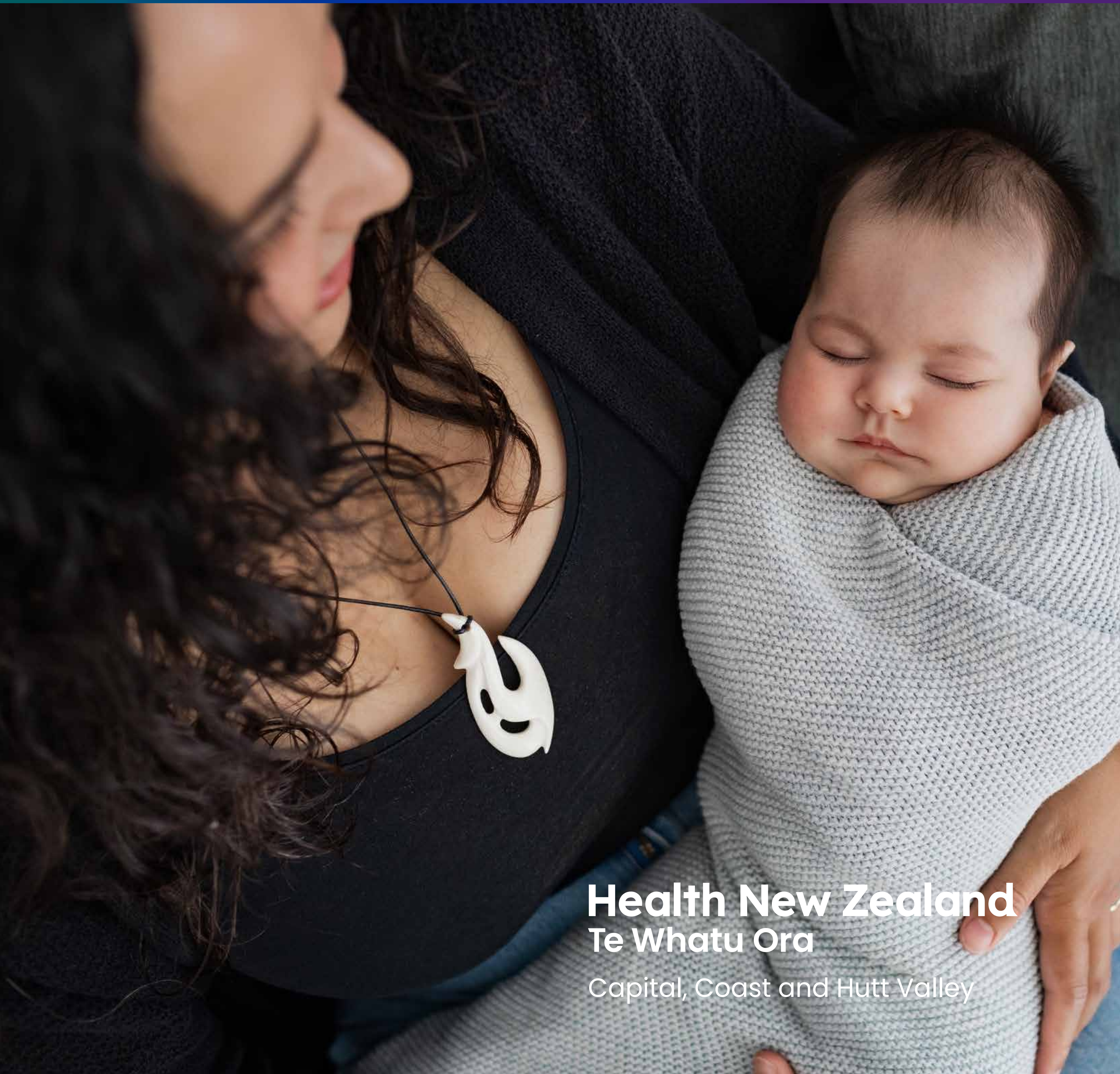
2023
MATERNITY QUALITY & SAFETY PROGRAMME
ANNUAL REPORT



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Enahara taku toa i te toa takitahi Engari, he toa takitini

My successes are not mine alone, they are ours – the greatest successes we will have are from working together

- Māori proverb

ACKNOWLEDGEMENTS

Thank you to the many administration, midwifery and medical staff who have contributed to the content of this report.

Thanks especially must go to our Maternity Quality & Safety Programme (MQSP) 2023 team including Michelle Graham, Linda Elvines, Ali Barkman, Clare O'Loughlin, Elaine Newman, Gargee Mohanty, Hollie Clark, Jenny Quinn, Jeya Wilkes, Krystal Williams, Nicole Anderson, Rose Elder, Simone Curran-Becker, Teejay Joshi, Vee Samoa, Shelley James, Laura Ellis, Patria Tamaka, Gemma Nightingale, Amanda Ashcroft, Sonya Hitchcock, Rose Dew, Maggie Howie, Jess Maxwell, Emma Adams, Carolyn Coles, Wendy Castle and Karen Daniells.

It is with genuine appreciation that we thank our workforce, consumers, lead maternity carers (LMCs) and wider health care partners and communities.

Thank you also to all the whānau and staff who kindly let us use their images to illustrate our report.

ACKNOWLEDGEMENT OF GENDER

Not all people who become pregnant identify with the female gender. This document uses terms specific to female identity for ease of understanding, while acknowledging that this is a cis and heteronormative approach. The Ministry does not intend to exclude people of diverse gender identity, gender expression or sex characteristics where this document uses the words 'wāhine', 'woman', 'she' or 'her'. Pregnant people should advise the health professionals involved in their care of their preferred pronouns so that these are used correctly and documented in their records. Health professionals should make every effort to use people's preferred pronouns.

REPRODUCTION OF MATERIAL

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FOREWORD

It gives Simone, Rose and I great pleasure to present Capital, Coast's Maternity Quality and Safety Programme (MQSP) report for 2023.

In 2022 Capital, Coast and Hutt Valley became one district. This was a welcome move that provides us with ample opportunity to streamline services and reduce unnecessary variation. If you are reading the hardcopy of this report you will find the Hutt Valley MQSP report on the reverse side of this publication.

One of the major challenges faced by midwifery services over the past few years remains securing a stable, skilled and full complement of midwives. Some of the ways we have tried to address this workforce issue is through: recruitment and retention packages, continuous professional development and active recruitment. During the past year the Wellington based Womens Health Service (WHS) have successfully recruited several internationally qualified and experienced midwives. Their welcome arrival adds to the breadth of experience and fresh eyes to our local workforce. We are also looking forward to Victoria University of Wellington's first cohort of graduate midwives joining us (as employees or LMCs) at the beginning of 2024.

In order to streamline services across the district, senior midwifery titles and role descriptions for Midwife Manager's, Clinical Midwife Managers and Midwife Educators have been aligned. A pilot has been undertaken whereby one Midwife Manager began overseeing the provision of care of the Community Midwifery Teams district wide. A second Associate Director of Midwifery was also appointed. The primary focus of this ADOM role includes increased collaboration and networking with the Lead Maternity Carers and the districts primary birthing units.

MQSP were thrilled to welcome three new consumer representatives to the MQSP Governance Group in 2023. These consumers bring a diverse set of skills, passion and a wealth of experience to the group. Welcome Jamie Martin, Patria Tamaka-Pairama, and Vee Samoa.

This year's highlights include the introduction of the Kenepuru Maternity Unit Open Days which were well attended, and the commissioning of an Indian women's focus group that we expect will provide us with valuable insights as to how we can improve our maternity services for this group of women. Another highlight has been Ngāti Toa inviting the WHS to run secondary antenatal clinics in their maternity hub at Te Puna Wairua in Porirua. Work is also underway to enable ultrasound scanning to be undertaken at the hub. This initiative is a great opportunity to work with tangata whenua to increase access for hāpu Māmā in Porirua.

During the past year Birthing Suite at Wellington Hospital has undergone extensive remedial work to replace faulty copper pipes. Whilst this work has been undertaken room by room it has provided us with the opportunity to refurbish each of the 12 birthing suite rooms providing a new colour palette, repositioning clinical equipment, softer lighting and the removal of fixtures which are no longer fit for purpose. The same remedial work will commence in Ward 4 North Maternity in January 2024.

A project to do an elective caesarean section list in the main theatre once a week has been undertaken. This enables elective caesarean sections to proceed without the disruption of emergency work and increased timely access to theatre for emergency births or procedures.

Maternity related policies, procedures, protocols, guidelines and patient information brochures have begun the enormous task of merging district wide. A task that is likely to take at least two years as the volume of documents utilised by maternity services is extensive. Each document will be reviewed by a multidisciplinary team using the latest evidence based information reviewed and agreed to by maternity clinicians.

The long awaited implementation of the Maternity Clinical Information System, BadgerNet, occurred in November 2023 across Kāpiti, Kenepuru and Wellington sites. Capital, Coast is the eighth district in New Zealand to implement the application within maternity services. The introduction of this application enabled maternity services to be paper light and shares a connection with most of the North Island. In May 2024, Hutt Valley and Wairarapa will be implementing BadgerNet and we welcome the connectivity this will bring.

During 2023 Maternal Fetal Medicine (MFM) temporarily expanded their referral catchment area. Gisborne, Bay of Plenty and Lakes which added to the existing catchment Nelson/Marlborough up the west coast to Taranaki. This change was required to assist Auckland MFM who had been experiencing disproportionality longer wait times. This resulted in a 30% increase in referrals and wait times as a result became equitable nationally. In April 2024 Lakes and Bay of Plenty districts will likely be returned to Auckland, and Gisborne will remain with Capital, Coast and Hutt Valley.

Simone, Rose and I would like to take this opportunity to express our genuine thanks to all the midwives, nurses, doctors, administrators and maternity healthcare workers who provided care to pregnant people within Capital, Coast. Your resilience, ability to adapt under challenging circumstances and collegial support for one another has meant that pregnant people were able to receive the best care possible.

Special thanks go to Emma Adams & Jessica Maxwell (MQSP coordinators) for compiling this report.

We hope you enjoy reading the report.

Carolyn Coles, Director of Midwifery

Simone Curran Becker Womens Health Service Operations Manager

Rose Elder, Clinical Leader of Obstetrics

Carolyn Coles
Director of Midwifery

Simone Curran Becker
Womens Health Service
Operations Manager

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Clinical Leader of Obstetrics

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Kupu Whakataki

Introduction

HEALTH NEW ZEALAND | TE WHATU ORA CAPITAL, COAST VISION AND VALUES

Health New Zealand | Te Whatu Ora (Health NZ) Capital, Coast is committed to meeting the Minister of Health expectations and delivering our vision of: Keeping our community healthy and well.

As a health care provider, we work according to the following three core values:

Manaakitanga is at the heart of Māori tikanga. We care for a person's mana by expressing hospitality, generosity and mutual respect.

Kotahitanga focuses on unity and collective action. We work in a fair and just way with each other and with the communities we serve.

Rangatiratanga challenges us all to use our personal power with absolute integrity to serve our communities and provide the best health services we can. We trust people to share power, influence and decision-making.

WOMEN'S AND CHILDREN'S SERVICE

The Women's and Children's Service Group is one of six within Capital, Coast and Hutt Valley District's Provider Services. Services and specialties within the group range from primary to tertiary level with service provision for the district, the Central Region and Wider Regions. The Group operates from four sites across the district including Wellington Regional, Hutt and Kenepuru Hospitals as well as the Paraparaumu Maternity Unit within the Kāpiti Health Centre.

Our services include:

- Obstetrics and Gynaecology
- Maternity
- Neonatal Intensive and Special Care Units
- Child Health including the Children's Cancer Unit
- Child Development
- Genetics
- Violence Intervention Programme

STRATEGIC ALIGNMENTS

NATIONAL:

PAE ORA – HEALTHY FUTURES

To deliver Pae Ora (Healthy Futures), six strategies were identified to set the direction for a system that is equitable, accessible, cohesive and people-centred.

These strategies were finalised in July 2023, and provide a long-term vision where all people and their whānau, regardless of their background, can achieve their best possible health.

The six strategies are:

The New Zealand Health Strategy

Pae Tū: Hauora Māori Strategy

Te Mana Ola: The Pacific Health Strategy

The Health of Disabled People Strategy

The Rural Health Strategy

The Women's Health Strategy

INTERIM NEW ZEALAND HEALTH PLAN | TE PAE TATA 2022

Interim New Zealand Health Plan | Te Pae Tata 2022 is the formal document that sets out the first two years of action for Health NZ as we transform healthcare in Aotearoa New Zealand.

Te Pae Tata outlines the first steps of what we will do differently to build the foundations of a sustainable and affordable, unified health system that better serves all of Aotearoas' people and communities.

The core sets of actions in Te Pae Tata will ultimately deliver key shifts in health service delivery.

1. Place whānau at the heart of the system to improve equity and outcomes
    - Pae ora | Better health in communities
    - Kahu Taurima | Maternity and early years
    - Mate pukupuku | People with cancer
    - Māuiuitanga taumaha | People living with chronic health conditions
    - Oranga hinengaro | People living with mental distress, illness and addictions
2. Embed Te Tiriti o Waitangi across the health sector
3. Develop an inclusive health workforce
4. Keep people well in their communities
5. Develop greater use of digital services to provide more care in homes and communities
6. Establish Health NZ to support a financially sustainable system

Most of MQSP work is under Kahu Taurima | Maternity and Early Years. A child's first 2,000 days lay the foundation for their future. It's a critical period that impacts a lifetime of health and wellbeing. The main goals for Kahu Taurima are;

- Maternity and early year's health services, for a child's first 2,000 days from conception to five years old, will be integrated, holistic and culturally appropriate for all whānau.
- Maternity and early years services that are Te Ao Māori, whānau-centred and Pacific fanau-centred will be more readily available.
- People will have better access to maternal mental health and wellbeing pathways of care, including access to bereavement and specialist mental health services.

- Wrap-around support for wāhine hapū antenatal and birthing care, including finding ways to provide long-term intervention and prevention services, will be provided.

WHAKAMAUA: MĀORI HEALTH ACTION PLAN 2020-2025

As kaitiaki of the system, Manatū Hauora has an important leadership role to play in creating an environment that enables Māori to live healthier, happier lives.

Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy – it will help us achieve better health outcomes for Māori by setting the government's direction for Māori health advancement over the next five years.

Whakamaua is underpinned by the Ministry's new Te Tiriti o Waitangi Framework, which provides a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

Whakamaua outlines a suite of actions that will help to achieve **four high-level outcomes.** These are:

- Iwi, hapū, whānau and Māori communities exercising their authority to improve their health and wellbeing.
- Ensuring the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
- Addressing racism and discrimination in all its forms.
- Protecting mātauranga Māori throughout the health and disability system.

TE TIRITI O WAITANGI

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through the founding document of Aotearoa. We value Te Tiriti and have adopted the following four goals, developed by the Manatū Hauora, each expressed in terms of mana and the principles of:

MANA WHAKAHAERE Effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.

MANA MOTUHAKE (Māori self-determination); Enabling the right for Māori to be Māori to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.

MANA TĀNGATA Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.

MANA MĀORI Enabling Ritenga Māori (Māori customary rituals) which are framed by Te Aō Māori (the Māori world), enacted through tikanga Māori (philosophy & customary practices) and encapsulated within mātauranga Māori (knowledge).

We will target, plan and drive our health services to create equity of health care for Māori to attain good health and well-being, while developing partnerships with the wider social sector to support whole of system change.

INTERIM PACIFIC HEALTH | OLA MANUIA PLAN JULY 2022-JUNE 2024

Interim Pacific Health Plan | Ola Manuia is the companion document to the Interim New Zealand Health Plan | Te Pae Tata, that sets out the first two years of actions that will guide Health NZ's Pacific health work programme in the reformed system.

Ola Manuia provides more detail on Health NZ's approach to strengthening Pacific health enablers and taking action on the Pacific Health priorities.

We know many areas of the health system are not working well for Pacific people, aiga, ngutuare tangata, famili, kāinga, magafaoa,

kaiga, vuvale and kaaiga (families) and communities.

The actions we take over the next two years will support Pacific families and communities in New Zealand to stay well, and to enable Pacific people to access the care they need, where they need it.

Priority Areas for Pacific Health:

- Mothers and babies
- Children and youth
- Older people
- Tagata sa'ilimalo | disabled people
- Mental health and wellbeing
- Long-term conditions, including cancer, diabetes, and gout

THE NEW ZEALAND HEALTH CHARTER - TE MAURI O RONGO

Te Mauri o Rongo guides how we relate to each other to serve our whānau and communities, to continually improve their health outcomes and contribute to Pae Ora for all.

In this work, we are together, embraced and protected in this common purpose, trusted and privileged to share the responsibility of being guests in other people's lives.

Together we will do this by:

- caring for the people who care for the people;
- recognising, supporting and valuing our people and the work we all do;
- working together to design and deliver services; and
- defining the competencies and behaviours we expect from everyone.

As people working in health care, we have a whakapapa. We walk in the shoes of those that have come before us and in turn, we will shape the way for others to follow. As such, we are part of something much bigger than ourselves, something that is alive, something that makes us proud to be a part of, and with that, comes responsibility.

CAPITAL, COAST'S ALIGNMENT WITH NATIONAL STRATEGIES:

The Capital, Coast and Hutt Valley District have made sure that our Governance Group is made up with representation from consumers especially those from the priority groups (Māori, Pasifika, Under 20, Disabled and Mental Health), we also have representatives from Māori Health Unit, Pacific Health Unit and Disability. This means we are able to get the perspective of all these groups when working on any improvements we are making to our service.

Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025

Living Life Well – A Strategy for mental health and addiction 2019-2025

Health System Plan 2030

2DHB Maternity and Neonatal System Plan

Ō mātou tāngata – he aha ai, he pēhea hoki

Our People – Why and how

HEALTH NEW ZEALAND | TE WHATU ORA CAPITAL, COAST REGION

Health New Zealand | Te Whatu Ora Capital, Coast is the provider of health services to residents living in the Kāpiti Coast District, Porirua City and Wellington City.

The region was home to an estimated 327,540 people in 2021/22, which is projected to grow by an additional 17.160 people by 2030/31.

Capital, Coast is an ethnically diverse region. 12% of our population identify as Māori (39,340), and 7% as Pacific peoples (23,760). The remaining 80% (264,440) of the population identify as non- Māori and non-Pacific (i.e. 'Other' ethnicities).

Most of the population are aged between 25-69 years (58%). Age structures however differ by ethnicity and between geographic areas. The regional population differs from the maternity population.

While most of the region's population are relatively advantaged, there are significant pockets of socioeconomic deprivation. These are focused in Porirua, small parts of central Wellington and the Kāpiti Coast. Māori and Pacific peoples, in particular, experience inequitable health outcomes, and improving their experience in our maternity services has been a focus for the MQSP team from 2021.

The Women's Health Service (WHS) is responsible for tertiary maternal transfers from the central region of Aotearoa, which includes MidCentral, Whanganui, Hawkes Bay, Wairarapa and the Hutt Valley. The WHS is also responsible for maternal transfers from Nelson Marlborough, which is outside of the central region.

The Capital, Coast Maternal Fetal Medicine (MFM) service provide sub-specialist care. They are part of a national network with sub-specialists in Canterbury and Auckland. 2023 saw our MFM service pick up additional work to assist both the Auckland & Waikato regions.

The multidisciplinary diabetes and endocrine antenatal clinic provides tertiary pre-conception counselling and pregnancy care to people with complex needs who live in Capital, Coast and Hutt Valley and well and the Wairarapa.

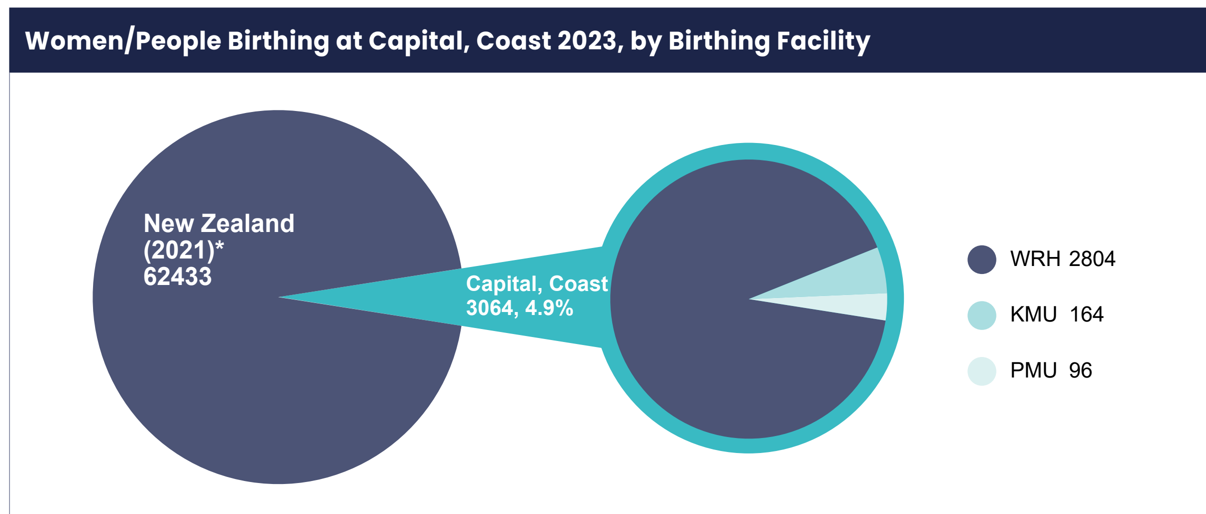
A multidisciplinary team provides care for people with complex cardiac conditions during their pregnancy from the Central Region and the Nelson Marlborough districts. These people would then birth in Wellington.

Wellington Regional Hospital accepts maternal transfers from outside the central region when neonatal units elsewhere in the country have reached capacity. The neonatal intensive care unit (NICU) provides tertiary healthcare services to premature, surgical, and sick newborns, and while not part of the WHS, works closely with the team.

THE MATERNITY POPULATION

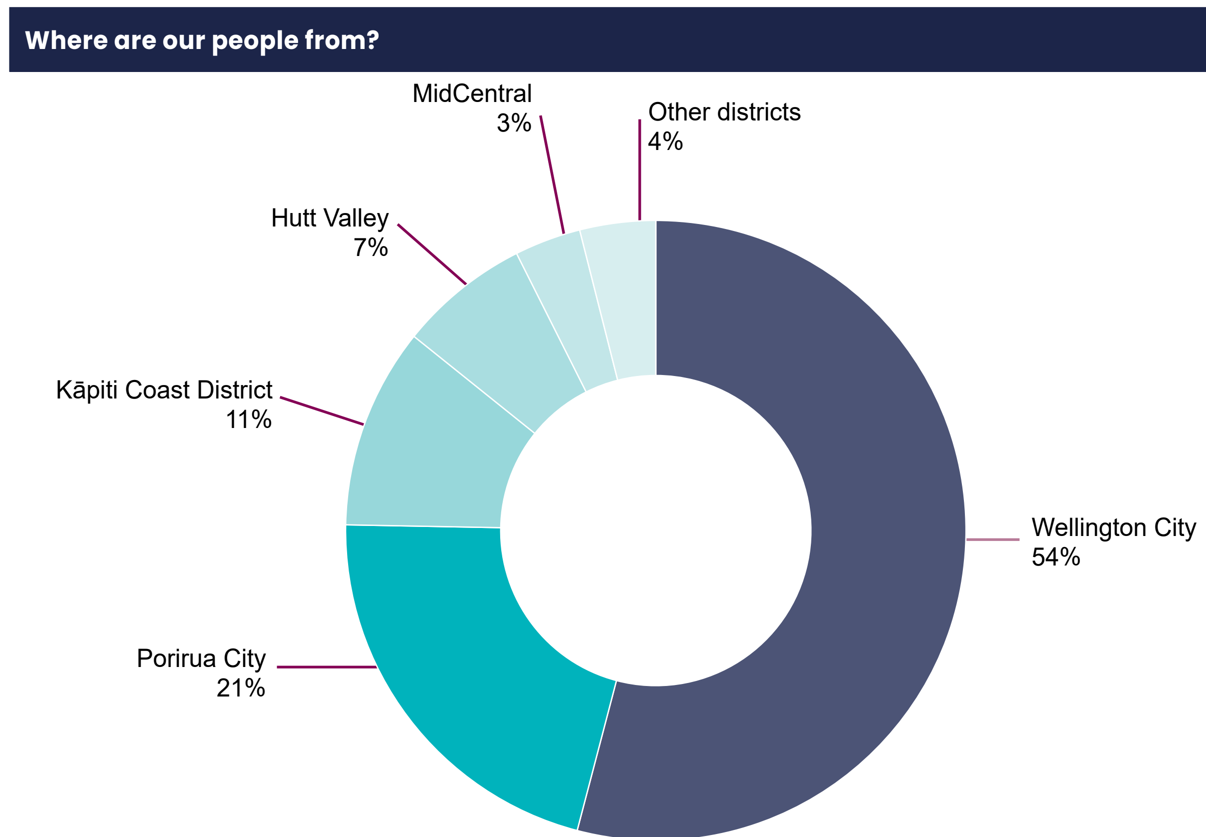
There were 62,433 women/people recorded as giving birth in Aotearoa New Zealand in 2021, according to Health NZ's Report on Maternity web tool, released in 2023. In 2023, Capital, Coast recorded 3064 people who either birthed at their facilities, had an unplanned birth at home, or birthed in transit to hospital. Capital, Coast births equate to 4.9% of the birthing population of Aotearoa. There were an additional 104 homebirths which did not require hospital admission. This additional cohort are not included in Capital, Coast birth statistics.

Women/People Birthing at Capital, Coast 2023, by Birthing Facility



* (Health NZ, 2023)

Where are our people from?



BIRTHS 2023

4.9% of NZ birthing population

3130 babies born

3064 births

66 sets of twins

That's an average of... **9** BABIES BORN EACH DAY

BIRTH OUTCOMES 2023

52.3% Vaginal Births Rate (Overall)

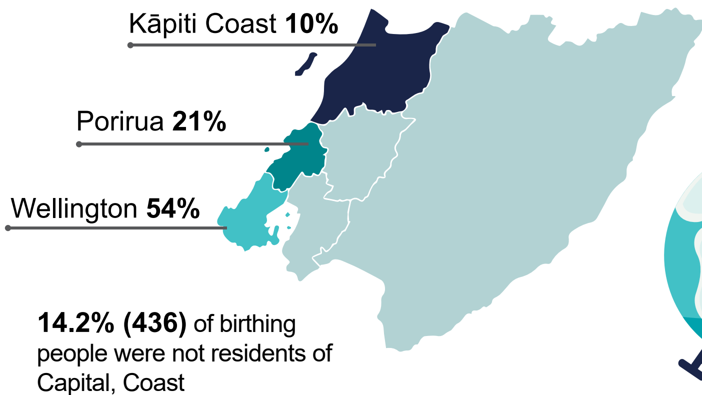
28.2% Induction of Labour Rate (Overall)

35.8% Caesarean Section Births Rate (Overall)

11.8% Assisted Vaginal Births Rate (Overall)

DOMICILE 2023

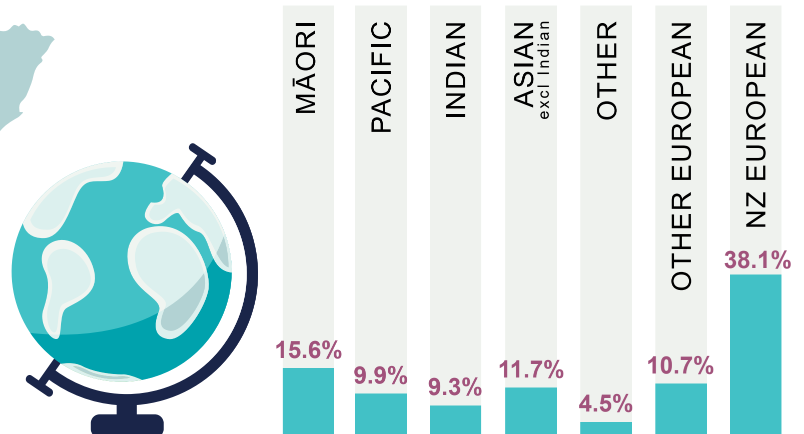
Capital, Coast resident birthing people were from:



14.2% (436) of birthing people were not residents of Capital, Coast

ETHNICITY 2023

Capital, Coast has fewer Māori and more European mothers than the national average



BIRTH FACILITY 2023

8.2% of Capital, Coast resident people birthed at Primary Birthing Units

3.2% of Capital, Coast resident people birthed at home

88.5% of Capital, Coast resident people birthed at Wellington Regional Hospital

AGE 2022

Capital, Coast mothers are older than the national average

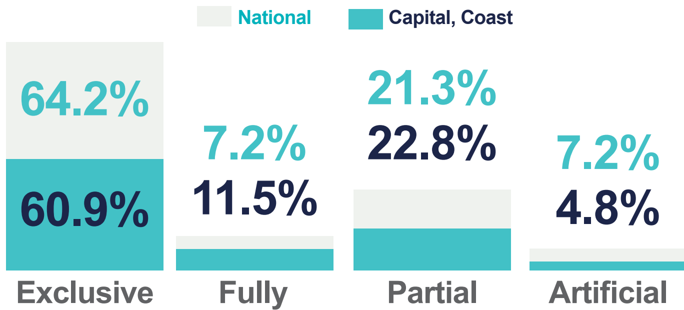
35+

23% National

31% Capital, Coast

BREASTFEEDING STATUS 2022

Capital, Coast resident people were more likely to be breastfeeding two weeks after birth



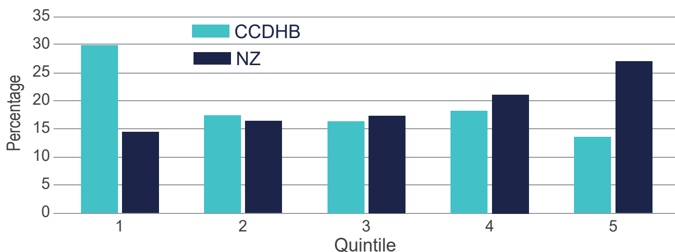
PARITY 2022

50% Capital, Coast resident people are more likely to be first time mothers 42% than people nationally

DEPRIVATION 2022

14% Fewer than average living in the most deprived quintile

31% Higher than average amount of mothers living in the least deprived quintile (NZ Dep 2013)



SMOKING 2022

8.6% of Māori women/ people were smokers at 2 weeks postnatal (6.2% fewer than the national average) a reduction of 16.2% from 2017

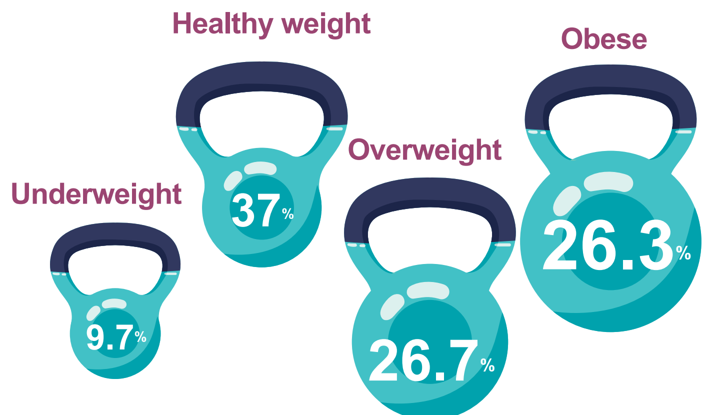
2.4% of Capital, Coast women/people were smokers at 2 weeks postnatal (3.0% fewer than the national average)

REGISTRATION 2022

75% of Capital, Coast resident pregnant people registered with an LMC in the first trimester

BODY MASS INDEX 2023

At the time of booking, Capital, Coast pregnant people were more likely to be the healthy weight range and less likely to be obese than pregnant people nationally



2023 Data sourced from local maternity database
2022 Data sourced from Ministry of Health Qlik Sense hub 2022 (the most complete year of data)

MATERNITY FACILITIES

Birthing facilities are available at three locations – Wellington Regional Hospital, Kenepuru Community Hospital and Kāpiti Health Centre.

WELLINGTON REGIONAL HOSPITAL (WRH) – PRIMARY, SECONDARY, AND TERTIARY

Birthing suite

Twelve labour and birth rooms with pools

One operating theatre

Ward 4 North Maternity

Twenty six resourced maternity beds

One bereavement room

Two assessment beds for LMCs (not resourced)

Acute Assessment Unit

Five assessment rooms

Four additional assessment spaces

KENEPURU MATERNITY UNIT (KMU) – PRIMARY

Eight bed capacity

Two birthing rooms

One birthing pool

Six postnatal rooms

PARAPARAUMU MATERNITY UNIT (PMU) – PRIMARY

Three bed capacity

One birthing room

Two postnatal rooms

A virtual tour of our three facilities can be accessed at CCDHB website:
www.ccdhb.org.nz/our-services/maternity/giving-birth-at-our-hospitals/

WELLINGTON BIRTHING SUITE COPPER PIPES AND REFURBISHMENT:

As part of the overall hospital copper pipe project, throughout 2023, there has been a gradual replacement of all copper pipes to every sink and shower in Birthing Suite.

The plumbing work has meant that there has been significant disruption to Birthing Suite with a decrease of available birthing rooms. However, the project has given scope to be able to upgrade the facilities across the birthing rooms.

Structural changes were required to accommodate the new Panda resuscitaires and the BadgerNet hardware so there was an opportunity to incorporate these needs with other improvements. The staff were canvassed to find out what changes would help work flow and improve the birthing environment for women and whānau.

The Kensway and Naylor Love contractors have worked tirelessly to incorporate staff requests with the needs of the copper pipe work.

The birthing rooms have had the light system rationalised; the call bell, electrical sockets and data points incorporated into trunking behind the head of the bed; the old neonatal cupboards removed and the medical gases enclosed in a smaller unit. New Rada units have been installed in the birthing pools and bathrooms; the rooms repainted and prepared for large murals chosen by the MQSP Māori and Pacific Representatives. The rooms provide a more natural area dedicated to whānau and a separate staff work space.

Staff have commented that the rooms are less cluttered and provide a comfortable and intuitive working environment.

Work in one of the postnatal pods will commence in early 2024 with the rest of the maternity ward to follow at a later date.

WORKFORCE

Workforce issues within the maternity sector are well documented with midwives an ageing population and retention an ongoing issue. Te Tatau o Te Whare Kahu (The Midwifery Council of New Zealand) conducts an annual workforce survey and results from 2023 show an overall increase in the number of midwives holding practising certificates. It is thought this number has increased compared to previous years due to post pandemic conditions. Capital, Coast currently has 0.65 midwives per 1000 population (census 2018). We have outlined below steps taken to recruit and retain within the region.

STAFF ENGAGEMENT & CULTURE

We endeavour to create an inclusive and collaborative workforce culture as we are acutely aware of the stressors experienced when dealing with high-risk situations. The Wellbeing and Care Group are a multidisciplinary group who provide wrap around collegial support when an adverse event occurs. A member of this group is nominated to provide peer support to check in on the wellbeing of those involved and guide re professional support where required. RAISE mental health are contacted promptly to provide a multidisciplinary debriefing for those wanting to attend following a stressful incident.

During the COVID pandemic the Wellbeing and Care Group delivered care packages to staff at home while unwell with the virus. These care packages were well received and much appreciated.

Wherever possible the WHS engage staff in social, informal settings for example mid-winter and Christmas dinners, picnics, movie and quiz nights.

RECRUITMENT & RETENTION

The recruitment and retention of midwives is fundamental to ensuring that we have a capable and effective workforce to meet the growing needs of our diverse birthing population. Strategies we have implemented to recruit and retain midwives include:

- Relocation packages for midwives who have been recruited nationally and internationally
- On-call payments being made to senior midwives after-hours
- An on-call component being added to the contracts of all newly recruited midwives to support roster shortfall.
- Retention payments being made to all midwives that have been employed for over the preceding six months. These payments will continue to be paid until 85% of the required midwifery FTE is recruited to, or for a period of five years, whichever comes first.
- Additional shift payments are made to any midwife who agrees to increase their contracted FTE for a sustained period of three, six, nine or twelve months.
- New graduate midwives receive a 'sign-on' fee that is paid after one month's employment, a second payment is made at the end of twelve month's continuous service.
- Incentive payments are also made when employed midwifery or nursing staff pick up additional shifts during periods of high acuity.
- Nationally agreed incentive payments were implemented over the summer period for employed midwives in order to support critical staffing shortages.

Ongoing concerns nationally regarding SMO workforce in MFM are being considered at the national level. Workforce planning to enable support to the MFM service is ongoing. Fragility of the gynaecology services impact on obstetric services with operative management of complex placenta accreta spectrum disorders. Urgent addressing of the fragility of this service is required at a national level.

CULTURAL SAFETY & QUALITY INITIATIVES

The MQSP Governance Group has representation from Māori and Pacific People. Recently these representatives contributed to the aesthetic enhancements of the refurbished birthing suite rooms to ensure they were inclusive and welcoming to all cultures.

OUR FUTURE WORKFORCE - STUDENT MIDWIVES

OTAGO POLYTECHNIC | TE KURA MATATINI KI OTAGO

The Otago Polytechnic undergraduate midwifery programme is taught via a combination of online lectures, face-to-face tutorials, practice experiences and intensive block courses, in various locations across the motu. This provides students with flexibility to fit their studies around their individual lifestyles. Otago Polytechnic staff attend career expos to encourage enrolment into the programme, and also offer whānau information evenings outlining expectations of the programme.

At Otago, student midwives can link into a national programme, Te Ara ō Hine — Tapu Ora, to support learners who whakapapa Māori or Pasifika. Resources to help them study and complete their midwifery qualification are provided, so that *"Māori and Pasifika babies can be born into Māori and Pasifika hands"*. They have Te Ara ō Hine (TAOH) and Tapu Ora (TO) liaisons who meet regularly with Māori and Pasifika tauira in each of the satellite regions. They also meet with Māori and Pasifika applicants to discuss programme expectations and offer assistance in completing the application for enrolment into the programme. Otago provides Teams study sessions and also have a presence at the Bridging Health

Certificate block courses by facilitating an introduction to midwifery course. Prior to orientation, the TAOH & TO meet and greet tauira to assist with forming connections with each other and local midwives.

Over 22% of the current tauira midwifery identify as Māori, and almost 5% as Pasifika. So a total of 27% of Otago's current Bachelor of Midwifery students identify as Māori or Pasifika.

Local Māori and Pasifika midwives' mentor and support tauira on Otago's midwifery programme and where possible, place Māori and Pasifika tauira with Māori and Pasifika midwives when in clinical practice. Otago's programme has kaiako who meet weekly with small groups of tauira to support debriefing experiences and practicing skills. There are established Kaiārahi Teina roles who are Māori and Pasifika tauira offering peer support to Māori and Pasifika tauira.

In addition, practical support is offered in a variety of forms:

- Supporting tauira to attend regional and national hui and fono (including their whānau) which is paid for by TAOH & TO fund.
- There is funding available for registration to NZCOM, Ngā Maia or Pasifika Midwives Aotearoa.
- A Koha Aroha fund and petrol and grocery vouchers are also available for immediate assistance with hardship.

VICTORIA UNIVERSITY | TE HERENGA WAKA

The inaugural cohort of the Bachelor of Midwifery at Victoria University of Wellington will complete their degree at the end of 2023 and enter the workforce. Of the students who have sat the National Midwifery Examination (20) in 2023, there has been a 100% pass rate. This includes two Māori tauira. This group will have their formal graduation ceremony on 15th May 2024.

Recruitment for the 2024 cohort has been very busy with attendance by the midwifery team at various events across the lower North Island and evening sessions at the school for prospective students and their families. The school has been well supported by the Pou Korito and Pasifika Liaisons funded by Te Ara o Hine Tapu Ora. The Te Ara o Hine Tapu Ora liaisons were included in the screening, selection, and interviewing of Māori and Pasifika applicants and provided continued contact with these applicants over the summer break until the trimester began. 2024 will see a total of 79 students with 15.2% who identify as Māori and 5.1% identify as Pasifika

The students receive wrap-around support and some financial support through this service. The Pou Korito and Pasifika Liaisons worked alongside the midwifery team on the selection and interview processes for the 2024 intake. They maintained pastoral support over the summer for Maori and Pasifika applicants.

Midwifery students from Victoria University on placement at Wellington Hospital

CULTURAL EDUCATION AND LEADERSHIP OPPORTUNITIES

The Midwifery Council of New Zealand (MCNZ) have recently mandated Cultural Safety Education for all midwives. From 1st April 2024 mandatory cultural safety education will commence and midwives will be immersed in a full eight hours of mātauranga Māori. This eight hour education day will be required once in the three year cycle. A further four hours of Cultural Safety education will be provided during the three yearly cycle through a variety of ways to enable flexibility.

In March 2023 Hukatai Consultants were engaged to deliver a suite of cultural education workshops that included:

- Two full day **Te Tiriti o Waitangi workshops**. This workshop focused on building the understanding of Te Tiriti o Waitangi, with a focus on the collective relationships of both Tangata Whenua and Tangata Te Tiriti. The provisions stipulated within Te Tiriti were described and action plans created with regards to applying these in clinical practice.
- Two full day **Te Aronga Māori / Māori World View** workshops. Attendees were introduced to the Māori worldview, the kaupapa or values that stem from this worldview and examples of tikanga in birth and death during pregnancy and the birthing process.
- Two full day **Tikanga in Hapūtanga** workshops. This wānanga provided an opportunity to deepen and develop our understanding of culturally appropriate processes relating to hapūtanga or pregnancy and baby, founded in Māori values. Hukatai Consultants also looked at some dos and don'ts as practical and helpful guidelines. This workshop also provided an opportunity to use te reo Māori and learn a waiata to build collective capacity.

A condensed two hour education workshop on **Tikanga in Hapūtanga** was also made available for those clinicians unable to commit to a full day workshop, and 60 minute cultural competency sessions were included in all Emergency Skills Refresher days undertaken in Capital, Coast during 2023. This means that 100% of midwives employed by the WHS have attended at least one short workshop.

Pacific Education was also offered in 2023 including:

- Two full day **Engaging Pacific** workshops where attendees were offered the opportunity to learn the foundational attitudes, knowledge and skills to safely engage with and effectively deliver quality services for Pacific people and their families.
- Two full day **Transformative Pacific Engagement** workshops that focused on learning how to identify Pacific values and explore Positive Pacific relationships. This included gaining better insights and some simple tools that can be used to build relationships.

These cultural education workshops have enabled staff to increase their awareness of the Māori and Pacific practices. Practical suggestions have meant that staff are more familiar and confident in supporting and enabling the use of muka tie, use of te reo Māori in daily greetings, and karakia has been introduced at beginning of each morning and night shift. Laminated lanyards have also been created that contain opening, closing and kai karakia.

NGĀ MANUKURA O ĀPŌPŌ AND ANIVA PROGRAMME

Ngā Manukura o Āpōpō (Tomorrow's Clinical Leaders) is designed to offer Māori midwives and nurses the opportunity to participate in a Māori clinical leadership programme. The programme runs over a four month period, and consists of four, two day wānanga. The programme is designed to stimulate learning, discussion, debate and action.

The Aniva Programme, a workforce development programme funded by Health NZ is delivered by Pacific Perspectives Limited and hosted by Te Pukenga - Whitireia New Zealand. It provides pathways for senior Pacific midwives and nurses to gain post-graduate qualifications and also supports their leadership development. A key aspect of the Aniva programme is the tailored leadership mentoring and cultural support provided to participants, which is reinforced by extensive administrative support and activities that build and strengthen a Pacific health leader's network.

Capital, Coast supports Māori and Pacific midwives to attend these leadership opportunities and in 2024 we have committed two midwives to attend.

TE WHAKAWHIRINAKI – HUI PROCESS TRAINING

Te Whakawhirinaki - Hui Process Training will facilitate new and deeper cultural understanding and ways of engaging with whānau to help clinicians provide care that is both culturally and clinically safe. In October 2023 a number of senior midwives along with other health practitioners, were able to attend Te Whakawhirinaki at Te Whare Mārie ki Puketiro in Porirua.

Using the **Hui Process Model** as tikanga for whānau hui:

- honours the principles of Te Tiriti ō Waitangi
- recognises that tikanga Māori is beneficial for relationship building in the health environment
- acknowledges that mana enhancing principles of Te Āo Māori are beneficial for staff and patients, and whānau in Aotearoa

The principles of The Hui Process (gathering of people) are used every day in healthcare, at hui in workplaces, on Marae, when Māori meet other Māori. In health services, the hui process incorporates tikanga to structure conversations between health professionals and whānau.

LOOKING AHEAD FOR 2024:

- Look at ways to incorporate tikanga into daily practice
- Applying the Hui Process Model in interactions with whānau

Te kounga me te haumaru o te taurima wāhine hapū

Maternity quality and safety

MATERNITY QUALITY AND SAFETY PROGRAMME

The MQSP is a national programme which establishes and builds upon national and local maternity quality improvement activities. It seeks to ensure the highest possible safety and best possible outcomes for all pregnant women/ people and their babies. A key function of the Group is to support associated programmes of work and the implementation of activities that deliver on the strategic plan.

MQSP is a mandated activity through the Ministry of Health Crown Funding Agreement (CFA). It involves an ongoing, systematic review by local multidisciplinary teams working together to identify potential improvements in maternity services, to implement these improvements and evaluate their effectiveness.

The Capital, Coast and Hutt Valley MQSP governance committee ensures that systems are in place to enable clinicians and managers to share responsibility and accountability for patient safety, to minimise risks to pregnant people and babies and to continuously monitor and improve the quality of clinical care provided.

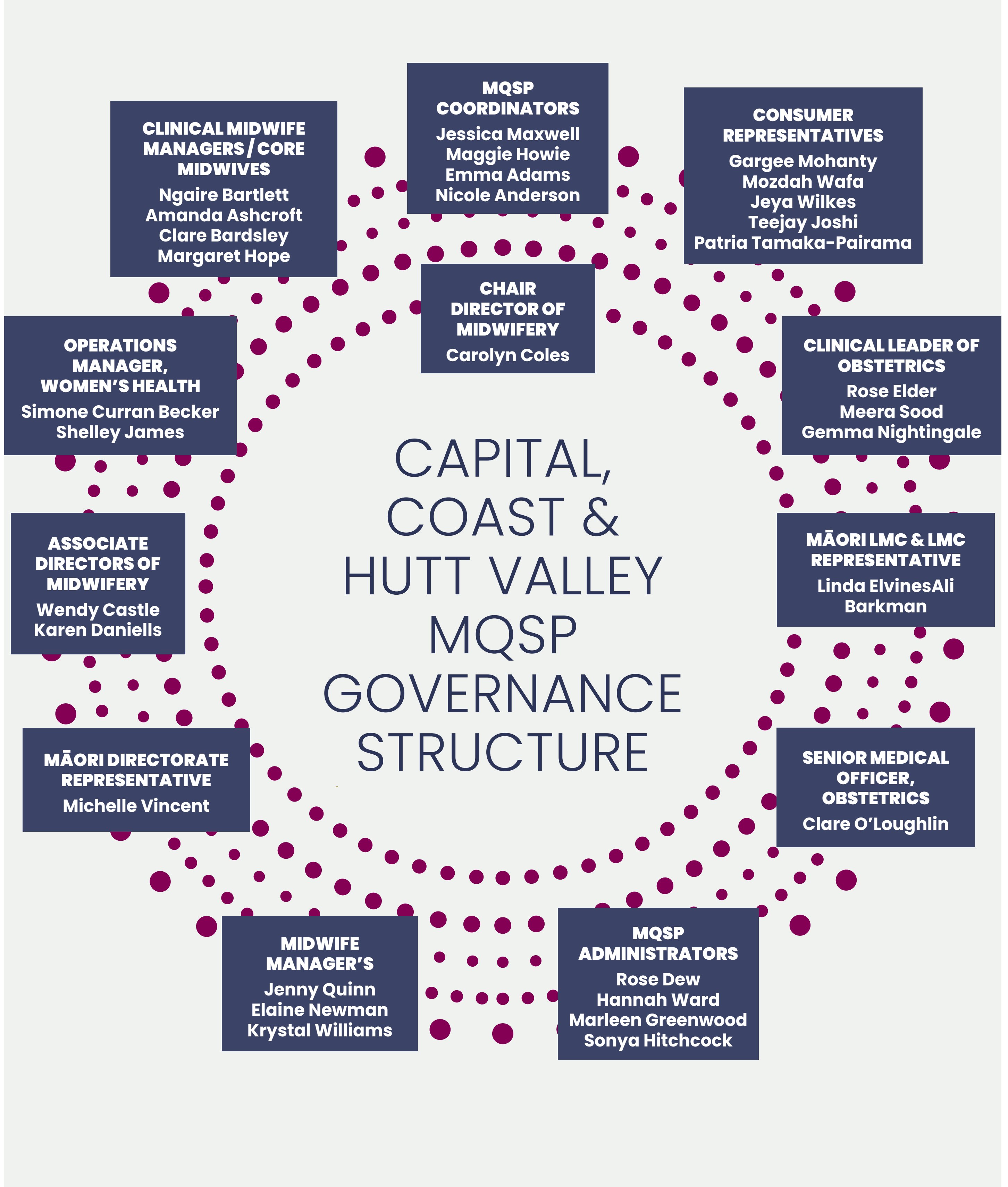
At the beginning of 2022 we combined our two governance groups to cover the whole district, with the view of working collaboratively across the district, and combining work plans, so that all new improvements would be made across the four sites we cover.

At Capital, Coast and Hutt Valley the MQSP governance group includes: representation from consumers and LMC midwives, two Māori health representatives, a Pacific health representative, a disability representative, obstetric and midwifery clinical leads, MQSP coordinators, an operational lead, and a representative from Strategy, Planning & Performance. Representation from other stakeholder groups is co-opted on a project-by-project basis throughout the year.

The current work programme was developed with stakeholder input and key actions were identified. A record of ongoing achievements to date is contained in previous annual clinical reports. The 2021-2023 report is publicly available online at www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/ccdhb-whs-2021-2022-maternity-quality-safety-programme-annual-report.pdf.

Our MQSP governance group is well established and we continue working towards embedding maternity quality into a strategic quality framework to improve outcomes for pregnant people and their babies.

Figure 1: **Capital, Coast & Hutt Valley MQSP Governance Structure**



VOICES OF PREGNANT PEOPLE AND THEIR WHĀNAU

Pregnant people and whānau continue to provide feedback about our maternity services in a number of ways, and it is very much appreciated.

Consumer survey posters are displayed around the wards, and can be accessed by scanning a quick response (QR) code. For consumers who prefer to reflect and feedback at a later date, a feedback card is placed inside the Well Child Health Book.

People also share their experiences and perspectives with their LMCs and these experiences are discussed at the bi-monthly LMC forums run by our representatives. This feedback is brought to the attention of the MQSP Governance Group.

Finally, our consumer representatives spend time engaging with a diverse range of whānau, seeking their valued thoughts and experiences of our services. Any suggestions or concerns are discussed and actioned as required.

The following is a selection of feedback received:

"Great, friendly staff and midwives available always. I'm very grateful for their kindness. Thank you."

"We were really well cared for and supported by staff. The level of care was excellent and far exceeded my expectation!"

"Kenepuru is a fantastic resource before heading home. I am so glad we knew about it and asked Wellington hospital to transfer us there. Please advertise this more and offer to new mothers more actively."

"The midwives at the Paraparaumu unit are incredible and go above and beyond to help in every way they are able."

"Lovely kind midwives, I felt very cared for."

"We loved the comfort and support from the team. We never felt uncomfortable or judged in any way. Every person that came in was so encouraging. My partner and I loved the support."

"I liked the relaxed nature of the birthing unit, being close to medical services if required but being able to give birth in an environment that wasn't heavily clinical was nice. It's really nice having a single bed room after birth too."

"The team at Kenepuru are absolutely amazing! I definitely don't think I would be ready to go home today without their love, support and guidance. They really set us up for success at home. Thank you so so much."

"The support from the midwives at the Kāpiti Maternity Unit was outstanding. Each one of them made me feel so supported & put everything at ease for me as a new mum. I actually wish I stayed the 2nd (sic) night instead of going home. Thank you all for your amazing service, it really did leave a mark on my new journey as a first time mum."

"We, tired, and emotional and we were so well supported. We really appreciate the experiences we had at both units."

"Our experience at Kenepuru has been above excellent and would recommend it to anyone who needs care around recovery, latching and breastfeeding to come to Kenepuru. The ward was quiet, single large rooms with the ability for my husband to stay and as a whānau we felt very supported. The nurse on arrival at Kenepuru addressed our concerns and fears about breastfeeding. We feel so much more confident going home and our baby is now latching and breastfeeding well. Also the food is a lot nicer at Kenepuru."

We want to acknowledge that we also received some negative feedback in relation to the staffing of our unit in Wellington with whānau feeling the effects of staffing and feeling like they weren't seen regularly enough. The midwifery workforce shortage is a nationwide issue. We continue to recruit both nationally and internationally and have the first cohort of Bachelor of Midwifery Graduates from Victoria University Wellington Te Herenga Waka beginning work in January 2024. Whilst this may relieve some of the workplace pressures we will still be working with a staffing deficit.

IMPROVING FEEDBACK MECHANISMS – FACE-TO-FACE DISCUSSIONS

Following on from previous work in this area the focus has gone into recognizing the best way to capture feedback from consumers. Cards with the survey QR code continue to be given out in Well Child Health books and posters displaying the code present in each postnatal room. Despite this, there is still poor survey participation.

2021 saw a trial of face to face discussions between the breastfeeding advocates and Māori and Pacific women/people. It was thought that sharing feedback in a relaxed environment would build trust and transparency, and allow for more discussion and honest feedback to be given. Questions were tailored towards identifying strengths and weaknesses within the service, and understanding more about how we could meet the cultural needs of Māori and Pacific women/people

Upon seeing the positive response to these face to face discussions the WHS supported a student midwife internship through Kia Ora Hauora. One of our Māori student midwives spent her summer break working within the inpatient service at Wellington Hospital obtaining feedback from consumers. From November 2022 to January 2023, she was able to facilitate in-depth discussions with Māori and Pacific women/people, maintaining a focus on meeting cultural needs and ways the service could improve this. Our next step for 2023 was implementing an ongoing method of this type of open discussion to gather feedback.

We also looked at the survey questions and they were redesigned to include the entire district and reflect more on people's choice of birth place. Feedback is monitored monthly.

LOOKING AHEAD

- Together with the Maternal Child Health Coordinators a plan is in place for our target populations to have the opportunity to do the survey together via relaxed open discussion. As this was implemented at the end of 2023 data will continue to be gathered but we hope to see an increase in the amount of feedback we receive.

ENGAGEMENT WITH STAKEHOLDERS ACROSS CAPITAL, COAST

Capital, Coast host a number of midwifery and multidisciplinary forums to keep clinicians up to date, publicise changes in guidance and policy, and promote good communication in the maternity care environment. These meetings enabled effective two-way communication between governance and clinicians so that information about current issues, impending changes, improvements and policy updates were shared. LMCs are encouraged to attend to ensure diverse perspectives are represented. Fetal Surveillance study days are scheduled during the year. PROMPT courses are held in the regional tertiary hospital and the primary birthing units. CTG multidisciplinary meetings occurred monthly supported and run by a multidisciplinary team.

Capital, Coast and Hutt Valley offers various ways for users of the service to share and receive information. Examples of these are:

LMC Capital, Coast Interface Hui

The LMC Capital, Coast interface hui is organised by the Co-LMC MQSP representatives. Hutt Valley LMCs are also welcome. The LMC interface hui is usually held monthly. The forums provide a space for LMCs, maternity services and other health providers to share information and find solutions to issues as they arise. They also provide an opportunity for whakawhanaungatanga, enabling people to build relationships and collaborate in care initiatives. There is often a speaker or an education session as part of the hui. The LMC interface is supported by an ADOM with a focus on enabling quality improvement and relationships in this important area.

Paraparaumu LMC interface hui

This hui is for LMCs practising on the Kāpiti Coast and staff employed PMU. It is held every other month and is a space for providing updates and raising issues. This hui also usually has an education component and includes midwifery case presentations.

Kenepuru Maternity Staff and LMC shared lunch

Monthly meeting for KMU staff and LMCs to share notices, events and discuss any issues arising. Collaborative education sessions also run from time to time.

Perinatal Education Meeting (PQAA protected)

This is a multidisciplinary forum for the discussion and review of recent cases of perinatal mortality and morbidity to facilitate organisational and clinician learning. LMCs are invited to attend regularly. They may also be invited to present cases alongside other members of the multidisciplinary team. Perinatal mortality and morbidity review meetings brought together midwifery, obstetric, neonatal, genetics, pathology and paediatric surgical staff for case reviews. Recommendations on system and practice changes were fed back to relevant areas or to the clinical governance groups.

4M

Monthly Maternity Multidisciplinary Meeting is an education session focusing on a range of issues to inform the improvement of our collaborative care. Zoom capability increases access to community working clinicians. Education certificates are provided.

Midwives are encouraged to regularly attend study days that are relevant to clinical care and maintain clinical competence. Examples include:

- Epidural study day (every 3 years)
- Newborn Life Support (3 years)
- Fetal Surveillance Education (alternating annually FSEP full/ FSEP refresher)
- PROMPT, where attendance at your local unit is encouraged.

All education is offered free of charge to LMCs.

CONSUMER ENGAGEMENT IN MQSP

The MQSP consumers are supported by the CCHV Consumer Engagement Team (CET). They receive training to help support them in their roles, for example in July 2023 MQSP consumers attended training provided by the CET '*Bringing the Voice of Consumers*: *How to bring your own story and link it the community and other voices'*.

Prioritising the development of consumer capabilities and providing ongoing support has been a central focus. The CET attend MQSP meetings to support consumers in their roles and to identify any issues. For instance, at one point, consumers were unsure about how to effectively contribute to the Service's initiatives. In response, the CET organised a Zoom meeting with MQSP consumers to help them identify projects from the MQSP work plan that align with their interests. This initiative resulted in consumers becoming more integrated into the MQSP project framework.

Furthermore, the MQSP Māori representative also serves as a member of the District Consumer Advisory Group (DCAG). This role allows them to bring MQSP-related issues to the attention of the DCAG for consideration and keep the DCAG updated on MQSP projects and developments. The DCAG comprises representatives from various priority groups, including Youth, Rainbow, Asian, and Disability, which enables discussions of MQSP matters within a broader context. DCAG holds representation on District and Regional Governance, ensuring that the MQSP representative is well-informed at higher levels of decision-making and has the ability to escalate any pressing issues as needed.

Additionally, the MQSP Māori representative receives support and mentorship from the DCAG Co-Chair, who is also Māori. The CET provides specific financial support to facilitate this mentorship.

Throughout 2023 the group had consumer representatives from priority groups including Māori, Pacific and Indian ethnicities. Consumers are connected to their communities through events, regular meetings of different groups and through personal connections. This allows information and feedback to be shared at both a formal and informal level encouraging open communication channels. One gap in representation is in the under 20 year's old group and in 2024 we are hoping to add a consumer from this cohort.

LEAD MATERNITY CARERS (LMCS) ENGAGEMENT:

Kia ora

I have been the LMC Māori rep for MQSP on previous occasions and in 2023 took on the role again along with Ali Barkman, a Porirua LMC.

Being a part of the governance committee for MQSP; sharing and participating with initiatives coming through the program has been enjoyable and makes a difference to the quality we can provide for our community.

Organising meetings and participating in interactions with LMCs and issues that arise has been a privilege. Enabling change and building collegial relationships has enhanced the services we provide in the maternity space. LMC interface huis are a safe space for LMCs to voice concerns, bring suggestions to the table and ultimately seek to bring change for the better for all midwifery in the region. Working together with the tertiary unit and the other member of the MQSP ensures that all voices are heard when looking for change.

Being able to make a change in the safety and quality of midwifery care for my colleagues and the wāhine in the community is a role I cherish.

Linda Elvines
LMC

OPTIMISING BIRTH INITIATIVES

TENS MACHINES

As a part of the Optimising Birth work, six transcutaneous electrical nerve stimulation (TENS) machines were purchased for Birthing Suite at Wellington, four for Kenepuru and two for Paraparaumu maternity units. These are loaned out to people in early labour with some people choosing to use them throughout labour. Feedback has been really positive and repurchasing of the pads had to be bought forward to accommodate demand.

PLACE OF BIRTH

When pregnant in Aotearoa, you are able to choose with your Lead Maternity Carer the location you wish to birth your baby – at home, a birthing centre or in hospital.

A key outcome sought from the MQSP optimising birth initiative is to increase safe, community birth. Research in both Aotearoa and internationally has consistently found that birth centres enable healthy people with low risk pregnancies to birth closer to home, with easier access for whānau, reduced rates of intervention, better rates of exclusive breastfeeding and higher levels of satisfaction with their experience of birth and early parenthood (Bailey, 2017; Dixon et al., 2014; Grigg et al., 2014; Grigg et al., 2015; Grigg et al., 2017; Scarf et al., 2018).

Homebirth is also a safe choice for pregnant people who have no complications or risk factors that exclude birthing outside a hospital. Evidence shows that pregnant people who choose to birth at home or in a birth centre are more likely to have a normal birth, than those who give birth in hospital (Dixon, L., Prileszky, G., Guilliland, K., Miller, M., and Anderson, J. 2019).

Despite this, the homebirth rates nationally reported over the past 10 years, have continued to remain less than 4% of all births. Reported rates of homebirths have increased from 2.9% in 2016, to 3.4% in 2023 for Capital, Coast domiciled births.

HOMEBIRTH SUPPLIES

At the end of 2022 homebirth supplies were purchased designed to be loaned out to LMCs. This included birth kits, birth pools (including the fill kit, pool liners and covers), TENs machines and pulse oximetry meters. When a homebirth is planned these loan supplies can be requested through an online system that is coordinated by our Maternal Health team. LMCs retain responsibility for the equipment which reduced additional costs for whānau.

Since the launch, use of this service has been rapidly increasing.

LOOKING AHEAD

- Extra pools are going to be purchased to accommodate the growing demand for the equipment from Porirua and Kāpiti.
- Data will continue to be collected to see how we can best utilise this service.

Feedback from Uma, pictured above with her whānau about the homebirth supplies: "The birthing pool from the hospital was great! The fact that it came from the hospital is also nice - it shows the hospital and public health system is supportive of home births. I think this is important as home births still feel a bit "fringe" and you do not get a lot of messages that home birth can be/is mainstream and supported. "

KENEPURU MATERNITY UNIT

In 2023 MQSP made a concentrated effort to increase the visibility of Kenepuru Maternity unit (KMU).

KMU is a eight bed primary facility in Porirua. It has two birthing rooms, a birth pool room and six postnatal beds with ensuites. The birthing rooms and some of the postnatal rooms open out onto a covered verandah and shared garden. Each shift is staffed by either two midwives or a midwife and a nurse, who support the LMC midwives providing labour care. They also provide the postnatal care for whānau during their stay. Anecdotally, KMU midwives report that often people arriving for a postnatal stay at KMU say that they did not know they could have their baby at KMU.

Over the last 25 years, the proportion of people giving birth at KMU has more than halved and the proportion of healthy people with normal pregnancies travelling to WRH to have their babies has increased (figures 2. & 3.).

The Capital, Coast 2022 data shows that the use of KMU as place of birth varies across its surrounding suburbs (see figure 4). Of the people who gave birth from these suburbs, 423 (32.5%) were eligible to birth at KMU in 2022. Many of the closest suburbs have a higher proportion of Māori and Pacific people than the Wellington general population and the 2022 data shows that relatively higher proportions of Māori and Pacific whānau are choosing to birth at KMU (figure 5).

Figure 2: **Number of WRH births & KMU births 1997-2022**

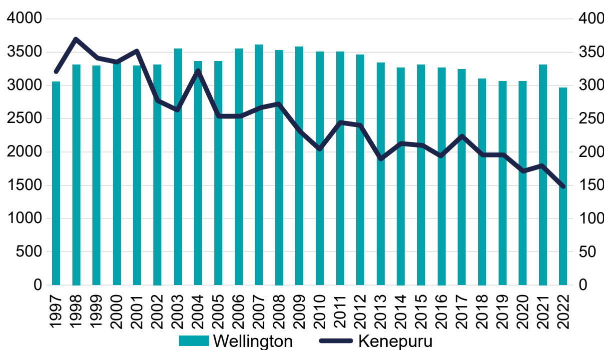


Figure 3: **Number of births at Kenepuru Maternity Unit 1997-2022**

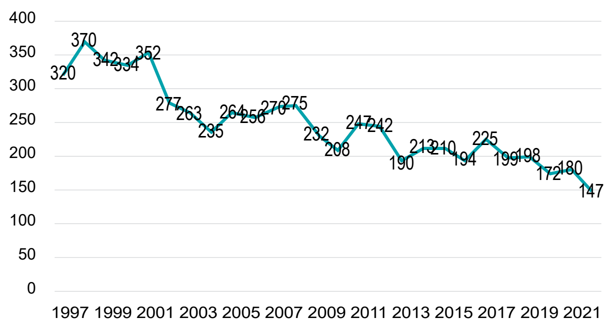


Figure 4: **Suburbs contribution to KMU and Wellington births 2022**

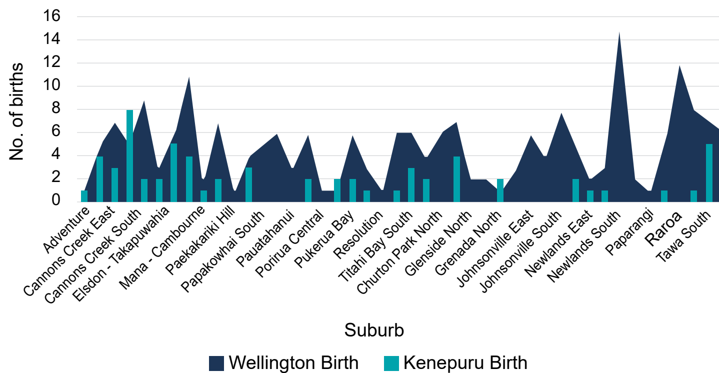
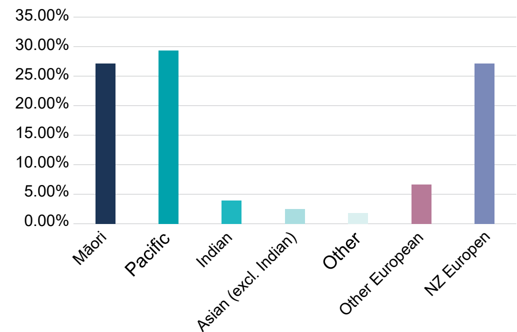


Figure 5: **% people by ethnicity who birthed at KMU**



KENEPURU MATERNITY UNIT OPEN DAYS

In order to raise the visibility of KMU as a place to birth and as a means to gather community feedback, two open days were held in November and December 2023. This provided an opportunity to showcase what KMU had to offer as a place to have a baby and its points of difference from birthing in hospital.

An advertising and communication strategy was developed by the communication team and MQSP. LMCs, Ora Toa, Pacific primary care providers, the Community Midwifery Teams, community based maternity related organisations and antenatal education providers were invited to attend and asked to share information about the KMU Open Days widely. A variety of social media platforms were established and shared for each open day.

Over the two, three hour Open Days, 155 people were shown through the unit. The feedback about the Open Days was very positive and as a result of their visit several people decided to change their place of birth to KMU. Consumers from the Hutt Valley also attended the Open Days**.**

Whānau feedback

Everyone that attended the Open Days was encouraged to provide written feedback and specific questions were asked about how they

What did you like about KMU?

found out about the Open Days, what they liked about KMU, what KMU could do better and what they wanted from their birthing unit.

As a result of the attendance at the KMU Open Days and the feedback provided, regular Open Days will now be planned. It is anticipated that these events will continue to offer excellent opportunities for ongoing whānau input into the services provided at KMU.

Baby coming soon?

Don't miss the Kenepuru Maternity Unit Open Days!

- *hapū māmā & whānau*
- *midwives & GPs*
- *community organisations*
- *antenatal education providers*

Bring the whānau & tamariki for some kai.
Give us your thoughts on Porirua's local birth unit.
Check out Moving Essence - a projection feature in the new waterbirth room.

WHERE:
Kenepuru Maternity Unit,
Kenepuru Hospital,
Porirua.

WHEN:
Fri 17 Nov 12 - 3pm
Sat 2 Dec 12 - 3pm

Talk to your LMC or see our website for more information:
https://www.ccdhb.org.nz/our-services/a-to-z-of-our-services/maternity/giving-birth-at-our-hospitals/kenepuru-maternity-unit/

Te Whatu Ora
Health New Zealand
Capital, Coast and Hutt Valley

BIRTHING AT KENEPURU (BAK) TRIAL

The Community Midwifery Teams (CMT) caseloads in Wellington and Hutt Valley have grown considerably and include people with low risk pregnancies. Choice of place of birth is a maternity service, however, people under the care of CMT have historically only been offered hospital birth as a result of capacity and model of care issues. This builds in inequitable access to choice of place of birth.

In early 2023, Lead Maternity Carer midwives (LMCs) in the Porirua area and surrounding suburbs proposed that they provide labour and birth care at KMU for CMT whānau wanting this option. The BAK trial was established to set up this service across the district to provide choice, to increase the visibility and benefits of community-based birth and to evaluate its value of the service to the community. The trial will initially run for one year and then be reviewed to see if there is a case for an ongoing, business as usual, service.

The option to birth at home or at KMU is provided by the collaboration of four teams of midwives – BAK LMC midwives, the CMT midwives, the KMU core midwives, the birthing suite Clinical Midwife Managers. An incidental benefit of this collaboration has been the commitment of homebirth LMCs across the district to provide full continuity LMC care for people who opt for a homebirth when birth place options are discussed by the CMT as part of the BAK trial protocol. A formal consent document and process clearly explaining why the trial is being offered and what it is involved is required for all whānau who decide to participate.

Under the trial so far, seven people have birthed at home or at KMU and six people have birthed at Wellington Hospital. A proposal to evaluate the outcomes and experience of participants and audit practice against the trial protocols has been submitted.

LOOKING AHEAD

- Follow-up is expected during 2024 to review community feedback of the service, and usage of the equipment. Wider promotion through the Pēpe Ora website and consumer information is also expected.

ENHANCED RECOVERY AFTER SURGERY PATHWAY

The enhanced recovery after surgery (ERAS) pathway is well established and used at Capital, Coast. An audit of the pathway was undertaken with a focus on Patient Controlled Oral Analgesia (PCOA) in 2023.

The plan is to roll out the ERAS pathway across the District, so the ERAS Patient Information Booklet is currently being reviewed, before being translated into different languages to support the diverse ethnic groups cared for within the Capital, Coast and Hutt Valley District.

PATIENT CONTROLLED ORAL ANALGESIA (PCOA) FOR ELECTIVE CAESAREAN SECTION

In October 2022, MQSP rolled out the PCOA blister packs at Capital, Coast. Staffing constraints within our inpatient pharmacy meant we were having to outsource the making of PCOA packs. This meant they can only be offered to people having an elective caesarean section, as a script needed to be filled prior to surgery whereby allowing the community pharmacy to make the blister pack and deliver it to Birthing Suite. In the second half of 2023 we received audit results

of the PCOA which meant looking at alternative options to streamline and improve the system.

Recurring themes included:

- Not all who are eligible are receiving the packs (only 31% of eligible patients at time of audit).
- There were failures in documentation at every step of the process.
- Sporadic outpatient pharmacy deliveries.
- Documentation of discussion at clinic did not consistently result in administration of blister packs.
- When the caesarean section date was changed or the person presented in labour and had an emergency caesarean the pack was often not available.
- Private providers not prescribing packs.
- Some blister packs were removed from the controlled drugs safe without being signed out against a patient's name.

As a result of this we changed the process entirely. Now people having an elective or emergency caesarean section are given a box of 20 paracetamol and 20 ibuprofen (if no contra indications) in the Post Anaesthetic Recovery Unit (PACU). This eliminates the need for an antenatal prescription and we no longer need to outsource blister packs. People are given an information sheet and a form to track their medications so they can self-administer. Initial feedback is that clinicians are finding the process much easier to follow and most people having caesareans are receiving this method of pain relief.

LOOKING AHEAD

- Expand the ERAS Pathway to Hutt Valley.
- Translation of the ERAS pamphlet into several languages increasing equitable access to care.
- Audit of PCOA process and satisfaction of people's experience of the new PCOA process for pain management.
- Investigate the possibility of using PCOA packs for people having instrumental and normal vaginal births.
- Investigation into the potential of a midwifery-led discharge process, with the intention of streamlining the discharge process, leading to families being discharged home in a timely manner.

IMPROVING MATERNITY OUTCOMES FOR THE INDIAN COMMUNITY

In 2023, Indian women made up 9.3% of Capital, Coasts birthing population. The classification of ethnicity is based off the New Zealand Standard Classifications. When referring to our 'Indian' population this includes; Indian (not further defined), Bengali, Fijian Indian, Indian Tamil, Punjabi, Sikh, Anglo Indian, Malaysian Indian, South African Indian and Indian NEC (not elsewhere classified). For our CMT team Indian women made up 11.3% of their caseload.

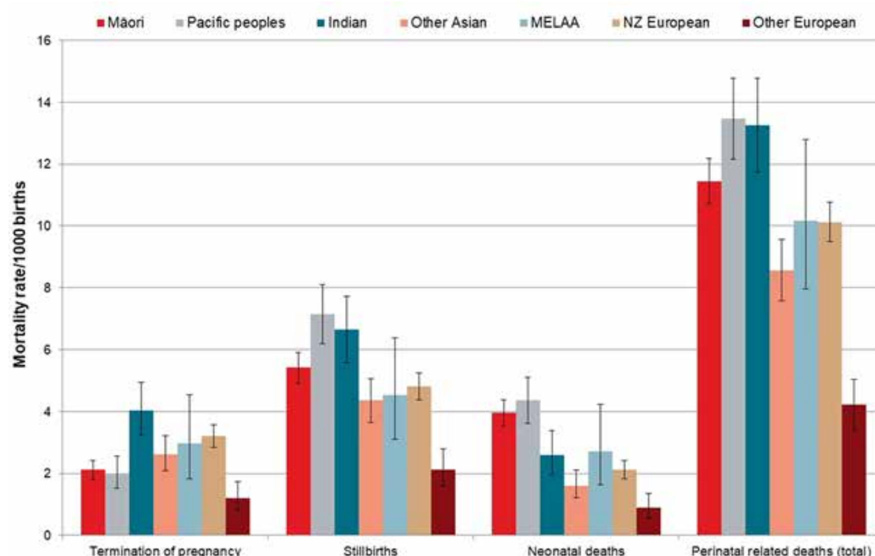
The Fifteenth Annual Report 2020 (published Dec 2022) from the PMMRC reported mothers of Indian ethnicity experienced high rates of perinatal related deaths, statistically significantly higher than most other ethnic groups. Indian mothers and babies are also over-represented in NICU admissions, emergency caesarean sections, and formula feeding. The underlying causes of these inequities is the subject of ongoing research in Aotearoa.

As a result of a recommendation made in 2019, MQSP has funded a research project through Victoria University in 2023. It proposed that research be undertaken to better understand the needs and experiences of pregnant Indian people using our service. Findings will inform recommendations or interventions to improve the outcomes for Indian people. These could include further education is needed for staff, changes to the way we deliver information or changes to current clinical practice.

The name of the project is "***Motherhood away from home - Indian women's maternity care experiences in the Wellington Region"*** and the aim of the project is to explore the people, places, and things that impact Indian women's journeys of becoming a mother in the Wellington Region. The initiative will work to identify whether changes are needed to the current model of care to meet the needs of Indian people. It is not known why our Indian birthing population continue to have higher rates of stillbirth despite interventions as other changes in practice that have improved rates across other ethnic groups.

LOOKING AHEAD

Work is currently underway on this project and we expect to have the findings in mid-2024. We will then be investigating next steps as a result of this research.



Source: Fifteenth Annual Report of the Perinatal and Maternal Mortality Review Committee Reporting mortality and morbidity 2020 (published Dec 2022)

MANAAKI MATS

For whānau experiencing the sad loss of a pēpi, any resource that can provide support during the precious time they have following birth is valued. MQSP helped to implement Manaaki Mats with the aim to simplify whānau handling and taking their pēpi home.

Manaaki mats are a simple and portable cooling system that does not interfere with whānau ability to hold and cuddle their pēpi. These cooling mats have been made available for those whānau wishing to use these resources, either in the hospital or at home. Manaaki mats provide a means for keeping the pēpi cool, as cooling can slow down some of the natural processes that occur. The mats are made with a non-toxic freezable gel and once cooled are then placed in a cover of whānau choice. This cover may be one provided by volunteers from Sands or a wrap of special importance to the whānau. The manaaki mats can then be placed discreetly within the fabric.

We also have a portable freezer we can loan to whānau to use with the same mats they used while in the hospital. The mats can be refrozen and reused during their time at home. This further supports precious time with their pēpi allowing whānau to gather and say their final farewells.

We have good community support for bereaved whānau from the Sands support group and other willing volunteers, who sew the covers to support our whānau during the difficult time of a bereavement.

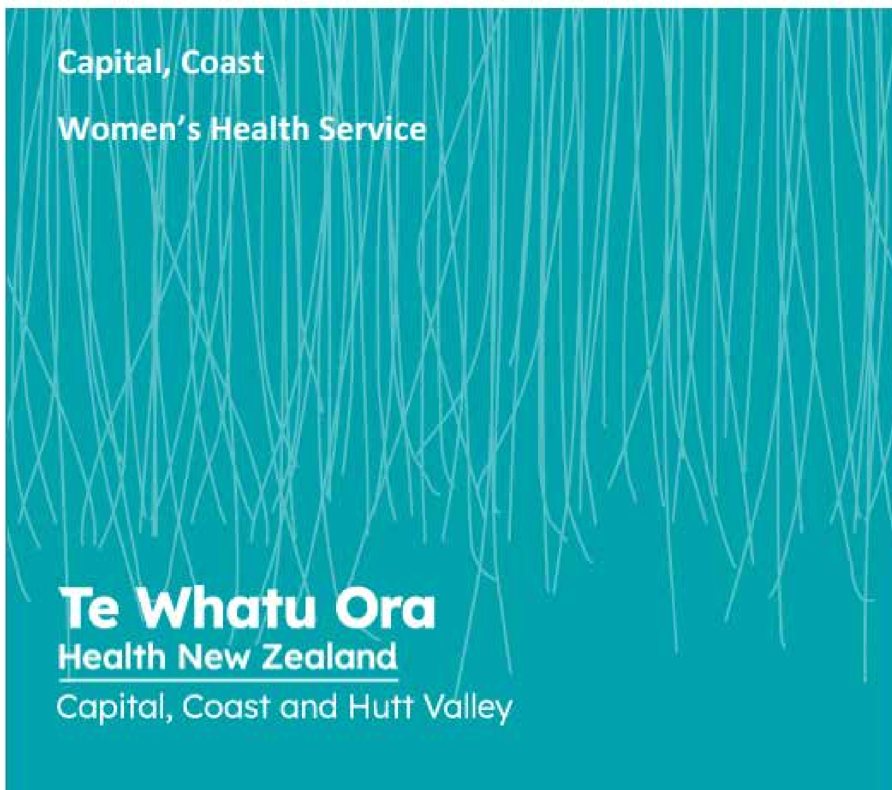
A whānau who used the manaaki mats at home have expressed that they were very grateful to have been able to take the system home. The use of the mats was easy, taking away one stress.

LMC HANDBOOK

Each year a LMC handbook is produced by MQSP designed to assist graduate and new LMCS in the area. In 2023 it was recognised that a significant overhaul of the current information was needed to reflect changes in the district and also in the wider Health NZ space. This was worked on ready for publication in February 2024.

Setting up Capital, Coast computer access, car parking, referral guidelines and community services are some of the examples included in this handbook. It is an interactive document, designed to sit online in the LMC hub space of the intranet so that links can be conveniently used to refer people or direct LMCs to current policies. By keeping it online we can also add or remove information in real time to ensure an accurate and comprehensive document is always available.

Lead Maternity Carer Access Holders Handbook 2024



NATIONAL PRIORITIES AND RECOMMENDATIONS

MATERNAL MENTAL HEALTH

The availability of primary mental health services are key to ensuring maternal and baby wellbeing. Evidence regarding the positive impact on outcomes for children and families of good mental health during the perinatal period is substantial, and is strongly supported by research on attachment, and prevention of conduct disorders and neurodevelopmental impacts on children. There is also evidence linking poor mental health and wellbeing during the perinatal period with suicide and self-harm risk, family violence and increased demand for the need for specialist mental health services.

Health NZ Capital, Coast specialist maternal mental health service (SMMHS) is for people who are pregnant or have a baby under one year of age (at the time of referral), who are experiencing moderate to severe mental health issues. This service also covers the Hutt Valley.

The team is able to offer a number of services, including:

- specialist assessments
- treatment and planning
- individualised support and therapy
- medication reviews and advice
- mental health information
- linking referrers into available community support.
- networking and liaison with other maternity professionals and community service providers.
- offering a face to face triage clinic for mild to moderate mental health concerns
- education and professional development for other health professionals and others working in the perinatal area.

The team also provides advice to health professionals regarding medication for people who have pre-existing moderate to severe mental health problems who are considering becoming pregnant, and those who are pregnant or breastfeeding.

REFERRALS

Referrals can be made by health professionals and self-referrals to our Intake/Triage. Referrals are received by SMMHS intake clinicians for telephone contact and screening. For Māori or Pacific people living in Te Whatu Ora Capital, Coast catchment, referral to Te Whare Marie or Health Pasifika is also available

From 2021 to 2022 there were 590 referrals made to the SMMHS. Capital, Coast residents made up only 49.2% (290) of the referrals. For people resident in Capital, Coast, there were 257 referrals to SMMHS and 33 requests for maternal mental health consultation. The majority of these referrals and requests came from General Practitioners (GP) (51%) followed by midwives (13%), and Other Hospital Departments (10%).

The SMMHS closed a total of 554 maternal mental health referrals in 2021 and 2022 of which 276 (49.8%) were residents of Capital, Coast. This figure may have included referrals from previous years. The majority were closed due to treatment being completed (59.4%). A very small number were closed due to the service declining the referral (5.8%) and 24.3% of referrals were closed by the client themselves. The majority of these due to the client declining treatment (10.1%), with other reasons including being lost to services, being uncontactable, moving from the area, or not attending appointments.

INPATIENT SERVICES

Capital, Coast does not have a specific maternal mental health inpatient ward. Maternity

clients who present with severe mental health symptoms can be assessed and considered for admission to Te Whare o Matairangi, an inpatient facility. SMMHS fully support and promote the principle that a baby should remain with their mother, and arrangements that assist this should be considered while maintaining safety and initiating treatment for the person.

There is no provision for a baby to stay with a mother who is admitted at Te Whare o Matairangi. Unfortunately, usual practice is for the baby to remain in the care of whānau, who are encouraged to visit often with the baby. During the inpatient period women/people are encouraged to continue expressing breastmilk if they are able, and breast pumps are accessed through the central equipment pool.

OTHER PRIMARY AND COMMUNITY BASED SERVICES

Since 2020 'Access and Choice' a new primary mental health initiative significantly increased the availability of free mental health support to women and whānau in primary care. During the 2021 calendar year, Access and Choice provided over 19,000 sessions to more than 7,000 individual clients in a primary care setting, across the Capital, Coast, Hutt Valley and Wairarapa hospitals. Additional investment was planned in 2021 in order to increase resources in the Integrated Primary Mental Health and Addiction sector, in the 2022 to 2024 years. Access has increased and these primary mental health resources will provide greater practice coverage and access through to 2024.

In 2020, Capital, Coast also commenced planning to further enhance the network of support services for people who experience mild to moderate distress related to their pregnancy. In 2021, Capital, Coast and Hutt Valley invested in additional support in the Lower Hutt Women's Health Centre and Little Shadows for maternal mental health, and funded increased access to counselling sessions. Capital, Coast and Hutt Valley also invested in additional roles to increase resources for children of parents with mental illness which can include perinatal needs.

In our experience there remains a lack of low cost services for perinatal people with mild to moderate mental health needs, with specific knowledge of perinatal issues.

CULTURALLY SAFE CARE

SMMH have funded throughout 2023 a fortnightly clinic at Te Puna Wairua, staffed by a Psychiatry Registrar in the Porirua community. Priority is for Māori and Pasifika people who are pregnant or up to three months postpartum with mild-moderate mental health problems who live in the Porirua area. This initiative alongside Ora Toa has worked as a brief intervention that has helped people get support early and prevented the need for referral to secondary mental health services.

SUPPORTING SERVICES TO MANAGE MATERNAL DEPRESSION

The SMMH clinical team provide support to primary care maternity services in this area through a range of activities.

- A maternal wellbeing clinic is provided at WRH and Kenepuru Hospital. The aim of the clinic is to provide space for pregnant people to talk with a maternal mental health care provider about their mental health. Referral is through LMCs, employed midwives and obstetricians for pregnant people where there may be concerns for mental wellness during the antenatal period. The clinic offers consultation and assessment with the pregnant person, and provides guidance and advice to the referrer. Referrals to secondary care mental health services (the SMMHS team) can also be facilitated.
- Consultation and liaison is available from our SMMHS for GPs and other health professionals engaging with pregnant and postnatal people, and includes information such as advice about medications, or any presenting symptoms. Team clinicians are available on a daily roster.

Education and networking occurs with LMCs, employed midwives, and Non-Government Organisations (NGO's), (e.g. Little Shadows). Education is supported and shared with Perinatal Anxiety & Depression Aotearoa (PADA) – a charity providing advocacy and awareness through training and education to primary healthcare professionals and the community about perinatal mental health. Information about PADA can be accessed at pada.nz/.

SUPPORTING HEALTHCARE PROVIDERS DURING AND AFTER COMPLEX CASES

There are a range of support services available to healthcare providers who are looking after people with complex maternal mental health issues and/or suicide cases.

- Capital, Coast postvention (activities which reduce risk and promote healing after a suicide death) service, provide a review and support following a suicide.
- Critical incident debriefing is also available on request to Capital, Coast staff.

CHALLENGES

Challenges to the maternal mental health pathway include limited facilities within inpatient mental health wards, and a lack of funding and workable arrangements to assist mothers with babies within mental health respite facilities. Current respite facilities are unable to accommodate a baby during the admission of a mother due to a lack of appropriate staff funding. Staff of current respite facilities also do not have identified or specific maternal mental health training.

A more appropriate treatment and recovery pathway would include support and assistance for women to continue their role in mothering their baby as much as able. Safety and reassurance of respite intervention could provide this, if the baby could remain with the mother within the respite facility, where staff also have the relevant and appropriate training in maternal mental health care and training to support mothers caring for their babies.

LOOKING AHEAD

- The Maternal Mental Health team has been invited to be part of a project *'Building System Readiness for Trans Inclusive Perinatal Mental Health Services'* led by Dr George Parker and associates following the report *'Understanding the need for trans, non-binary and takatāpui inclusive care.'* The team is excited to be a part of this project with a view to improving healthcare access and delivery for transpeople and achieving better health equity via services and professions looking to better serve transpeople and whānau.
- There is currently a proposal to increase senior medical staff at SMMH with a plan to seek funding for a Māori SMO. The proposal aims to improve access for hapū Māmā and whānau and to provide a leadership role to grow the Māori workforce to seek better engagement with Māori.

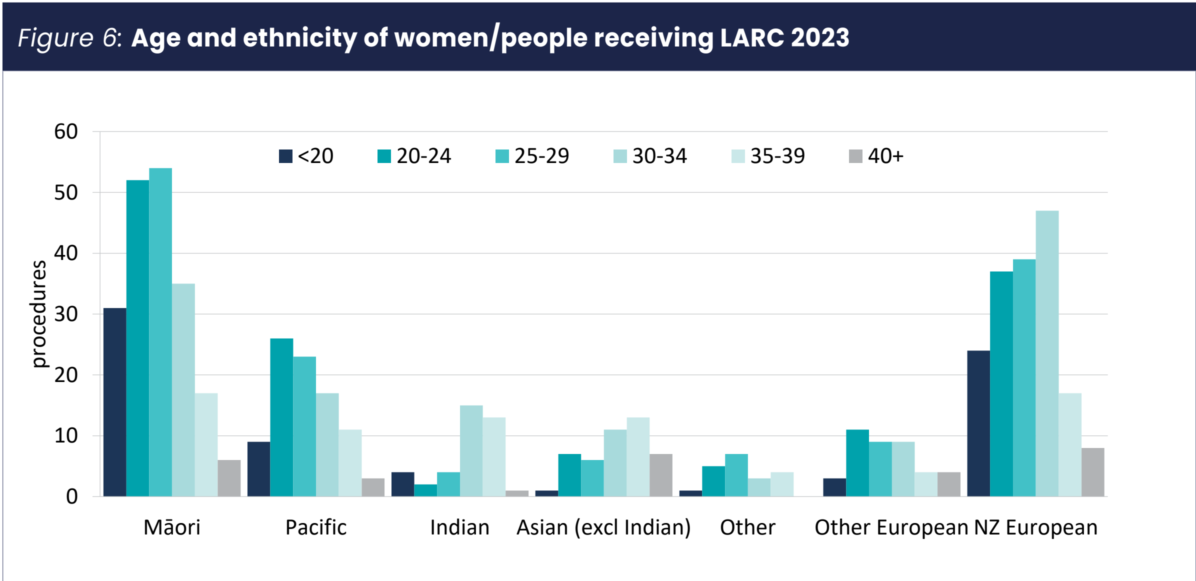
EQUITABLE ACCESS TO CONTRACEPTION

The need for equitable access to contraception was recognised and has been widened with funding gained for free contraception consultations. This service is available to all people aged 15-44 years who live in quintile five areas, or hold a community services card, through their GP. Women are also able to access free insertion and removal of long-acting removable contraceptive (LARC) devices such as Mirena, Jaydess, and Jadelle from their GP.

People under LMC care are usually offered contraceptive advice postnatally in the community as a part of midwifery care. Those people who have had input from secondary or tertiary care have contraception discussed and offered prior to discharge. The GP and LMC are advised of the outcome of this discussion.

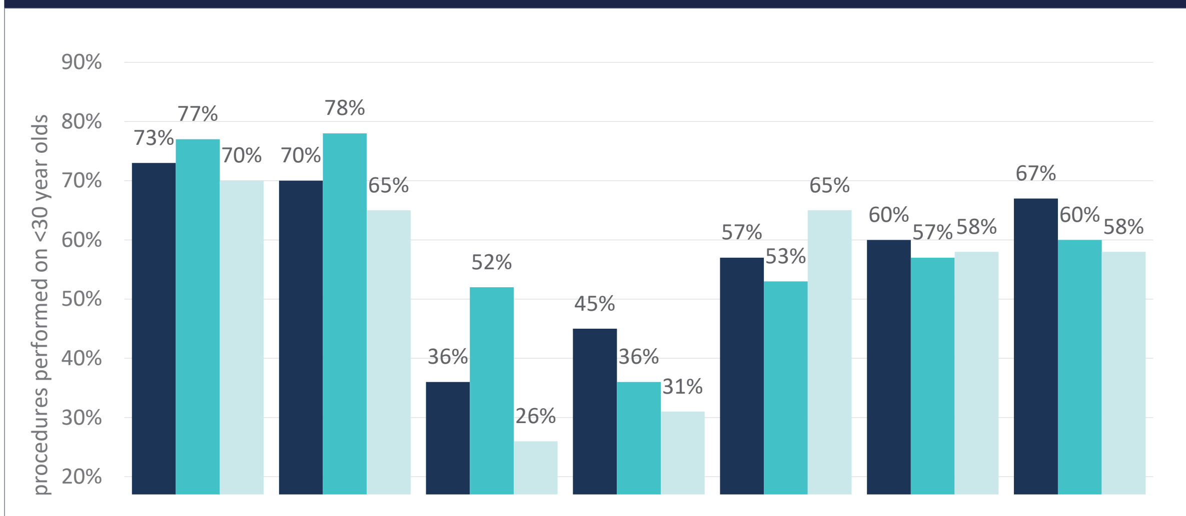
In 2023 there were 600 instances of people having a contraceptive device inserted during an inpatient admission, either through Te Mahoe (Termination of Pregnancy and Counselling Service) or maternity specialty services.

Figure 6: **Age and ethnicity of women/people receiving LARC 2023**



The data shows that Māori (70%), Pacific (65%), European (58%), and Other (65%) women were more likely to have a LARC inserted at less than 30 years old, while Asian (71%) women were more likely to be 30 years or older. Although, as can be seen by the graph below, the numbers are too small to show any meaningful trends.

Figure 7: **Percentage of LARC insertions performed on <30 year olds by Ethnicity 2021, 2022, 2023**



LOOKING AHEAD

- To improve access and equity we have midwives and nurses working in inpatient facilities who are willing and able to insert LARCs once their education requirements have been completed. This will involve online learning modules and practical training components.

PRETERM BIRTH

Data from Ministry of Health show that in 2021, 7.9% of babies were born preterm (before 37 weeks gestation). Preterm births were more common among women under 20 years and those aged 40 years and over, Māori women, Pacific women, and women residing in areas of high deprivation.

There were significantly higher neonatal death rates for babies without congenital anomalies, of Māori, Pacific, and Indian parents compared to Asian (excluding Indian), Other European, and New Zealand European ethnic groups.

Wellington has good overall outcomes for these babies. Since 2020 there has been more consideration in the use of rescue dose steroids and our current policy on Antenatal Corticosteroid Administration has given more clarity around which gestations require administration as well as when to give a rescue dose.

PRETERM BIRTH AT CAPITAL, COAST

In 2023, 331 people (10.8%) had a preterm birth at Capital, Coast. The preterm birth rate for Capital, Coast domiciled people was 7.3%, and 32.0% for people from other districts (interdistrict transfers).

Most preterm births occurred between 32 to 36 weeks gestation (58% of preterm births and 6.3% of all births).

The highest overall rates of preterm births were in wāhine Māori (15.3%), followed by Indian (11.2%). The highest preterm birth rate for Capital, Coast domiciled birthing people was for Pacific women at 9.2%. Looking at preterm birth rates of Capital, Coast domiciled people over the last five years, Indian and Māori ethnicities have the highest rates with 9.1% and 9.0% respectively.

The age group with the highest preterm birth rate was the under 20 year group, with 15.3% of their births being preterm. This rate decreased to 4.5% when restricted to Capital, Coast domiciled people. It is worth noting that overall pregnant people under 20 years account for only 1.7% of the birthing population, and as such these results are unlikely to be a true reflection of the population.

Looking at combined data from the last five years of Capital, Coast domiciled births, the groups with the highest rates of preterm birth are the under 20 years group (9.1%) and the 35-39 and 40+ years groups (7.8% each) which is reflective of national data.

Table 1: **Preterm birth rate for Capital, Coast domiciled people combined 2019-2023, by ethnicity group**

	<32 weeks		**34 - 36 weeks**		**All preterm births**	
Ethnicity	**%**		**%**		**% of total births of ethnicity**	
Māori	35	1.7	130	**6.3**	185	9.0
Pacific Peoples	31	2.1	81	5.6	120	8.3
Indian	34	**2.9**	61	5.3	105	9.1
Asian (excl Indian)	28	1.6	86	4.9	103	7.4
Other	13	2.2	18	3.0	38	6.4
Other European	21	2.2	81	4.5	110	6.2
NZ European	70	1.2	254	4.5	369	6.5
Total		**232**		**711**	**1057**	**7.3**

Table 2: **Preterm birth rate for Capital, Coast domiciled people combined 2019-2023, by age group**

	<32 weeks		**34 - 36 weeks**		**All preterm births**	
Age group	**%**		**%**		**% of total births in age group**	
<20	3	1.1	20	**7.5**	24	9.1
20-24	23	1.9	47	3.9	76	6.3
25-29	57	1.9	142	4.7	225	7.5
30-34	75	1.4	263	4.8	385	7.0
35-39	57	1.6	194	5.4	280	7.8
40+	17	2.0	45	5.2	67	7.8
Total		**232**		**711**	**1057**	**7.3**

LOOKING AHEAD

- A previous audit of preterm birth outcomes at Capital, Coast was unable to show whether there was equity of access to optimising treatments and transfer for people birthing outside WRH as limited denominator data was available. Consideration is currently being to developing an audit to investigate areas where we can further optimise preterm birth.
- Nationally, the Carosika Collaborative (a multidisciplinary group including healthcare professionals and consumers) is working within the maternity sector to improve the care and outcomes for preterm birth across Aotearoa, with a specific focus on equity for all whānau. Activities aim to reduce spontaneous and provider-initiated preterm birth, as well as improve preparation for preterm birth to optimise outcomes. Capital, Coast will take direction from this group.

GROWTH DETECTION PROGRAMME FOR SUSPICION AND DETECTION OF SMALL FOR GESTATIONAL AGE

Growth Detection programme (GAP) is a program designed by the Perinatal Institute to improve detection of small for gestational age (SGA) babies. It has been linked to increased SGA detection, and a decrease in stillbirth in the United Kingdom (Hugh et al, 2021).

GAP provides a systematic review tool for the collation of data from records collected by the GAP champion. This informs a comprehensive report provided by the Perinatal Institute for Capital, Coast to use for quality improvement.

For each pregnancy a customised growth chart (GROW) is generated which takes into account the pregnant persons ethnicity, age, BMI, number of previous births, the birth weights of previous babies and calculates a "term optimal weight " for the current pregnancy. The chart calculates and plots 5th, 10th, 90th and 95th centiles allowing for detection of small for gestational age, large for gestational age and slowing of growth based on estimated fetal weights from ultrasound scanning.

WHERE ARE WE NOW?

Reports show that in 2022, 96.6% of births had a complete GAP/GROW record. The number of babies born SGA (< 10th centile) was 12% of total births recorded. Of these SGA babies 37.1% were detected as being SGA and 55.8% were identified as severely SGA (<3rd centile) in the antenatal period. These rates were slightly less than the national averages and identified the need for further investigation.

When we then compare to 2023, reports show that 100% of births had a complete GAP/GROW record. The number of babies born SGA was 11.7% of total births recorded. In 2023 antenatal detection of SGA and severe SGA was 47.1% for SGA babies, an increase of 2.2% (1.8% above national average), and 61% for severe SGA (1.5% above national average). The improvement in these rates are attributed to education and ensuring that charts were present for all antenatal admissions and including birth centiles as standard in postnatal handover.

LOOKING AHEAD

- Auditing of cases where SGA was not detected in the antenatal period continues. GAP 2.0 was introduced in November 2023. 201 health practitioners at Capital, Coast have logged in and registered with the GAP 2.0. GROW 2.0 is embedded within the BadgerNet Maternity system so birth centiles will be able to be automatically generated. Training sessions for GROW 2.0 have been circulated. Clinicians are encouraged to attend a full GAP workshop every 2 years, and an annual e-learning update.

MATERNITY VITAL SIGNS CHARTS AND MATERNITY EARLY WARNING SYSTEM

The Maternity Vital Signs Charts (MVSC) with Maternity Early Warning System (MEWS) have been business as usual within Maternity Services at Capital, Coast since 2019. In November 2023, we made the switch from paper notes to BadgerNet Maternity, so we now complete these electronically.

We also had a successful roll out of the MVSC for all maternity patients within the hospital. It was intended to audit the roll out of the hospital wide charts but it has been difficult to track those who are on other wards using the MEWS. We are still working on a way to do this.

MATERNAL SEPSIS PATHWAY AND PROTOCOL

The Maternal Sepsis Pathway and Protocol have been business as usual at Capital, Coast since 2019. In 2022, we reviewed our Maternal Sepsis Pathway as there was a change in the antibiotic recommendations from the Infectious Disease Team. This was done at the same time as Hutt Valley was about to roll out their sepsis pathway, this allowed us to develop a district wide protocol with localised pathways. Staff rotating between sites have the same protocol to follow reducing the potential for errors. 2023 saw the continued use of these pathways and staff feel confident in recognising and treating sepsis.

The 'Sepsis 6' bundles and pathways are being taught to midwives on the annual Midwifery Emergency Skills Refresher Day and a sepsis simulation is one component on the PROMPT day. This allows a multidisciplinary team to put into practice the learnings behind sepsis management.

LOOKING AHEAD

- Audit outcomes since roll out once the sepsis auditing tool has been finalised.

NEONATAL OBSERVATION CHARTS AND NEONATAL EARLY WARNING SCORE

The Neonatal Observation Charts (NOC) and Neonatal Early Warning Score (NEWS) are business as usual within Maternity Services at Capital, Coast. With the charts being used for all babies. However some improvement in completion of the risk assessment is still required. In November 2023, we made the switch from paper notes to BadgerNet Maternity but we are still using paper versions of NOC/NEWS, as the risk assessment is not pulling through on BadgerNet and there is work being done to remedy this.

QUALITY AND TIMING OF FIRST TRIMESTER ANTENATAL CARE

Registration with an LMC in the first trimester remains an important step in equitable and safe maternity care. Capital, Coast has a localised find a midwife service which pregnant people can access to see who is practising in their area. This ensures that pregnant people are receiving timely tests and scans as well as advice to ensure that people have the right information. Within Capital, Coast the LMC registration rate is 78%. When broken down into ethnic groups the rates are: Māori 61%, Pacific 51%, Indian 83%, Asian (excl Indian) 80% and European/Other 85%.

The implementation of BadgerNet will make identifying first trimester registration with an LMC easier. With more accurate figures we can then target the groups that need more attention and move forward from there.

Community initiatives are key in promoting access to maternity services. Te Puna Wairua, a hapū whānau hub is an iwi run community service promoting early engagement with maternity services based in Porirua. We expect that this will have a positive impact for the priority populations in the area for timing of antenatal care.

'Your Pregnancy Checklist' was redesigned in 2023 to highlight the Pepe Ora website and outline important steps for pregnant people to take. It includes contact information on the local Find a Midwife website to aid in locating a LMC. This checklist is distributed to primary health providers and will be available to view and download from the Capital, Coast website.

REDUCING MATERNAL SMOKING

While Capital, Coast as a whole has significantly lower rates of smoking, Māori continue to have significantly higher rates than the whole ethnicity national rate. (17.5% vs 7.3%). Also the under 20 age group has significantly higher smoking rates in pregnancy sitting at 23%.

Available in the community, Whānau Ora Hapū Māmā (Aukati) is a service midwives can refer people to in pregnancy. Wider awareness of this service is needed to be circulated to both core and LMC midwives.

Although the Ministry of Health suggest vaping as an alternative to smoking (if you are already a smoker) they also advise not to start vaping during pregnancy if the pregnant person does not smoke.

Most e-cigarettes deliver nicotine (in various doses) along with a mixture of other chemicals (such as propylene glycol, ethylene glycol and glycerol), and heavy metals such as nickel and lead. Although e-cigarettes contain smaller amounts of harmful products than tobacco products there are still negative effects for growing pēpi from the nicotine contained.

Studies have also suggested that e-cigarette use is linked to reduced bone health, sleep disorders and compromised healing from physical injuries, all relevant issues for hapū māmā.

LOOKING AHEAD

- Work with our younger population will help to highlight if tobacco products have been replaced with vaping and how we need to adjust our advice to match.

MQSP PROGRESS REPORT 2023

PROJECT STATUS

- [teal] Work has been completed and/or in business as usual phase
- [amber] Work is in progress/underway and nearing completion
- [purple] There is still a significant amount to achieve before completion

Table 3: **MQSP Project Progress Report 2023**	**Status**
Optimising birth initiative	[teal]
Enhanced recovery after surgery care pathway	[teal]
Evaluation of a tailored approach to Antenatal Education Services	[teal]
Māori and Pasifika Midwifery Team	[teal]
Optimising preterm birth	[purple]
Hospital-wide implementation of maternity vital signs charts	[teal]
Establish a clinical pathway for pregnant women/people with identified placental implantation abnormalities	[teal]
Audit outcomes for pregnant women/people with placental implantation abnormalities	[amber]
Improving outcomes for Indian women/people	[amber]
Improving outcomes for women/people under 20 years	[purple]
Surveying women/people about their inpatient experience	[teal]
Postpartum Haemorrhage and Active Management of Third Stage of Labour	[teal]
Maternal Sepsis Pathway	[teal]
Neonatal Hypoglycaemia	[amber]

MQSP PROJECTS IN 2024

A detailed copy of the MQSP work programme 2023-2024 can be found in 'Appendix 1'

HOMEBIRTH DOCUMENTARY

Capital, Coast and Hutt Valley District are committed to supporting opportunities to optimise birth outcomes, and support place of birth options for the pregnant people. This includes supporting strategies for pregnant people who are well in pregnancy to access resources, which enable them to birth at home.

There are myths about homebirth that this documentary would seek to dispel through inspirational stories from wāhine, whānau and midwives on their experiences and perspectives. Midwives and childbirth educators often report that the most effective way to promote homebirth is through sharing positive stories. Midwives report that promoting homebirth as an option is made harder by a lack of good supporting material they can recommend. MQSP has provided a range of supports for homebirth including the availability of pools and TENS and homebirth supplies.

A request to help fund a homebirth documentary put together by a local midwife and filmmaker has been approved and collaborated on by the MidCentral Districts. There has been a lot of interest in participating in the project from homebirth whānau and midwives. Several whānau of diverse identities have offered to be filmed.

The documentary is being produced in 2024.

IMPROVING UNDERSTANDING OF MĀORI AND PACIFIC PREGNANT RANGATAHI UNDER 20 YEARS OF AGE

Although pregnant people under 20 account for a minority of the Capital, Coast birthing population (1.7% in 2023), they are at significantly higher risk of adverse outcomes related to preterm birth and intrauterine growth restriction, and are more likely to benefit from smoking cessation and the promotion of timely antenatal care access, than any other age group.

The PMMRC Fifteenth Annual Report (Dec 2022) highlighted that rangatahi aged under 20 years of age are part of the group that experience disproportionate perinatal outcomes and experienced the highest rate of neonatal death, at a rate of 5.46 deaths per 1000 live births, compared with an average rate of 2.72 deaths per 1000 live births for all maternal age groups. Further research is needed to identify what interventions may reduce mortality rates in babies born to people under 20 years of age.

The PMMRC report specifies:

Health New Zealand | Te Whatu Ora districts prioritise the development of evidence-based solutions in consultation with young mothers; maternity services that meet the needs of, and are acceptable to, rangatahi under 20 years old; and develop adequate resources for these services.

Given the majority of youth services are up to age 25, we will include the pregnant population in our region up to this age. This will help us to cover a wider range of people who have used maternity and other health services to discover how best to serve their needs.

LOOKING AHEAD

On the workplan for 2024 is a project to:

- Improve understanding of pregnant rangatahi under 25 years old
- Explore barriers in accessing maternity services
- Develop a strategy to engage with this group of people and ensure appropriate antenatal education is offered
- Ensure all pregnant rangatahi under 25 years are being risk assessed for;
    - Smoking cessation
    - Sexually transmitted, and urinary tract infections
    - IUGR
- This programme of work will use the HEAT tool to provide an equity lens.
- Recruit a consumer representative to the MQSP that can offer additional insights.

In the following table, maternity service users under 20 years old are highlighted to show if the results are statistically significantly different from the average Capital, Coast user. Due to small annual sample sizes, the differences failed to reach significance for most indicators. Increasing the sample size to a five year period showed that this group are statistically significantly different to the average Capital, Coast domiciled pregnant person in most areas.

The data for the table below comes from Capital, Coast's Clinical Indicator Qlik application and shows data for the 2020 calendar year for Capital, Coast resident people. It is not possible to present 2021 data due to changes to the Maternity Notice which came into effect in November 2021. The changes caused the Ministry of Health to pause updates on their Maternity Qlik application. At the time of writing, the data has still not been updated, and as the Ministry data feeds into our Qlik application, there is no data past October 2021. Indicators 2-9 are not included as the standard primapara person has to be at least 20 years of age. Indicators 13-15 are not included due to small numbers.

Table 4: **New Zealand Maternity Clinical Indicators 2020, by District of residence, showing Capital, Coast under 20 years group compared to the Capital, Coast average.**

Clinical indicators: Capital, Coast District under 20 years group compared to the Capital, Coast average		2016-2020	
		Capital, Coast	**<20 years**
1	Registration with an LMC in the first trimester	76.4%	50.6%
10	Women/People having a general anaesthetic for caesarean section	7.1%	15.6%
11	Women/People requiring a blood transfusion with caesarean section	3.1%	3.1%
12	Women/People requiring a blood transfusion with vaginal birth	1.9%	2.8%
16	Maternal tobacco use during postnatal period	5.4%	23.0%
17	Preterm birth	7.5%	10.5%
18	Small babies at term (37–42 weeks' gestation)	2.9%	6.8%
19	Small babies at term born at 40–42 weeks' gestation	31.0%	52.4%
20	Babies born at 37+ weeks' gestation requiring respiratory support	2.7%	1.6%

LGBTQIA+ TAKATĀPUI ANTENATAL CLASSES

While there have been many positive policy changes towards LGBTQIA+ inclusive maternity care over recent years, LGBTQIA+ Takatāpui whānau continues to face discrimination. This is highlighted in the following recently published guideline: *'Warming the Whare: A Te Whare Takatāpui informed guideline and recommendations for trans inclusive perinatal care'* (Parker et al., 2023).

A request was put in for MQSP funding to run antenatal education in Te Awakairangi (Lower Hutt) specifically designed for LGBTQIA+ Takatāpui whānau on their pregnancy/parenting journey. There has been significant feedback received from rainbow clients over the years that the antenatal education currently available in the Capital, Coast and Hutt Valley district is not appropriate for them and their whānau. Examples of this feedback include:

- trans and non-binary birthing parents feeling uncomfortable with gender-based activities; misgendering of trans and non-binary parents
- same-sex couples needing advice on induced lactation for non-birthing parent
- a general sense of othering/exclusion as they're often the only LGBTQIA+ Takatāpui whānau in their antenatal group.

A successful example of such education has been provided in Auckland/Tāmaki Makaurau through midwives via EMPWR since 2020. EMPWR initiated a pilot of evidence-based LGBTQIA+ Takatāpui-centered antenatal classes and the outcome of this pilot was overwhelmingly positive. EMPWR now offers regular in-person LGBTQIA+ Takatāpui-centered antenatal classes in Tāmaki Makaurau; over 100 LGBTQIA+ Takatāpui whānau have attended. EMPWR has agreed to let local LMCs deliver their antenatal course to the wider CCHV region so that local LGBTQIA+ Takatāpui whānau can finally receive antenatal education that's designed by the rainbow community, for the rainbow community.

LOOKING AHEAD

- Funding request for EMPWR has been approved and classes are set to commence in 2024.

EMPWR WELLINGTON

ANTENATAL CLASSES

An EMPWRed birth experience, regardless of how you have grown or plan on birthing your baby starts with antenatal classes unique and tailored to you.

LGBTQIA+ Takatāpui celebratory antenatal classes taking place over 6 weeks at a fully accessible venue. Subsidised classes available for low-income families, no questions asked.

09.30-11.30AM SATURDAY MORNINGS

at Te Ngākau Kahukura o Te Awa Kairangi

He whakatutuki kia kairangi

Steps towards excellence

MATERNITY SCORECARD

Births					
Total Women	3064	Total Babies	3130	Liveborn Babies	3091 98.8%
Mode of Birth					
Spontaneous Birth	1604 52.3%	Instrumental Births	363 11.8%	Caesarean Sections	1097 35.8%
Preterm Birth					
Less than 32 Weeks	139 4.5%	34 to 36 Weeks	158 5.2%	Less than 37 weeks	331 10.8%
Maternal Blood loss / Morbidity					
Two litres or more	60 2.0%	One litre or more	341 11.1%	Transfers to the Intensive Care Unit	15 0.5%
Babies APGARS / Morbidity					
Liveborn babies with an Apgar score less than seven at five minutes of age	91 2.9%	Liveborn babies transferred to the Neonatal Intensive Care Unit	551 17.8%		
Maternal Transfers					
Postnatal transfers from Wellington to Kenepuru	452	Postnatal transfers from Wellington to Paraparaumu	104	Postnatal transfers from Wellington	556 19.8%

ROBSON 10 CLASSIFICATION:

The Robson 10 Classification System has been recognised by the World Health Organisation as the global standard of assessment for labour and birth. The use of Robson 10 also allows analysis of events and outcomes in comparable groups within units over time and between units globally.

In 2024 Dr Michael Robson will be visiting Aotearoa and a discussion on potential ways forward to improve quality and increase safety in our country's setting will be discussed. Maternity units from around the country will be coming together to present data using the Robson 10 method.

Table 5: **Robson Classification 2023: Capital, Coast District**
Ref 1. Group size (%) = n of women/people in the group / total N women/people delivered in the hospital x 100 Ref 2. Group CS rate (%) = n of CS in the group / total N of women/people in the group x 100 Ref 3. Absolute contribution (%) = n of CS in the group / total N of women/people delivered in the hospital x 100 Ref 4. Relative contribution (%) = n of CS in the group / total N of CS in the hospital x 100
Group
1. Nulliparous women/people with a single cephalic pregnancy and ≥ 37 weeks gestation in spontaneous labour
2. Nulliparous women/people with a single cephalic pregnancy and ≥ 37 weeks gestation who had their labour induced or were delivered by CS before labour
2a. Labour induced
2b. CS before labour
3. Multiparous women/people without a previous CS with a single cephalic pregnancy and ≥37 weeks gestation in spontaneous labour
4. Multiparous women/people without a previous CS with a single cephalic pregnancy and ≥37 weeks gestation who had their labour induced or were delivered by CS before labour
4a. Labour induced
4b. CS before labour
5. All multiparous women/people with at least one previous CS with a single cephalic pregnancy and ≥37 weeks gestation
5a. One previous CS
5b. Two or more previous CS
6. All nulliparous women/people with a single breech pregnancy
7. All multiparous women/people with a single breech pregnancy including women/people with previous CS(s)
8. All women/people with multiple pregnancies including women/people with previous CS(s)
9. All women/people with a single pregnancy with a transverse or oblique lie, including women/people with previous CS(s)
10. All women/people with a single cephalic pregnancy < 37 weeks gestation, including women/people with previous CS(s)
Total

Number of CS in group	Number of women/people in group	Group size - (Ref 1)	Group CS rate - (Ref 2)	Absolute group contribution to overall CS rate - (Ref 3)	Relative contribution of group to overall CS rate - (Ref 4)
144	687	22.4%	**21.0%**	4.7%	**13.1%**
226	523	17.1%	43.2%	7.4%	20.6%
163	460	15.0%	**35.4%**	5.3%	**14.9%**
63	63	2.1%	100%	2.1%	5.7%
21	636	20.8%	3.3%	0.7%	1.9%
79	343	11.5%	23.0%	2.6%	7.2%
26	290	9.5%	9.0%	0.8%	2.4%
53	53	1.7%	100%	1.5%	4.8%
330	421	13.7%	78.4%	10.8%	30.1%
260	351	11.5%	74.1%	8.5%	23.7%
70	70	2.3%	100%	2.3%	6.4%
84	97	3.2%	86.6%	2.7%	7.7%
51	62	2.0%	82.3%	1.7%	4.6%
51	66	2.2%	77.3%	1.7%	4.6%
13	14	0.5%	92.9%	0.4%	1.2%
98	215	7.0%	45.6%	3.2%	8.9%
Total number CS	**Total number people delivered**			**Overall CS rate**	
1097	**3064**			**35.8%**	

EDUCATORS UPDATE

Throughout 2023, the education team remained active, offering a total of 436 spots across a range of study days and workshops. We provided orientation and continuous training for new graduate midwives, new starters, and student midwives.

Our endeavours were aided by the acquisition of a second 'Sophie and her mum' model, specifically designed for simulating cephalic birth, breech birth, and shoulder dystocia. This addition has enhanced our ability to replicate emergencies and births with greater realism, affording midwives more opportunities to hone their manoeuvres and skills. With two models now at our disposal, we have retired the older, rigid plastic models previously utilized. Additionally, one of the models has been intermittently loaned out to KMU and various LMC groups, garnering substantial interest, especially after the 'Breech without Borders' workshop held in the region during the year.

Thanks to the Hospital Health Foundation, the hospital simulation suite procured a high-fidelity childbirth simulator, named Maia. Currently, we are exploring the myriad possibilities this simulator offers, foreseeing its crucial role in multidisciplinary training environments such as PROMPT.

PANDAS

The introduction of the new Panda resuscitaires to replace the old neopuff version was ably supported by the education team and the vendors. The resuscitation equipment is streamlined and enables effective care of the newborn. Although it took time for the staff to adapt to the Pandas there has been overwhelming support for the new kit with its inbuilt weighing machine, good lighting, radiant heat and inbuilt pulse oximetry. They also take up less space in the birthing and postnatal environment being more portable and no longer fixed in the space.

PM ELECTIVE CAESAREAN SECTION LIST

In 2023 a PM caesarean list in main theatre was introduced in order to separate the obstetric theatre based in Birthing Suite. This was to reduce the chances of pregnant people having their elective section delayed or moved to another day. The Birthing Suite operating theatre is used for both elective and emergency procedures which impacted on the elective caesarean section list due to emergencies taking priority. Not only does this mean that pregnant people would spend a long time fasting, but if delayed until later in the day could lead to their elective procedure being cancelled and moved to another day. This causes emotional stress and logistical difficulties for pregnant people and their whānau as well as impacting LMCs and increasing the future workload for birthing suite.

An opportunity arose where we were offered some dedicated caesarean time in main theatres, where elective cases would not be affected by obstetric emergencies on a Thursday afternoon.

The process is quite separate from Birthing Suite and the people in this list are treated like any other elective procedure. A plan was implemented to educate staff in Surgical Assessment Unit (SAU) to be able to prepare the pregnant person for theatre. A multi-disciplinary group was started to write a policy to streamline this process and ensure each department were aware of their responsibilities.

On the whole it has been a successful initiative as there has been very few delays or cancellations to the elective caesareans. This has been well received by pregnant people, their whānau, core staff and LMCs. Staffing issues in main theatre and Birthing Suite are the main factors when cases have been moved or rebooked. It is an ongoing project that we are currently auditing to try and find ways to improve the experience for pregnant people.

LOOKING AHEAD

- Results of a staff survey will be considered and there is potential for dedicated staff to permanently staff this theatre slot.

BADGERNET

Under the direction of Health New Zealand, Capital Coast have achieved the long-standing goal of maternity records becoming digital. On 7th November 2023, the BadgerNet system was turned on, and records for pregnant people switched from predominantly paper-based to digital.

We had support from System C (formerly Clevermed) and BadgerNet super users from around the country who arrived to support our clinicians 24/7 for the first two weeks. We provided an around the clock phone support service for a further two weeks, and have ongoing support phone and a dedicated generic email address. There is support from BadgerNet global ongoing 24 hours a day.

The Perinatal Spine is part of the BadgerNet Platform. It stores and exchanges specific information in real time from BadgerNet and authorised third party digital systems, such as Expect and Solutions Plus. Information can then be shared nationwide between community and hospital systems, supporting continuity of care. Capital Coast was the first district to go live with the spine also active. It has a staged implementation, and is currently bringing demographic data from the third party platform into BadgerNet records.

We appointed a team of Super Users for the implementation period and tasked them with learning the system, developing resources and training colleagues across all disciplines. The team held 100 face to face sessions, set up online learning modules in ConnectMe specific to role, held drop in sessions, gave access to practice accounts and prepared step by step user guides. Ahead of 'go live' 60% of users had received training. Five hundred user accounts were set up prior to 'go live', and another three hundred since, including all midwifery students across all years from Otago Polytechnic and Victoria University in the region. This team have been focusing on data cleansing and correcting records, sending reports and continuing to support users following implementation.

System C and Health NZ have collaborated to enable maternity-related data to be reported to the National Maternity DataMart. This means that specific reporting data will be sent automatically from BadgerNet to the Health NZ database. The work on this is due to start in early 2024.

LOOKING AHEAD

- Integration with GAP/GROW, CTGs, NOC/NEWS, Aotearoa Immunisation Register
- Investigate the referral, IOL and ELCS booking features within BadgerNet to see if these can enhance workflows
- Incorporate Anaesthetics more fully
- A longer term goal is to look at Badger Notes, a women-held application which displays details of the pregnancy, postnatal visits and lots of other useful information
- The project team will be implementing BadgerNet Maternity at Hutt Valley and Wairarapa in 2024.

CLINICAL GUIDELINES AND AUDITS

CAPITAL, COAST AND HUTT VALLEY COMBINED PPG

Hutt Maternity's Policy, Protocol and Guideline (PPG) group continued to meet approximately monthly in 2023 to oversee the development and renewal of clinical practice in the unit. In late 2022 the group was advised that as a newly formed district, the process would merge with analogous processes at Capital and Coast. This was formalised in mid-2023, with one of the joint chairpersons of the Hutt PPG group taking the lead in creation of a district-wide PPG group and eventually amalgamating our maternity clinical guidance. Processes for guideline allocation and creation are markedly different between hospitals within the district at present, and primary facilities and primary birth care have little visibility in current guidelines, so an early focus of this process has been identifying all existing maternity guidance, forms and patient information for direct comparison of content and areas covered. A multidisciplinary group from across the district have convened to create terms of reference for both the project and the eventual district-wide PPG group, to start making recommendations as to the prioritisation, purpose and style of our maternity clinical guidance, and to advocate for whānau-centred, equitable, accessible maternity guidance.

Some district-wide guidelines were released in advance of the amalgamation project. In the past 18 months, a brand new district-wide guideline was produced on Hypertensive Disorders of Pregnancy (based heavily on the 2022 national guidance), a guideline from Hutt Maternity on reduced fetal movements was adapted for district-wide use in combination with a new practice algorithm, and our Hutt Valley package of fetal monitoring/fetal blood sampling/uterine hyperstimulation guidance and associated documents was adapted and made district-wide.

Currently Hutt Valley, Capital and Coast and District-wide guidance can be accessed, searched and compared across the region using the new District Docs engine, which replaced separate document libraries in mid-2023. Sadly, public access to the clinical guidance determining care was lost in this process, as Hutt maternity clinical guidance was previously publically available. The District-wide Maternity Clinical Guidance Project Team see this as a flaw, and have identified public access to clinical guidance as an area requiring our advocacy as a group.

NEONATAL HYPOGLYCAEMIA POLICY

Significant work over the last few years has been undertaken in the management of Neonatal Hypoglycaemia. The '*Prevention and Management of Neonatal Hypoglycaemia'* policy was updated in 2020 and ongoing audits into compliance have been completed.

It was identified that the current method within the birthing and postnatal areas of heel pricks on neonates and the measurement of neonatal hypoglycaemia on point-of-care analysers are unreliable. The recommendation that all babies have blood glucose levels analysed on reliable cost-effective glucose oxidase analysers was taken on board and a funding request for reliable blood gas machines for maternity wards are pending.

Paper recording of babies' blood glucose results is still normal process until NOC/NEWS is established in the BadgerNet.

LOOKING AHEAD

- ABL90 Blood Gas Analysers have been approved for implementation in the Maternity Units at Wellington and Hutt Hospitals in 2024
- Electronic recording of blood glucose levels to be implemented in BadgerNet.

PRE-TERM PRE-LABOUR RUPTURE OF MEMBRANES POLICY

The Spontaneous Rupture of Membranes (SROM) policy was updated and released in May 2021, following review. Pre-term pre-labour rupture of membranes (PPROM) occurs in 2% to 3% of pregnancies, but accounts for 30% of all preterm births.

Outpatient management is now an option for women/people who have been inpatients for 72 hours, completed a course of intravenous antibiotics, and been assessed for signs of intrauterine infection. Those that meet the criteria are allowed to go home and are seen twice weekly for assessment, once in a secondary obstetric antenatal clinic and once by a midwife. This option is well received by the people effected, enabling them to continue some semblance of normalcy in their lives until otherwise indicated. People who are from out of town are accommodated in Ronald McDonald house (or alternatives) and have good contact with the hospital team.

Work continues in the identification of the most appropriate antibiotic prophylaxis for this group. Consideration of a larger BMI vs stewardship of antibiotic use needs to be clarified and this work continues. It is hoped that the work Carosika is undertaking will provide consistency and clarity across the motu.

LOOKING AHEAD

- Review the policy to make it easier to follow in clinical practice with an emphasis on appropriate antibiotic use.

POSTPARTUM HAEMORRHAGE AND THIRD STAGE OF LABOUR POLICIES

In March 2022, the Ministry of Health released an updated guideline for the treatment of Postpartum haemorrhage (PPH). Following the release, Capital Coasts PPH policies were updated to align with the national guideline. The update also included a review of current 'third stage of labour' policies, as these are closely linked.

The third stage of labour policy was updated with the latest research and international recommendations. We are now using 10IU Oxytocin IM or IV (slowly over one minute) OR 1ml Syntometrine IM for active management of the third stage of labour. Previously 5IU of Oxytocin was recommended IV and there was variance in 5IU or 10IU being given IM between clinicians.

The diagnosis and definition of PPH is dependent on the mode of birth, as caesarean births allow for a higher blood loss before being categorised as PPH. PPH is defined as blood loss of 500ml or more following vaginal birth (including assisted births), or 1,000ml following caesarean section birth. A severe PPH is blood loss of more than 2,000ml. Any severe PPH is reported as an adverse event and investigated.

These changes to PPH definition, choice of ecbolic, and dosage were communicated widely in our newsletter, and by email. They are also being taught on the mandated Emergency Skills Refresher Days.

The table below shows blue if the rate has changed significantly in 2023 from the same category in 2018-2022. It also shows that the PPH rate overall for both vaginal and caesarean births has increased despite the introduction of increased ecbolic use. Particularly concerning is the rate of PPH for people having their first baby and being induced.

Table 6: **PPH Rates for Capital, Coast 2018-2022 vs 2023**

Type of birth	% PPH 2018-2022	% PPH 2023	Significant increase?
Vaginal birth (incl. assisted)*	18.2%	↑ 20.7%	Yes
Caesarean section birth**	14.4%	↑ 17.5%	Yes
Vaginal birth (incl. assisted) following induction	20.9%	↑ 24.5%	Yes
Vaginal birth (incl. assisted) no induction	17.2%	↑ 18.9%	No
Caesarean section birth following induction	19.5%	↑ 24.6%	No
Caesarean section birth no induction	12.9%	↑ 15.7%	Yes
Vaginal birth (incl. assisted) primipara (first birth)	23.5%	↑ 27.5%	Yes
Vaginal birth (incl. assisted) multipara (previous birth/s)	13.6%	↑ 14.8%	No
Vaginal birth (incl. assisted) primipara following induction	26.9%	↑ 32.6%	Yes
Vaginal birth (incl. assisted) primipara no induction	22.2%	↑ 24.7%	No

* Vaginal birth PPH is blood loss ≥ 500mL
** Caesarean section PPH is blood loss ≥ 1000mL

When looking at the PPH rates by ethnicity, and comparing them with the overall PPH rates at Capital, Coast, wāhine māori having vaginal births had significantly lower rates of PPH. Indian people had significantly higher rates of PPH when birthing vaginally, but significantly lower rates of PPH following a caesarean section.

Table 7: **PPH Rates by Ethnicity at Capital, Coast 2019-2023**

	Vaginal Birth (including assisted) Blood Loss ≥ 500mL			**Caesarean Section Birth Blood Loss ≥ 1000mL**		
Māori	1812	306	↓ 16.9%	760	131	17.2%
Pacific	1053	216	20.5%	507	82	16.2%
Indian	766	175	↑ 22.8%	542	54	↓ 10.0%
Asian (excl. Indian)	1158	235	20.3%	766	126	16.4%
Other	379	76	20.1%	257	38	14.8%
Other European	1238	237	19.1%	736	114	15.5%
NZ European	4327	808	18.7%	2345	339	14.5%
Total	**10733**	**2053**	**19.1%**	**5913**	**884**	**17.5%**

LOOKING AHEAD

- Continue to monitor the PPH rate.
- Identify the areas where rates are worsening and the reasoning behind this involving a multidisciplinary approach.

ROUTINE ANTENATAL ANTI-D PROPHYLAXIS GUIDELINE

Routine Antenatal Anti-D Prophylaxis (RAADP) between 28 and 34 weeks of gestation is recommended for Rhesus negative women by RANZCOG and the New Zealand Blood Service (NZBS). Pregnant people who have a Rhesus negative blood type are at risk of developing antibodies against Rhesus positive fetal red blood cells, if there is cross over of fetal cells into the maternal circulation (sensitisation). This can affect the baby in the current or future pregnancies. Provision of Anti-D both during sensitising events in pregnancies and postnatally for Rh- negative people significantly reduces the risk of sensitisation and subsequent effects on the baby.

Since 2022 we have had an Anti-D clinic running at both WRH and KMU to enable equitable access to RAADP. With the implementation of BadgerNet, Anti D administration can now be recorded electronically so health providers have an up to date and accurate record of administration.

NEWBORN NOTIFICATION FORMS

The Well Child Tamariki Ora (WCTO) programme is a key resource for care delivery and support to pēpi, tamariki, māmā and whānau from birth to five years. Timely notification enables WCTO providers to plan their workloads, and ensures the first core check takes place within 50 days of life. It also enables a smooth transition from midwifery to WCTO services, reducing the risk of tamariki having delayed checks and access to wider support services (particularly for vulnerable families).

In the Capital, Coast, Hutt Valley and Wairarapa districts, WCTO providers are notified via completion of the Newborn Notification Form, either at baby's birth, or prior to discharge home.

In 2022, at the CCHV WCTO Quality Improvement Hui, data analysis together with narrative from WCTO providers identified that some pēpi were not receiving early notification to WCTO services. Data from the Quality Improvement Framework indicated there was an equity gap in early notification of 17% to 19% for Māori and Pacific. (Ministry of Health target is 95%).

In order to identify process gaps and minimise this occurring, the Early Notification to Well Child Tamariki Ora Project was developed. To manage the Early Notification Project effectively, the project Sponsor, and Co-Leads, decided initially, to concentrate on one tertiary unit (Wellington Regional Hospital) and one primary birthing unit (Kenepuru Maternity Unit). The insights gained from this initial focus will inform a broader project covering the entire CCHV district.

A stakeholder group was established. This group consisted of a wide range of representatives from Health NZ, Capital, Coast and Hutt Valley, including Māori and Pacific Directorate representatives, Kaimahi, Lead Maternity Carers, WCTO Providers and other stakeholders. A smaller working group, formed from the wider stakeholder group, continued to progress the mahi. This included involvement from Consumers (Maternity service users) with co-designing the look and content of the Newborn Notification Form, and associated other public facing information.

The Early Notification Project has been instrumental in bringing to light gaps in the notification process. Through process mapping, variations in practices were identified, such as lack of completion of WCTO providers on the Newborn Notification Form and lack of knowledge about providers and their services. This information, gathered throughout the discovery phase, guided the rolling out of a more cohesive process.

Key achievements of this mahi have included the streamlining of the Newborn Services Information Form (for parents), the clarification of responsibilities when completing the Newborn Notification Form, the establishment of early notification as a hospital-driven process and the development of an on-line education package to clarify the early notification process.

Integral to the ongoing sustainability of outcomes of this project was the development of an information brochure on Well Child Provider options in the district, co-designed with consumers and WCTO providers. This information brochure is intended as a resource for staff, LMCs and parents to assist with making a choice of WCTO provider for pēpi. The information brochure is available in paper format and on the Pēpe Ora website (https://www.wellington.pepeora.nz/) Posters with a QR code link to Pēpe Ora, socialising the information brochure are displayed in a variety of settings including the maternity wards, LMC rooms, Community Midwife Team clinics, antenatal class providers and GP Practices.

Kaupapa puta noa i te rohe

Projects across the District

PĒPE ORA

Pepe Ora has been online for the CCHV district since 2021. It is based around the four pillars of health:

- **Taha wairua** (spiritual health)
- **Taha tinana** (physical health)
- **Taha hinengaro** (mental health)
- **Taha whānau** (family health)

Since the beginning of 2023, the two Maternal Health Coordinators have been fully operational, leading to a notable surge in the growth and engagement of the Pēpe Ora Collectives network, website, and social media presence. This success stems from various strategic initiatives implemented during this period March 2023 through into 2024.

Beginning with three district hui, and culminating in an all-district meeting, the focus was on whakawhanaungatanga, fostering relationships, enhancing networking, and improving website usability. These gatherings also addressed community challenges and advocated for increased social media engagement, emphasising the importance of connectivity.

The introduction of QR codes in Well Child Tamariki Ora booklets for breastfeeding support, along with the launch of a monthly newsletter and a dedicated email Pepeora@ccdhb.org.nz streamlined communication and service promotion efforts.

- **QR Codes:** Integrated into Well Child Tamariki Ora booklets for updated breastfeeding support.
- **Monthly Newsletter:** Introduced to keep the community informed and facilitate service promotion.
- **Dedicated Pēpe Ora Email:** Established to streamline communication and updates.

Digital enhancements and metrics underscored the impact of these initiatives. The website experienced an impressive 138% increase in visits, reaching 5,100 visitors over the past year. Similarly, Facebook activity saw substantial growth, with a 92.9% increase in reach and significant engagement with posts.

- **Pēpe Ora Service Updates:** The website saw eight service updates and the addition of one new service from July to December 2023.

Additionally, the Pēpe Ora Facebook page analytics reveal a gender disparity among its 182 followers, with women representing 97.5% of the audience. This indicates that the content and outreach efforts are significantly resonating with the female demographic, successfully hitting the target audience.

Overall, Pēpe Ora collective network meetings for whakawhanaungatanga, community engagements, and digital advancements have contributed to improving service accessibility and support within the community, reflecting a commitment to ongoing enhancement and collaboration within the Pēpe Ora space.

LOOKING AHEAD

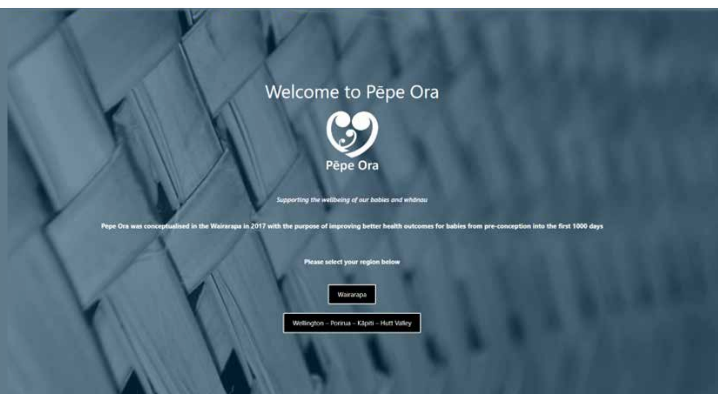
- In February 2024, the first governance meeting is planned to design a redefinition of Pēpe Ora’s mission, emphasising its role as a comprehensive maternity service directory.

Pēpe Ora:

https://www.wellington.pepeora.nz/

Facebook:

https://www.facebook.com/PepeOraNZ



SAFE SLEEP PROGRAMME

As part of the Ministry of Health National SUDI (sudden unexplained death in infancy) Prevention Programme, Capital, Coast continues to coordinate a well-established Safe Sleep Programme. The programme aims to capture those pēpi who are most vulnerable.

DISTRIBUTION OF SAFE SLEEP BEDS (SSB):

In 2023, our region distributed a total of 467 safe sleep beds, including both wahakura and Pēpi-Pod, to local providers. Additionally, 314 safe sleep beds were directly provided to whānau. The distribution of these beds reflects our commitment to promoting safe sleep practices and safeguarding the well-being of pēpi. There have been instances where safe sleep forms were not returned, potentially affecting the accuracy of distribution records due to the lower-than-expected numbers reported. Efforts are underway to encourage compliance with the completion and return of all forms to better assess the impact and reach of our safe sleep initiatives within the community.

CONTINUED SUPPORT FOR WAHAKURA WĀNANGA:

In collaboration between Ora Toa, Puhi Nuku and her whānau, Capital Coast continues to support safe sleep practices through ongoing engagement in wahakura wānanga for hapū māmā and whānau. These workshops offer valuable opportunities for expectant mothers and families to learn about the importance of safe sleep, create their own wahakura, and receive practical guidance on effective wahakura usage.

DISCUSSING SSB REFERRALS AT PĒPE ORA NETWORKING EVENTS:

In addition to facilitating Pēpe Ora events, Capital Coast also engages in conversations about the referral pathway for accessing Safe Sleep Beds and support regarding safe sleep practices. This efficient method guarantees that community providers are kept informed of the information. Whānau are able to receive a SSB through their midwife, Well Child Tamariki Ora nurse, or in some cases, other health or social services providers. Health providers who distribute SSBs receive training on delivering strengths based, culturally appropriate safe sleep messaging. The providers accessing training often have existing relationships with whānau who commonly meet risk-assessment criteria that qualify them for additional support with keeping baby safe during sleep.

ENGAGEMENTS FOR SUDI PREVENTION EDUCATION:

Capital Coast collaborated with second year midwifery students by delivering presentations on SUDI prevention. These presentations provided students with valuable insights into the importance of safe sleep practices and strategies for effectively communicating SUDI prevention messages to expectant whānau. By engaging with future healthcare professionals, Capital, Coast contributes to building a knowledgeable and skilled workforce equipped to promote safe sleep practices and support whānau in reducing the risk of SUDI.

COMMUNITY MIDWIFERY MERGE

2023 saw the change of the Midwifery Manager role from managing the Hutt Community midwifery team (CMT), outpatients clinic, early pregnancy clinic, administration team and Breastfeeding services but, increase those teams to include the Capital, Coast CMT, breastfeeding inpatients service, Māori and Pacific Breastfeeding team and Newborn Hearing screeners. This has meant that this is the first Midwife Manager role across the district.

The first six months of the role was challenging in terms of working across three different sites with different ICT systems, different processes and the addition of four new teams. However, the benefits of being across the district have been immense, with information sharing much more seamless. Great relationships have been built and different ways of working have been introduced across all sites after seeing some success in different spaces. This has been a pilot and will be evaluated in June 2024 as to whether this will become a permanent role across district.

Also in 2023 the Capital, Coast based CMT needed to find a space to run their antenatal clinics as the copper pipe project began in Womens Clinics. This was a great opportunity for CMT to re-locate to community locations that were more available to our community. The five day a week hospital based clinic moved across the road to share the Wellington Ultrasound premises, an additional clinic was commenced at Strathmore Park and a new clinic opened in Thorndon Medical Centre. All have been received well by the community and the midwifery team have enjoyed working outside the hospital. The number of pregnant people who received care from the CMT at Capital Coast in 2023 was 521. This accounted for 17% of the pregnancies at Capital, Coast.

NEURODIVERSITY PODCAST

The Neurobirth Podcast is a seven episode limited series about the childbearing journey, from preconception through to the early weeks of parenting, through the lenses of ADHD and Autism. It was commissioned by Carolyn Stobbs on behalf of Health NZ, Capital Coast and Hutt Valley in early 2023 with a vision to bring research, evidence-based practice, and lived experience of pregnancy, ADHD, and Autism to a wide reaching audience in an audio format.

Hosts Bronwyn Rideout and Amy Taylor are neurodivergent midwives in Aotearoa who work in different sectors of the maternity system: Amy in the community as a Lead Maternity Carer and Bronwyn at a Tertiary Hospital as a Core Midwife. They were approached to produce the podcast due to the impact of their venture with Hutt Maternity and the Wellington branch of the New Zealand College of Midwives, the Neurodiversity in Pregnancy, Birth, and Early Parenting Workshop.

Each episode in the Neurobirth Podcast focuses on different topics pertaining to pregnancy and how sets of neurodivergent traits and behaviours may present and impact perinatal care.

PODCAST TOPICS:

Episode 1: Neurodiversity 101 – What is neurodiversity; what it means to be neurodivergent; intersectionality; and who is missing out on timely diagnosis?

Episodes 2 & 3: The Senses – A two-parter which covers sensory processing; hypo- and hypersensitivity; stimming; and controversies around weighted blankets and fidget toys.

Episode 4: Communication – Tips on improving communication between health care providers and neurodivergent consumers; Spoon Theory; The Double Empathy problem.

Episode 5: General/Preconception Health – What current research says about health outcomes for Autistics and ADHDers and its implications for perinatal care.

Episode 6: Antenatal, Labour, and Birth- What does research tell us and where are the gaps.

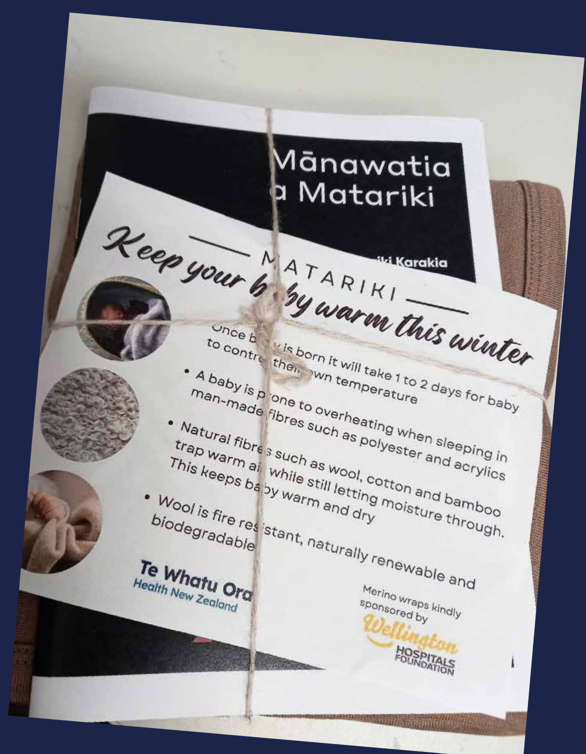
Episode 7: Postnatal and Early Parenting – Mental health; infant feeding; adjusting to parenting; and contraception.

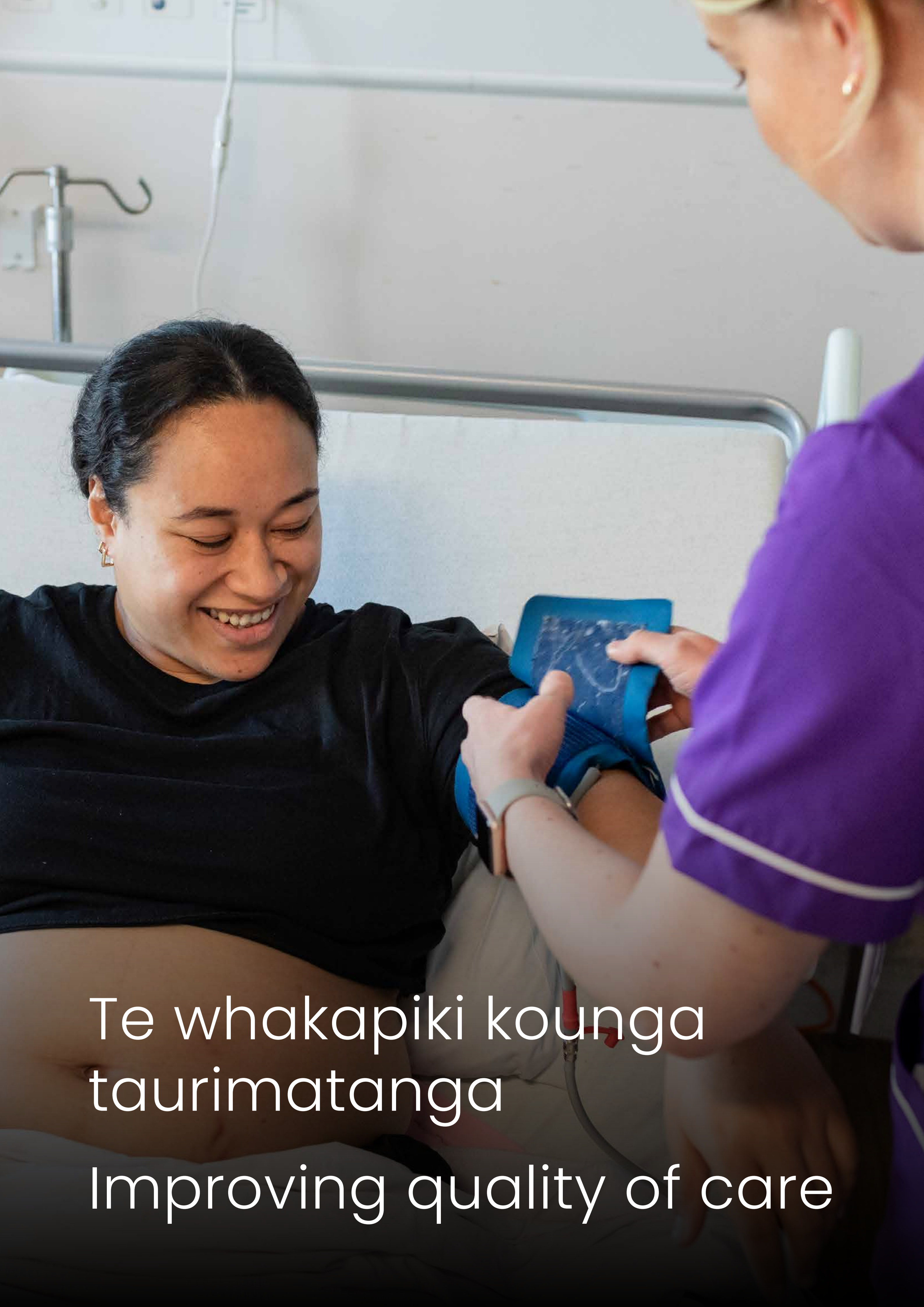
(Midwives can claim time listening and reflecting on the podcast as part of the Midwifery Council Continuing Education requirements)

MATARIKI CELEBRATIONS

On 14 July 2023, Aotearoa celebrated Matariki, our newest official public holiday. The arrival of Matariki signals that it is time for people to gather, honour the dead, celebrate the present, and make plans for the future. To acknowledge this special time of the year the CCHV district organised with the Hospital Foundation to gift new pēpi with a merino blanket and a native tree.

One hundred blankets and trees were donated and given to whānau who welcomed a new pēpi over this time. Along with this a special karakia and Information about keeping your baby warm was included. These were gratefully received and appropriate considering the time of year!





Te whakapiki kounga taurimatanga

Improving quality of care

ADVERSE EVENTS

LEARNING THROUGH REPORTABLE EVENTS

In maternity services, ensuring the highest standards of quality and safety is paramount. The Health Quality & Safety Commission (HQSC) quality improvement framework is used to provide a robust structure for achieving these standards through continuous quality improvement practices. This reportable event framework emphasizes learning from adverse events and near misses, viewing them as valuable opportunities for system-wide enhancements.

Adverse events are unintended incidents that result in harm to patients, while near misses highlight situations where harm was averted but had the potential to occur. Both are thoroughly reviewed to understand if there are any underlying systems which could be improved, to prevent future harm to our maternity community, their whānau, or staff working in our services. By fostering an environment where we can all report and discuss incidents or near misses helps identify and address weaknesses in our processes.

Every year, we review and examine adverse events reported by consumers or staff to uncover root causes and contributing factors, leading to actionable insights. Consumer participation within the adverse event process is critical to understanding how we can improve services for our community. Engaging patients and their whānau in the review process not only enriches the insights gained but also helps build trust and accountability. The outcomes identified through the reportable event process are used to design and implement targeted quality improvement projects for the community and staff within our services.

A total of 307 reportable events were generated in the WHS during 2023, with 107 (34.8%) events being categorized as Maternal/Childbirth, the next highest being Clinical Care/Service/Coordination with 48 (15.6%) events, followed by Staff and Others Health and Safety with 40 (15%) events, Staffing with 24 (7.8%) events, Medication 21 (6.8%) and ID, Documentation or Consent 17 (5.5%).

Over the past year, such reviews have led to a continuous series of improvements within the services, and some larger projects aimed at enhancing patient safety and care quality.

FRESH EYES

Following a SAC review we reintroduced “Fresh Eyes, Safe Eyes” on all CTGs. There is now a systematic ‘fresh eyes’ check of every CTG, regardless of whether there are concerns or not. This approach recognises that fatigue, familiarity with a pregnant person and limited knowledge or experience can lead to a lack of objectivity and can affect accurate interpretation of a CTG.

CTG ‘Fresh Eyes’:

- In labour the CTG should be independently reviewed by another midwife or doctor at least every two hours and more frequently in the presence of concerns regarding fetal wellbeing. This can be any member of staff who has completed the appropriate training (RANZCOG Fetal Surveillance Education Programme (FSEP))
- BadgerNet has a Fresh Eyes documentation space to clearly state who reviewed the CTG and the subsequent outcome
- Where there is a concern about fetal wellbeing all midwifery staff complete the CTG assessment tool in BadgerNet which will prompt the midwife to request a review by the senior midwife in the first instance, or a member of the medical team.

A District Wide Policy will include Fresh Eyes as the standard. Regular CTG teaching meetings take place for all of the team to discuss real life CTGs and their outcomes.

FRESH EYES SAFE EYES

Check in with another midwife or the CMM at a minimum of every two hours, and document in the appropriate places.

This means that there is a systematic "fresh eyes" check of every trace, regardless of whether there have been particular concerns raised or not.

The fresh eyes approach recognises that fatigue, familiarity with a patient and limited knowledge or experience can lead to a lack of objectivity and can affect accurate interpretation of a CTG

If you have any questions or concerns, talk to the CMM on shift

August 2023

Te Whatu Ora
Health New Zealand
Capital, Coast and Hutt Valley

NEW ZEALAND MATERNITY CLINICAL INDICATORS

Clinical indicators give an opportunity for Districts and local maternity stakeholders to identify areas for further investigation and potential service improvement.

The New Zealand Maternity Clinical Indicators show key outcomes for each District's secondary and tertiary maternity facilities.

Data is presented in the report in two ways.

- By District of residence: this data is intended to provide the District's with information relevant to their usually resident population.
- By facility of birth: this data is intended to allow for the monitoring of trends over time at the facility level.

Data for these indicators were extracted for all pregnancies and live births recorded on the National Maternity Collection (MAT) dataset. MAT integrates maternity-related data from the National Minimum Dataset (NMDS) and LMC claim forms submitted to and compiled by the Manatū Hauora.

Clinical indicators are monitored by comparing data for a defined subgroup of women who are considered to be *'low risk'*. This group is referred to as the *'standard primiparae'* (SP) group.

A *'standard primiparae'* is defined as 'a woman aged between 20 and 34 years at the time of birth, having her first baby at term (37 to 41^{+6} weeks gestation) where the outcome of the birth is a singleton baby, the presentation is cephalic and there have been no recorded obstetric complications that are indications for specific obstetric intervention'.

The 'standard primiparae' represents a woman expected to have an uncomplicated pregnancy. Intervention and complication rates for such women should be low and consistent across all hospitals nationally. Standard primiparae represent approximately 15% of all births but this proportion varies across the districts.

The following page shows results for Capital, Coast as a whole and by each ethnic group, for the year 2021 (Ministry of Health, 2023). The table and commentary is based on the clinical indicator results by District of residence. The data can also be seen here: https://tewhatuora.shinyapps.io/maternity-clinical-indicator-trends/

OVERVIEW OF CAPITAL, COAST VS AOTEAROA RATES

In the table below, the Capital, Coast rate is compared against the Aotearoa National rate and the clinical indicators are highlighted to show if the Capital, Coast rate is statistically significantly different to the Aotearoa rate. The Capital, Coast data is further broken down by ethnicity to show how that ethnicity compares to the Aotearoa National rate (whole of Aotearoa, all ethnicities), and is again highlighted to show if the rate is significantly different from the Aotearoa rate. While some indicators have what appear to be significant differences in rates, small sample sizes can mean the differences fail to reach statistical significance. Indicators 13-15 are not included due to small numbers.

Table 8: **New Zealand Maternity Clinical Indicators 2021, by District of residence, showing Capital, Coast ethnicities compared to the whole of Aotearoa.**

Clinical indicators: Capital, Coast rate compared to the Aotearoa rate		Aotearoa Rate (%)	Capital, Coast Rate (%)	Capital, Coast ethnicity groups compared to the Aotearoa national rate (whole of NZ)				
				Māori Rate (%)	Pacific Rate (%)	Indian Rate (%)	Asian (excl Indian) Rate (%)	European /Other Rate (%)
1	Registration with an LMC in the first trimester	78.2	78.1	61.5	51.6	83.8	80.5	85.8
2	SP who have a spontaneous vaginal birth	61.5	58.0	69.3	73.0	40.5	60.0	55.3
3	SP who undergo an instrumental vaginal birth	19.2	22.8	14.7	10.8	33.3	21.7	25.0
4	SP who undergo caesarean section	19.1	19.3	16.0	16.2	26.2	18.3	19.7
5	SP who undergo induction of labour	9.1	8.2	5.3	5.4	16.7	10.0	7.7
6	SP with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy)	24.1	16.1	19.0	12.9	12.9	10.2	17.4
7	SP undergoing episiotomy and no 3rd- or 4th-degree perineal tear	26.7	31.1	14.3	25.8	41.9	26.5	35.7
8	SP sustaining a 3rd- or 4th-degree perineal tear and no episiotomy	4.1	3.6	3.2	9.7	3.2	2.0	3.3
9	SP undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear	2.1	1.9	0.0	0.0	6.5	4.1	1.7
10	Women having a general anaesthetic for caesarean section	7.5	5.9	10.5	4.5	2.7	5.6	5.7
11	Women requiring a blood transfusion with caesarean section	3.9	2.9	3.5	2.2	1.8	5.0	2.5
12	Women requiring a blood transfusion with vaginal birth	2.5	2.8	3.1	2.8	3.0	5.2	2.1
16	Maternal tobacco use during postnatal period	7.3	4.3	17.5	5.4	0.4	0.0	1.4
17	Preterm birth	7.9	7.8	9.4	7.6	10.1	9.8	6.3
18	Small babies at term (37–42 weeks' gestation)	2.9	2.6	2.2	1.7	6.4	3.6	2.0
19	Small babies at term born at 40–42 weeks' gestation	27.0	24.1	15.4	0.0	35.3	38.5	19.4
20	Babies born at 37+ weeks' gestation requiring respiratory support	3.1	3.1	2.9	2.0	3.7	2.5	3.4

CLOSER CONSIDERATION OF CLINICAL INDICATORS

Indicator One; Registration with an LMC in the first trimester is not significantly different as a whole but when looking at individual ethnicities, the Indian, and European/Other ethnicity groups, have higher than average rates of early registration. There was a significant drop in rates of registration in the first trimester in Māori and Pacific people in recent years, we still have work to do to enable early registration. Over a ten year period at Capital, Coast the rates of first trimester booking increasing by 32.5% for Māori and 24.3% for Pacific people.

Indicator Two; SP who have a spontaneous vaginal birth is not significantly different for the district as a whole, but when broken down by ethnicity, we see a significantly lower rate of vaginal births among SPs in Indian and European/Other people, with Indian women being 21% less likely to have a spontaneous vaginal birth than nationally. Work with the local Indian community remains ongoing and 2024 should provide some insight on why this figure is so different.

Indicator Three; SP who undergo an instrumental vaginal birth is significantly higher at Capital, Coast, driven by both Indian and European/Other ethnicities, but particularly Indian women, with rates of 33.3% which is 14.1% higher than the national rate.

Caution needs to be executed when studying indicators six through to nine, as small numbers can confound the results.

Indicator Six; SP with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy), and Indicator Seven; SP undergoing episiotomy and no 3rd- or 4th-degree perineal tear has historically been driven by the Indian ethnicity group, although the rates vary significantly year on year due to small numbers. This year, the Indian ethnicity rates failed to reach significance, but the Asian (excluding Indian) and European/Other ethnicity group did. The MQSP working group devised initiatives to improve access to warmed towels for the perineum during birth to enhance the elasticity of the perineum and education on perineal protection is ongoing. There has been significant training in the diagnosis of perineal injury over recent years and pictorial aides were introduced to enable accurate diagnosis documentation. This may have impacted the rates of *'intact'* genital tract diagnoses. The rates of episiotomy may be influenced by the mode of birth, that is, higher instrumental births.

Indicator Nine; SP undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear now fails to reach significance.

Indicator Sixteen; Maternal tobacco use during postnatal period shows Indian, Asian (excluding Indian), and European/Other ethnicities having significantly lower rates of smoking than the national average. While Capital, Coast as a whole has significantly lower rates of smoking, Māori continue to have significantly higher rates than the whole ethnicity national rate. Comparing Māori to Māori around the country, Capital, Coast has historically low rates of smoking, however the rate has been unchanged in the last four years. This data shows us the populations where we may need to target our smoking cessation support. It also shows that we need to work on our smoking cessation support for everyone. *See 'Reducing Maternal Smoking' within this report.*

Indicator Eighteen; Small babies at term (37-42 weeks' gestation), while not statically different for Capital, Coast, Indian people have higher than average rates (6.4%). Meanwhile, the European/Other ethnicity group has significantly lower rates of small babies born at term (2.0 %). It is worth noting that the calculation for size does not take maternal ethnicity into account and so could give unreliable results. The high rates of small babies at term highlights the importance of access to scanning for growth, especially at term. Also these rates are not taken from GROW but rather Intergrowth 21 – which our facility does not use.

EQUITY WITHIN CAPITAL, COAST

While it is good to see how Capital, Coast compares nationally, to know outcomes are equitable, we need to compare each ethnicity against the average for the district. Ideally we would like there to be no significant differences between any of the ethnicities. In the following table, the ethnicity columns show the rate for each ethnicity compared to Capital, Coast rate (all ethnicities). Once again, the clinical indicators are highlighted to show if the indicator is statistically significantly different from the Capital, Coast average. While some indicators have what appear to be significant differences in rates, small sample sizes can mean the differences fail to reach statistical significance. Indicators 13-15 are not included due to small numbers.

Table 9: **New Zealand Maternity Clinical Indicators 2021, by district of residence, showing Capital, Coast ethnicities compared to the Capital, Coast rate (%).**

Clinical indicators: Capital, Coast ethnicity groups compared to the Capital, Coast rate (%)		Capital, Coast Rate (%)	Māori Rate (%)	Pacific Rate (%)	Indian Rate (%)	Asian (excl Indian) Rate (%)	European/Other Rate (%)
1	Registration with an LMC in the first trimester	78.1	61.4	51.6	83.8	80.5	85.8
2	SP who have a spontaneous vaginal birth	58.0	69.3	73.0	40.5	60.0	55.3
3	SP who undergo an instrumental vaginal birth	22.8	14.7	10.8	33.3	21.7	25.0
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6	SP with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy)	16.1	19.0	12.9	12.9	10.2	17.4
7	SP undergoing episiotomy and no 3rd- or 4th-degree perineal tear	31.1	14.3	25.8	41.9	26.5	35.7
8	SP sustaining a 3rd- or 4th-degree perineal tear and no episiotomy	3.6	3.2	9.7	3.2	2.0	3.3
9	SP undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear	1.9	0.0	0.0	6.5	4.1	1.7
10	Women having a general anaesthetic for caesarean section	5.9	10.5	4.5	2.7	5.6	5.7
11	Women requiring a blood transfusion with caesarean section	2.9	3.5	2.2	1.8	5.0	2.5
12	Women requiring a blood transfusion with vaginal birth	2.8	3.1	2.8	3.0	5.2	2.1
16	Maternal tobacco use during postnatal period	4.3	17.5	5.4	0.4	0.0	1.4
17	Preterm birth	7.8	9.4	7.6	10.1	9.8	6.3
18	Small babies at term (37–42 weeks' gestation)	2.6	2.2	1.7	6.4	3.6	2.0
19	Small babies at term born at 40–42 weeks' gestation	24.1	15.4	0.0	35.3	38.5	19.4
20	Babies born at 37+ weeks' gestation requiring respiratory support	3.1	2.9	2.0	3.7	2.5	3.4

CLOSER CONSIDERATION OF CAPITAL, COAST CLINICAL INDICATORS BY ETHNICITY

The areas of inequity, (where one or more groups has a more desirable outcome, and one or more groups has a less desirable outcome in the same indicator) are indicators one, two, seven, ten, twelve, sixteen, and eighteen. Some of these indicators contain small numbers and the data changes from one year to the next. The main areas where there seems to be consistent inequity are Indicator One; Registration with an LMC in the first trimester, and Indicator Sixteen; Maternal tobacco use during postnatal period.

While Capital, Coast has equal rates of early registration with an LMC when compared to the whole of Aotearoa, there is disparity between ethnicities within Capital, Coast. There is some work to be done to facilitate early booking of Māori and Pacific people registering with an LMC in the first trimester. There is also a need to design programs to support lowering rates of tobacco use by the Māori and Pacific people birthing at Capital, Coast. The MQSP 2024 focus on the optimisation of care for young Māori people is planned.

The most advantaged ethnicity is the European/ Other group who are better off in two indicators and have no indicators where they are worse off than the average Capital, Coast birthing woman/person. Indian women have lower than average rates of normal vaginal births (Indicator Two: SP who have a spontaneous vaginal birth), but this indicator is based on small numbers and seems to change year on year.

Ngā Āpitihanga
Appendices

APPENDIX 1 – MQSP WORK PROGRAMME

As a district we have identified MQSP priorities for 2024 and beyond. We have taken into consideration the National Maternity Monitoring Group (NMMG) priorities for monitoring and investigation, as per the National Maternity Monitoring Group Annual Report 2019 (NMMG, 2020). We have also reviewed and included any priorities and recommendations from the Fifteenth Annual Report of the Perinatal and Maternal Morbidity Review Committee (PMMRC, 2022) and identified quality work to address our clinical outcomes following review of our local data.

Table 10: **MQSP Work Programme 2020-2023**

Project No.	Improvement Initiative	Objective / Descriptor / Actions	District	Planned delivery
1	**Optimising Term Birth**			
1.1	Primipara Induction of Labour	• Caesarean Section Audit and Introduction of Robson 10	CCHV	Ongoing
		• Introduction of Misoprostol	Hutt Valley	Commenced
		• Design a tool for IOL indications, optimal process and decisions for CS	Capital, Coast and Hutt Valley	Planning
1.2	Develop an ERAS pathway for women/people having elective caesarean sections	• Amend written information given to women/people to cover the district	Capital, Coast and Hutt Valley	Ongoing
		• Introduce patient controlled oral analgesia		BAU
		• Investigate potential of midwifery-led discharge process, streamlining the process, leading to timely discharge		Ongoing
		• Standardise the perioperative and postpartum management of care for Group 5 people		Ongoing
		• Translate the ERAS pamphlet in to different languages to promote equitable access to care	Capital, Coast and Hutt Valley	Yet to commence
1.3	Setting the scene for future pregnancies	• Develop a robust process where women/people whose birth has resulted in a caesarean section are advised of their likelihood of achieving a vaginal birth in a future pregnancy, before leaving hospital inpatient services	Capital, Coast	Planning
1.4	Acupuncture Clinic	• Establishment of Acupuncture clinic to monitor effect on IOL and CS Rate	Capital, Coast	Not progressing
			Hutt Valley	Completed
		• Audit clinic data to measure improvement of IOL and CS rates	Hutt Valley	Completed

2	**Optimising Preterm Birth**			
2.1	Explore alternative model of care options for women/ people presenting with preterm pre-labour rupture of membranes (PPROM)	• Review the policy and make district wide	Capital, Coast and Hutt Valley	Ongoing
		• Education of all health care providers about updates to the policy and encourage the use of outpatient management if clinically appropriate		Planning
2.2	Preterm birth referrals	• Improve the antenatal screening and referral process for women/ people at risk of preterm birth	Capital, Coast and Hutt Valley	Yet to commence
		• Establish a structured triage process		
2.3	Preterm birth management audit	• Consider another audit for more in-depth data to determine whether there was equity of access to optimising treatments, this would be done by prospective collection of data at referral centre and referring districts	Capital, Coast and Hutt Valley	Yet to commence, awaiting outcome of Carosika Collaborative
2.4	Preterm Birth Rate	• Reduce preterm birth rate and neonatal mortality related to preterm birth	Capital, Coast and Hutt Valley	Yet to commence, awaiting outcome of Carosika Collaborative
3	**Maternal Outcomes**			
3.1	Develop a maternal sepsis pathway	• Work with district wide Sepsis working group to develop an audit tool or measure to monitor the improvement following the introduction of the pathway	Capital, Coast and Hutt Valley	Underway
		• Audit outcomes since roll out in 2019		Yet to commence
		• Present findings		
3.2	Hypertension in Pregnancy	• Update to district wide Hypertension in Pregnancy Guideline that aligns with the new National Guideline	Capital, Coast and Hutt Valley	Completed
		• Implementation and education for all health care providers about updates		Completed
3.3	Postpartum Haemorrhage	• Update to district wide Postpartum Haemorrhage Guideline that aligns with the new National Guideline	Capital, Coast and Hutt Valley	Completed
		• Monitor PPH rates		On going
		• Identify any areas for improvement following implementation		
		• Audit the PPH that have occurred since implementation		Yet to commence

4	**Neonatal Outcomes**			
4.1	Neonatal encephalopathy (NE) outcomes	• Reduce number of newborns born with NE	Capital, Coast and Hutt Valley	Ongoing
		• Auditing of outcomes		Awaiting national NOC/ NEWS working group agreed measures to report on
4.4	Neonatal Hypoglycaemia	• Update to district wide Neonatal Hypoglycaemia Policy following recommendations on Neo-check clinical audit	Capital, Coast and Hutt Valley	On hold as work starting on a national guideline
		• Complete business case to acquire blood gas analysers for more accurate blood glucose levels on neonates district wide		Completed. Awaiting outcome
		• Implementation of blood analyser and education for health care provider		Planning
4.5	Newborn Notification Form	• Scoping and review of Newborn Notification Form	Capital, Coast and Hutt Valley	Completed at WRH & KMU. Kāpiti & HV planning.
5	**Improving Equity**			
5.1	Understanding the needs and outcomes of woman/people 20 years and younger	• Improve our understanding of pregnancy women/people 20 years and younger	Capital, Coast and Hutt Valley	2024, work to commence
		• Audit their birth outcomes		
		• Develop, in consultation with young mothers, acceptable and safe methods to access and engage with care to achieve equitable health outcomes		
		• Identify and adequately resource evidence-based solutions to address risks, paying attention to smoking cessation, screening and treatment for infections, screening for fetal growth restriction and providing adequate information about the causes and symptoms of preterm labour including prevention of preterm labour		
		• Commencing maternity care before 12 weeks		
		• Providing appropriate antenatal education		
		• Consider how we can support LMCs caring for mothers aged under 20 years		
		• Develop strategies to further engage with this age group		

5.2	Smoking	• Reduce the number of Māori and Pacific women/People smoking during pregnancy	Capital, Coast and Hutt Valley	To commence 2024
		• Engage with young Māori and Pacific women/people to explore the barriers to them stopping smoking during pregnancy		
		• Revisit and re-promote nicotine replacement therapy with staff		
5.3	Survey women/ people about their inpatient experience	• Seek to find ways we can improve our services	Capital, Coast and Hutt Valley	Completed
		• Create an appropriate way to gather feedback		
		• Recurring themes will become part of the MQSP programme of work, areas will be notified of feedback about them		
5.5	Cultural competency programme	• Improve our workforce cultural appropriateness and awareness	Capital, Coast and Hutt Valley	Ongoing
		• Implement regular education opportunities		In progress
		• Survey Indian women/people about the model of care required		
5.7	Monitor key maternity indicators by ethnicity to identify variations in outcomes and improve areas where there are differences in outcomes	• Qlik Data can be filter by ethnicities	Capital, Coast	Business as usual
		• Qlik Data – access and training to create a scorecard for monitoring outcomes and filter by ethnicity	Hutt Valley	Planning
5.8	Reduce the number of adverse maternal and fetal outcomes for our Indian maternity community	• Improve our understanding of the Indian communities needs during pregnancy	Capital, Coast and Hutt Valley	In progress
		• Audit their birth outcomes		
		• Develop a plan of action with specific recommendations of changes and actions		
		• Create a Vitamin D guideline		Complete
		• District-specific addendum to national gestational diabetes testing guideline to be created		Awaiting new national guideline
		• Further investigation needed on influence of ethnicity of gestational length variance and guidelines following this		Planning
		• Indian breastfeeding peer support counsellors to be recruited		Yet to commence
		• Review of handout material given to maternity clients to assess cultural appropriateness and possibility of translation.		

6	**Bereavement**			
6.1	Investigate the possibility of employing a bereavement midwife	• Develop a business plan to support the role of a bereavement midwife	Capital, Coast and Hutt Valley	Commenced
6.2	Te Wai Bereavement Symbol Process	• Te Wai Trolleys for 4 North Maternity and Birthing Suite	Capital, Coast	Business as usual
		• Te Wai Trolleys for Birthing Suite and Maternity Ward	Hutt Valley	Completed
7	**NMMG Recommendations**			
7.1	NMMG recs for 2020 relevant to MQSP (1)	• Encourage low risk people to birth at home or in primary facility	Capital, Coast and Hutt Valley	Ongoing
		• Promotion of primary birthing facilities		
7.2	NMMG recs for 2020 relevant to MQSP (2)	• Equitable access to postpartum contraception, including regular audit	Capital, Coast and Hutt Valley	Ongoing
8	**MMWG Recommendations**			
8.1	MMWG Principles of Te Tiriti	• Should partner with wāhine Māori and their whānau in meaningful, participatory ways to understand their maternity health priorities and work with them to design and implement solutions		In progress
		• These solutions must recognise and respond to the authentic needs of Māori aspirations for self-determination in the health and wellbeing of themselves and their whānau, and must safeguard Māori culture concepts, values and practices. We highly recommend using co-design to best develop a service that is responsive to the needs wāhine Māori.		
8.2	MMWG (Subgroup of PMMRC) (3)	• Establish a clinical pathway for pregnant women/people with identified placental implantation abnormalities	Capital, Coast	Completed
			Hutt Valley	Completed
		• Audit the first 10 women/people to use the pathway	Capital, Coast	Underway
8.3	MMWG Women's Narratives	• Women who are admitted to an HDU or ICU should be offered the opportunity to debrief and discuss their experience between three and six months following the event. Maternity services should ensure an appointment is arranged through an appropriate clinical appointment (as close to the woman's/person's residence as possible), such as gynaecology outpatient, prior to discharge from the maternity service, directing her to agencies to enable attendance.	Capital, Coast	Planning
			Hutt Valley	Completed

9	**PMMRC Recommendations**			
9.1	Communication and Coordination & Maternal Mortality	• Pregnant women/people who are admitted to hospital for medical conditions not related to pregnancy need to have a specific pathway for perinatal care	Capital, Coast and Hutt Valley	Planning
10	**Governance**			
10.1	Consumer Engagement	• Increase consumer engagement on MQSP GG	Capital, Coast and Hutt Valley	Completed
10.2	LMC Engagement	• Recruit LMC Reps to MQSP GG	Hutt Valley	Completed
10.3	District Wide PPG	• Establishment of Multidisciplinary Group to review and approve clinical policies, guidelines and information for across the district	Capital, Coast and Hutt Valley	Ongoing
11	Corrective Actions			
11.1	NSU National Metabolic Screening Audit	• Update Metabolic Screening policy	Capital, Coast and Hutt Valley	Completed
12	**Other**			
12.1	Theatre Hats	• Embroidered Hats for staff that attend theatre to help with easy identification during emergencies	Capital, Coast	BAU
			Hutt Valley	BAU
12.2	Manaakitanga Poster	• Engage with consumers as a project for them along with a working group	Capital, Coast and Hutt Valley	Ongoing
12.3	Embracing Diversity	• 3 Year Photo Campaign	Capital, Coast and Hutt Valley	On hold
		• Birth for Everyone Workshop		
12.4	Pro-noun signage	• Engage with consumers as could be done during refurbishments	Capital, Coast and Hutt Valley	2024
12.6	Volunteers	• Develop Volunteer pathway and role description	Hutt Valley	Commencing 2024
12.7	Anti-D Prophylaxis	• Consideration of non-hospital administration sites for Anti-D	Capital, Coast and Hutt Valley	Completed
		• Survey LMCs to be able to identify any other barriers to current policy		
12.8	Maternal Mental Health Project	• Health New Zealand | Te Whatu Ora National Mental Health Commissioning Team in Partnership with Kahu Taurima are looking at Maternal & Infant Mental Health Services for the Central Region	Capital, Coast and Hutt Valley	Planning

APPENDIX 2 – DEFINITIONS

This report includes maternal and infant data pertaining to people giving birth to babies at and beyond twenty weeks gestation at any of the three birthing facilities in the Capital, Coast area. Also included are those people who were booked to give birth at a facility but had an unplanned home birth or gave birth en route to a birthing facility.

A monitoring and audit programme of the Perinatal Information Management System (PIMS) maternity database includes daily and monthly checks, and then BadgerNet from November 2023 with queries and corrections made on key data fields.

ETHNICITY REPORTING

Reporting of ethnicity is complex and different systems were used in various reports.

The Ministry of Health uses a prioritised ethnicity group classification system (Ministry of Health, 2010). This system is used when an individual chooses multiple ethnicities based on their preferences or self-concept. The classification system then determines the ethnicity group value for multiple ethnicities using a hierarchical system of 21 ethnicity descriptions. This is based on the following priority: Māori, Pacific Peoples, Asian, other groups except Other European, New Zealand European. Tables within this report have grouped New Zealand European, Other European, and Other Ethnicities together as a combined number where Manatū Hauora nationwide data is used. Indian women/people are separated out from Other Asian women/people to reflect the growing disparity of outcomes for Indian women/people.

Table 11: **Prioritised ethnicity groups**

Ethnicity group	Ethnicity	Priority order (MOH)
Māori	Māori	1
Pacific Peoples	Tokelauan	2
	Fijian	3
	Niuean	4
	Tongan	5
	Cook Island Māori	6
	Samoan	7
	Other Pacific Island	8
	Pacific Island not further defined	9
Other Asian	Southeast Asian	10
	Chinese	12
	Other Asian	13
	Asian not further defined	14
Indian	Indian	11
Other	Latin American/Hispanic	15
	African	16
	Middle Eastern	17
	Other/Not stated	18
Other European	Other European	19
	European not further defined	20
NZ European	New Zealand European	21

ABBREVIATIONS AND DEFINITIONS

Table 12: **Abbreviations**

Abbreviation	Definition
ELCS	Elective caesarean section
ERAS	Enhanced recovery after surgery
FTE	Full time equivalent
GAP	Growth Assessment Protocol
GHMP	Global health media project
GP	General practitioner
GROW	Gestational related optimal weight
HEAT	Health Equity Assessment Tool
HQSC	Health Quality and Safety Commission
ICT	Information and communication technology
IM	Intramuscular
IOL	Induction of labour
ISSN	International standard serial number
IUGR	Intrauterine growth restriction
IV	Intravenous
KMU	Kenepuru Maternity Unit
KPI	Key performance indicator
LARC	Long-acting reversible contraception
LMC	Lead maternity carer
MAP	Medical applications portal
MAT	National maternity collection
MEWS	Maternity Early Warning Score
MFM	Maternal Fetal Medicine
MHAIDS	Mental Health, Addictions and Intellectual Disability Service
MIQ	Managed isolation and quarantine
MMWG	Maternity Morbidity Working Group
MQSP	Maternity Quality & Safety Programme
MRI	Magnetic resonance imaging
MVSC	Maternity Vital Signs Chart
NE	Neonatal Encephalopathy
NGO	Non-governmental organisations
NICU	Neonatal Intensive Care Unit
NIPT	Non-invasive prenatal testing
NMDS	National minimum dataset
NMMG	National Maternity Monitoring Group
NOC/NEWS	Newborn Observation Chart/Newborn Early Warning Score
NZ	New Zealand
NZBS	New Zealand Blood Service
OA	Occiput anterior
OP	Occiput posterior
PACU	Post anaesthetic care unit
PADA	Perinatal Anxiety & Depression Aotearoa
PAS	Placenta accrete spectrum
PCOA	Patient controlled oral analgesia
PIC	Primary intrapartum care
PIMS	Perinatal Information Management System
PMMRC	Perinatal and Maternal Mortality Review Committee
PMU	Paraparaumu Maternity Unit
PPH	Postpartum haemorrhage
PPROM	Preterm Pre-labour Rupture of Membranes
PROM	Pre-labour Rupture of Membranes
PROMPT	Practical Obstetric Multi-Professional Training
QR	Quick response
RAADD	Routine antenatal anti-D prophylaxis
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
SAC	Severity Assessment Code
SCBU	Special care baby unit
SGA	Small for Gestational Age
SMMHS	Specialist Maternal Mental Health Service
SP	Standard primiparae
SROM	Spontaneous rupture of membranes
SSB	Safe sleep bed
SUDI	Sudden Unexplained Death in Infancy
TENs	Transcutaneous electrical nerve stimulation
WHS	Women's Health Service
WRH	Wellington Regional Hospital

Table 13: **Definitions**	
ACC	Accident Compensation Corporation
BAU	Business as usual
BFHI	Baby friendly hospital initiative
CMT	Community midwifery team
CS	Caesarean section
CTG	Cardiotocograph
DDU	Diploma of Diagnostic Ultrasound
Body mass index	A measure of weight adjusted for height.
Dashboard	A modern analytics tool to monitor healthcare KPIs in a dynamic and interactive way
Deprivation	A lack of the types of diet, clothing, housing and environmental, educational, working and social conditions, activities and facilities which are customary in a society
Domicile	A persons usual residential address
Ethnicity	The ethnic group or groups that women/people identify with or feel they belong to
Jadelle	A hormone releasing sub-cutaneous contraceptive implant
Jaydess	A hormone releasing intra-uterine contraceptive device
Kairaranga	Traditional weaver
Kaupapa	Topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue or initiative.
Manatū Hauora	Ministry of Health
Mirena	A hormone releasing intra-uterine contraceptive device
Misoprostol	A synthetic prostaglandin medication used to induce labour
Morbidity	The consequences and complications (other than death) that result from a disease
Multidisciplinary team	A multidisciplinary team involves a range of health professionals working together to deliver comprehensive health care
Normothermia	The maintenance of normal core body temperature
Nulliparous	Has not given birth previously
Pākehā	New Zealander of European descent

Parity	The number of previous pregnancies that were carried to 20 weeks
Pēpi	A baby or infant
Qlik	An end-to-end cloud based data integration and data analytics application
Robson 10	A classification system by which all perinatal events and outcomes can be compared
Tamariki	Children
Tertiary	Specialised consultative health care, usually for inpatients and on referral from a primary or secondary health professional
Wahakura	A woven flax bassinet for infants up to 5-6 months of age
Wānanga	Teaching and research that maintains, advances, and disseminates knowledge and develops intellectual independence
Whānau	Extended family, family group, a familiar term of address to a number of people

APPENDIX 3 – DATA SOURCES

The information in this report has been sourced from the following database systems:

- Health NZ |Te Whatu Ora – Capital, Coast District Business Intelligence and Analytics Unit
- Health NZ |Te Whatu Ora – Capital, Coast District patient management system
- Perinatal Information Management System (PIMS)
- BadgerNet
- Health NZ |Te Whatu Ora – Capital, Coast District Maternity Clinical Indicators (PIMS) Qlik application
- Health NZ |Te Whatu Ora – Capital, Coast District Maternity Clinical Indicators (Manatū Hauora) Qlik application
- Ministry of Health Report on Maternity web tool
- Ministry of Health Qlik Sense Hub

APPENDIX 4 – REFERENCES

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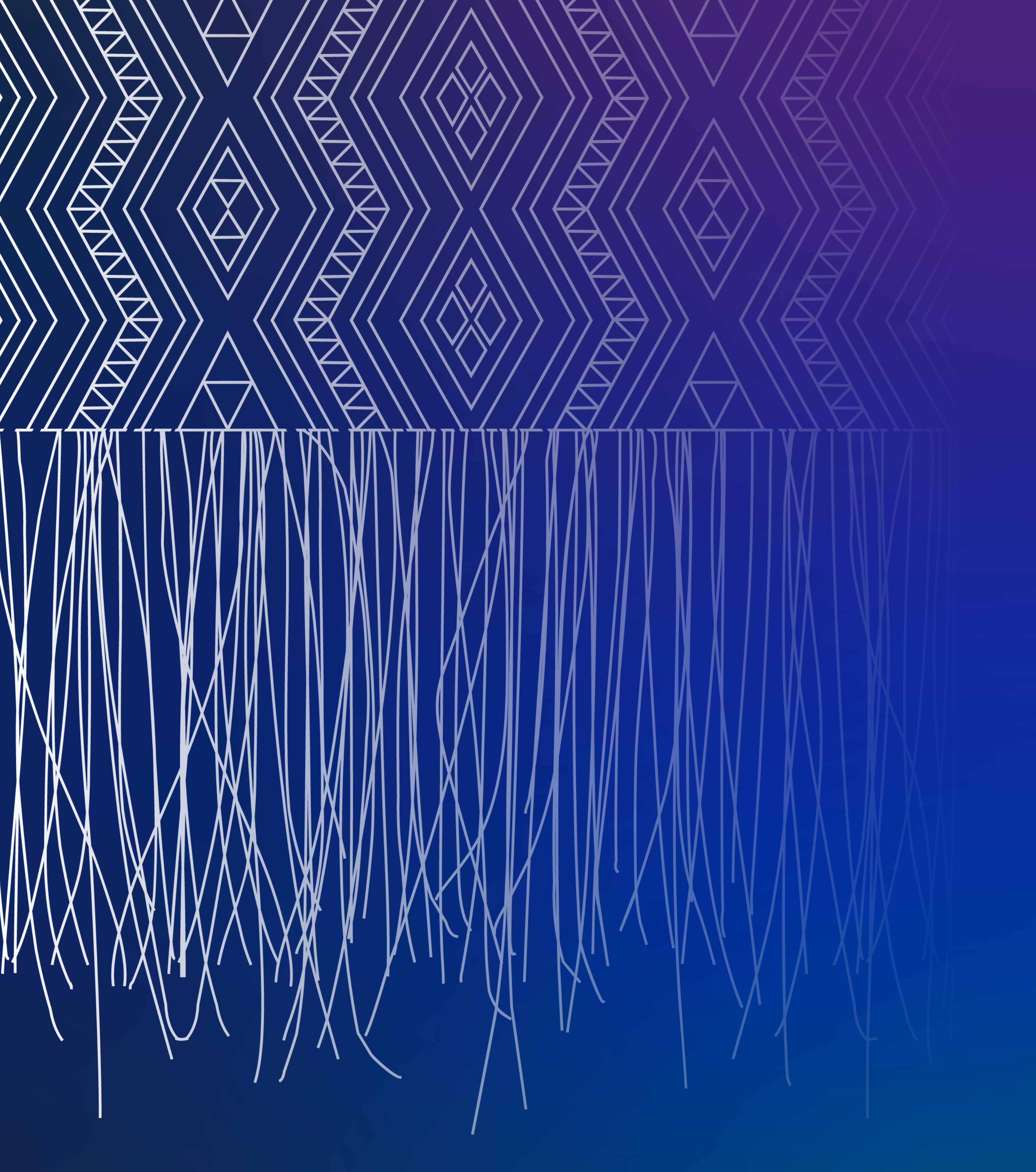

“Me mahi tahi tātou, mo te oranga o te katoa”
“We must work together for the wellbeing of all”
- Māori proverb