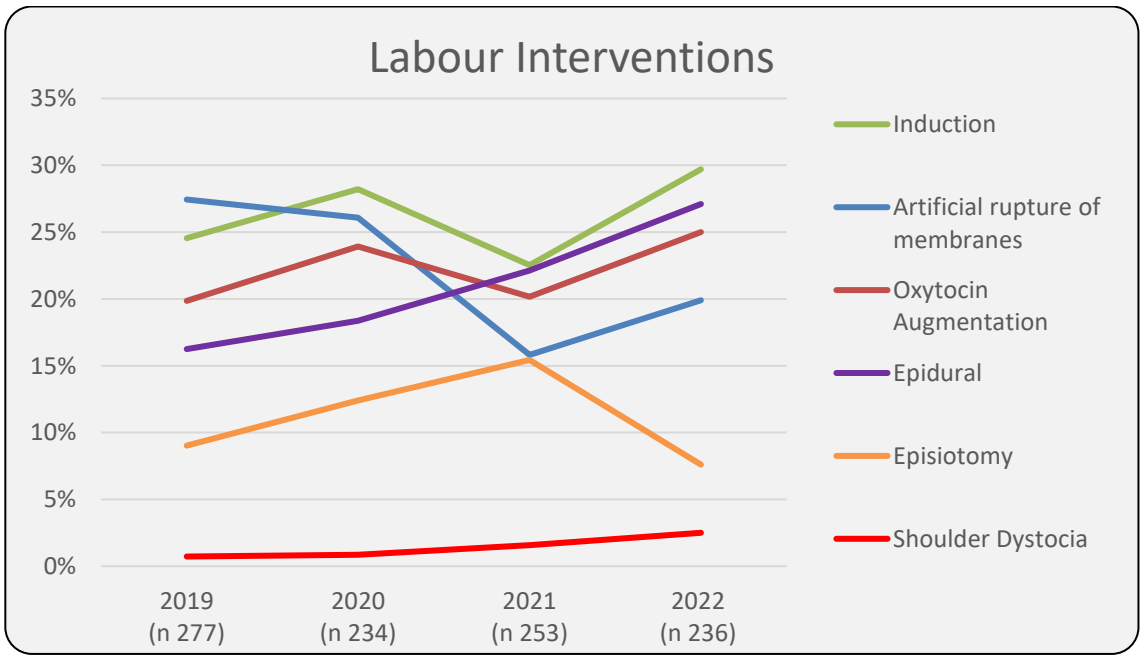


The increase seen in the rate of vaginal birth can primarily be contributed to having fewer instrumental births, but small progress is being made to lower the rate of caesarean sections. In June 2022 we celebrated a new record of 65 days between emergency caesarean sections greatly surpassing our previous record of 41 days. We made it to 86 days for women having their first baby.



In 2020 we introduced oral misoprostol as the primary method of induction of labour, which had an immediate effect of reducing caesarean sections with these women having instrumental births. We then increased the rate of vaginal birth in 2022 with a slight adjustment to the timing of recognition of established labour. This led to women, especially those having their first baby receiving one more dose of misoprostol than they had previously. This change again lowered the rate of caesarean sections for this group.

Labour Interventions



We have seen a marked increase in the number of women receiving epidural analgesia during labour, with the increase set to double the rate over the five years to the end of 2023.

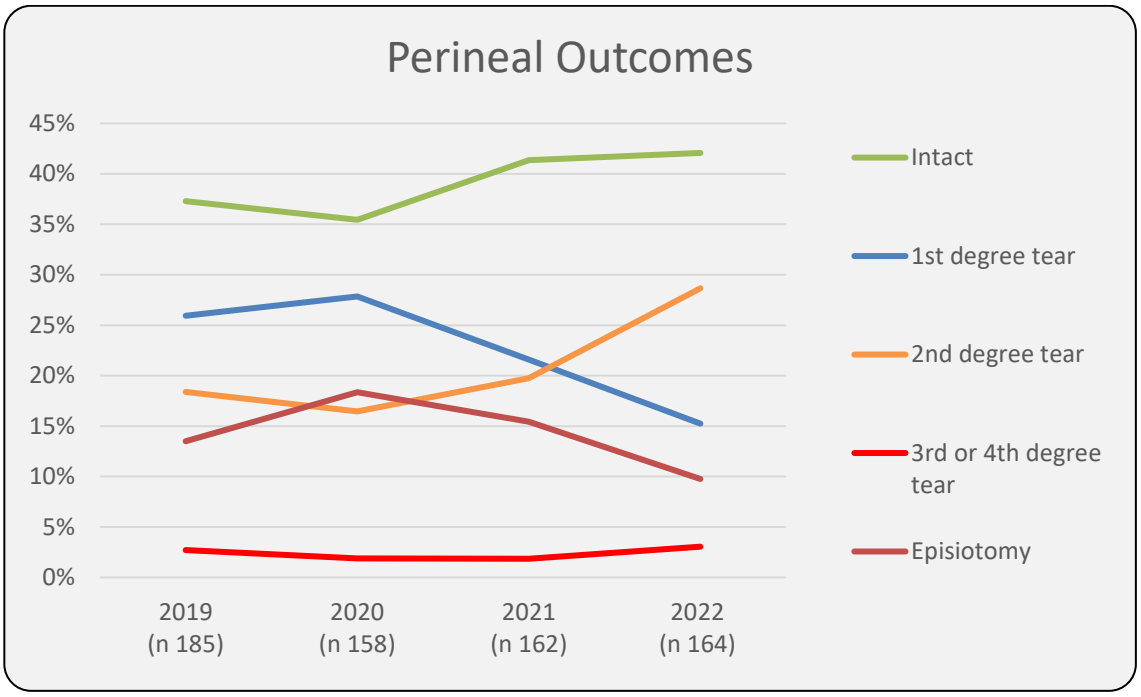
Fewer women are undergoing an artificial rupture of membranes (ARM) during labour, primarily due to the change in induction of labour method. These women tend to have a spontaneous

rupture of membranes as they are establishing, rather than the previous method where an ARM was undertaken as part of the IOL process.

The change observed in the episiotomy rate is discussed below.

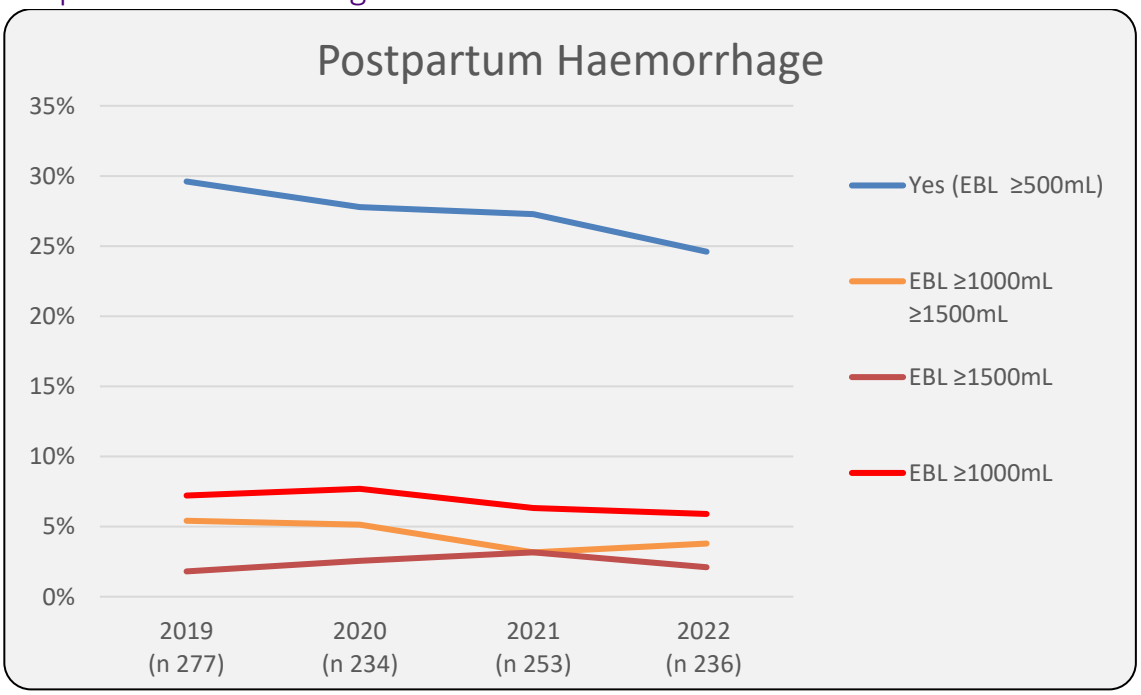
Perineal Outcomes

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



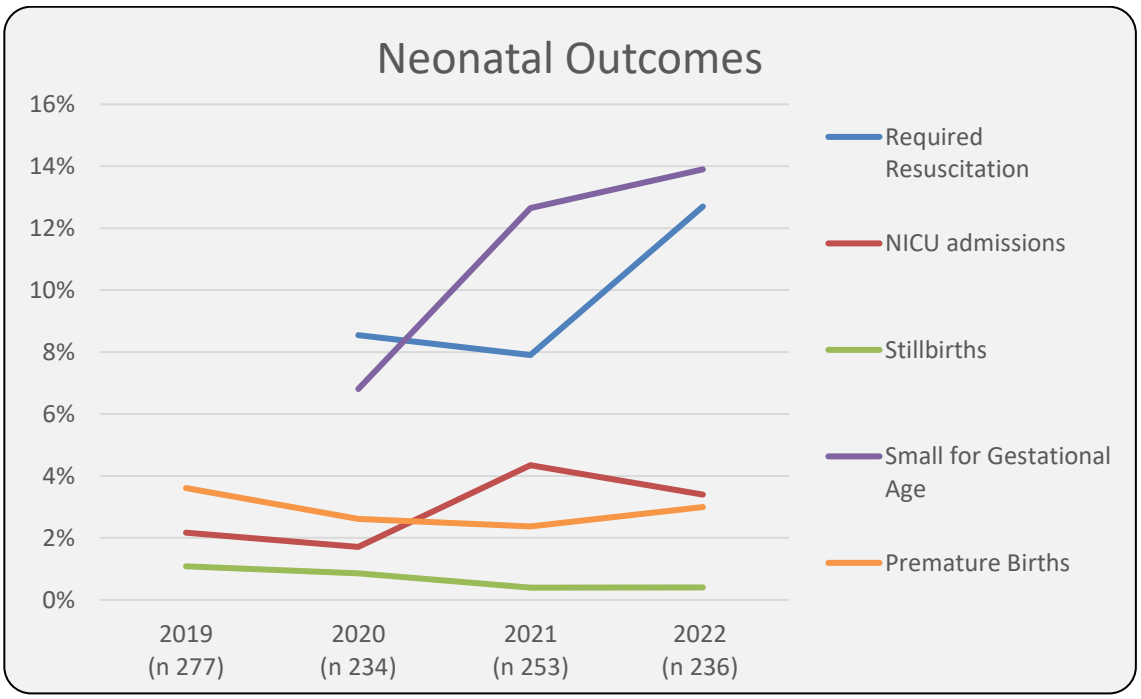
The decline in episiotomies follows the decline in instrumental births, with no apparent increase in the rate of severe tears. The move to Te Nīkau came with access to warmers for perineal compresses during the second stage, possibly increasing the rate of intact perineums.

Postpartum Haemorrhage



We are very pleased that our PPH rate is steadily decreasing, although we have not been able to identify the exact cause for this, since 2019 we have been faster to give Tranexamic acid – a medication used to slow down the breakdown of blood clots. PPH management and identifying ongoing loss is covered in mandatory annual education days. Going forward we have started looking at identifying the rate of symptomatic PPH by identifying women needing an iron infusion following birth, which we hope to present in next year's report.

Neonatal Outcomes



At end of October 2021 we changed to using the Growth Assessment Protocol (GAP) and customised birth centiles for babies, this has resulted in a larger number of babies being identified as under the 10th centile for birth weight.

Feeding Method on Discharge

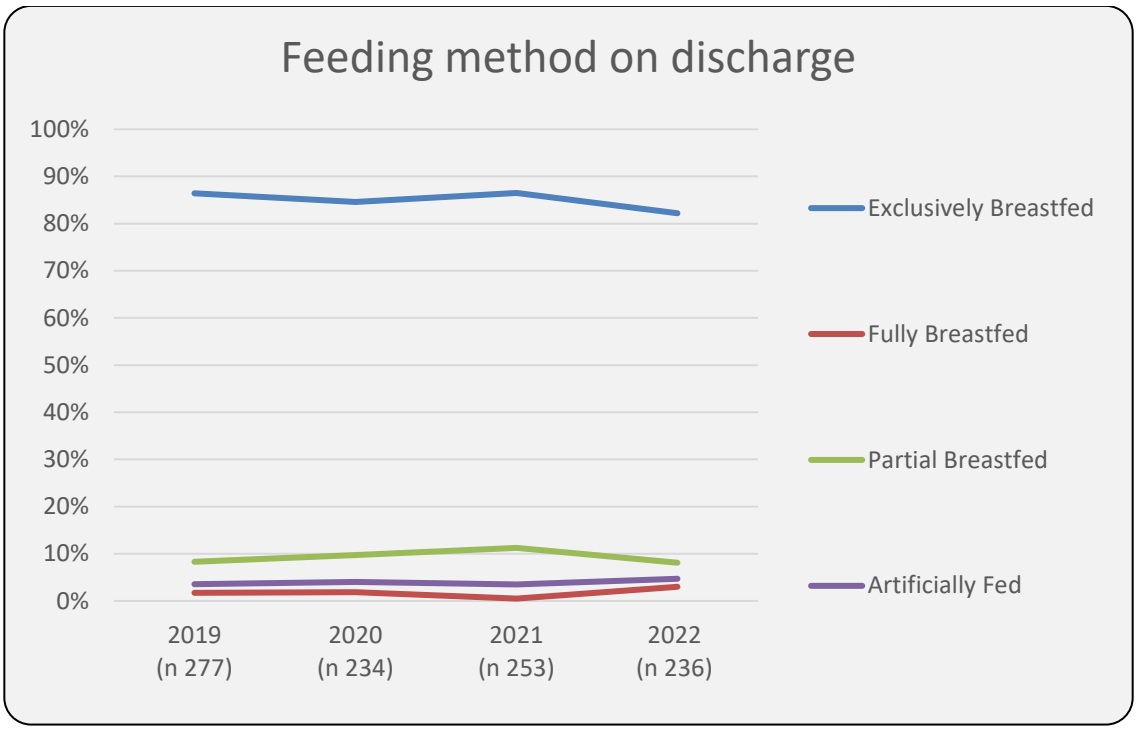
The method of feeding on discharge is based on the breastfeeding definitions used by the Ministry of Health and are as follows:

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

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

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

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



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

Feedback & Consumer Engagement

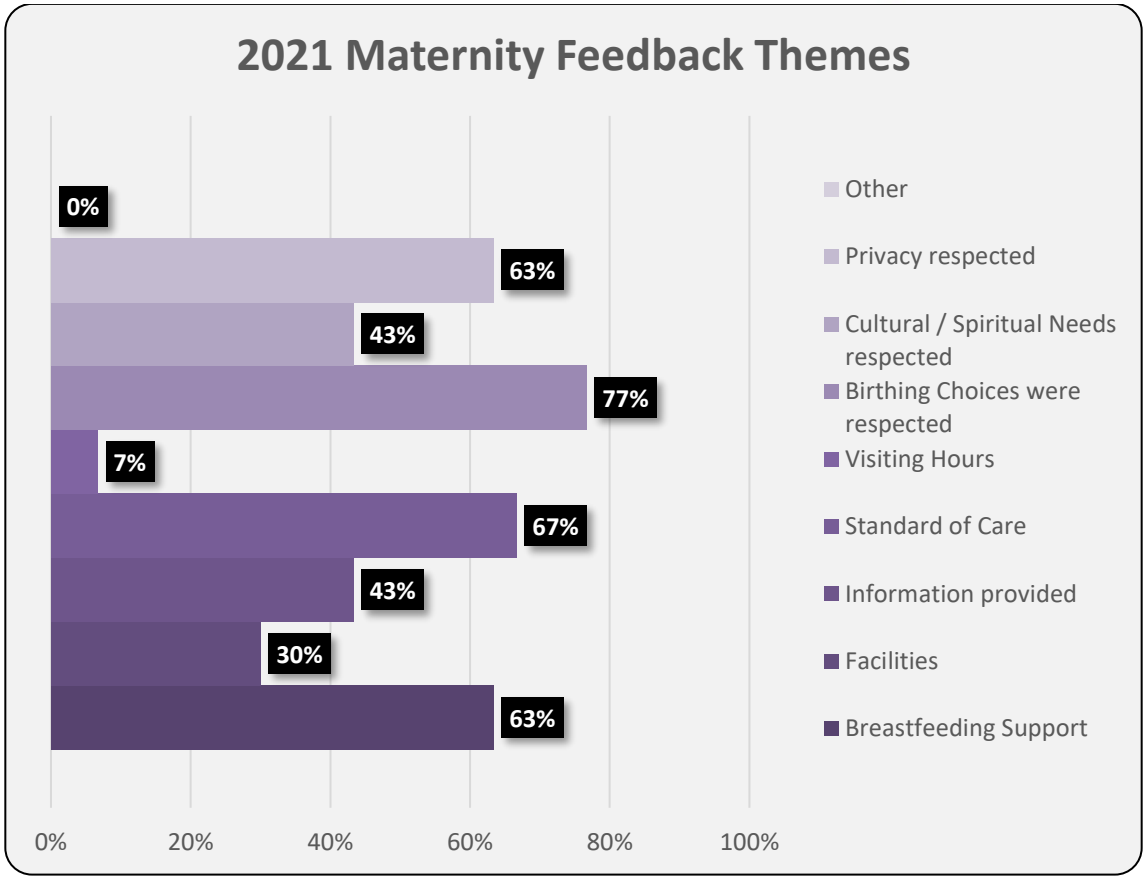
Maternity Consumer Council

As mentioned elsewhere in this report, before COVID-19 struck we were in the process of setting up a Maternity Consumer Council. The intention of this group being a place where consumers of maternity services can go to discuss issues or ideas for service improvement that can then be brought to our attention. This work has now been restarted with recruitment underway by visits to groups where maternity consumers gather. This group will be chaired by our maternity consumer representative with administration and logistical support from the MQSP Coordinator.

We are looking forward to working with the council to improve the service that we offer, and to have an easy point of contact for consumer consultation on policies, patient information etc.

Feedback

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



Best things:

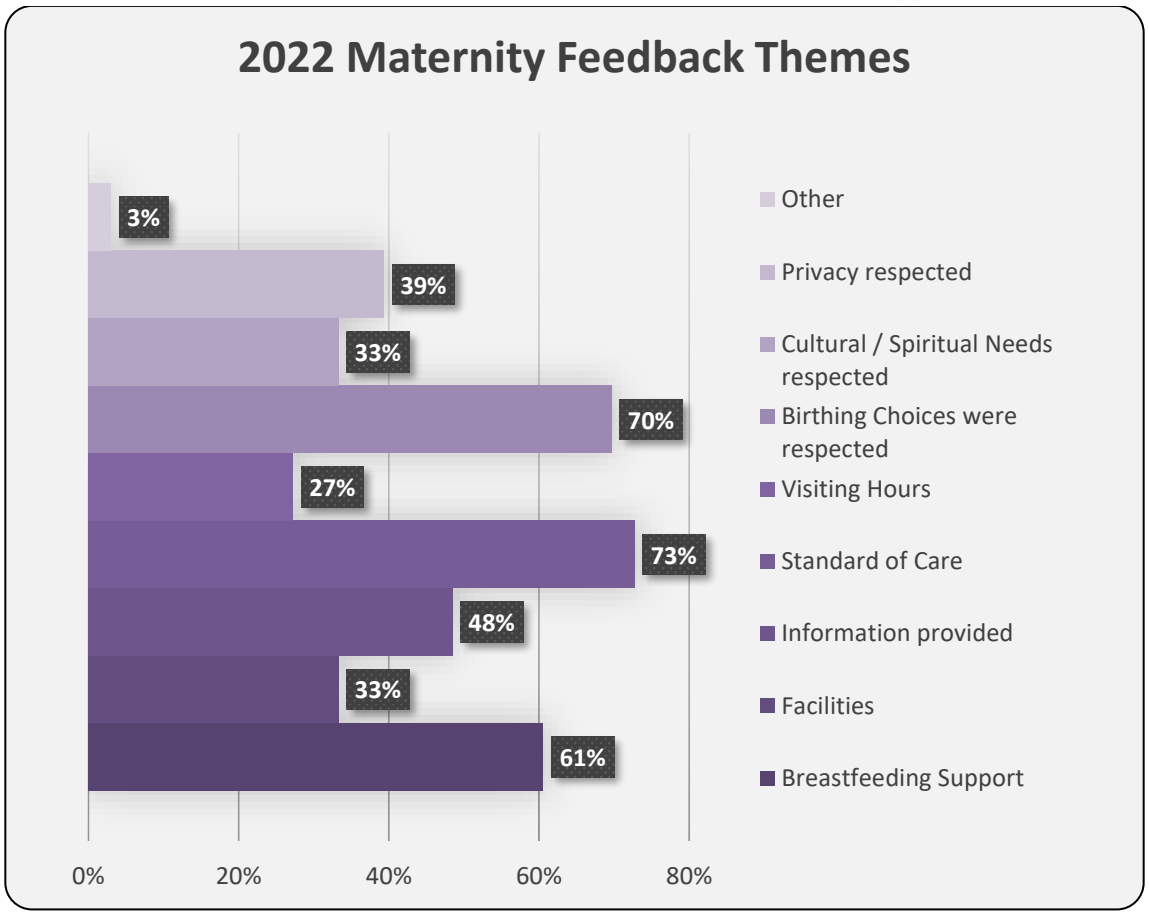
"The best things about the care provided were the calm, nurturing attitude of the midwives, the relaxing environment, the birth pool and the professional handling of all matters during and after the baby was born."

"Everyone's attitude when I was struggling to breastfeed the support was awesome; all questions I had got answered in a way I could understand. I felt like my voice was being heard. Keep doing everything you're doing, can't fault anything."

"All of the staff (midwives, nurses, doctors, theatre staff) were absolutely amazing throughout our stay at Te Nīkau. After the birth there were a few complications resulting in an extended stay. The level of kindness and care was unparalleled and exceeded all expectations. The new facilities are wonderful and the birthing suites were decorated beautifully. We can't thank all the staff enough for their care and support during a difficult time."

How we could improve:

"Having an option for the birth partner to be provided with the 3 meals as well; even if a system was set up so payment could be made if budget was an issue. Was quite difficult for my husband to keep leaving to get decent food." – As a result of this feedback we can now offer partners meals than can be ordered through the onsite café to be delivered with the patient meals.



Best things:

"Not being rushed out of hospital; all the midwives were on the same page, and their care was exceptional; The Whānau house. We live in South Westland, so having a place for my husband and son to stay was very important."

"Thank you so much for all the help, care and support. I was absolutely in a panic about having to come in to a hospital but I'm so glad we came in. All the learning has set us up so well for the next step and we really appreciate you all."

"To the wonderful midwives who have taken great care of Imogen and myself over the last few days. You have all made the experience of welcoming number 3 into our family a lot easier. It's been 6 years since our last child so everything felt like the first time again. Thanks for the emotional and physical support and letting me ask so many questions."

How we could improve:

"Better chairs or beds for partners to sleep on. Up north they have double beds so both parents could get a good night sleep" – All our rooms are single and have the option of either a lazyboy chair or a single fold-out bed that can be used by a support person overnight.

Quality Improvement

Maternity Incident Review Group

Our Maternity Incident Review Group includes representatives from all disciplines involved in the maternity journey, as well as consumer representation and members that sit across the

transalpine partnership. Recommendations and learnings from these reviews are presented at staff meetings and build into multidisciplinary education days outlined under the education section above.

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

Findings from the review of cases are presented at staff meetings and education sessions, with adjustments to policies and procedures made as required. One such change was the creation of a tocolysis kit to be located in theatre in order to avoid having to get this from a birth room upstairs.

Amos Jasper Ruru Langridge, born 19/02/2022 with mum Robyn

Other Quality Projects

Alternative access for wāhine in active labour

A consumer led project. There is one main entrance to Te Nīkau - wāhine came through a central area where all patient cohorts congregate. This led to issues of privacy, confidentiality and potential for contamination during COVID-19 resurgences. Lower ground access provides closer parking and provides a more direct route to the maternity unit. Camera, doorbell and swipe card access is available so wāhine can either be met by their LMC or the door can unlocked by main reception, providing access to lower ground floor. They then have direct access to step into the lift, then directly to maternity, avoiding central public area. The procedure was developed and implemented.

Pathway for West Coast pēpi discharged from NICU

It was identified that often West Coast LMCs / maternity unit and associated well child services were not aware when pēpi were discharged back to the West Coast. So there is the potential to miss the follow up for the wāhine / pēpi with Well Child services. The National Immunisation Register is also not linked in. A pathway was developed whereby the Christchurch NICU notify

WC Maternity via email of a planned discharge date. This is copied to their LMC and the NIR Co-ordinator links in well child services, contacts whānau for NIR, etc. This is monitored by the NIR coordinator notifying the MQSP Coordinator of any babies with NHIs generated domiciled on the Coast that they have not received contact information for.

Emergency Kit for Breastfeeding Women Guide

Multiple flooding events across the West Coast identified women are unprepared for safe feeding of their babies during natural disasters. A guide of essential items has been developed to have ready in an "Emergency Kit" should natural disaster or other serious event occur, so women are prepared.

LMC direct referral to Brief Intervention Counselling Services

LMCs could not directly refer their wāhine to brief intervention counselling services, requiring wāhine to visit the GP. This barrier has been removed. LMC can now phone GP Practices and directly refer their wāhine via phone call and hand over of clinical information to the Practice Nurse.

Monitoring of COVID-19 vax status of WC wāhine, Monitor outcomes for COVID-19 Positive women

We had the desire to observe if infection with COVID-19 during pregnancy creates ongoing complications with the pregnancy i.e. intrauterine growth restriction, pre-eclampsia or preterm labour. Vaccination and infection status is recorded in the woman's clinical record. A data base was created to record gestation, vax status, and pregnancy outcome to identify trends. This is ongoing, with no identifiable increase in adverse outcomes so far, and only two women receiving a COVID-19 vaccination in the six-week period following birth.

Early referral to Breastfeeding Support

Breastfeeding advocates have advised that they would like earlier referral to our wāhine so they can start the conversations / establish relationships with hapū māmā prior to pēpi being born, so wāhine would know where to go for support. LMCs can refer their wāhine to West Coast PHO Breastfeeding support practitioners in the antenatal period. Wāhine can have one to one education / advice and can be linked with Mum4Mum peer supports in this early stage. This initiative supports the work done in the unit and by PPE. Breastfeeding advocate visits to the maternity ward were suspended due to restrictions during the COVID-19 surge, but were restarted with the lowering of alert levels.

Additional antenatal "birth talks" monthly for wāhine referred by their LMC

There was an identified a disruption to antenatal education classes caused by COVID-19 restrictions and limited availability of PPE during this time. A Core midwife held a two-hour session once per month during increased alert levels to answer any PPE questions wāhine may have and to provide another chance to visit the unit prior to birthing. This midwife is a trained PPE educator and has been a key trainer in the haputanga wananga Māori PPE programme. LMCs will refer their wāhine direct to this session.

Create Midwife led GDM Clinic

We identified a delay faced by women diagnosed with GDM, sometimes waiting in excess of two weeks to start receiving intervention and monitoring and needing to travel to Greymouth to attend visits creating an equity of access barrier. With the assistance of localising guidelines from Waitaha – Canterbury we established a midwife led Diabetes in Pregnancy clinic. Referrals from LMC's come to one central place with education and monitoring to be provided by a

dedicated core Midwife in consultation with obstetric and diabetic teams. This provides one point of contact for women and their LMCs. This has allowed an increase in the use of technology to avoid unnecessary travel for our remote rural women.

Audits

In addition to our regular in-house audits in 2022 we had four external audits: Baby Friendly Hospital Initiative Audit; Newborn Universal Hearing Screening Programme Audit; Newborn Metabolic Screening Programme Audit; and the hospital wide Certification Audit.

Te Tai o Poutini MQSP Workplan for 2023-2024

The following table sets out the Work Plan for the West Coast Maternity Quality and Safety Programme for 2023, based on the projects directed by the Te Whatu Ora and reported quarterly. This Work Plan for 2023-2024 will be expanded with the development of a Te Tai o Poutini Maternity Strategy once updated priorities from interest groups are released, and we have the report from the 'Growing up well on the West Coast' project.

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
1	National	Implementation of NEWS/NOC as per national roll out	• All staff working within maternity services or with our pregnant women are trained in the use of NEWS and are using the tool appropriately. Annual refresher training available for current and new staff using the tool, incorporated within compulsory education sessions.	• Random audit to indicate compliance in using the tool and appropriate escalation when tool indicates action. Exception reports to Te Whatu Ora via MQSP Programme.
2	National	NE Taskforce projects	• Head circumference measured in NEWS/NOC screening to monitor an early warning sign for NE • Growth Assessment Protocol (GAP) used to monitor fetal growth throughout pregnancy and early referral any identified risk factors	• Audit of medical charts to indicate appropriate use of GAP tool and follow up referrals being made • Ensure that baseline data (broken down into ethnicity) identifies hapū māmā who will require additional scans due to increased risk factors and audit of these māmā indicates

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
			• GAP education is provided on at least bi-annual basis to all maternity carers both internal and external to the WC team. Data captured to inform the Radiology requirements to meet the GAP guidelines.	referrals were made and scans provided. Review maternity booking form to identify this information. Collected through GAP programme • Conversations and information with māmā requiring additional scans is culturally appropriate. Report to Radiology for expected scan volumes completed six monthly
3	NMMG Recs 2019 MQSP (1)	Improvements to work place culture and safe staffing	• Staff working within the Te Nīkau Maternity Unit are oriented to and familiar with the environment • Full implementation of the CCDM programme to ensure staffing levels are managed within safe staffing guidelines and management aware of and act on any variation to staffing levels • Staff training in the use of submitting Safe Staffing Form in Safety1st • Regular staff meetings which include community based LMCs to identify any issues that require a	• Policies, procedures and information packages are updated to reflect the Te Nīkau environment and Trans Alpine model of care • Safe Staffing escalation plan used when appropriate • CCDM Co-ordinator reviews Safe Staffing incidents on Safety1st and feeds back to CMM Maternity. • Monthly meetings across the different staffing disciplines to ensure timely and appropriate action to identified workplace culture issues. • Utilise opportunities for WC staff to upskill by shadowing

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
			collaborative approach to resolution. • Foster Transalpine relationships at all levels of the Maternity System Expand support roles to maternity	counterparts in Canterbury maternity specialist areas Statements of Accountability produced for new maternity positions: Maternity Care Assistants and Kaiawhina
4	NMMG Recs (2)	Encouraging low-risk women to birth at home or in a primary facility	• Promotional material / information reviewed and distributed • Primary facility and home birth promoted via Facebook and good news stories Ensuring the Maternity Facilities on the West Coast maintain a normal birth focus, with easy access to quality secondary care	• Increase in number of women choosing to birth or have post-natal care in the Westport Primary Birthing Facility opening May 2023 Sustain or increase number of women choosing to home birth on the West Coast
5	NMMG Recs (3)	Cultural competency workshops for all Maternity Service staff	• Māori Health Team to encourage all LMCs and Core facility staff to participate in the Takarangi Cultural Competency Framework and aligning it to the Turanga Kaupapa • Ensure our maternity services provide care in a culturally appropriate way including the use of te reo in signage and conversations	• At least one session on cultural competency per year is delivered to staff working in maternity services • All maternity services staff meet WC cultural competency training requirements • See an increase in the use of Te Reo across communications both written and verbal Support a WC Cultural Working Group to develop a programme of work aimed at improving the

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
			• Maternity Services identify cultural education appropriate to their setting.	cultural competency of the maternity workforce
6	NMMG Recs (4)	Access to post-partum contraception, including regular audit	• Establish a working group to review post-partum contraception access and availability Informational resources identify how to access post-partum contraception	• Increased numbers of women accessing post-partum contraception • Post-partum contraception is to be discussed with all women prior to discharge from maternity unit
7	NMMG Recs (5)	Equitable access to primary mental health services	• Maternal Mental Health (MMH) Pathway is reviewed, and updated information is current • Work with the WC PHO to capture number of referrals to MH services in primary sector • Liaise with PHO to determine number of women accessing MH services via GP or self-referral Liaise with LMCs to ensure appropriate data capture, referral and follow up to MH services	• Audit of women who indicated current MH issue on their booking form identifies all were offered access to MH services • All women with identified MH issue at booking are screened using EDPS or other recognised maternal mental health screening tool Yearly review of MMH pathway
8	PMMRC Recs relevant to MQSP (1)	Reduce preterm birth and neonatal mortality	• Appropriate identification of high-risk pregnancies is made at booking • Identify whanau who smoke and ensure	• Review of referrals to obstetric services to indicate that they are timely and appropriate and that referrals occur early in the pregnancy

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
			appropriate advice and referral to cessation services occurs. • Appropriate referrals to secondary and tertiary provider for pregnancies identified as at high risk, including utilising technology for these ongoing discussions to increase equity of access to services • Communication between WC and Christchurch provides for seamless follow up of WC women referred to tertiary provider on their return to the Coast in the hub and spoke model Universal implementation of GAP to identify and monitor other high-risk pregnancies.	• Audit of women with previous uterine surgery to identify appropriate management throughout their pregnancy • Facilitate closer working relationships with NGOs for staff working within maternity services to engage our priority populations • Ensure appropriate referrals made for pregnancies with abnormal placentation Women with previous preterm births have early referral in subsequent pregnancies for management plan
9	PMMRC Recs (2)	Co-design models of care to meet the needs of Indian women	• Meet with Indian women and their families to identify any barriers to accessing maternity care Consumer Council up and running	• Strategies developed ensure equitable access to services • Demonstrate at least one episode / engagement with these target groups At least one representative of these women on our Maternity Consumer Council.
10	PMMRC Recs (3)	Co-design models of care to meet the needs of women <20 years of age	• Provide a forum for women <20 years where they can communicate any specific issues facing	

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
			them in pregnancy and access to care and support. Review alternative ways of provision of information to this cohort of women (increased use of technology)	
11	PMMRC Recs (4)	Interdisciplinary fetal surveillance education for all clinicians involved with intrapartum care	• Multi-disciplinary FSEP provided by Te Nīkau Hospital for all clinical staff working within maternity services and facilitated for all community-based access holders 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
12	PMMRC Recs (5)	Implementation of HQSC maternity morbidity review toolkit and SAC rating (Maternal and NE Case review)	• Continued use of the HQSC Maternity SAC rating tables to capture incidents within Safety1st that match this list. All LMCs and Maternity staff are aware of the "Trigger List" and record incidents this matching this list in Safety1st	Review of all Maternity incidents recorded within Safety1st and escalation for RCA investigation if warranted.
13	MWWG (subgroup of PMMRC) (1)	Implementation of Hypertension guideline, with a review / restock of medication to ensure easy availability in	Work with South Island counterparts to create overarching policy	Guideline implemented

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
		acute care settings		
14	MWWG (2)	Continued audit of MEWS charts / implementation	Continued business as usual	Random audit of MEWS charts to indicate appropriate use and if required opportunities for further education which are followed up
15	MWWG (3)	Use of the Health Equity Assessment Tool (the HEAT) to assess services for the impact of health equity	• Use HEAT tool in guiding of any maternity related strategies, policies, guidelines Staff education on HEAT tool	HEAT Tool used as a guiding document for new policies and procedures.
16	MWWG (4)	Establish a clinical pathway for women with identified placental implantation abnormalities	Trans Alpine working group to develop pathway for women with identified placental implantation abnormalities	Pathway easily accessible for staff working within the maternity setting
17	MWWG (5)	Establish septic bundle kits to address human factor components, such as stress in high-acuity settings	• All staff working within the maternity setting can locate the Sepsis Clinical Pathway across primary / secondary / tertiary sectors • Policy localised	• Sepsis pathway implemented Education sessions run prior to implementing sepsis bundle and pathway
18	MWWG (6)	Establish clinical pathways across primary and secondary/tertiary care to enable earlier recognition and treatment of sepsis		
19	Local Project	Growing up well on the West Coast project	• Project report published Project engages with women / whanau to capture the communities' needs for the period from conception to at least the first 3 years of life.	• Maternity Strategy for the delivery of services as an outcome of engagement Consumer groups as Maternity Consumer Council established across the Coast in "regional hubs"

Ministry of Health MQSP Projects – Reported Quarterly				
No.	Driver	Project Title	Expected Outcome	Measure
				that are representative of our community
20	Local Project	Maternity Consumer Council	• Increased consumer consultation on quality initiatives, policies, procedures, and patient information Membership reflective of population accessing maternity services	Consumer Council meeting regularly feeding into Maternity Quality and Safety Governance Group
21	COVID-19	Endemic COVID-19 plan	• Monitor pregnancy outcomes for women diagnosed with COVID-19 during pregnancy Identify the pregnancies in this category that would benefit from extra support	Prospective audit of pregnancy management and outcomes for all women identified within this group
22	Maintaining Competence	Ongoing Education	• All maternity staff to meet professional and organisational requirements for ongoing education New education added as specified	• Ongoing education: GAP, PROMPT, Emergency Skills, STABLE, FSEP, NLS, BFHI requirements, Cultural Competency New education: Integrating Abortion Care into the Midwifery Scope of Practice

The maternity team Christmas 2022

Addendum 1 – Trigger List for Incident Review

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

Canterbury and West Coast
MATERNITY CARE

Maternity Trigger List to fill Safety 1st form

We want to be in An Organisation with a Memory, and we need to learn from clinical error

Purpose of Trigger list:

- To identify and review the severe complications of pregnancy and the puerperium
- To help learn lessons to improve future care and not finding the fault

Whom to fill: Health professional involved with care of woman and the baby or who were present at that time of event

Maternal Incident	Foetal/Neonatal Incident
Maternal Death	Still birth or Neonatal death
Undiagnosed breech coming in labour	Apgar scores < 7 at 5 minutes
Shoulder dystocia	Unexpected NICU admission
PPH >1500 or	Birth trauma
Blood Transfusion within 1 week post delivery	Cord ph <7.0 arterial or <7.1 venous
Return to Theatre	Lactate >5.8
Prolonged 2nd stage (Primip 3 hrs, Multip 2 hrs, with epidural 4 & 3 hrs.)	Undiagnosed Foetal anomaly
More than 2 hours delay suturing or Manual removal of placenta	Neonatal Seizures
Eclampsia	Sepsis
3 b, c and 4th degree tears	
Unexpected ICU admission	
DVT or PE in pregnancy and postpartum	
Readmission of mother after delivery	
Uterine Rupture	
Retained swab or instrument	
Delay in Emergency section 40 min cat 1, >90 min cat 2.	
Sepsis	