TE WAIORA Nelson Marlborough Health

# Maternity Quality and Safety Programme Annual Report

2019/20

# Contents

# Foreword

Tenā koutou katoa

It is with pleasure that we present the Nelson Marlborough Health Maternity Quality and Safety Programme Annual Report. It provides an overview of our maternity services across the region.

The programme has become a key focus for us over the last year. While COVID-19 has impacted us all, we have taken the opportunity to look at how services are provided to our women and their whānau, and how we can best present data to reinforce the fact that any changes are making a positive difference. This work will become more evident in future reports and we look forward to providing annual reports that show innovation, quality care, consumer engagement and vastly improved data collection.

We would like to acknowledge the women, their families and whānau who have provided valuable feedback on our maternity services. Through this feedback we are able to work towards improving the quality and safety of our maternity services in the Nelson Marlborough region.

We also acknowledge our other stakeholders for their feedback, support and commitment to the safety and quality of our maternity services—our clinicians (employed and self-employed), administrators and others who have engaged with Maternity Quality and Safety Programme (MQSP) over the last year. Thank you to the MQSP governance board representatives and the Clinical Governance Committee for your time and energy.

We would like to thank the Ministry of Health for its continued support of the programme—this has enabled us to ensure that we have the resources to support clinical staff in making positive change to the service we provide.

In addition we would like to thank the many people who have contributed to the compilation of this Maternity Quality and Safety Annual Report. This includes the families, staff and LMC midwives who so kindly gave their time and permission for photographs to illustrate our Annual Report.

*Donna Addidle*
Service Manager, Women Child & Youth

*Debbie Fisher*
Associate Director of Midwifery

# Nelson Marlborough Health – Vision, Mission, Values

## Our Vision: Ko te Whakakitenga

Working with the people of our community to promote, encourage and enable their health, wellbeing and independence.


## Our Values: Ā Mātou Uara


## Midwifery Vision Statement

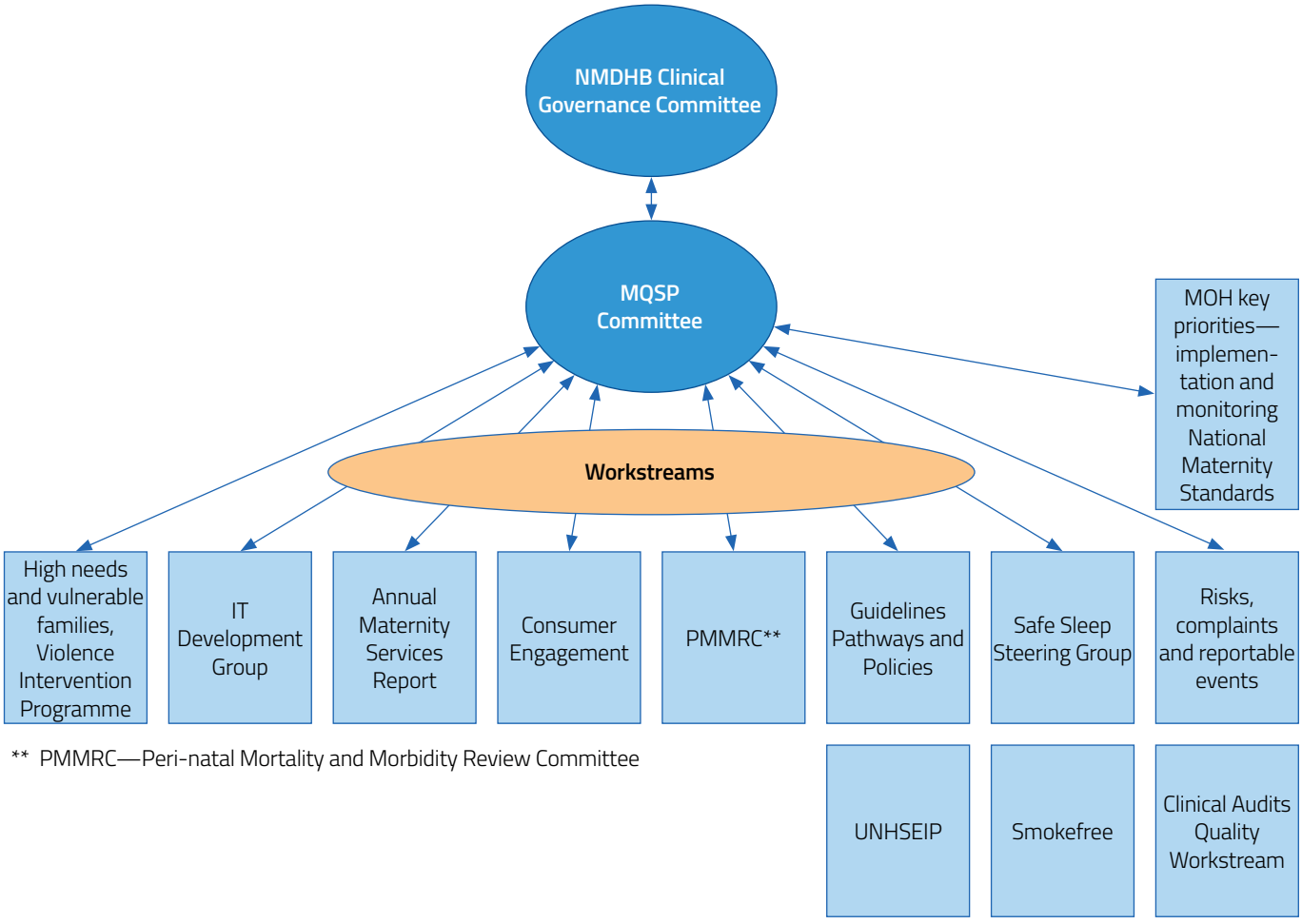
"We believe that wāhine, their pēpi and their whānau should have access to high quality, safe midwifery care that acknowledges pregnancy and childbirth as a normal life event."

# Maternity Quality and Safety Programme

This is the seventh Nelson Marlborough Health (NMH) Maternity Quality and Safety Programme Annual Report since the establishment of the Ministry of Health (MoH) MQSP in 2011.

The purpose of the Maternity Quality and Safety Programme is to review and improve the quality and safety of maternity services as experienced by women and their whānau throughout the region. We recognise that to be successful a collaborative multidisciplinary team approach is needed, including the voice of consumers at all levels of service planning and review. The MQSP committee reflects this multidisciplinary approach whilst acknowledging that consumer involvement has been a particular challenge over the last year and currently we do not have consumer representation in the MQSP committee. Our plan moving forward is to engage with consumer groups within the community and for 'expressions of interest' to be advertised.

## Governance Structure




** PMMRC—Peri-natal Mortality and Morbidity Review Committee

The role of MQSP coordinator was vacant for a period of 6 months with the new coordinator taking up the role in mid-June 2020. Regular MQSP meetings have since taken place and occur monthly. This will change to bi-monthly once the committee has become completely re-established.

In accordance with the principles of the Te Tiriti o Waitangi it is our commitment to have an equity focus for tangata whenua in all aspects of MQSP in accordance with the DHB priorities.

# Aims and Objectives

We are committed to providing and improving the quality of maternity services for our women, babies and whānau.

The maternity services aims and objectives are to:

- Provide woman-centred maternity care that meets the needs of the population
- Continue to establish, implement, and review, as required, systems and processes to support the provision of quality safe care
- Take a whole of systems approach towards improving the health of women and children as guided by national priorities and health service expectations
- Develop the maternity workforce to ensure our maternity services are responsive to the needs of the population
- Develop and strengthen regional links.

# Purpose of Report

The purpose of this report is to:

- Describe the population we serve and the work we do
- Be responsive, transparent and accountable to the women and whānau we serve
- Outline the initiatives underway to ensure our maternity workforce is supported to ensure high quality, safe care
- Benchmark our performance against the New Zealand Maternity Clinical Indicators
- Provide information about the quality improvement work taking place
- Provide information about the work underway in addressing priorities identified by the National Maternity Monitoring Group, the Perinatal and Maternal Mortality Review Committee and the Maternal Morbidity Working Group.

# Alignment with Key Strategic Documents

## The New Zealand Maternity Standards

www.health.govt.nz/publication/new-zealand-maternity-standards

NMH has aligned the MQSP with the National Maternity Standards and use them to inform future plans. Evidence of alignment is demonstrated throughout this report whilst acknowledging the areas we are aiming to improve. The standards are:

1. Maternity Services provide safe, high quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies
2. Maternity Services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage
3. All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

## National Maternity Monitoring Group (NMMG) Annual Report 2018

www.health.govt.nz/system/files/documents/publications/nmmg-report-2018-revised-final.pdf

The NMMG acts as a strategic advisor to the MoH on areas of improvement in the maternity sector and provides a national overview of the quality and safety of New Zealand's maternity services. This group oversees and reviews the National Maternity Standards.

The 2019 NMMG report was delayed as a result of COVID-19 and was only published towards the end of 2020 meaning that it was not used to compile the NMH report.

## Perinatal and Maternal Mortality Review Committee (PMMRC) 13th Annual Report

www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3823/

The PMMRC reviews the deaths of mothers and babies in New Zealand. The 13th Annual Report, released in 2019, is the most recent report available at the time of compiling NMH's annual report.

## Maternity Morbidity Working Group (MMWG) 3rd Annual Report

www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3837/

The MMWG was established for a three-year term to improve the quality and experience of maternity care for women, babies, families and whānau through robust, women-centred maternal morbidity review, and through the development of quality improvement initiatives.

## Nelson Marlborough Annual Plan 2019–2020

www.nmdhb.govt.nz/quicklinks/news-and-publications/published-documents/nmh-annual-plan

## Nelson Marlborough Māori Health & Wellness Strategic Framework 2008–2038

intranetlibrary/Māorihealth/General Documents/Nelson Marlborough Māori Health and Wellness Strategic Framework.pdf

# Our District

## Understanding who we are


### AREA

The land area of our district is **227,000 km²**

### DISTRICTS

There are three territorial local authority districts: Tasman, Nelson and Marlborough.

- Our age profile tends to be older than the national average
- We have a lower proportion of Māori and Pasifika people compared to the national average, but do have a higher rate of young Māori (under 25 years)
- We have a lower proportion of people in the most deprived section of the population compared to the national average
- Nelson and Wairau (Blenheim) are refugee resettlement areas.

### NELSON TASMAN

Nelson Tasman comprises three large settlements—Nelson, Richmond and Motueka; smaller urban and rural communities such as Māpua, and remote rural communities such as Golden Bay, Tapawera and Murchison. Marlborough comprises the main town of Blenheim, with Renwick, Picton and Havelock forming small rural settlements. The Marlborough Sounds, Ward and Seddon form our smallest rural communities.

### POPULATION

We have a population of **152,090** which is estimated to rise to **160,000** by 2029.

### ETHNICITY

NMH population by ethnicity 2019:

**Māori**
16,110 (10.6%)

**Asian**
7,510 (4.9%)

**Pasifika**
2,600 (1.7%)

**European/ other**
125,870 (82.8%)

Source: Te Pou o te Whakaaro Nui (2019). DHB population profiles 2019–2029

# Our Birthing Community

Our community demographics are taken from the NMH database and the National Maternity Collection which provides statistical, demographic and clinical information.

The below diagram provides a visual picture of health statistics for women giving birth in Nelson Marlborough in 2019.

## BIRTH RATE

**1422** in 2019

On average, **163** babies born every day in New Zealand

**4** babies born every day locally

## MATERNAL AGE

Highest percentage of mothers are in the **30–34** year bracket

## BIRTH BY FACILITY

Nelson Maternity **884** (62.1%)

Wairau Maternity **420** (29.5%)

Motueka Maternity **32** (2.3%)

Golden Bay **18** (1.3%)

Home birth **68** (4.8%)

## MATERNAL ETHNICITY

Māori **227**

Pasifika **38**

Indian **39**

NZ European/other **1020**

Asian **98**

## REGISTRATION

**95.5%** registered with an LMC

**80.7%** within first 12 weeks

## QUINTILES

Q1 (least deprived) **141**

Q2 **411**

Q3 **304**

Q4 **478**

Q5 (most deprived) **88**

## SMOKING

At first registration **75**

At 2 weeks postnatal **17**

# Our Maternity Services

What we offer: our maternity services provide a range of primary and secondary level care to support women with normal birth and to provide additional care for women with more complex pregnancies and births. In addition to maternity care women in the region have access to Māori specific health and social care services, Pregnancy & Parenting education in a variety of forums, breastfeeding support services including donor breast milk service, newborn hearing screening programme, safe sleep service and the Pēpi First Quit Smoking Programme.

Nelson and Wairau have secondary level neonatal services for babies requiring additional care after birth.

Where possible we promote and support partners/support person staying overnight as family centred care. In the secondary units we provide pull out beds and in the primary units there are double beds.

## Nelson Maternity

4 birthing rooms, 1 birthing pool room, 1 pregnancy loss area 'The Rose Room',
1 clinical assessment room, 4 antenatal beds, 10 postnatal rooms, 10 SCBU cots


## Wairau Maternity

3 birthing rooms (1 with birthing pool), 8 combined antenatal and postnatal beds,
4 neonatal cots, Tatau Pounamu (Maternity Hub)

## Motueka Maternity Unit (Te Whare Whānau)

1 birthing suite with new birthing pool,1 clinical assessment room (can be adapted for a second birthing area), 3 postnatal rooms with double beds

## Golden Bay Maternity

1 combined birthing and postnatal suite, 1 clinic room

There are 3 midwives in Golden Bay employed by the Nelson Bays Primary Health Organisation to provide LMC care. The unit is based in the Golden Bay Integrated Family Health Centre. The midwives also are on-call providing urgent maternity care for women temporarily in the region who may require maternity care. The team have an annual caseload of around 60 women with approximately half of these birthing in the Bay.

Birth rates in our primary maternity units have historically been low as a high proportion of our birthing women have chosen to birth at the secondary unit in Nelson. We are pleased that the last four years has seen the numbers of women choosing to birth at Motueka Maternity rising. Forty-one women birthed their babies here in 2018, a rise from 24 in 2017. In 2020, 37 women birthed here and this is likely to have been higher if not for the unintended closure of the maternity unit during the national level 4 COVID-19 lockdown. Postnatal admissions to the unit have also been rising from 118 in 2017 to 184 in 2020.

For women in Marlborough the maternity unit is based at Wairau Hospital. It has a birthing suite which provides an environment for both low risk and high risk women. Women choosing home birth are also supported by the LMCs. There isn't an additional primary maternity unit in Marlborough.

The Nelson Marlborough region is a satellite area for the undergraduate Bachelor of Midwifery Programme at the Ara Institute of Canterbury. We recognise the importance of nurturing our student midwives and value the opportunity to educate and support them within our region. Once they enter midwifery practice we continue to support and nurture them. A number of local midwives offer support via the midwifery first year in practice programme (MFYP).

Our 'home grown' midwives tell us how much they appreciate already feeling part of the team by the time they have completed the degree programme. This makes it much easier for them to transition to midwifery practice in either core midwifery or LMC practice. They are a key component in our workforce plan for the future.

*"I believe that having home grown midwives is pivotal to the sustainable future of midwifery in Aotearoa.*

*I was able to study in my own region which gave me insight into the unique lived experiences of local women and the daily challenges they experience as part of living provincially.*

*Learning, experiencing and coping with studying midwifery as a satellite student is challenging. Yet by overcoming these adversities it has made me an insightful, adaptive and thoughtful midwife.*

*I feel that this model of studying midwifery also supports the diversity, innovation and creativity that is vital for the profession going forward.*

*I acknowledge how privileged I feel to have been able to be a satellite midwifery student and how extremely humbled and honored I am to now be caring and supporting women within that community as a registered midwife."*

Natalie Ogilvie (new graduate midwife)

We face challenges that are common with other regions: increasing complexities; balancing intervention with the promotion of normal birth; support of LMC midwives in an increasingly complex world which also results in more demands on the core midwifery staff. Good relationships and communication are key. Throughout the region the midwifery workforce is regarded as one and this is a real strength. It is recognised that workforce issues that affect either the employed or self-employed midwives will have a knock-on effect on the other.

An acute LMC workforce shortage has resulted in the short term establishment of caseloading teams across the district to ensure women have access to continuity of primary maternity care. Longer term solutions are being worked through in 2020–2021.

Nelson maternity unit has also introduced a mixed 8 and 12 hour roster in response to staff requests. This has been a big success and staff feedback has been very positive.

Regular Access Holder meetings provide a forum for self-employed LMC midwives to come together as a group with the service managers. Here they can connect with their colleagues, raise issues and challenges as well as discussing new ideas. COVID challenges has led to these meeting being held virtually and attendance has improved.

## Midwifery Education

The Midwifery Educators support midwives across the region to meet their Midwifery Council education and professional development requirements as well as our service requirements. Women and their families can be reassured they are receiving care from highly skilled and evidence based midwives. There are 2 Educators,

one based in Wairau and one in Nelson. They work closely together to ensure that education is delivered consistently across the region. They also provide education for the primary units in Motueka and Golden Bay.

The formal education content is open to all midwives in the region and is free-of-charge. The scheduled full day workshops include:

- Normal Birth workshop
- Midwifery Emergency Skills Refresher
- PROMPT (PRactical Obstetric Multi-Professional Training)
- Newborn Life Support (NZRC-accredited)
- Midwifery Skills workshop
- Breastfeeding workshop (aligns with Baby Friendly Hospital Initiative requirements).

The workshop content is usually pre-planned but there is also flexibility to respond to the need for specific education within workshops when this arises. For example, breastfeeding issues related to COVID-19 were covered in the Breastfeeding workshop. The midwifery educators also work closely with the MQSP coordinator to link identified topics into midwifery education. Sepsis will be an education topic throughout 2021 to align with our new sepsis protocols.

Other workshops which are critical to our maternity services, including Leadership and Cultural Competency, have been supported in the past and will continue to focus as priorities moving forward.

Informally, Midwifery Journal Club and Maternity/Paediatric 'Coffee Club' sessions are also held. These bite-sized (one hour) education snippets make use of local skills and knowledge, including from community resources and are usually very popular.

COVID-19 has had a significant impact on the delivery of education this year. The educators have worked hard to make use of creative resources and technology during the challenges in 2020 to deliver ongoing education. Extra capacity has been added into next year's schedule in response to the challenges experienced with the COVID-19 responses.

One of the real strengths in terms of quality and safety in our maternity services is the national requirement for all midwives to attend mandatory ongoing education – irrelevant of their role. In other professions the mandatory emergency skill education varies depending on work place and role. This requirement for midwives is set by Midwifery Council and provides reassurance to women that no matter what environment they birth in – they can be reassured that the midwives looking after them receive the same standard of education in terms of how to manage birth and neonatal emergencies – irrelevant if they are community or maternity unit based.

# Support in Pregnancy

## Pregnancy to Parenting Education (PPE)

Pregnancy to Parenting Antenatal Educators provide up-to-date information and advice on pregnancy and parenting in an informative, interactive and relaxed way. The program is innovative and reaching all corners of our region with our new mixed model of delivery.

Pregnancy to parenting education is a six week class series where women and their whānau gain the skills to take them through pregnancy, labour and birth, the early days of parenting and beyond. During the classes there is information on forming a birth plan, coping skills and the process of labour and birth; what to expect after the birth; feeding your baby and planning your new roles as parents. They also have an opportunity to meet other expectant parents and a variety of community providers that will help whānau experience a healthy pregnancy, birth, and ease the transition into parenthood.

Also included in this series is the Rest and Relaxation class which offers an online opportunity to access antenatal yoga classes, guided relaxations, and sleep advice. It is recommended that women make this a part of their weekly preparations for birth.

The mixed model of classes encourage and enable participants from across our region to benefit from antenatal education. They can do the weekly online modules at their own pace, while also having an opportunity to meet up virtually with the antenatal educator weekly, meet other expectant parents, and finish the series with a fun and informative in-person expo night, meeting and interacting with classmates and providers of health and wellness services in the community that relate to their current life stage.

> *"We live in a remote rural area and are happy that we have been able to access pregnancy education to help us prepare for the birth and the early days with our baby."*

Women and their partners or support person can choose to tour which ever maternity ward(s) they are considering birthing it.

PPE has recently moved the registration process online as well. Once the registration form is completed they are granted access to all of the class modules. Registration for classes is accepted at any point in their pregnancy. Our innovative model ensures women can get into the class series that suits them and their whānau best.

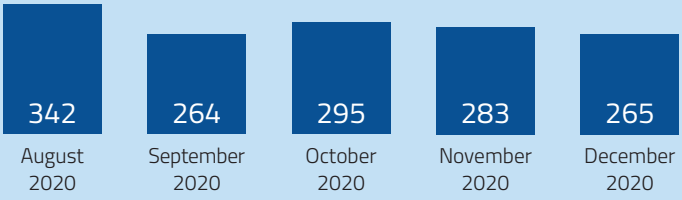
We also offer series for our young mums (23 years old and younger) and for women who have English as a second language.

### Registrations

2019: 116

2020: We had an open access process during COVID-19 lockdown and through to the end of the year so actual numbers are not known. We have anecdotal evidence of a high number of people accessing the website where the modules were available.

### Website viewings




# Wānanga Hapūtanga—
# Kaupapa Māori Pregnancy and Parenting Programme

In 2017-2018 Te Waka Hauora proposed to launch the first kaupapa Māori pregnancy and parenting programme in our health services. Māori women and their whānau have since enjoyed better access to pregnancy and parenting education, with the first programme launched in Wairau in November 2018. The programme is now offered across the region in identified high need areas—with the vision to provide support and education within a kaupapa Māori framework.

The programme has proven to be very successful. Between July 2019 and June 2020 66 hapū māmā have attended, as well as numerous whānau. Taking place over two full day sessions in local communities, wānanga hapūtanga embraces the principles of te reo, tikanga and mātauranga Māori to share knowledge and key messages in a way that upholds and acknowledges Te Ao Māori. We continue to have strong engagement with and linking to local support services in line with the ethos of the wānanga—with local presenters and services such as smoking cessation, whānau support services and poumanaaki also attending to extend knowledge sharing of locally available supports with the whānau. At the completion of the programme wāhine are gifted a wahakura woven by local weavers, to support the safe sleep message, and an Aroha pack filled with items for māmā and pēpi.


With the COVID-19 lockdown came an increased demand for Wānanga Hapūtanga. Hapū māmā were of a vulnerable group, who were highly affected during this time. Te Waka Hauora made the decision to continue the wānanga via Zoom, thereby giving whānau the opportunity to access information. It also ensured important messages were able to be shared, particularly around safe sleep. Risk factors changed during lockdown with some whānau being affected financially and socially, causing stressors within home environments.

> *"100% using Māori culture and adding it into childbirth, and future parenting, is beautiful."*
>
> A good example of the comments from one whānau member.

Feedback has continued to be collected from each wānanga, from both the hapū māmā and whānau who attend and it is collated within a smart survey system.

Common themes include: **very informative, useful for first time mums, environment was supportive, and made you feel comfortable**. 100% of those who attended said they would **recommend the course, one reason being that they learned useful, new things**.

There were many comments on the way the wānanga connected whānau to "their taha Māori" and how the wānanga was different and whānau orientated, and how enjoyable it was to learn tikanga Māori.

# Pēpi First Quit Smoking Programme

Through the Pēpi First programme, we aim to support women to give their pēpi the best start in life through being smoke free in pregnancy and the homes they live in. This free programme is available for all hapū māmā who smoke and provides intensive one-to-one support with a quit coach, as well as nicotine replacement therapy and vouchers to reward achievement of smokefree goals. Quit coaches offer flexible appointment times and options, giving women the choice of being seen at one of our community clinics, in their workplaces or at home. We also offer support to partners and other family members who smoke in order to give women the best chance of quitting and staying smokefree.

The Manager of Māori Health and Vulnerable Populations is a champion for the local programme, which mirrors others that have been shown nationally to improve quit rates for Māori and vulnerable population groups.

In 2019–2020, the service received 71 referrals and quit coaches worked with 43 women throughout alerts levels one to four. When face-to-face appointments were not possible due to COVID-related constraints, quit coaches quickly transitioned to phone-based support and home delivery of nicotine replacement therapy. Prior to Alert Level Four, quit rates sat around 55%. At times it has not been possible to validate quit rates through the use of carbon monoxide monitors due to health and safety reasons. During these periods, self-reported quit rates sat around 45%.

Pictured is one of our local hapū māmā who engaged with the Pēpi First programme. The link below leads to details of her story.

www.tpo.org.nz/te-puna-december-2019/2019/12/13/ppi-comes-first-for-naomi-smoke-free-and-loving-it

Moving forward, the service is looking at moving to an 'opt out' smoking cessation programme commencing in March 2021.

# Hei Pa Harakeke— First 1,000 Days Pilot

The First 1,000 Days project pilot is being run in the Motueka area. The Hei Pa Harakeke team is made up of health and social professionals from across the area. The aim of the team is to bring together people and organisations supporting whānau to provide focus on developing nurturing relationships which are vital to a baby's development. The relationship starts during pregnancy when there may be signs that additional support may be needed. All women in the Motueka region are offered the programme of support during pregnancy to nurture the maternal-infant relationship and prioritise infant mental health in those vital first years.

## Violence Intervention Programme (VIP)

The Violence Intervention Programme (VIP) aim is to reduce the health impacts of family violence for families. The VIP Coordinators work across the district to ensure staff are educated to recognise and respond to intimate partner violence and child protection concerns. This work involves developing pathways, policies and procedures to assist and inform staff of the processes to follow to ensure the well-being of women and babies when family violence is identified. Maternity staff attend our VIP 8 hour core training with follow up refreshers to integrate the knowledge learned into practice. We support these practices through consultation, auditing and mentoring to ensure staff have the necessary tools to encourage their success. It is a difficult and complex issue for staff to consider within their work and therefore they need the support and guidance the VIP service provides.

Women over 16 years of age should be routinely asked family violence screening questions and when a positive disclosure is made, be provided the support needed to ensure their safety and that of any children involved, including unborn babies. Over the last five years there has been a reduction in the number of disclosures made by women when asked the family violence screening questions. Routine Enquiry screening rates are always monitored, however this is a work in progress and needs an all systems approach.

The focus for 2019/2020 is reviewing the memorandum of understanding for the Maternal Care Interagency Group that meets regularly to ensure appropriate supports are in place where vulnerabilities are identified in pregnant women. There have been some delays due to the impact of COVID-19. The referrals to this group have increased over the recent years so it is important that we ensure we have all the appropriate people and systems in place to enable best outcome possible for baby and whānau.

# Newborn Care

## Paediatrics and Neonatal Care in Wairau

At Wairau Hospital, neonatal care is provided by the paediatric service within a combined paediatric & neonatal unit, caring for neonates from 34 weeks gestation. The unique configuration of the unit, which has designated swing beds between the maternity and paediatric wards, enables most newborns requiring neonatal care to receive this in the same room as their mother.

Babies requiring more complex specialist interventions are transferred to tertiary services.

2019 was a busy year with 120 babies being admitted. This was an increase from the 103 admissions in 2018, 115 in 2017 and 100 in 2016. To date in 2020 we have noticed a reduction in the number of admissions compared to 2019. This may be related to the impact of COVID-19 and we look forward to reporting further on this in our next annual report.

## Neonatal Care in Nelson

Mirroring the national trend, Nelson Special Care Baby Unit had a busy year with 200 babies admitted in 2019. This was similar to our admission rate of 198 in 2018 and lower than the 224 admitted in 2017. Nearly all families using the services live in the greater Nelson Bays area but the unit has also provided care for babies from Wairau, West Coast and Canterbury. Rooming in, boarder rooms and onsite accommodation also supports our service philosophy of keeping mothers and babies together.

Nelson neonatal services have been working to grow and develop our new model of Family Integrated Care (FIC) with the aim of supporting and educating parents and valuing them as their baby's main care-giver in all care given. This is a change to traditional neonatal care which often results in the parents being passive visitors to their baby. This has involved working in partnership with parents in all areas of decision making and coaching them to become independent as much as they wish and are able.

Additionally, although occupancy can be challenging at times, the layout of single rooms allows us to keep mothers and babies together if at all possible, often with fathers staying overnight for support and to promote bonding and attachment. We also work closely with our maternity colleagues to ensure this happens. This model of Transitional Care together with FIC as described above are both criteria outlined in the Malatest International, Review of Neonatal Care in New Zealand, January 2019, as opportunities for improvement.

## Safe Sleep

We are committed to supporting the quality 'safe sleep every sleep' key objectives, undertaking local safe sleep audits, and creating a more visible regional Pēpi-Pod programme relating to safe sleep practices.

Sudden Unexpected Death in Infancy (SUDI) is preventable in most cases if parents and caregivers provide protective care, including safe sleep. With this in mind Te Waka Hauora (TWH) has implemented a system to monitor the distribution of safe sleep beds (SSB), including wahakura, alongside education, and to ensure the evaluative component of the programme is followed. The possible creation of 'safe sleep champions' within the three main maternity units is also being discussed, alongside a new pathway for assessing need and distributing the pēpi pods. The focus is on removing barriers to access.

Due to COVID-19 face to face education of staff has been difficult. A multiservice agency working group has been established to discuss Pēpi First, hapū wānanga and safe sleep to focus on how we can ensure collaboration and joined up service initiatives which meet the needs of whānau by focussing on equity and removing barriers to access. Plans to promote Safe Sleep Day are being discussed through this forum. The programme provides mini pēpi-pods (used in the hospital setting), pēpi-pods and wahakura. The beds come with safe sleep messages and practices attached to them and they act as a practical tool that aims to enable behaviour change to support safe sleep.

COVID-19 lockdown proved very challenging for whānau isolated from their usual sources of support during the early postnatal period where babies are most at risk of SUDI and the messaging to distributors was very clear—continue to provide safe sleep beds. Everyone remained committed to the safe sleep cause.

# Universal Newborn Hearing Screening and Early Intervention Programme

We provide the national newborn hearing screening and early intervention programme in all of our maternity units. We also visit whānau at home when needed—because ensuring every pēpi has their hearing checked is really important and we want to ensure whānau don't have any barriers to accessing the service.

There are 3 screeners, all based in Nelson but travel to all the units and undertake home visits as needed. Within the last year all 3 screeners have undertaken the Unconscious Bias in Healthcare training modules.

Offering screening to the 1422 babies, identifying the very few numbers of babies born with a hearing loss and offering early intervention gives them the best opportunity for the least amount of impact from their hearing loss on their future development.

**1422**
babies born in 2019 (NMDHB)

**1422**
families offered screening within 30 days of birth

**1437**
screening completed and passed

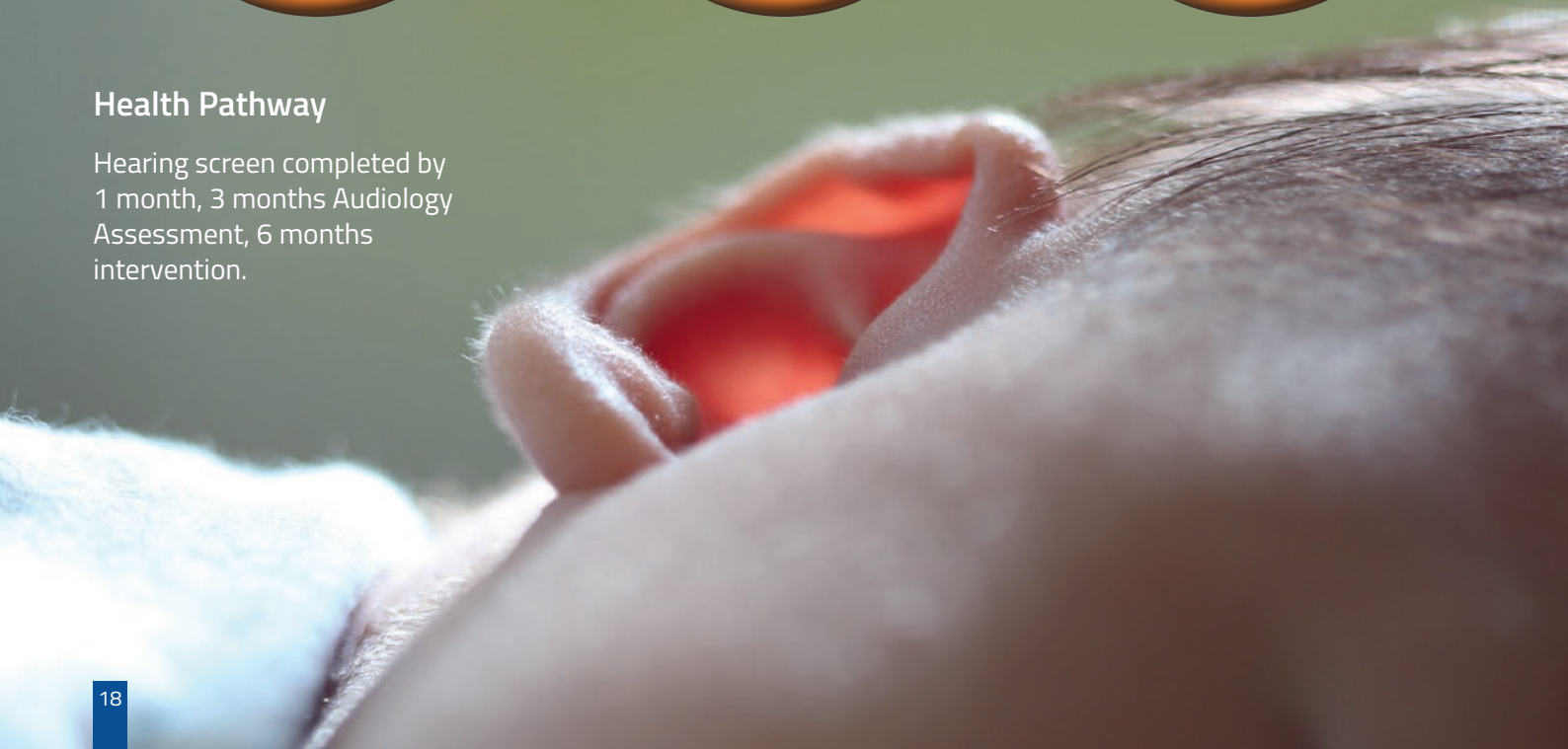
**9**
**Declined**
Parents offered screening but declined.
Percentage per eligible 0.83% of population.

**13**
**Audiology Diagnostic Assessment**
Refer to audiology for diagnostics as hearing screen not passed.

**15**
**Audiology Ongoing Monitoring**
This group of babies have passed the initial screen but due to having a "Risk Factor" require diagnostic assessment.

## Health Pathway

Hearing screen completed by 1 month, 3 months Audiology Assessment, 6 months intervention.



# Newborn Observation Chart (NOC) Neonatal Early Warning Score (NEWS)

The NOC is a vital signs chart which has been developed to standardise the initial assessment and care of all newborns in New Zealand. The NOC will also provide a single view of clinical information and assist in recognising trends which may indicate a baby's condition has deviated from the norm. The NEWS has been developed to assist with the early recognition of clinical deterioration of infants who are at risk, with the aim of improving outcomes for these infants and to help us detect and reduce the severity of Neonatal Encephalopathy and other neonatal conditions.

There has been a delay in implementing the NOC/NEWS. However, progress and national agreement on the chart and system has been made. Staff education continues and champions are in place across the maternity units. A commencement date for February 2021 has been identified. We look forward to reporting on progress in our next annual report.

# Small for Gestational Age (SGA) Babies

SGA babies require additional monitoring due to increased risk of hypoglycaemia and other morbidities. Care for these babies begins in the antenatal period. Clinical Indicators for 2017 and 2018 alerted us to the fact that we had higher than average rates of SGA babies being born when compared to the national average. Our response has been to implement the Growth Assessment Programme (GAP). GAP Clinical Leads were appointed at Wairau and Nelson from the beginning of 2020. Processes to implement GAP have been put into place and all community midwives (LMCs), and most maternity unit staff, are now GAP accredited. In addition, many other associated staff such as neonatal nurses, obstetricians and paediatricians have also attended GAP workshops or had in-service education. GAP went 'live' in March 2020, ensuring all women have a customized growth chart prepared in early pregnancy, and all babies to have a birthweight centile generated at birth as best practice.

GAP training is required to be undertaken and updated yearly by all maternity practitioners. GAP training provides necessary knowledge, understanding and competence in fetal growth surveillance. This optimises detection of fetal growth restriction (FGR) and SGA throughout pregnancy. Recognition of risk factors for SGA at booking are part of GAP training alongside guidelines for growth scans and obstetric referral according to risk. Antenatal detection of FGR and SGA significantly reduces adverse perinatal outcomes through further investigation, surveillance, and timely delivery. Birthweight centiles identify babies who are below the 10th centile and require additional monitoring.

The implementation of the GAP programme has been a success. Currently 98% of babies born at Nelson and Wairau maternity units have a customized birthweight centile. The latest quarterly report from the Perinatal Institute shows that our region has just below 60% of babies SGA at birth detected antenatally. This is just 0.3% below the highest-ranking GAP-using DHB nationally. Unfortunately, due to issues with data collection, we have been unable to obtain the information required to complete a baseline audit which would provide information on how this compares with detection rates prior to introduction of GAP. This is currently being worked on. However, research indicates that with population-based charts only about 25% of babies born SGA will be detected antenatally.

Moving forward, the objectives of the GAP programme are to complete both the baseline and missed SGA audit; to identify areas of improvement which will increase the SGA detection rate further; to ensure compliance with GAP continues to be high and we can improve the quality of our maternity care by reducing the number of stillbirths associated with fetal growth restriction to ensure the best outcomes for all babies. In the next report we will be providing the outcomes from the programme implementation and examining the impact it is having on our babies.

# Newborn Metabolic Screening

Our maternity services continue to strive to meet the national standard of 95% of blood spot cards for newborn metabolic screening reaching the laboratory in the 4 day standard because we recognise that any delay can lead to a delay in diagnosis and treatment. In the final quarter of 2019, 92.7% of NMHs cards reached the laboratory in the 4 day period. 99.2% arrived within a week of being sampled. Quarterly performance in the 4 day rate of return improved compared to the same time period in 2018. In November 2019, a 4 day transit time of 96.6% was achieved which is the highest monthly result since reports began.

We look forward to receiving our 2020 data to inform our service initiatives to ensure we continue to meet quality standards.

# Donor Milk Service

Wairau has an established Donor Breast Milk service which is well utilised. The last quarter of 2020 saw the launch of the Donor Breast Milk service in Nelson's neonatal and maternity units. This service gives whānau the option of donated breastmilk instead of formula. To date over 45 litres of donated breast milk has been provided to over 50 babies resulting in a significant decrease in formula use. Screened breastmilk is provided by a small number of generous donors who have recently had a baby. Donors undertake extensive lifestyle screening and blood tests. A breastmilk pasteuriser has been purchased for Wairau and in future the aim of the service is to procure funding for a breast milk pasteuriser to enable donated breast milk to be used more extensively in Nelson too.

We would like to acknowledge the amazing women who have so generously given this precious gift to other women and their babies.

# Consumer Engagement

## Tell us what you think—what can we do better?

Engaging with woman and whānau in our community has been identified as one of the priorities of the MQSP so that we can continue to learn how we can do things better. As mentioned earlier in the report, we acknowledge that the programme requires a significant investment to ensure consumers are part of the committee going forward. Two consumers gave up their roles when MQSP was inactive in the first 6 months of 2020. A consumer who identified as Māori took part in the MoH consumer hui in late 2020 however has not been able to continue as a MQSP consumer member. We recognise that the lack of consumer representation is a disadvantage to our programme and therefore we are prioritising initiatives to ensure our programme demonstrates effective consumer engagement and representation at all levels of our service.

Consumers are encouraged to feedback about their experiences in our maternity units. Feedback forms are available throughout the units and online feedback can also be given. All feedback, complimentary and complaints, are seen by the maternity unit managers who in turn share it with the wider workforce. Complaints or concerns about care are taken seriously and the service works hard to support families to share their experiences and answer the questions they may have about their experience. Recommendations and improvements for our service are shared with the families and the services implement these recommendations – reporting back to the DHB clinical governance group.

Consumers were also a key part of looking at what changes we could make to our COVID response if another lockdown were to happen. A survey was developed with input from Canterbury/West Coast and MidCentral DHBs who helped in the original design. Also involved was a māori advisor who looked at it with an equity lens. It was then adjusted to suit the needs of the Nelson Marlborough region. It was divided into sections and covered the following areas: postnatal midwifery visits; support in hospital; breastfeeding support; phone consultations; length of stay; visitor restrictions; mental health and place of birth. **See over page for survey results ►**

## MIDWIFE VISITS

92% of women continued to have some face to face postnatal visits with their midwife although most would have preferred more.

*"I had one initial visit a couple of days after and one final visit at 6 weeks. This isn't a reflection on my midwife but physical visits are an important part of this journey so it is hard without them."*

## MIDWIFE PHONE CONSULTATIONS

71% of women had phone consultations with their midwife. Most were okay with this for some of the time, but in general people wanted to see their midwife.

*"It was hard—and it would have been nice for her to be able to visit but we made it work."*

## LENGTH OF STAY

55% of women said they left hospital sooner than they wanted.

20% felt some pressure to leave before they were ready.

*"We felt like the hospital staff would prefer us to go home."*

## SUPPORT IN HOSPITAL

45% of women felt either well or very well supported in hospital following the birth. Many commented on how helpful the staff were.

*"It was VERY hard being all alone but the midwives were AMAZING."*

40% of women felt they were poorly supported.

*"Horrible time and very little support."*

## BREASTFEEDING SUPPORT

70% of mums felt they were well supported with breastfeeding, both in hospital and at home.

*"All the nurses/midwives at the maternity unit always asked how I was doing in regards to breastfeeding. They were nice and very helpful."*

8% of mums felt they were poorly supported.

*"I was always going to breast feed but the ward staff weren't that great. My own midwife was her usual supportive self."*

## VISITOR RESTRICTIONS

65% said they were unhappy about visitor restrictions although most acknowledged the need for it.

*"I would have loved for my husband to be able to stay longer and for my other child to have met her brother but the situation was out of everyone's control and I respect that these limitations were made for the health and safety of me and my newborn."*

## MENTAL HEALTH

16% of women felt that COVID-19 and the resultant change to their care had a big impact on their mental health, with a further 29% saying it had a moderate impact.

*"This had a big impact on me, although I didn't actively seek help or advice."*

## PLACE OF BIRTH

Two women had a homebirth, neither of which was planned before the Level 4 restrictions were in place.

*"I hadn't planned a homebirth but felt scared about going to hospital in case I got infected. It went really well and I'd do the same again next time."*

## BETTER OR WORSE?

**50%** of women who were not first time mothers said their experience was better than last time. The main reason for this was having time and peace to bond with their babies. **38%** said it was worse than last time—the main reason being visiting restrictions.

# Our Outcomes for wāhine and pēpi

We are all committed to providing and improving the quality of maternity services for our women, babies and whānau.

- The maternity services aims and objectives are to:
- Provide woman-centred maternity care that meets the needs of the population
- Continue to establish, implement, and review, as required, systems and processes to support the provision of quality safe care
- Take a whole of systems approach towards improving the health of women and children as guided by national priorities and health service expectations
- Develop the maternity workforce to ensure our maternity services are responsive to the needs of the population
- Develop and strengthen regional links.

## Clinical Indicator Analysis

How do our maternity services impact on wāhine and pēpi birthing experiences?

The New Zealand Maternity Clinical Indicators 2018 was published in October 2020. The publication shows key maternity outcomes for each DHB from 2015 to 2018 and is the most recent data available for compilation of this Annual Report.

The following information shows our performance and position in relation to both the indicators and the national averages. Clinical Indicators 2–9 are based on the standard primiparae only.

The standard primiparae group are:

- Aged 20–34 (inclusive) with a first, uncomplicated, singleton pregnancy
- Birthing at full term (37–41 weeks) with a baby with a cephalic presentation.

This group represents the least complex situations for which intervention rates can be expected to be low and therefore give valid comparisons between DHBs.

Standard Primiparae make up approximately 15% of all births nationally.

The purpose of the Clinical Indicators is to highlight areas where quality improvement can potentially be made.

In addition, we have looked at the clinical indicators with a health equity lens to establish where we are doing well and, more importantly, what we should be focussing on in order to improve equity of outcomes for the different ethnicities within our region. When interpreting the data it is important to remember that some ethnicities are represented by small numbers of women.

Further information around this data can be found at:
https://www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2018

| New Zealand Maternity Clinical Indicators 2018 | | | | | |
|---|---|---|---|---|---|
| | better than NZ average / within NZ average / worse than NZ average | NMH 2017 (%) | NMH 2018 (%) | All DHBs 2018 (%) | How do we look? |
| 1 | Registration with a Lead Maternity Carer in the first trimester.<br><br>**Comment:** Consistently over the national average but we continue to prioritise initiatives which support early engagement with maternity services. | 79.7 | **80.3** | 72.7 | |
| 2 | Spontaneous vaginal births among standard primiparae.<br><br>**Comment:** In 2017 we were slightly above the national average—in 2018 we are slightly below. However, this data does not include home births or births at primary units so does not represent all births across the region.<br><br>Local NZCOM have funded 2 educational workshops (Spinning Babies) to increase confidence and skills in normal birth. Also, moving forward, a trial of low dose epidurals is due to commence late 2020 which may have an impact. MoH data will not reflect this until 2022 but we will audit this locally to see what impact it has. | 65.7 | **63.1** | 64.7 | |
| 3 | Instrumental vaginal births among standard primiparae.<br><br>**Comment:** 2017 data showed us to be well below the national average but we are above it in 2018. This needs to be interpreted in the context of a reduction in caesarean section rate for the same group (see below). | 12.1 | **18.4** | 17 | |
| 4 | Caesarean section births among standard primiparae.<br><br>**Comment:** Whilst still over the national average the 2018 data shows an overall reduction which is encouraging. However, more recent local data suggests that this figure will have risen in 2019 & 20. Further details on initiatives to reduce this rate is outlined in the work plan on page 34. | 21.9 | **18.1** | 17.2 | |
| 5 | Inductions of labour among standard primiparae.<br><br>**Comment:** NMH has been well below the national average for the last 3 years. | 5.3 | **4.1** | 7.8 | |
| 6 | Standard primiparae giving birth with intact lower genital tract.<br><br>**Comment:** Consistently below the national average since 2013. We are currently looking at a 'care of the perineum' package to see what lessons we can learn from other DHBs. | 25.1 | **22.5** | 26.5 | |
| 7 | Standard primiparae giving birth vaginally and undergoing episiotomy (and no third- or fourth-degree tear).<br><br>**Comment:** Whilst there has been an increase in the rate of episiotomies we are still well below the national average. | 16.4 | **20.4** | 24.6 | |
| 8 | Standard primiparae giving birth vaginally sustaining a third- or fourth- degree tear and not undergoing an episiotomy.<br><br>**Comment:** This is an increase on the NMH 2017 rate but remains below the national average. | 1.9 | **2.9** | 4.5 | |

| New Zealand Maternity Clinical Indicators 2018 | | | | | |
|---|---|---|---|---|---|
| | better than NZ average / within NZ average / worse than NZ average | NMH 2017 (%) | NMH 2018 (%) | All DHBs 2018 (%) | How do we look? |
| **9** | Standard primiparae giving birth vaginally undergoing episiotomy and sustaining a third or fourth degree tear.<br><br>**Comment:** This is a slight increase on the NMH 2017 rate but remains below the national average. | 1.4 | **1.7** | 2.1 | |
| **10** | Women undergoing a caesarean section under general anaesthetic.<br><br>**Comment:** Consistently below the national average. | 7.3 | **5** | 8.5 | |
| **11** | Women giving birth by caesarean section and undergoing blood transfusion during the birth admission.<br><br>**Comment:** Below the national average in both 2017 and 2018. | 1.9 | **1.7** | 3 | |
| **12** | Women giving birth vaginally and undergoing blood transfusion during the birth admission.<br><br>**Comment:** This data represents our lowest rate since initial collation in 2009. | 1.9 | **1.2** | 2.1 | |
| **13** | Diagnosis of eclampsia during birth admission. | 0 | **0.07** | 0.03 | |
| **14** | Women having peripatum hysterectomy. | 0 | **0** | 0.06 | |
| **15** | Women admitted to ICU (intensive care unit) and requiring over 24 hours of mechanical ventilation any time during the pregnancy or postnatal period. | 0 | **0** | 0.03 | |
| Clinical Indicators 13–15 are all events that should trigger a maternal case review by the multidisciplinary team. Work towards setting up this group has just begun towards the end of 2020. We will report further on this in our next annual report. | | | | | |
| **16** | Maternal tobacco use during the postnatal period (2 weeks after birth).<br><br>**Comment:** The national average has decreased year on year since 2010. NMH has been up-and-down in this timeframe but we have seen a pleasing decrease in 2018. | 11.3 | **9.3** | 9.4 | |
| **17** | Premature births (babies) born under 37 weeks gestation.<br><br>**Comment:** This is a pleasing decrease from the 2017 rate and is below the national average. | 8.2 | **6.9** | 7.5 | |
| **18** | Small babies at term (37–42 weeks gestation).<br><br>**Comment:** NMH was above the national average for the first time in 2017. 2018 shows a continuing upward trend. However, the formal introduction of GAP appears to be having a positive effect. | 4.0 | **5.2** | 3.1 | |
| **19** | Small babies at term born at 40–42 weeks gestation.<br><br>**Comment:** This data shows a significant reduction in the NMH rate between 2017 and 2018. It is in line with the national average, sitting just slightly above. However, ongoing work with GAP is showing encouraging results. | 51.9 | **30.6** | 29.9 | |
| **20** | Babies born at 37+ weeks gestation requiring respiratory support.<br><br>**Comment:** The 2018 rate remains consistent and below the national average. | 1.2 | **1.2** | 2.1 | |

We will continue to use the Clinical Indicators, the PMMRC report, the NMMG report and local data to drive our MQSP programme. We have identified the areas in which we are outliers and work is underway to address these areas. The GAP programme, as detailed on page 19, gives us confidence that there are improvements in indicators 18 and 19. Indicators 2 and 4 have alerted us to our lower than average rate for normal birth and our higher than average rate of caesarean section amongst standard primiparae women. A 2020 audit suggests that our caesarean section rate in this group is rising. We have looked with interest at other DHBs who have lowered their caesarean section rate and increased their normal birth rate by changing their induction of labour method. We have started collecting data and guidance from these DHBs and hope to review our practice accordingly.

## Clinical Indicator Equity: Table 1

MQSP has further analysed its 2018 clinical indicators to include ethnicity based data. This informs us as to what issues affect women and babies of different ethnicities and informs our workplan moving forward. The top number in each box is the local rate, the bottom number is the NZ average. The figures need to be interpreted cautiously as some groups are represented by very small numbers (see page 6 for population detail).

| NMH vs New Zealand average<br>better than NZ average<br>within New Zealand average<br>worse than New Zealand average<br>**All numbers represent percentages** | | **All ethnicities** | **Māori** | **Pacific** | **Indian** | **Asian** | **European or other** |
|---|---|---|---|---|---|---|---|
| **1** | (All women) 1st trimester registration with an LMC | 80.3%<br>72.7% | 71.1<br>59.7 | 67.4<br>46.7 | 89.3<br>74.4 | 71.6<br>76.2 | 84.6<br>83.1 |
| **2** | (SP) Spontaneous birth | 63.1<br>64.7 | 77.6<br>77.0 | 63.6<br>68.9 | 70.0<br>48.1 | 45.8<br>57.4 | 61.3<br>64.3 |
| **3** | (SP) Instrumental birth | 18.4<br>17.0 | 4.1<br>11.0 | 18.2<br>11.9 | 10.0<br>26.5 | 29.2<br>19.8 | 21.1<br>17.6 |
| **4** | (SP) Caesarean Section | 18.1<br>17.2 | 18.4<br>11.0 | 18.2<br>18.0 | 20.6<br>23.6 | 20.8<br>21.1 | 17.6<br>17.2 |
| **5** | (SP) Induction | 4.1<br>7.8 | 0.0<br>6.4 | 9.1<br>7.8 | 10.0<br>12.4 | 4.2<br>5.9 | 4.5<br>7.8 |
| **6** | (SP) Intact lower genital tract | 22.5<br>26.5 | 37.5<br>40.2 | 11.1<br>20.8 | 0.0<br>10.9 | 5.3<br>12.3 | 22.6<br>27.9 |
| **7** | (SP) Episiotomy and no 3rd/4th degree tear | 20.4<br>24.6 | 10.0<br>13.1 | 22.2<br>20.3 | 37.5<br>41.1 | 31.6<br>39.4 | 20.7<br>23.7 |
| **8** | (SP) 3rd/4th degree tear and no episiotomy | 2.9<br>4.5 | 2.5<br>4.4 | 0.0<br>5.3 | 0.0<br>6.9 | 0.0<br>4.3 | 3.7<br>3.9 |
| **9** | (SP) Episiotomy and sustaining 3rd/4th degree tear | 1.7<br>2.1 | 0.0<br>0.7 | 11.1<br>1.3 | 0.0<br>6.4 | 5.3<br>4.3 | 1.2<br>1.5 |
| **10** | (All women) GA for caesarean section | 5.0<br>8.5 | 6.1<br>12.8 | 0.0<br>11.1 | 0.0<br>6.8 | 2.9<br>6.9 | 5.5<br>7.1 |
| **11** | (All women) Blood transfusion with caesarean section | 1.7<br>3.0 | 4.9<br>4.7 | 0.0<br>4.3 | 0.0<br>2.3 | 0.0<br>3.3 | 1.1<br>2.1 |
| **12** | (All women) Blood transfusion with vaginal birth | 1.2<br>2.1 | 1.6<br>1.9 | 0.0<br>3.3 | 6.3<br>3.2 | 1.5<br>2.9 | 1.0<br>1.6 |
| **16** | (All women) Tobacco use during postnatal period | 9.3<br>9.4 | 22.4<br>25.0 | 4.4<br>6.0 | 0.0<br>0.38 | 2.0<br>0.44 | 6.3<br>5.5 |

| NMH vs New Zealand average<br>better than NZ average<br>within New Zealand average<br>worse than New Zealand average<br>**All numbers represent percentages** | | **All ethnicities** | **Māori** | **Pacific** | **Indian** | **Asian** | **European or other** |
|---|---|---|---|---|---|---|---|
| **17** | (All babies) Preterm birth | 6.9<br>7.5 | 8.4<br>8.1 | 14.6<br>7.2 | 16.1<br>7.5 | 3.1<br>7.1 | 5.9<br>7.2 |
| **18** | (All babies) Small babies at term | 5.2<br>3.1 | 5.4<br>3.5 | 5.1<br>2.1 | 4.0<br>7.3 | 7.4<br>4.0 | 5.0<br>2.2 |
| **19** | (All babies) Small babies born at 40–42 weeks | 30.6<br>29.9 | 22.2<br>30.3 | 50.0<br>29.2 | 100<br>29.4 | 28.6<br>25.3 | 31.8<br>31.8 |
| **20** | (All babies) Born 37+ weeks requiring respiratory support | 1.2<br>2.1 | 1.5<br>2.4 | 0.0<br>2.7 | 0.0<br>2.7 | 1.1<br>1.3 | 1.2<br>2.0 |
| Indicators 13,14 and 15 not included as numbers are nil or too small for meaningful comparison. | | | | | | | |

## Table 2

The table below examines equity rates in the 2018 clinical indicators using comparisons between the ethnicities and statistical average. We recognise that to increase equity in the clinical indicators area, focusing on improving those that are lower than the local average will make a difference to the women of that ethnicity. We are in the early stages of identifying areas of concern. Again, the below table needs to be interpreted in the context of some ethnic groups being represented by small numbers.

| better than NMH average<br>within NMH average<br>worse than NMH average<br>**The indicator is shaded to show if it is better (green), worse (red) or the same (orange) as the national average** | | **Māori** | **Pacific** | **Indian** | **Asian** | **European or other** |
|---|---|---|---|---|---|---|
| **1** | (All women) 1st trimester registration with an LMC | | | | | |
| **2** | (SP) Spontaneous birth | | | | | |
| **3** | (SP) Instrumental birth | | | | | |
| **4** | (SP) Caesarean Section | | | | | |
| **5** | (SP) Induction | | | | | |
| **6** | (SP) Intact lower genital tract | | | | | |
| **7** | (SP) Episiotomy and no 3rd/4th degree tear | | | | | |
| **8** | (SP) 3rd/4th degree tear and no episiotomy | | | | | |
| **9** | (SP) Episiotomy and sustaining 3rd/4th degree tear | | | | | |
| **10** | (All women) GA for caesarean section | | | | | |
| **11** | (All women) Blood transfusion with caesarean section | | | | | |
| **12** | (All women) Blood transfusion with vaginal birth | | | | | |
| **16** | (All women) Tobacco use during postnatal period | | | | | |
| **17** | (All babies) Preterm birth | | | | | |
| **18** | (All babies) Small babies at term | | | | | |
| **19** | (All babies) Small babies born at 40–42 weeks | | | | | |
| **20** | (All babies) Born 37+ weeks requiring respiratory support | | | | | |

# PMMRC, NMMG and MMWG Recommendations

The following information demonstrates where our maternity services sit in relation to recommendations from the above groups.

 **Completed/near completion**  **Work in progress**  **Significant work still to be done**

| 1. Neonatal encephalopathy (PMMRC) | |
|---|---|
| In 2017, NMH notified ACC that they were aware of a higher than usual number of potential NE cases, and asked for help to set up a local review to determine what improvements could be made. At no time had the NE rate, as reported by the PMMRC, been noted to exceed the national rate.<br><br>A review group was established to review cases of NE, with oversight from the PMMRC national coordinator. As a result of this work NMH have taken the following actions:<br><br>The NE project coordinator role, commenced in May 2020, was established to support the ongoing work and recommendations from the NE review. The 0.6 FTE role will co-ordinate further reviews as well as support action on recommendations to reduce future risk. This role is for 12 months and is funded by ACC. | |
| The PMMRC recommends that DHBs provide interdisciplinary fetal surveillance education for all clinicians involved in intrapartum care on a triennial basis. This is to be provided free for staff and at no cost to lead maternity carers (LMCs). The PMMRC encourages the Midwifery Council, the New Zealand College of Midwives (NZCOM) and Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) to work with DHBs in the implementation of this recommendation.<br><br>a) This education includes risk assessment for babies throughout pregnancy as well as intrapartum observations.<br><br>b) The aims include strengthening of supervision and support to promote professional judgement, interdisciplinary conversations and reflective practice.<br><br>  | ▪ Mandatory fetal surveillance face to face education will be provided to DHB employed staff every 3 years. It is also recommended that staff engage with the yearly online fetal surveillance education programme.<br><br>▪ All self-employed midwives will be offered face to face education as above free of charge (in line with PMMRC recommendations).<br><br>▪ Intrapartum fetal surveillance guidelines updated in line with current recommendations.<br><br>▪ Introduction of a new CTG interpretation tool which is being trialled in both secondary units with a view to being implemented in early 2021.<br><br>▪ Case reviews of CTGs presented in a multidisciplinary forum. These 'face the trace' meetings are now well established in Wairau with good attendance by both midwives and obstetricians. They are in the early stage of being established in Nelson.<br><br>▪ An ISBAR tool is being developed to improve communication. |
| All neonatal encephalopathy (NE) cases need to be considered for a Severity Assessment Code (SAC) rating.<br><br>  | ▪ All NE cases are entered into the Safety First incident system and a SAC score applied.<br><br>▪ A SAC review of all NE cases is carried out. |

| | |
|---|---|
| All babies with NE, regardless of severity, should have a multidisciplinary discussion about whether to refer to the Accident Compensation Corporation (ACC) for consideration for cover as a treatment injury, using ACC's Treatment Injury Claim Lodgement Guide. Parents should be advised that not all treatment claims are accepted. | ▪ All babies with suspected NE are transferred to our tertiary care provider in Wellington. If and when NE is diagnosed then an ACC referral is done.<br>▪ On occasion, local Paediatricians may be requested to refer to ACC. |
| Other changes that have resulted from the NE project include emphasis and education on collecting cord blood samples. Wairau midwives identified this as an area where upskilling was warranted.<br><br>Moving forward, a proforma for neonatal resuscitation documentation is near completion and will be implemented in Theatre and SCBU as well as maternity units across the region. | |

| 2. Mothers of Indian Ethnicity (PMMRC) | |
|---|---|
| DHBs should monitor key maternity indicators by ethnic group to identify variations in outcomes. They should then improve areas where there are differences in outcome. | ▪ We have recognised the importance of looking at health outcomes for our mothers and babies with a health equity lens. To this end, our clinical indicator information has highlighted the areas of concern in relation to our Indian mothers. These have to be taken in the context of our small number of Indian mothers within the region.<br>▪ Further work will continue to address inequity and establish a way forward to improving outcomes locally for our Indian community. |

| 3. Equitable access to contraception (NMMG) | |
|---|---|
| What percentage of women has a contraception plan as part of their birth plan?<br>  | ▪ Currently, due to the lack of an electronic maternity database, there is no reliable way to capture this information.<br>▪ Birth plans are formulated by the woman in partnership with her LMC. |
| What percentage of women leave our maternity units with contraception?<br>  | ▪ Again, the lack of an electronic database has made this information difficult to collate.<br>▪ It has been identified that discussion on contraception is not part of the documented discharge planning. NMH plans to review their discharge documentation to include contraception discussion and provision. |
| What services are being provided to meet the contraceptive needs of women prior to discharge from hospital or from a primary birthing unit, and how well does this service meet the demand?<br>  | ▪ Secondary maternity services provide a limited postbirth service for the insertion of a Jadelle. This is largely provided by senior house officers on request from the LMC and/or woman. LMCs can also refer women back to the maternity unit in the postnatal period for this service. 2020 saw one employed midwife in Nelson complete a learning package for insertion of Jadelle. Midwives in the remote rural region of Golden Bay are also undertaking education.<br>▪ All women who undergo caesarean section are offered contraception prior to discharge, with prescriptions and/or advice given.<br>▪ Community based services providing women with contraceptive options vary across the region and are generally accessed via general practice, family planning services and nursing practices. |
| What percentage of women leave our birthing unit with a LARC?<br>*'if a LARC service is provided for postnatal women in the community, what percentage of women are referred to this service, and what percentage access it? To what extent is the service reaching Māori and Pasifika women and women under 25 years of age?'*<br>  | ▪ This information is currently not collected but anecdotally we know very few women leave with a long acting reversible contraceptive (LARC).<br>▪ There is no specific service for postnatal women. Women in Wairau have access to a Family Planning service which is funded directly by the MOH. Nelson does not. At Independent Nursing Practice (INP) in Nelson and Motueka Family Service Centre there is a free LARC insertion and removal service for those with a community services card (CSC), in quintile 5 or are Māori/Pacific. GP practices identified as being in areas where access is important also offer this free to the same group of women. |

| 4. Sepsis (MMWG) | |
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| MMWG recommends DHBs include early recognition and treatment of sepsis as a component of the regular training and education sessions for multidisciplinary teams.  | ▪ Sepsis has been included in the PROMPT training throughout the region.<br>▪ Sepsis will be included as part of the Midwifery Skills Workshops scheduled to take place throughout 2021.<br>▪ Education has been provided in the Motueka primary unit in relation to obtaining blood cultures and the treatment of anaphylaxis. |
| Consider establishing clinical pathways across primary and secondary care to enable earlier recognition and treatment.  | ▪ NMH is currently working on a clinical pathway and protocol for sepsis in pregnancy and the postpartum period. It is envisioned that this will be in place throughout the region in the first quarter of 2021. |
| Establish sepsis kits to address human factor components.  | ▪ The contents of sepsis kits particular to the needs of both the primary and secondary units are being finalised in line with the above pathway. All units have identified where these kits will be kept. |

| 5. Maternal Mental Health (NMMG) | |
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| What are the criteria for admission to a secondary care unit?  | ▪ Model of care document has criteria for admission. Usually mothers and babies are referred to Christchurch Mothers and Babies service (MBS) or MBS are used for consultation/supervision. |
| What facilities are available for inpatient care and is there provision for babies to stay?  | ▪ MBS in Christchurch. Mothers and babies have stayed locally at Wahi Oranga whilst waiting for a bed in Christchurch but this is not ideal. |
| What proportion of referrals are accepted or declined due to lack of service provision or because they would be more appropriately managed in the community?<br>What challenges are making pathways difficult?  | ▪ Mental Health services report that no mothers are declined due to lack of service provision if they are an appropriate referral.<br>▪ Waiting lists for therapy in secondary services. |
| How is primary care being supported to manage women with mild to mode depression during pregnancy and postpartum?  | ▪ We provide consultation & education; He Pai Harakeke initiative; Brief intervention counsellors, Wellbeing practitioners in primary care. The Care Foundation has provided training (re He Pai Harakeke) for Family Start, Te Pipi Oranga, Plunket & further training is planned in 'circle of security' and Te Piki Oranga have a targeted programme for māori whānau. |

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| What measures are being taken to ensure all women (and particularly those at increased risk) are being screened for mental wellness during pregnancy and postpartum?  | ▪ There is a perinatal MMH pathway (on health pathways; also has information on resources in community & apps) that outlines what screening should be done by midwives & other primary care providers; medicine information for GPs and referring to specialist services. Also there is the specific information sheet for midwives about contacting mental health addiction services (MHAS). |
| Are mechanisms being implemented that raise awareness/deliver education among midwives so they feel safe/confident to discuss/address mental health wellness with women and their whānau?  | ▪ There is education for midwives from the MBS.<br>▪ The Midwifery Educators have included Maternal Mental Health as part of the education agenda for 2021. |
| Follow up service for babies and attendance rates (including by ethnicity).  | ▪ NMH is unable to report on follow-up and attendance or ethnicity of pre-term birth as the DHB data systems don't record any coding data for outpatient visits. It is an ongoing issue and a problem for many years.<br>▪ This problem may be overcome with an integrated electronic maternity information system. |
| We recognise that there is work to be done around Maternal Mental Health (MMH). The absence of a MQSP coordinator for the first 6 months of 2020, followed by the orientation of a new coordinator has meant that little work has been done in this area. Whilst there is a MMH pathway in place there is anecdotal evidence that it may not be meeting the needs of women throughout the whole region, particularly in relation to mild and moderate mental health concerns.<br>The lack of inpatient mother and baby facilities within the region is also anecdotally problematic. More work is needed in auditing MMH services. This will form part of our workplan moving forward.  | |

| 6. Preterm Birth (NMMG) | |
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| Current activities to reduce preterm birth and associated inequities.  | ▪ Ongoing work around smoking cessation. Looking at adopting an 'opt out' system to increase uptake in Pēpi-First programme.<br>▪ Activities may include: cervical length monitoring, progesterone, cervical cerclage, use of aspirin and calcium if women are referred to clinic.<br>▪ Referral of woman to antenatal clinic as per the Referral Guidelines. |
| Processes in place to follow up women with previous preterm birth.  | ▪ Currently there is no formal follow up process for women who birth preterm. Women are followed up on an ad-hoc basis depending on the clinician.<br>▪ Women with severe preeclampsia and indicated preterm delivery are ideally reviewed postnatally and early in next pregnancy but no formal process is in place to enable this to happen routinely. |

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| Processes in place to ensure early engagement of women who have had a preterm birth with a midwife in a future pregnancy.  | ▪ If seen by an Obstetrician in the postnatal period then advice relating to this may be given. But it is very ad-hoc and cannot be reliably measured. |
| Follow up service for babies and attendance rates (including by ethnicity).  | ▪ NMH is unable to report on follow-up and attendance or ethnicity of pre-term birth as the DHB data systems don't record any coding data for outpatient visits. It is an ongoing issue and a problem for many years.<br>▪ This problem may be overcome with an integrated electronic maternity information system. |

| 7. Place of Birth (NMMG) | |
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| How are women informed of the full range of place of birth options?  | ▪ NMH public website has information on options throughout the region.<br>▪ Home birth is the first option on the list and is linked to the Homebirth Aotearoa website.<br>▪ Primary Unit birthing in Golden Bay and Motueka is next with information provided on what women can expect.<br>▪ There is also information on birthing in both Wairau and Nelson secondary birthing units.<br>▪ A video is provided which gives a virtual tour of Wairau, Nelson and Motueka birthing units. |
| What methods are used to promote primary birthing?  | ▪ As above.<br>▪ We have a number of LMC midwives who are committed to primary birthing and are strong advocates for this.<br>▪ All LMCs discuss birthing place options with women and advise accordingly if changes become necessary.<br>▪ NMH provides free access to Practical Obstetric Multi-Professional Training (PROMPT) to LMCs to ensure confidence in managing emergency situations in the primary setting.<br>▪ NMH is aware that their primary units are underutilised for birth and, as part of the work plan over the next 2–3 years, will be looking at this issue. |

# MQSP Workplan 2020–2023

The below workplan will form the basis for MQSP activities over the next 3 years. It will be fluid in nature so that items can be added as necessary, for example as a result of sentinel events, other incidents or complaints. We have recently added prophylactic Anti D to our workplan following an event. We also anticipate looking at developing guidelines for the use of muka pito ties after a recent event.

Completed/near completion  Work in progress  Significant work still to be done

| Initiative | Action | Status | Expected Outcome |
|---|---|---|---|
| **National Projects** | | | |
| Implement the Sepsis 6+2 | Include in multidisciplinary education. Establish sepsis kits in all 4 units Establish sepsis pathways across primary and secondary units | | Anticipated completion date of March 2021. Audit of the pathway in 'real time' will enable changes to be made |
| NOC/NEWS implementation | Access to education for staff Clarification of continuing local guidelines in conjunction with new charts. Roll out date to be established in the 3 units. | | Implementation in February 2021 with ongoing audit. |
| Maternity Early Warning System (MEWS) | Ensure ongoing audit takes place now that MEWS is 'business as usual'. | | Responsibility and accountability for ensuring ongoing audit is delegated to appropriate people. |
| Improve access to postnatal contraception | Adjust discharge paperwork to include specific discussion on contraception and if script for contraception given. Aim to increase access to LARC by education of midwives who are interested in upskilling in this area. Consult with maternity workforce to see what interest exists.<br><br>Encourage LMCs to have discussions around contraception in the antenatal period. | | Increase in number of women leaving our units with contraception given/ prescribed |
| Neonatal Encephalopathy | Complete trial of CTG interpretation stickers. Invite feedback and make necessary changes. Implement stickers in both secondary units.<br><br>Completion of ISBAR communication tool and proforma for neonatal resuscitation. | | CTG interpretation stickers to be in place across the DHB by end of February 2021.<br><br>ISBAR tool and resuscitation proforma to be in place by end of March 2021. |
| Maternal Mental Health | Service manager for Mental Health to address questions posed by NMMG. Consult with LMCs to establish effectiveness of the MMH pathway.<br><br>Acknowledge complexities of initiative and add action points along the way. Approach Planning & Funding to establish budgetary aspects. | | By end of 2021 a review of the current pathway to take place; managers and clinicians to have set up a communication stream; any budgetary issues will be fed back to the MoH. Work will be needed across the whole 3 years. |

| Initiative | Action | Status | Expected Outcome |
|---|---|---|---|
| Reduce preterm birth and neonatal mortality | Conduct an audit of preterm birth, corticosteroid administration and referral to tertiary centres. Enlist help from trainee interns and/or junior medical staff. Ongoing actions to be decided once audit completed.<br><br>Continue with bid for electronic maternity information system to ensure reliable data is collected to inform change. | | Audit to be completed by end 2021. Results to be discussed at MQSP meeting and actions added.<br><br>Bid will be successful and a reliable data system will be available across the DHB. |
| Place of birth | Forge links with community groups to find out what our community wants/needs are.<br><br>Consumer input is key to making changes so engaging consumer representation will be the first step. | | This will be ongoing work across the 3 year period.<br><br>Expression of interest to be completed and place on public website and sent to consumer groups. |
| Review data for our high risk communities including Indian mothers and under 20s | Follow up of ethnicity data from 2018 clinical indicators.<br><br>Audit 2020 data for numbers and outcomes to see what issues exist in NMH. | | Work has started and will be ongoing throughout the 3 year period. |
| Implementation of national guidelines on hypertension in pregnancy and prophylactic Anti D | Both guidelines to have local interpretation, including practical aspects of implementation by end 2021.<br><br>Stakeholder consultation.<br><br>Clinical Guidelines Group oversight. | | Both guidelines to be implemented by end of 2021.<br><br>Available to all staff via intranet. |

| Initiative | Action | Status | Expected Outcome |
|---|---|---|---|
| **Local Projects** | | | |
| Induction of labour project using misoprostol | Multidisciplinary group to be established to review available data.<br><br>Consultation and feedback with stakeholders.<br><br>Further actions in line with results from above. |  | Change of process in induction of labour. |
| Integrated electronic maternity information system | Consultation with clinicians and other stakeholders to enable an evidence based bid to be put forward by service manager. |  | Bid will be successful and a reliable data system will be available across the DHB. |
| Work to develop consistency and integration across NMH to keep in line with National Maternity Standards | Clinical Guidelines Group to have representation from all units. Updating of guidelines to reflect the geographical differences whilst still reflecting best practice.<br><br>Evidence based changes from incidents, complaints, PMMRC to be implemented across the region and not just in occurring unit. |  | Standardising of processes across the region whist still acknowledging the geographical differences. Clinicians working in different units will have access to and be aware of the same policies and guidelines.<br><br>Shared learning across the region. |
| Implement initiatives/ education to develop a culturally competent workforce. | All new staff to complete Te Tiriti o Waitangi education as part of orientation. All employed maternity staff will be requested to engage in the 3 cultural competency workshops run by Te Waka Hauora  Yearly performance appraisal for staff to have a cultural competency aspect, including compliance with the above.  Midwives to be encouraged to attend the NZ College of Midwives cultural competency workshop. |  | Development of cultural competency and decrease in equity. |

## A Note about Data

Data used within this report comes from a number of sources, for example, Ministry of Health, Stats NZ and NMHs Intelligence and Reporting Department. The Maternity Services within NMH do not have an integrated electronic information system thereby the quality and accuracy of the data collected and presented within this report cannot be guaranteed.


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