2019/2020

Maternity Annual Report

OURHEALTH
HAWKE'S BAY
Whakawāteatia

HAWKE'S BAY
District Health Board
Whakawāteatia

Hawke's Bay Maternity
Whare Kōhanga o Te Matau a Māui


HAWKE'S BAY
District Health Board
Whakawāteatia

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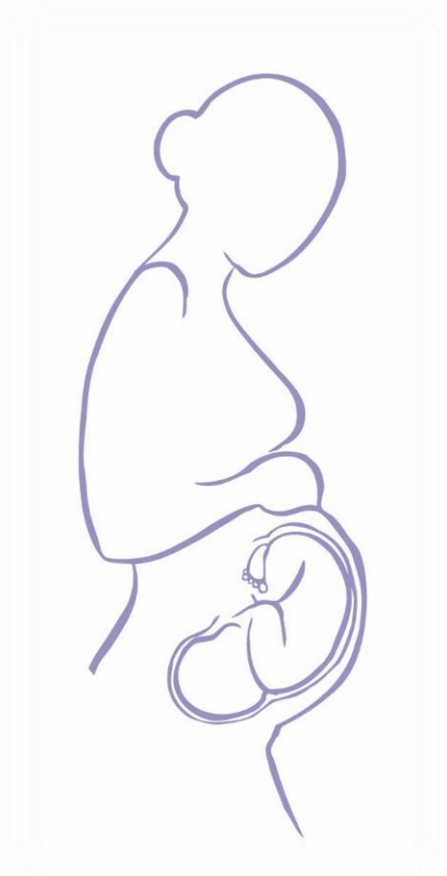


EXECUTIVE SUMMARY

'Me mahi tahi tātou mo te oranga o te katoa'

'We work together for the wellbeing of everyone'

Welcome to the 2019/2020 Maternity Annual Clinical report for the Hawke's Bay District Health Board.

This report will outline service delivery, clinical trends and outcomes from within the service, alongside celebrating achievements across 2020 and 2019.

Our maternity service makes a strong contribution to our vision and values for our Hawke's Bay health community. One of our top 5 DHB key strategic priorities is the first 1000 days and the importance of getting it right at the beginning of life, enabling and empowering our hapū wāhine and māmā to achieve wellness for themselves and their whānau.

2020 saw 2081 hapū wahine and 2114 babies born; midst a worldwide pandemic which saw changes and challenges in how care was provided, teams coming together to support our whānau and our workforce to carry on. As a leader during this extraordinary time, more than ever the importance of ensuring those we are caring for are kept at the centre was paramount; translating the national decisions to practical reality, supporting the whole of our workforce to be able to provide safe, quality care with decisions needing to be made constantly at a fast pace in an ever changing environment of information. I wish to acknowledge and commend all my colleagues for their resilience, their capacity to give, their selflessness and their professionalism. In this report is our consumer voice; their anxieties, their strengths and their challenges and what our response has been to them to continuously learn and improve and design our services with the people who are receiving care.

Key highlights and achievements in 2019/20 are:

- Strengthening our equity focus and building effective partnerships with our Māori community providers
- Māmā focussed Kaupapa Māori services being established e.g. Te Whare Pora, Mamaia, He Korowai Aroha and Tuai Kōpu
- The opening of our Central Hawke's Bay maternity resource centre in October 2020 and in partnership with establishing a community owned Ruahine Whakawhānau Tamariki Hub in Waipukurau. Enabling closer to home access to early midwifery and childhood care, support and connections for our CHB māmā, pāpara and whānau
- Our midwifery workforce strategy is beginning to evidence positive outcomes with increasing Māori undergraduate students, successful graduation and recruitment of Māori midwives and a number of key programmes intentionally being led and establishing by our Māori midwives for Māori midwives
- Developing of our facebook infographic providing our monthly stats to our community which has generated much discussion and happiness from our community

- Growing our maternity consumer members with the appointment of a Maori consumer with the intent of bringing the Maori consumer voice to our maternity governance table
- Further strengthening our Adverse Event process using the HQSC framework has evidenced themes and our response to effective systems and processes for safety
- Implementation of HQSC and ACC programmes to support early identification of risk and deterioration – MEWS, NEWS and GAP programme
- Re-establishing our Childbirth Afterthoughts Service support mama who have had a traumatic pregnancy/birth experience to empower maternal mental wellbeing and strength
- Smokefree māmā and households continues to improve with a 5% increase in smokefree māmā in the last 5 years; this continues to be a significant equity focus for maternity and population health

I am excited to share our report with you, highlighting our achievements, our challenges and our current and future focus.

Nāku iti nei

Julie Arthur
Midwifery Director

TE REO GLOSSARY

Wāhine	Female, women
Pēpi	baby
Māmā	Mother, mum
Hapū	Pregnant
Kaupapa	Topic, policy
Whare kōwhanga	Building for childbirth
Waharua kopito	Triangular patterns
Wānanga	Meet, learn, discuss
Kaitakawaenga	Mediator, arbitrator
Karakia	Prayer, grace, blessing
Oriori	Chant, lullaby
Whanaungatanga	Relationship, get together, get to know one another
Wahakura	Woven basket for infants
Kai	Food, eat
Pēpi pod	Baby bed
Kai whakawhānau	Birth worker, midwife
Tūranga Kaupapa	Māori Midwifery cultural values
Whakawhanaungatanga	Process of establishing relationships, relating to others

OUR MATERNITY VISION

He Āhuru Mōwai – He Maioha Hei Whakamana Whānaungatanga – He Tōtika

Hawke's Bay Maternity: Whare kōwhanga

A safe, welcoming, wāhine centred, empowering whānau friendly place that provides appropriate and expert care supporting wāhine, babies and whānau on their journey to becoming parents and caring for the next generation.

Waharua Kopito

Oranga Ngākau – our value that acknowledges the interconnectedness of our wāhine. Representing a focus on the holistic nature and wellbeing of our māmā and pēpē.

ALIGNING WITH OUR DHB VALUES

OURHEALTH HAWKE'S BAY *Whakawāteatia*

Our Shared Vision / Te Matakite
Healthy Hawke's Bay Te Hauora o Te Matau ā Māui

Our Mission / Te Kaupapa
Excellent health services working in partnership to improve the health and wellbeing of our people to reduce health inequities within our community.

Our Values
How We Work Together with Others / Ngā Tikanga
Health with Heart – Our Values to achieve this:
He Kauanuanu, Ākina, Raranga te tira, Tauwhiro.

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

OUR REGION

The Hawke's Bay region sits on the east coast of the North Island of New Zealand. It encompasses a large semi-circular bay that extends over 100 kilometres from Mahia Peninsula in the northeast to Cape Kidnappers and beyond in the southwest, overall covering 14,111 km_2 of beautiful landscape.

The region hosts an estimated population of 178,600, approximately 73% of which reside in Napier or Hastings, the two most urban areas located within 20 kilometres of one another. Smaller communities, such as Waipukurau and Wairoa have populations of approximately 4600 and 8680 respectively. The remaining population residing in the more rural and remote locations.

Hawke's Bay Fallen Soldiers' Memorial Hospital in Hastings is the main public health facility in the region and offers an extensive range of health services for all ages including the regional intensive care unit, emergency department, special care baby unit.

There are three District Health Board (DHB) birthing facilities in the Hawke's Bay, Ata Rangi the secondary unit within the region's main hospital, Waioha our primary birthing unit which sits alongside the secondary unit and Wairoa Primary Birthing Unit which is situated approximately 133 kilometres north of Hastings. There are two midwifery resource centres, one in Napier and one in Waipukarau offering midwifery drop in services, pregnancy testing and antenatal assessment



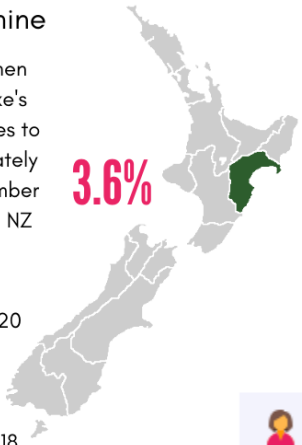

OUR MATERNITY POPULATION

Number of Wāhine

The number of women giving birth in Hawke's Bay in 2020 continues to represent approximately 3.6% of the total number of women birthing in NZ

2,081
Total Women HB 2020

58,503
Total Women NZ 2018



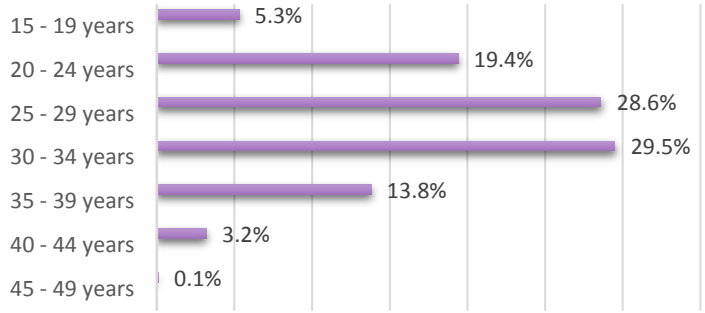
Ethnicity of Wāhine Birthing

Hawke's Bay has a proportionately higher percentage of Māori wāhine giving birth than the NZ average

	Māori	Pacific	Asian	European/ other
HB 2020	39.8%	5.7%	8.6%	45.9%
NZ 2018	25.1%	10.3%	18.2%	46.4%

First time mothers **39.5%**

Age of Wāhine Birthing



Deprivation

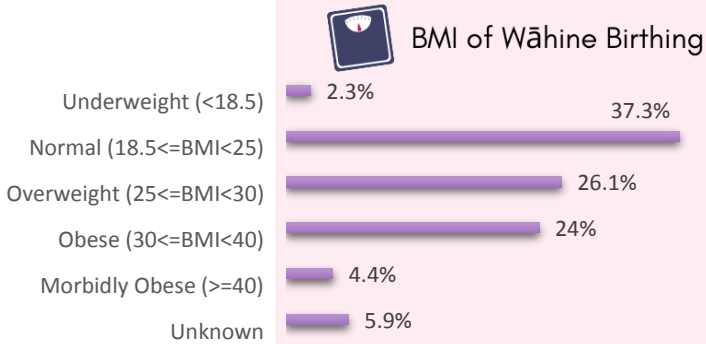
Hawke's Bay has a proportionately higher number of socio economic deprived mothers than the NZ average

	HB 2020	NZ 2018
1	6.7%	14.7%
2	13.7%	16.2%
3	9.2%	17.9%
4	20.1%	22.5%
5	43.6%	28.8%

6.7% unknown

Quintiles 1 (least) to 5 (most) deprived

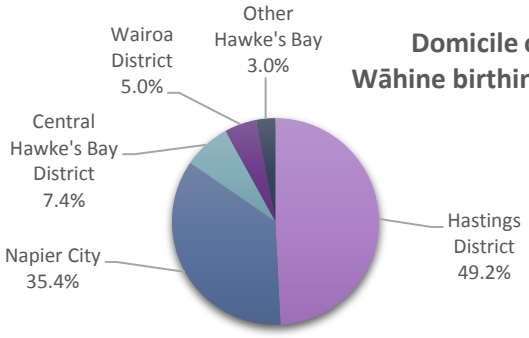
BMI of Wāhine Birthing



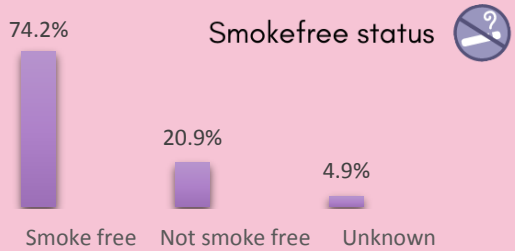
Number of pēpe born

2,114
HB 2020

Domicile of Wāhine birthing



Smokefree status



40.1% of Māori wāhine are not smokefree at booking

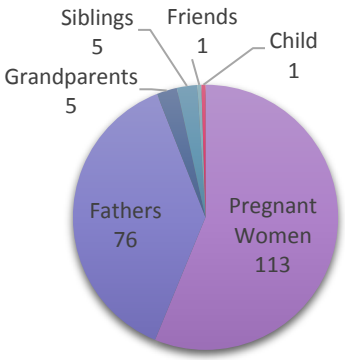
EQUITY FOR OUR POPULATION

The maternity population of Hawke's Bay is both ethnically and demographically diverse. Our population has significantly higher rates of Māori wāhine giving birth than average across New Zealand and is also one of the most socio economically deprived in the nation. We are working to ensure our services reflect the unique characteristics and needs of our population, addressing both equity and access challenges that affect our wāhine, pēpi and whānau.

WHANAKE TE KURA

Whanake Te Kura is an innovative and holistic antenatal wānanga facilitated over two days within a kaupapa Māori setting. Content is delivered using different interactive learning styles, with our target groups in mind. Information is easy to understand, practical, relevant and relatable.

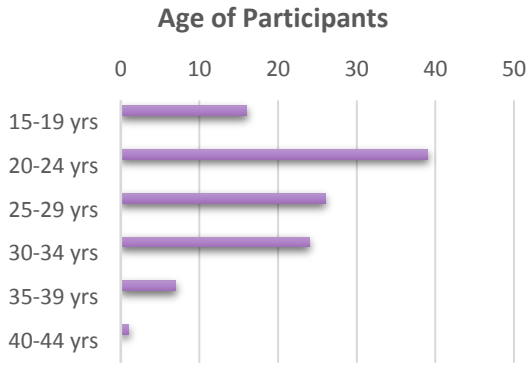
Although COVID-19 halted wānanga delivery from mid-March to mid-June, 201 participants still successfully completed the programme. 113 were pregnant women, 98 being first time



Whanake Te Kura Participants

mothers and 3 delivering twins. 15 ethnicities shared space, 12 of which were English as second language learners.

Whanake Te Kura is an environment where vulnerable community groups feel safe, cared for and equally on the same journey of transitioning to parenthood as any other.

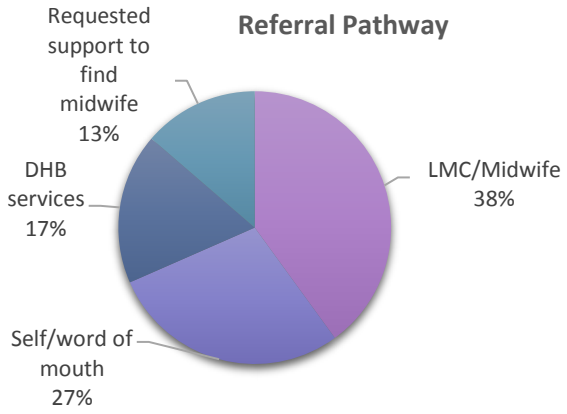


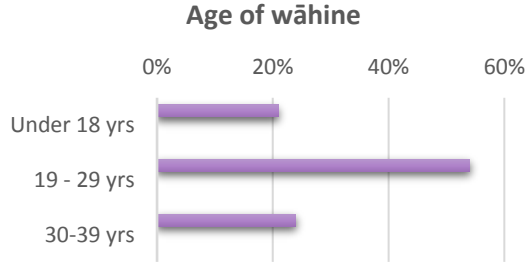
TUAI KŌPU

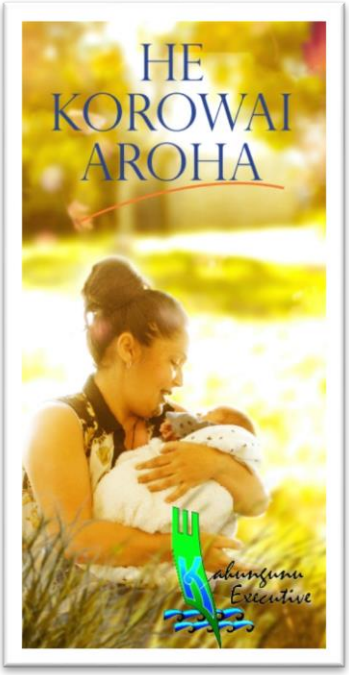
Tu meaning "the act of" and the ai meaning "creation" and Kōpu meaning the womb.

Tuai Kōpu was conceptualised in 2019 and commenced in March 2020. The programme is a coordinated, centralised referral service delivering quality care and support to wāhine hapū including advocating for and linking whānau with internal and external service to provide for clinical and non-clinical health impacting needs. The service uses a whānau centric model of care to achieve health equity for Māori and Pasifika wāhine and whānau. The service is well utilised and we are currently recruiting to expand the service we provide with the addition of a social worker and Kaitakawaenga.

Between March to December 2020 there were 55 Referrals to Tuai Kōpu, of which 45 were Māori, 3 Pacific and 7 NZE. There was an 87% conversion of referrals to enrolment rate, while 13% were supported to find or change midwife during pregnancy.







HE KOROWAI AROHA - WAIROA

He Korowai Aroha (cloak of love/affection/support) is a service to provide pregnancy and parenting, whānau health and wellbeing, cultural wellbeing and maternal mental health support programs to whānau in the Wairoa district. The overarching goal of the service is building a sustainable whānau. This is a joint initiative with the Kahungunu Executive and the Hawke's Bay DHB.

KARAKIA AND ORIORI

As part of our ongoing emphasis to embed cultural responsiveness within our maternity unit, the Karakia (prayer) and Oriori (lullaby) produced by the Ministry of Health have been placed in all of our maternity rooms. This is supporting our community to feel welcomed and our staff to be confident in enabling and supporting cultural practice. In every birthing room a Karakia is displayed to support and embrace Māori birthing cultural practices, for those who wish to recite a karakia after the cutting of the baby's iho or cord. In all assessment and postnatal rooms, the Oriori is displayed. Traditionally composed by whānau for their unborn pēpi, the Oriori would be imbued with traditional knowledge, whakapapa and the whānau's aspirations for their tamariki.

HAWKES'S BAY DHB BREASTFEEDING SUPPORT SERVICE

During 2020 an integrated Tamariki Ora Well Child breastfeeding specialist support service has been designed in the Hawke's Bay. The purpose of this service is to provide specialist breastfeeding support to new mothers of Māori babies and their whānau in our community. Our goal is to increase the breastfeeding rates for all pēpi and by doing so improve the health and well-being of our community now and into the future.

The service plans to provide specialist Lactation Consultant advice and support to māmā who are experiencing difficulties establishing and maintaining breastfeeding with the hope that māmā can continue to breastfeed for longer. The service will be delivered in a kaupapa Māori cultural context, with strong links and relationships with the smoking cessation services, Te Haa Matea, the safe sleep programme and the hospital and community breastfeeding services to enable a holistic and responsive approach to breastfeeding support and care.

There are three Well Child/ Tamariki Ora providers covering Wairoa, Napier, Hastings and Central Hawke's Bay areas. These providers will contract specialist breastfeeding support for the new māmā and whānau of

Māori pēpi enrolled with their service. This service will be delivered by culturally appropriate and qualified Lactation Consultants. The service will primarily be delivered in the māmā's home with the addition of phone support and if necessary the use of smartphone video to consult via video link. The specialist Lactation Consultants will develop a breastfeeding plan with the māma and use a wrap-around approach that considers the holistic needs of the whānau and may include parenting education, safe sleep device distribution, assistance with clothing for pēpi and educating re developmental and health checks. Engagement with the service will be via referral from WCTO, the Hospital Maternity Service, Lactation Consultants, LMC or self-referral and will usually cease at 6 months of age. It is hoped that this service can be fully implemented in 2021, our challenge has been the availability of Māori lactation consultants in the Hawke's bay area - the Māori workforce is addressed in the recruitment and retention section.

TEEN PARENT EDUCATION

The Hawke's Bay has two schools designed to help young mums continue with their education. The Hawke's Bay school for teenage parents is based at the William Colenso College in Napier and Te Tipu Whenua o Pa Harakeke is based in Flaxmere, Hastings. Both schools are open in term times and transportation to and from school is available. Education is tailored to suit individual needs and helps young māmā work towards NCEA level 1, 2 and 3. Life skills, antenatal classes, parenting, first aid, driving and budgeting are also taught. There is social worker input at the schools to provide assistance with housing, legal and financial assistance and help getting to appointments in the community providing these young māmās with a wraparound service. Child care is available at both centres and māmās and babies are encouraged to be together.

Maternity Kaitakawaenga Cala

KAITAKAWAENGA

Our Kaitakawaenga, or cultural advisor, is a valued member of the maternity team. Employed by Te Wāhanga Hauora Māori Health Services, the Kaitakawaenga role provides support for Māori and their whānau during their stay in Ata Rangi and Waioha, as well as supporting staff with cultural issues. The role also includes provision of health literacy, advocacy, and wellness planning.

WEAVING WHĀNAU WELLNESS

Mauri Ora ki te Mana Māori
– Strong Whānau, vibrant communities

Te Whare Pora is a safe space with tikanga and kawa values that provide whānau with opportunities to learn about raranga for hapūtanga. At Te Whare Pora wāhine and whānau can learn to weave a wahakura for their pēpi while experiencing pathways towards wellness through weaving and whānaungatanga.

ACCESS TO SCANNING

In 2019 we saw a surcharge applied to ultrasound scanning in pregnancy with all but one scanning provider in our community now charging women for scans. This has created equity issues for our population and has led to those most vulnerable wāhine in our community missing out on important scanning. Lack of scanning is detrimental to the implementation of our GAP/GROW programme (see implementing the GAP/GROW programme p.39) and may also contribute to higher rates of small babies born to Māori wāhine at term. In order to address this important equity issue our maternity leaders are seeking funding to ensure that all maternity scans are free to all pregnant wāhine.

OUR MATERNITY SERVICES

OVERVIEW OF OUR FACILITIES

ATA RANGI

Secondary Labour & Birthing Suite and Antenatal/Postnatal Ward

- 8 labour and birthing rooms
- 4 assessment rooms
- 12 antenatal/postnatal rooms
- Day Assessment Unit
- Fetal Medicine Clinic

WAIOHA

Stand alongside Primary Birthing Unit

- 7 birthing/postnatal rooms, all with birthing pools
- Wāhine birth and stay postnatally in the same room
- All rooms have facilities for partners/support persons to stay

WAIROA

Rural Primary Birthing Unit

- 3 birthing/postnatal rooms
- Midwife run antenatal clinics
- Monthly Obstetric Specialist clinics

TE KĀKANO

Antenatal Clinic with 5 consultant led clinics per week

DAY ASSESSMENT UNIT

Two bedded day assessment unit attached to Ata Rangi's labour and birthing suite

LEVEL 2A NEONATAL UNIT

- 12 neonatal cots
- Equipped to treat babies > 28 weeks' gestation or with a birth weight > 1000g

MATERNITY RESOURCE CENTRES

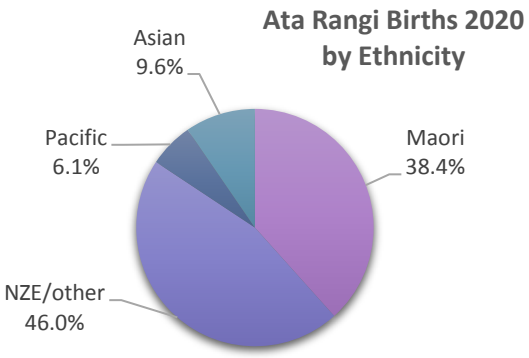
Two maternity resource centres situated in Napier and Waipukurau. The centres are supported by LMCs and provide a range of services

- Pregnancy testing
- Drop-in for wāhine seeking maternity care
- Clinic space ideally situated for wāhine and LMCs

OUR SERVICES

ATA RANGI SECONDARY LABOUR AND BIRTHING UNIT

Ata Rangi provides secondary maternity services for wāhine throughout our region requiring specialist obstetric care. Our skilled team of obstetricians and secondary care midwives provide 24/7 care for these wāhine and support for our LMC colleagues. In 2019, 856 babies were born in delivery suite, 576 born in theatre. In 2020, 959 babies were born in delivery suite, 576 in theatre.



TE KĀKANO – ANTENATAL CLINIC

The Te Kākano clinic is located in the main hospital grounds of our hospital. The clinic runs daily weekdays from 0830 to 1300. Referrals are taken from LMCs, community midwives and the Clinical Midwife Specialist in Diabetes. There is a weekly combined Obstetric and Endocrine clinic for wāhine with Diabetes/Gestational Diabetes and other medical conditions.

FETAL MEDICINE SCANNING

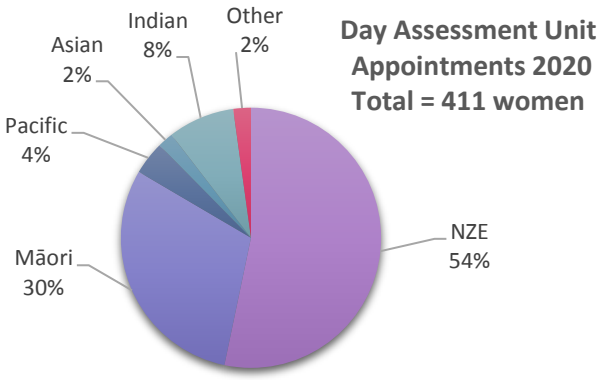
The fetal medicine scanning clinic operates once a week. This clinic provides care for wāhine with pregnancies complicated by fetal abnormalities. Our obstetrician with a specialist interest in fetal medicine offers amniocentesis and second opinion scans to confirm or preclude abnormalities and manages follow up for whanau with babies with complex abnormalities. Many of these whanau will transfer to Auckland or Wellington for birth but having this service in Hastings allows some or all of the care provided to be close to home and whānau. This has been a great addition to our service.

DAY ASSESSMENT UNIT

The Day Assessment Unit is situated next to the labour and birthing suite in Ata Rangi. The unit is staffed by DHB midwives three days a week and offers increased outpatient surveillance and treatment for high risk pregnancies. Referrals are accepted from the antenatal clinic, community midwives and LMCs.

Provides care for wāhine experiencing obstetric complications including:-

- Small for gestational age
- Intrauterine growth restriction
- Cholestasis
- Prolonged premature rupture of membranes
- Iron infusion
- Multiple pregnancies
- Increased monitoring for previous still births
- Gestational hypertension



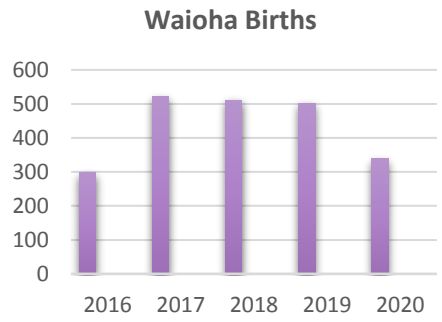
WAIOHA PRIMARY BIRTHING UNIT

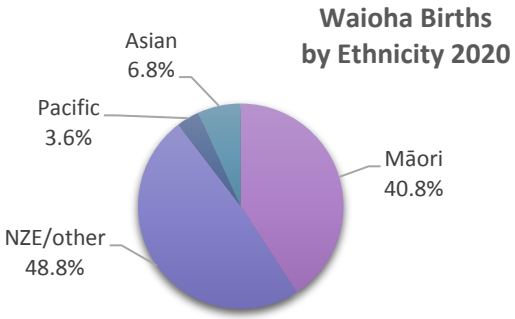
Waioha Primary Birthing Unit opened as a stand alongside unit in 2016. The unit was designed to provide a home away from home environment for healthy wāhine to give birth with the support of midwives. Our facilities offer spacious, private and secure suites with private bathrooms, individual birthing pools and beds for support people.

Primary birthing units like Waioha are linked to a higher vaginal birth rate with lower interventions for low risk, healthy wāhine. Research also shows that neonatal outcomes are similar for babies born in Primary Care Units and Secondary Maternity Units.

Waioha has been a success for our community. Wāhine feedback evidences the enjoyment of the private, calm atmosphere and the ability for support people to stay comfortably. LMCs also value being able to care for wāhine in this environment with the support of their DHB midwife colleagues. Hospital employed midwives benefit from working in partnership with LMCs in caring for primary wāhine.

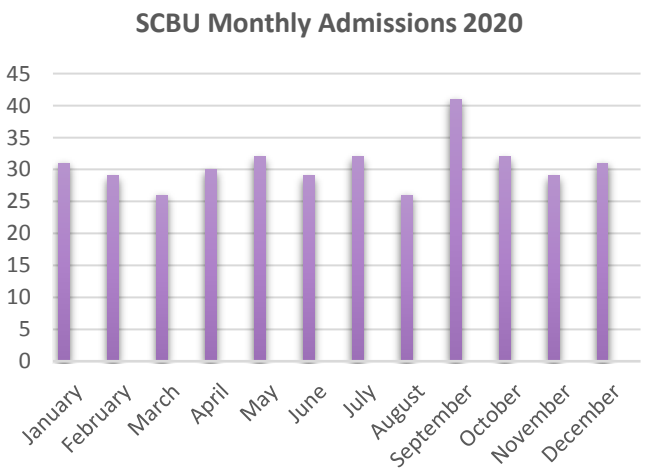
Waioha was closed for a period of 8 weeks during the national lockdown period. This is reflected in the reduced number of births for 2020 when compared to previous years.





SPECIAL CARE BABY UNIT

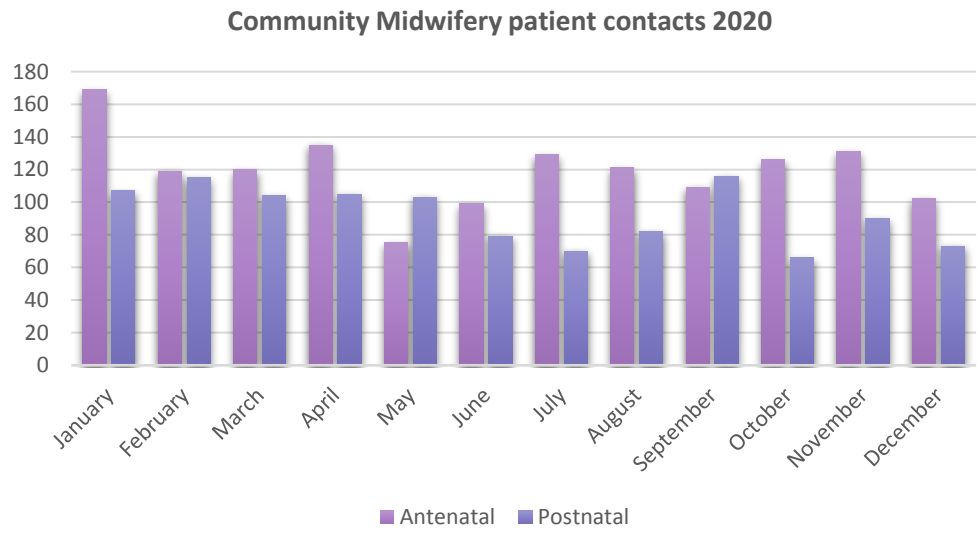
The special care baby unit (SCBU) is situated next to the labour and birthing suite and provides specialist care for pēpi requiring extra nursing and medical support. We care for pēpi with a gestational age of 28 weeks and above and a weight of over 1kg. There are 12 neonatal cots and four rooms for parents to room in. We usually encourage whānau to stay with their pēpi in the unit to enable bonding, breastfeeding and to support parenting before discharge home.



COMMUNITY BASED MIDWIFERY IN HASTINGS AND NAPIER

Community Midwives Louise, Poppy, Jayne, Cushla

Hawkes's Bay Maternity has a small and dynamic team of community midwives based at our Hastings maternity unit who cover a large geographical area and care for our most vulnerable wāhine. The team at present comprises of 4 midwives with a combined FTE of 1.8 and have a total of 100 years of midwifery experience between them. The team work with the most socially and medically complex wāhine and their whānau in our community and also take on the care of wāhine who are handed over from our LMC midwifery colleagues. The team provide antenatal and postnatal care to many vulnerable wāhine and work with social workers, kaitakawaenga, Tuai Kōpu (a service to coordinate care for Hawke's Bay's wāhine hapū), the mental health team and Oranga Tamariki to provide wrap around care for these wāhine, pēpi and their whānau.



"I have felt so supported since I met with the DHB midwives. I have had 24-hour support which is super helpful. The midwives are also very fast to respond to my calls. Definitely would recommend to any mum to be" Amelia

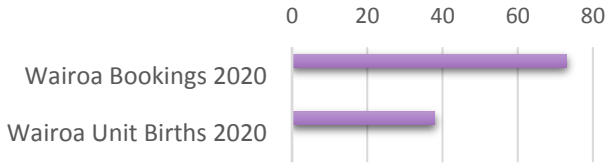
MATERNITY RESOURCE CENTRES

We now have two Maternity Resource Centres in the Hawke's Bay. The first resource centre was opened in 2014 in Napier and in October 2020 we opened a second centre in the Ruahine Whakawhānau Tamariki Hub in Waipukurau supported by our LMC colleagues. These centres provide a drop in centre for wāhine who seek pregnancy and maternity related care and advice from a midwife. They also provide a midwifery clinic space to support local access to midwifery services.

CENTRAL HAWKE'S BAY
Pregnancy & Parenting
RUAHINE WHAKAWHĀNAU TAMARIKI

WAIROA MATERNITY UNIT

The facility accommodates labour, birth and postnatal inpatient stay within its three combined birthing and postnatal rooms. Antenatal clinics occur in the newly integrated family health centre within the Wairoa Hospital building. Also accommodated within this building is a weekly clinic run by a Diabetes Nurse Specialists. This nurse specialist works in collaboration with the local midwives and the Clinical Midwife Specialist in Diabetes to ensure the best service for pregnant wāhine with diabetes in Wairoa. In 2020 there were 38 babies born in the unit.



BREASTFEEDING SERVICES

Clinical Lactation support is provided for inpatient women and their whanau by two International Certified Lactation Consultants and is available five days a week. This support is provided face to face to women across all inpatient wards within Hastings Hospital, and extends by phone to women and staff at Wairoa Health Centre as needed. The breastfeeding service also maintains the hospitals Baby Friendly Hospital accreditation, provides monthly free antenatal breastfeeding classes for all pregnant women and offers education around breastfeeding to all levels of staff.

2020 saw a fall in the exclusive breastfeeding status on discharge for all māmā discharged from both Ata Rangi and Waioha Maternity units. The trend toward lower breastfeeding rates is reflected nationally and the cause of such a drop will have many contributing factors. We are dedicated to investigating this decline in further detail to identify and address any areas for improvement of the breastfeeding support currently offered, to support an improvement in

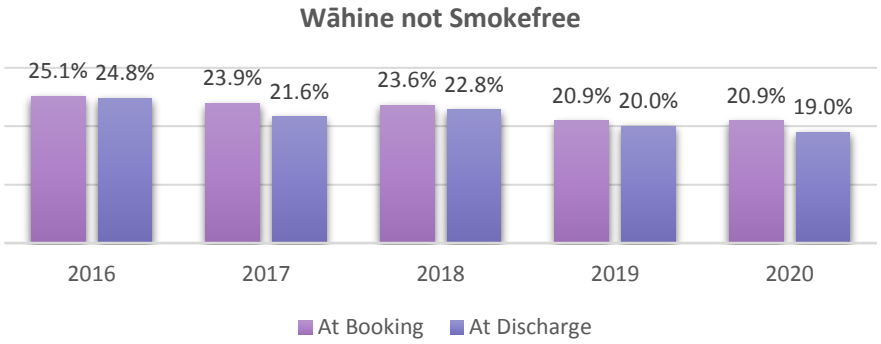
exclusive breastfeeding rates for our māmā and pēpi. Furthermore, Māori māmā and pēpi were found to have a lower overall rate of exclusive breastfeeding than their New Zealand European counterparts. This confirms a known equity gap around breastfeeding rates for Māori māmā, and further highlights the need for equal access to targeted Māori breastfeeding support developed within a Kaupapa Māori framework (see Equity section).

Discharge Breastfeeding status	Exclusive	Fully	Partial	Artificial Feeding	Exclusive breastfeeding by ethnicity	NZE	NZM
Ata Rangi	79%	3%	13%	6%		83%	75%
Waioha	91%	1%	4%	4%		95%	88%
Wairoa	100%						

TE OHAKURA: STOP SMOKING SERVICE

Hawke's Bay DHB Stop Smoking Service is providing specific projects and programmes towards Smokefree Aotearoa goal 2025. The Hawke's Bay DHB Smokefree team works in partnership with Te Taiwhenua o Heretaunga, Te Kupenga Hauora Ahuriri and Choices Kahungununu health services to provide a variety of Smokefree support under collaboration as Te Haa Matea Hawke's Bay Stop Smoking Service. From this team, the Maternity and Child Services Smokefree Coordinator works specifically with our pregnant māmā and whānau to increase smoke free pregnancies and smoke free homes with the Increasing Smokefree Pregnancy Project (ISPP).

2020 data shows that 20.9% of wāhine booked for maternity care were not smoke free. Of these wāhine, 76.3% were Māori, 2.8% were from the Pacific Islands and 20.9% were European or other. Although the total rate of wāhine not smokefree has slowly reduced from a five year high of 25.1% in 2016, the proportion of wāhine not smokefree that are of Māori ethnicity has increased, from 71.9% in 2018, 75.4% in 2019, to 76.3% in 2020.



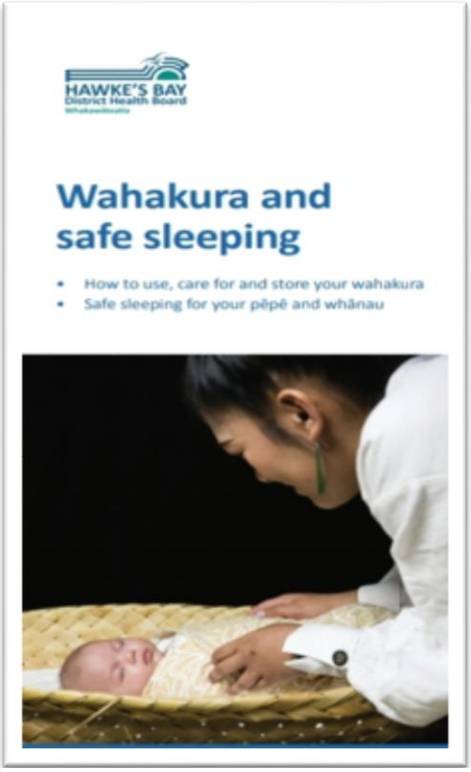
One of two main ISPP programmes addressing these rates is Wāhine Hapu. This 8 week stop smoking programme offers incentives of grocery vouchers and free nappies for those who manage to stop smoking and is available to pregnant wāhine and those with a baby under 6 months of age. Wāhine Hapu is a supportive programme that works with the goals, cultures and personalities of wāhine and whānau to become smoke free. Smoke Free Practitioners work in the comfort of clients' homes where they provide

friendly, supportive behavior counseling, free Nicotine Replacement Therapy and Carbon Monoxide testing and incentives to become smoke free. In 2020 the Wāhine Hapu Programme has helped 90% of the 111 pregnant wāhine referred to this initiative to become smokefree.

Another programme is the Carbon Monoxide-free homes initiative operating in Wairoa, Hastings and Napier. We plan to extend this service to Central Hawke's Bay in 2021. A total of 15 midwives in Wairoa, Hastings and Napier with the highest non-smoking rates of wāhine hapū are using Smokerlysers for Carbon Monoxide Screening and education. Carbon Monoxide screening is used to identify the amount of carbon monoxide exposure for mama, pēpi and whānau including exposure from first and second-hand smoking. We have found that the use of the Smokerlyser motivates mothers and their whānau to quit smoking for the health of the whānau and pēpi.

SAFE SLEEP PROGRAMME

The Safe Sleep Programme provides comprehensive safe sleep education across the Hawke's Bay to health workers, patients, whānau and community organisations, and distributes Safe Sleep Enablers (pēpi-pods and Wahakura) for high-risk, vulnerable pēpi at risk of SUDI.



New Patient Information Pamphlet produced in 2020

The focus in 2020 has been to increase the awareness of safe sleep principles to the wider community as well as Hawke's Bay's health work force and infant carers. Also, to increase the number of Antenatal referrals from LMCs and health care professionals in order to make our mothers feel more supported and prepared upon the arrival of their new addition, aiming to have māmā being referred at 20+weeks to provide quality and continuity of care, and have the whole whānau involved in keeping babies safe in their sleeping environment by providing education about correct safe sleep principles, smoking cessation agencies and breastfeeding support.

For 2020 there were 327 wāhine and their pēpi identified as having risk factors for SUDI and referred for a pēpi-pod, which creates a safe sleeping space for pēpi. This is a decrease from the 485 women referred in 2019, which may be related to the impacts of Covid-19 during 2020.

With the support of the Maternity unit during the Covid-19 Level 4 lockdown period there were 45 Wahakura and 7 Pēpi pods contactless deliveries to whanau within the community by the Safe Sleep Co-ordinator, with education to each whanau on the safe sleep practices. From Maternity there were 14 Wahakura and 20 Pēpi Pods distributed to whanau leaving the hospital. This was an amazing effort from the Maternity Unit and the Safe sleep Co-ordinator during this time.

SERVICES DURING COVID LOCKDOWN

Waioha Primary Birthing Unit was repurposed in response to the National level 4 Lockdown during March/April 2020 and was set up as our Covid isolation area for Maternity; thankfully this area saw little activity. Initially during the Level 4 lockdown period we had no support people or visitors. This was quickly changed when the impact for wāhine was identified. During the rest of the Level four and Level three lockdown one support person could remain with a wāhine at all times. Support people were catered for with the supply of bedding and kai which meant that support people did not have to leave the hospital.

As a result of the closure of Waioha Primary Birthing Unit and reduction in the number of support people and visitors allowed into our unit the interest in home births increased. Birthing at home was seen as a safe place to be, away from the multitudes of people present in hospital and where whānau members could remain present to support. This explained the reduction in the number of births in our maternity unit and also the number of home births during this time. Homebirths increased from 86 in 2019 to 161 homebirths in 2020.

Our antenatal clinic, Te Kākano continued to run throughout the Covid-19 Level 4 lockdown period but adapted to maintain a safe environment for wāhine and staff. Wāhine booked to attend clinic were triaged by the clinic midwife and many wāhine were reviewed by telephone. Chart reviews by telephone worked well for the majority of wāhine requiring antenatal assessment. Those wāhine requiring face to face assessment were called the day before the antenatal visit and screened. Visits to clinic were staggered which allowed for three or less wāhine to be in the waiting room at any one time and therefore allowing a 2-metre distance to be maintained at all times. Support people were asked to remain in the car during the consultation but could join in the consult via telephone from the car - this continued until Level 2 Lockdown.

COVID 19 and the level 4 lockdown also created a great challenge for our diabetes team, with every wāhine engaged in the service continuing to receive care though out the period. This included organising prescriptions and delivering blood sugar testing kits, insulin, needles and insulin pens to letter boxes so that testing and insulin administration could be taught via ZOOM or facetime. The Clinical Midwife Specialist in Diabetes maintained weekly contact (and often more regularly) with her caseload via electronic means until Level 3 lockdown commenced and restrictions eased. Antenatal clinic consults occurred via phone or ZOOM. The clinical midwife specialist role of 0.4 FTE was extended to full time to allow for the extra work involved in ensuring wāhine did not go without the care they needed maintain stable blood sugar levels during this challenging period.

Once in Level three lockdown we commenced a consumer survey via survey monkey. 91 women responded, with 37.4% identifying as Māori, 65% NZE or other, 5.5% Pacific, and 3.3% Asian. From analysing the responses to our survey, we identified that having a key support person present was the most important need for wāhine.

Social Media communication with our consumers

OUR UNEXPECTED LOCKDOWN HOME BIRTH…

To find out we were pregnant with our second son was a real surprise as we had IVF to fall pregnant with our first son. Other than being tired and a bit of nausea here and there, the pregnancy progressed well. This baby was strong and determined! The birth of my first son resulted in an induction 10 days past due date, and he was delivered with forceps. It turned out he was posterior and required a lot of force to get him out. I also had a tear that took months to heal and needed to be resected and treated with silver nitrate. Because of this experience I was really anxious about the upcoming birth and labour, and had decided I was definitely going to be going to Waioha or Ata Rangi in case this baby got stuck too.

Then lockdown happened. The idea of being in hospital without my husband or visits from my son or parents had me nervous, but as we got closer to my due date we had a plan that my parents would have our son when I went into labour, and my husband would be with me for the birth and then he would go home to be with our son. I was definitely doing a hospital birth.

My due date came, and two days later I started getting a few pains around 7pm. They were coming and going, but pretty mild so I text my mum to give them a heads up to have their bag packed, and went to bed around 9.30pm. I woke up after midnight with the pains still coming and going, and got up to move around a bit. Around 4am they were getting more painful so I had a shower, and then climbed back into bed and dozed off for a bit. At around 6am my husband suggested ringing my midwife, and I agreed at 6.15am thinking that I'd better get over there because if this was how I was coping with early labour, I was definitely going to need that epidural.

I needed to go to the toilet so said I'd do that and then get changed and out to the car, and when I sat down, everything changed. I felt intense pain and pressure, but was trying to hold it together so I didn't scare our son who had just turned two the week before. I suggested my husband turn on the wiggles, and that had him engrossed. Somewhere in that time he rang my midwife back and she told him she would come to us, and to get towels ready and prepare for a home birth. I was thinking surely I wasn't about to have this baby, 10 minutes ago I thought I was just being weak with early labour contractions. My midwife phoned when she was halfway to our house and spoke to me through a contraction on speakerphone. After she hung up I got the sensation to push, and I thought I had better check to see if I could feel his head. Yup he was coming! I was petrified that my old tear would come apart. I told my husband I thought he needed to get ready to catch him, my waters broke, and after 2 or 3 pushes, our second son was born on the bathroom floor while our first son had his nose pressed up to the wiggles. Our baby cried within 10 seconds or so, and I was so relieved to hear that sound. I sat down and we wrapped him in a towel. A couple of minutes later our midwife arrived, followed by my parents a few minutes after that. No one could believe what had just happened! I had gone from "I guess we should call her it's getting sore" to having our baby in the space of 20 minutes!

It was such a wonderful experience being at home, and not having to go into the hospital environment during lockdown. I wasn't looking forward to not being able to see my family or introduce our sons to each other for the first couple of days. Instead my son wandered in after his breakfast wondering where the baby had come from and why it wasn't in my tummy any longer. We couldn't thank our wonderful LMC enough for her support and encouragement throughout both pregnancies and births. Both experiences couldn't have been more different!

OUR MATERNITY WORKFORCE

Midwifery Director 1	**Obstetric Head of Department 1**	**Clinical Midwife Manager 1**	**Associate Clinical Midwife Manager 1**	**O&G Consultants 7**	**O&G Registrars 8**	**Senior House Officers 8**
MQSP Coordinator 1	**Māori Midwife Consultant 1**	**Midwifery Educator 1**	**Clinical Midwife Coordinators 8**	**Lead Maternity Carers 53**	**DHB midwives 48**	**Registered Nurses 11**
Diabetes Clinical Midwife Specialist 1	ChAT Midwife 1	**Lactation Consultant 2**	**Care Associates 10**	**Antenatal Clinic Midwives 2**	**Community Midwives 4**	**Administrative Staff 5**

HOSPITAL MIDWIFERY AND NURSING

MIDWIFERY WORKFORCE

Throughout 2020 there has been an increase in the numbers of birthing wāhine and of these wāhine an increase in the complexity and acuity, both medically and socially, which has been challenging for our DHB workforce.

Our LMC population has grown and we now have 53 LMC midwives accessing our units. This should bring greater choice, availability and early engagement with an LMC for pregnant māmā in our region. However, there has been a significant number of DHB midwives who have either retired this year or chosen to move into the primary sector. We have been successful in recruiting new graduate and experienced midwives from both New Zealand and overseas. With a national shortage evident and a limited pipeline, kai whakawhānau/midwife recruitment continues to be a high priority for our maternity service.

RECRUITMENT AND RETENTION

Hawke's Bay has a clear midwifery workforce strategy with a number of workstreams focusing on pipeline, recruitment and retention. Some of these workstreams are also being supported through the national midwifery accord work. In particular our DHB is intentionally recruiting midwives to match the community we serve and to support more Māori and Pacifica wāhine to uptake midwifery as a career with scholarships and accommodation funding throughout the training.

Recruitment of midwives and nurses continues with a combination of local, national and international advertisements in place. The maternity service is currently working with the recruitment department to produce a midwifery specific video to attract midwives to the Hawke's Bay. There are a number of initiatives to attract staff to the Hawke's Bay including relocation packages and contributions towards required education for midwives from overseas.

As a maternity unit we are closely aligned with WINTEC and regularly meet to discuss student placements in our unit. As a unit we feel it is our responsibility to ensure that all midwifery students feel supported during their placements here and gain a wide variety of clinical experiences. One of our most experiences midwives is also a clinical tutor and works alongside each student midwife. We have been successful in recruiting a number of student midwives from WINTEC into our midwifery workforce. HBDHB aims to further student placements in 2021 to allow student midwives to experience rural midwifery in our Wairoa Maternity Unit.

Our Māori Kai Whakawhānau Consultant continues to work with the midwifery incubator programme, an initiative developed to enable Hawkes's Bay DHB to "grow our own" health care staff. Students from year 13 visit Hastings Hospital for three sessions where they meet and engage with health professionals including midwives. Other events encouraging students into a health career include year 10 and 11 Health Careers Expo, year 13 transition to Tertiary Taster event and an annual evening hosted by our Māori Kai Whakawhānau Consultant introducing midwifery as a career option to students and those wishing to re-enter tertiary education. We are also working closely with Tūruki, a Māori Health workforce initiative to provide scholarships and funding for those wishing to study midwifery and who reside or have connections to Hawke's Bay through whakapapa.

Establishment of a pastoral care programme for students and new graduates is due to commence formally in 2021 to improve retention of midwifery students and improve the experiences of our new graduates as they enter the workforce.

Retention strategies include flexible rostering, trialling of 12 hour shifts alongside our traditional 8 hours, a visible and evident career pathway for midwives with opportunities for them to stretch themselves, develop leadership, project management and quality and safety skill sets; in particular 7 midwives have now completed the LEO (Lead Empowered Organisation) course that supports and develops newly emerging clinical leaders and is being supported by the HDB to invest and grow our new leaders in health care.

The 12-hour shift trial commenced in June 2020. This was in response to a number of staff requests. The trail has been successful with a number of midwives now choosing to only work 12 hour shifts, others working a mixture of both 8 and 12 hours shifts and some working the established 8 hour shift. Many staff report they enjoy the continuity of care that the 12-hour shift allows and of course the extra days off that come with working longer shifts.

SPECIALISED MIDWIFERY ROLES

MĀORI MIDWIFERY CONSULTANT

Our Māori Midwifery Consultant was appointed in November, 2017. One of the key targets for our Māori Midwife Consultant was to improve the cultural responsiveness of our workforce and to this end all staff have completed the Turanga Kaupapa workshop. Growing our Māori midwifery workforce, providing opportunities for Māori midwives to develop skills and ensuring Māori consumer engagement for maternity services has also been a large part of our Māori Midwife Consultant role over the past three years. The top three outcomes achieved have been:

- Securing and maintaining funding for the Hine-te-iwaiwa māori midwifery scholarship available annually
- 100% completion of maternity midwifery, nursing and care associate staff through Tūranga kaupapa training.
- Growing the māori midwifery consultant profile which means having input into many avenues to increase the health inequities within Hawkes bay maternity

MIDWIFE LACTATION CONSULTANTS

Clinical Lactation support is provided for inpatient women and their whanau by two International Certified Lactation Consultants in a combined 0.9 FTE role. Additional support is provided by four midwives and nurses who also hold lactation consultant qualifications. Our lead Midwife Lactation Consultant also facilitates Breast Feeding study days for midwives, nurses and care associates.

CLINICAL MIDWIFE SPECIALIST – DIABETES

The clinical midwife specialist role was established in the Hawkes Bay in 2017. This midwife works alongside clinical nurse specialists in diabetes, dieticians with specific interest in diabetes, endocrinologists and obstetric consultants to provide a comprehensive, wrap around service for these high risk wāhine. The role has grown considerably in the last three years and now includes supporting wāhine with diabetes throughout their pregnancy, being a point of contact and support for all LMCs and taking part in the mandatory education program for all midwives. 2021 will see the opportunity to further develop our model of care for women with diabetes in pregnancy.

CLINICAL MIDWIFE COORDINATORS

The clinical midwife coordinator (CMC) role was established in 2014 with just three midwives working 10 hour shifts across the week days. We now boast 8 CMCs working am and pm shifts throughout the week and in 2020 we gained CMC cover for a period of 8 hours each weekend shift as a trial. Our CMCs bring clinical expertise and oversight to each shift, ensuring that staff are supported, safety is maintained, the medical staff and LMCs are kept informed and the multidisciplinary team are heard. Their aim is to ensure that each wāhine and her whanau receive safe, effective and holistic care. Work is in progress to further this valuable support to our staff by employing 24/7 CMC cover.

CARE CAPACITY DEMAND MANAGEMENT (CCDM)

Over the last 6 months our Associate Clinical Midwife Manager has focused on optimising our TrendCare data with intensive training for staff which has resulted in an increased compliance and accuracy in using the TrendCare tool and data integrity with planned FTE calculations in 2021. Ongoing progress in the use of our VRM escalation and the establishment of local data council and using our Core data set measures sees our

progress to 83% implementation rate by end of 2020. This programme is crucial to ensure safe care provision, effective work environments and the sustainability of our midwifery workforce.

MEDICAL WORKFORCE

Consultant O&Gs Linda, Keith, Luis, Elaine, Jeremy, Kirsten. Leigh absent.

We have 7 Consultant Obstetrician/Gynaecologists who manage care in our secondary service. Since mid-2018 there has been a dedicated Obstetric head of department working closely with the senior midwifery team.

Our team underwent huge changes in 2020 with the entire team structure and roster altered to create two separate teams to manage the COVID response. This change has prompted the team to question how we can work differently in the future.

We are an accredited training centre for the Royal Australian & New Zealand College of Obstetricians and Gynaecologists. Second- and third-year registrar trainees rotate through our facility every six months in order to gain experience in our secondary unit. We also have one long term placement for a senior registrar, who usually continues to work for a one to two-year period in order to consolidate practice. Senior House Officers (SHOs) wishing to step up to the role of registrar are supported to do so, enabling to these junior registrars to take their firsts step towards a career in Obstetrics and Gynaecology. Obstetrics and Gynaecology continues to be a popular rotation choice for SHOs with many committing to and completing postgraduate certificates and diplomas in obstetrics and medical gynaecology.

We experienced a shortage in junior medical staff in 2020 and are extremely grateful to those doctors who worked so hard picking up extra shifts. The shortage in medical staff has had an impact on their ability to become involved in quality improvement within our department. However, the majority of our doctors have upskilled in how to work in an ICU environment during COVID level 4 lockdown.

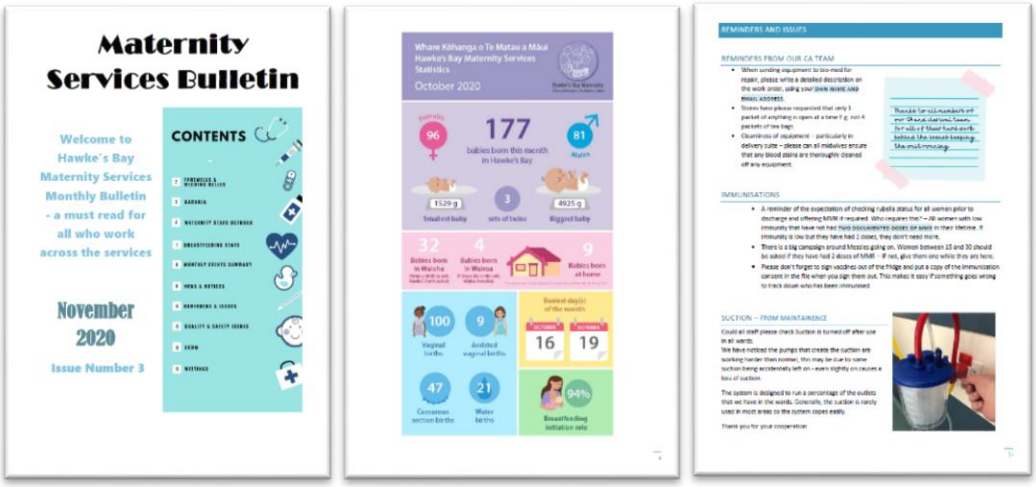
WORKPLACE CULTURE

In response to a workplace questionnaire in 2018/2019 the Positive Culture Group was initiated in 2019. The group consists of staff from across all disciplines working in the maternity unit and the broader hospital, with the aim to increase staff morale and improve work culture.

Initiatives include a quarterly morning tea/whakawhanaungatanga to introduce new staff members to our team, the 'You've been mugged' anonymous encouragement campaign, and a weekly cake club. The Maternity Unit social club has also been running for a number of years and is well supported with staff regularly getting together outside of work commitments to socialise.

As part of our mandatory annual education this year the BUILD (Behaviours, Understand, Impact, Listen, Do differently) model of constructive behaviours has been introduced. All staff have the opportunity to consolidate the training received at the mandatory day via a one day in house BUILD Cascade training day. These training sessions give staff the tools needed to have those difficult conversations, give and receive feedback, de-escalate situations, build empathy and listen non-judgementally. All helping clinicians to be able to speak up whenever they are concerned about workplace culture or safety issues.

With the introduction of a full time Associate Clinical Midwifery Manager, MQSP coordinator and a MQSP administrator, we have been able to reinstate our monthly Maternity Bulletin in 2020. Another method of communication with staff, sharing achievements and promoting a positive work culture. This is very well read by all of our workforce and includes monthly statistics of births, breast feeding, news and updates across the unit and news of celebrations and dates for diaries. This is also where we share improvement actions and recommendations including new policies from adverse events.



EDUCATION & PROFESSIONAL DEVELOPMENT

Midwifery education within Hawke's Bay DHB is co-ordinated and led by Sara Paley, the Midwifery Educator who holds a 0.6FTE position. Additionally, acknowledgement is due to the wider team of passionate clinicians who regularly teach alongside the Midwifery Educator, contributing their expertise and skills. The team includes: Katy Williamson (Midwife), Dr Kirsten Gaerty (Obstetrician and Gynaecologist), Dr Oliver Grupp (Paediatrician), Dianne O'Conor (Paediatric Educator), Melissa Jenson (Resuscitation Co-ordinator), Dr Sarah Sew-Hoy (Anaesthetist), and Gemma Steward (Midwife Lactation Consultant).

The aim of our education programme is threefold:

- To support midwives and registered nurses working in maternity to meet their annual recertification requirements.
- To provide stimulating and meaningful education opportunities across the year for all staff and Lead Maternity Carers to access.
- To offer interdisciplinary training which builds teamwork, enhances systems and processes and develops shared understanding.
- To ensure up to date evidence based, safety oriented high quality care provision by all maternity health care professionals

DEDICATED MIDWIFERY PROFESSIONAL DEVELOPMENT FUND

This initiative was created to enable DHB midwives aligned with MERAS an equitable access to professional development funding as their NZNO colleagues are. The Dedicated Midwifery Professional Development Fund is to support midwives seeking further education, professional development and assistance with the cost of attending courses and conferences. The fund is well utilised and lead by our Clinical Midwife Manger, Midwife Educator and our Consultant Māori Midwife.

LEADING AN EMPOWERED ORGANISATION (LEO) COURSES

During 2020 seven midwives from the HBDHB completed the LEO course. The course is run over three days and gives staff opportunity to reflect on their leadership styles and skills and also allows staff to explore other leadership strategies. A follow up day allows candidates to present a change strategy and their management of this.

Some of the management projects undertaken as part of the LEO course include: -

- Developing a patient information leaflet.
- Working to implement a VBAC clinic.
- Implementing the NOC/NEWS project.
- Developing a positive culture and teamwork model.
- Strategies to build a successful team.

"The LEO course was great. It supplied me with lots of tools to take back to my leadership role. Sometimes it's those little things that make the difference to creating a supportive working environment."

NEW GRADUATE MIDWIFERY PROGRAMME

In 2019 and 2020 we recruited four new graduate midwives, by ethnicity 25% Māori and 75% NZE. The new graduates are supported to complete the national Midwifery First Year of Practice programme (MFYP) run by NZCOM. In addition to this MFYP the HBDHB orientation programme allows for the new graduate to work super numerally for an extended period as well as working alongside a named preceptor. The orientation package allows for new midwives to orientate through all areas of maternity care including labour and birthing suite, postnatal/antenatal ward, community, antenatal clinic and the neonatal unit. It is intended that this will be extended in 2021 to include experience in the Wairoa rural primary birthing unit.

"Mā te tuakana e arahi i te teina, mā te teina e arahi i te tuakana - from older sibling the younger one is taught the right way to do things, and from the younger sibling the older one learns new things."

Also available in the Hawkes's Bay DHB is the Tuakana Teina, pastoral care programme for Māori graduate midwives. This is a kaupapa Māori based intership programme and has been aligned with our DHB to enhance the experience and development of those working in our maternity unit. New graduate midwives are given support and guidance by experienced Māori midwives, this process is fluid and may be reversed at any time meaning that those with many years of clinical experience can also gain insight and support from the newly qualified midwives.

EMERGENCIES TRAINING (COMBINED EMERGENCIES SKILLS DAY)

In Hawke's Bay we ran seven combined emergencies skills days during 2020 with seventy-five midwives in total participating. This total included several midwives from other districts which always adds fresh perspectives in practice and learning.

Topics for 2020 included risk assessment, maternal resuscitation, newborn resuscitation, management of shoulder dystocia, and bleeding emergencies.

Feedback from 2020 included:
"Plenty, of opportunity to have guided hands on experience."
"Very successful method with worksheet scenarios in small groups"
"Nice structure with carrying through of case studies"

PRACTICAL OBSTETRIC MULTI-PROFESSIONAL TRAINING (PROMPT) AND NEWBORN LIFE SUPPORT TRAINING

We continued with our approach of encouraging midwives to complete a full day Newborn Life Support course and a PROMPT course once in the three year cycle as an alternate to the Midwifery Emergencies day, as these develop different skill sets for participants. Both days are offered to the wider clinical team including Anaesthetic Registrars, Obstetric Registrars and House officers, Paediatric Registrars and House officers, Anaesthetic technicians, and Registered nurses from maternity, SCBU, PACU, and ED.

A total of four Newborn Life Support courses and four PROMPT courses were run over 2020 with a total of 118 clinicians participating.

RANZCOG FOETAL SURVEILLANCE EDUCATION PROGRAMME (FSEP)

The RANZCOG FSEP full day course is an outsourced course focussing on the foetal response to hypoxia and CTG interpretation. It is usually offered twice a year in the Hawke's Bay however with travel restrictions we were only able to run one in 2020. The day is fully funded by the Maternity service and is attended by DHB midwives, LMC midwives and doctors. There is an expectation that all attend this day once every three years with completion of the online course annually.

DIABETES EDUCATION TRAINING

In 2020 the Clinical Midwife Specialist (CMS) in Diabetes was invited to contribute her knowledge at the mandatory study day for nurses and midwives. This study day is held several times throughout the year and all staff must attend. The CMS midwife informed staff of her role, the Diabetes in Pregnancy Guidelines, how to access help for wāhine with diabetes and how wāhine are managed by the service.

QUALITY LEADERSHIP PROGRAMME (QLP)

The QLP programme provides a framework for midwives to develop responsibilities and further develop their skills and knowledge. It also provides a pathway through which the DHB can recognise, value and encourage the professional development of midwives. This programme is fully supported by the HBDHB and all midwives are encouraged to complete QLP certification. 48% of our core midwives are currently on the Leadership domain and 38% on the confident domain.

BREAST FEEDING STUDY DAYS

Breast feeding study days are facilitated by our Midwife Lactation Consultant and are attended by midwives and nurses. The curriculum changes every year but days always include the latest research on breast feeding and troubleshooting for mothers, nurses and midwives. The Lactation Consultant also runs breast feeding education days exclusively for care associates.

TURANGA KAUPAPA WORKSHOPS

Identified as a focus in 2017, we committed to developing our teams' cultural competencies. As part of realising this vision we engaged all staff in one day Turanga Kaupapa workshops and this continued into 2020 with a further workshop offered in September. Developed by Nga Maia– the national body that represents Māori birthing, and delivered by our Māori Midwifery Consultant feedback from staff has been very positive.

OUR QUALITY & SAFETY

MATERNITY QUALITY AND SAFETY PROGRAMME (MQSP)

The NZ Maternity Standards are the core foundation to our Quality and Safety programme. Comprising three strategic statements, the standards guide planning, funding, monitoring and provision of high quality, equitable and safe maternity services across the nation.

Standard One

Maternity Service provide safe, high quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.

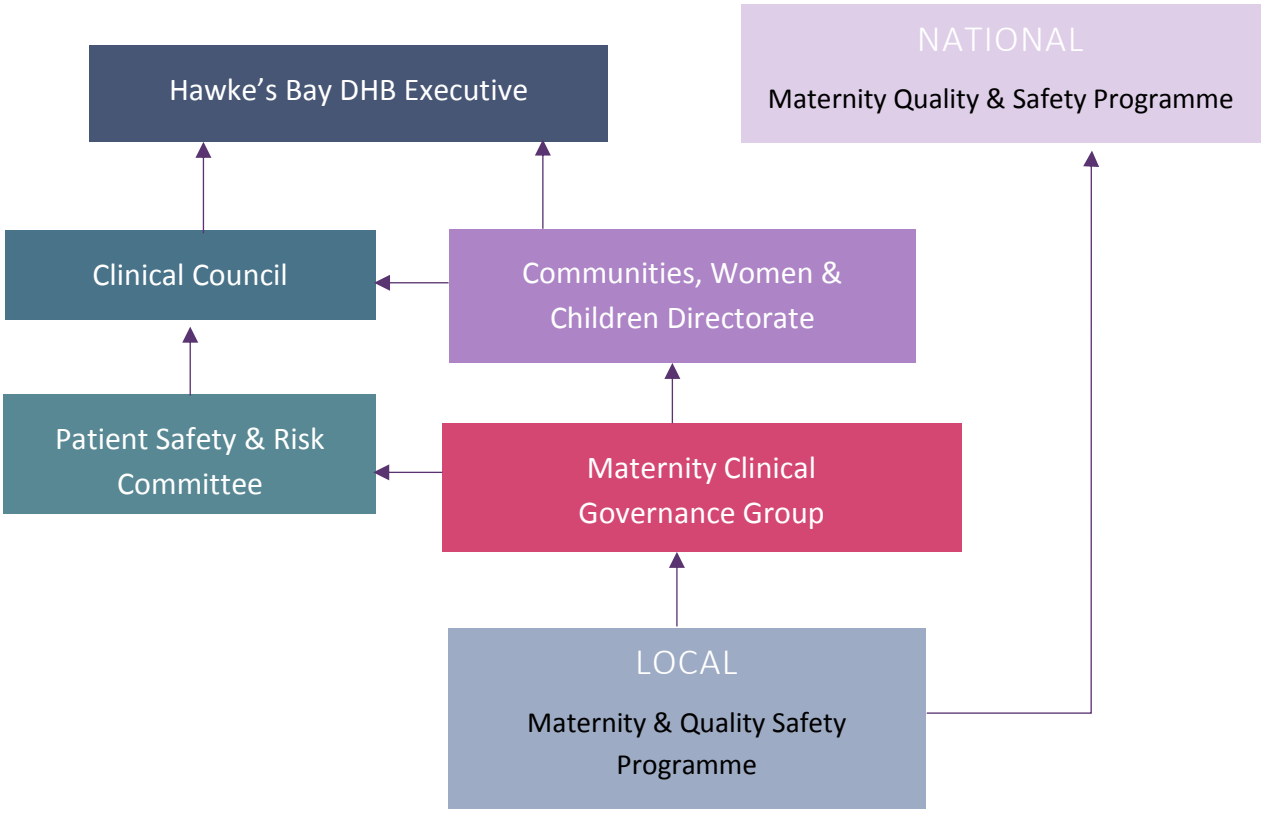
Standard Two

Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage.

Standard Three

All wāhine 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 wāhine.

The MQSP is overseen by the Maternity Clinical Governance Group (MCGG) and embedded in the wider HBDHB governance structure:



MEMBERSHIP OF THE MATERNITY CLINICAL GOVERNANCE GROUP (MCGG)

Our MCGG membership demonstrates a wide representation of key stakeholders in the maternity field, inclusive of both primary and secondary care practitioners and consumer representatives.

Members include the Head of Department for Obstetrics, a Senior Obstetrician, a Senior Paediatrician, Senior Anaesthetist, the Director of Midwifery, Patient Safety and Quality Manager, Maternity Quality and Safety Program Coordinator, Midwifery Educator, Māori midwife consultant, NZ College of Midwives representative, an LMC member, two DHB midwives, and two consumer representatives, Māori and Non-Māori.

We meet monthly with an aim of maintaining and improving upon the service we provide to wāhine, pēpi and whānau. We have a strong focus on ensuring the service we provide is appropriate, equitable and accessible for all wāhine and whānau.

Jules Arthur
Midwifery Director

Kirsten Gaerty
Head of Obstetrics

Philip Moore
Medical Director

Jeremy Meates
O&G Consultant

Julie Crawley
MQSP Co-ordinator

Roisin Van Onselen
Clinical Midwifery Manager

Sarah Sew Hoy
Anaesthetist

Susan Barnes
Patient Safety & Quality Manager

Donna Foote LMC

Julie Kinloch NZCOM Rep

Susan Hawken
Nurse Manager Wairoa

Shannon Bradshaw
Maori Midwife Consultant

Katie Mortlock
DHB Midwife

Sara Paley
Midwifery Educator

Jaime Cuppen
MQSP Administrator

CONSUMER ENGAGEMENT IN HAWKE'S BAY MATERNITY

A vital component of our MCGG is the representation and input of consumer voice into the quality and safety of our services.

Hello, my name is Gabby Allen - Consumer Representative for Maternity services at the Hawke's Bay DHB, wife, mother, aunty, and community advocate.

Consumer Representative Gabby Allen

Being in this role for over 5 years, together with two completely different births for my two babies I have developed not only understanding of what it means to represent you and your whanau but also the prevalence of inequities. To understand that not all of us have the same abilities to get equal care, our journeys are varied and we all start at different points in this journey. Understanding this makes the desire to be in this role even more meaningful. I strongly advocate for all families to have equity in all levels and aspects of pre and postnatal care. To be able to birth your babies with support and cultural awareness and sensitivity.

I stand for working together to provide a strong, nurturing environment for Hawke's Bay families to birth and raise your babies. I strive to represent all whanau at a DHB level so that all voices are heard. It is an honour to do this. Thank you.

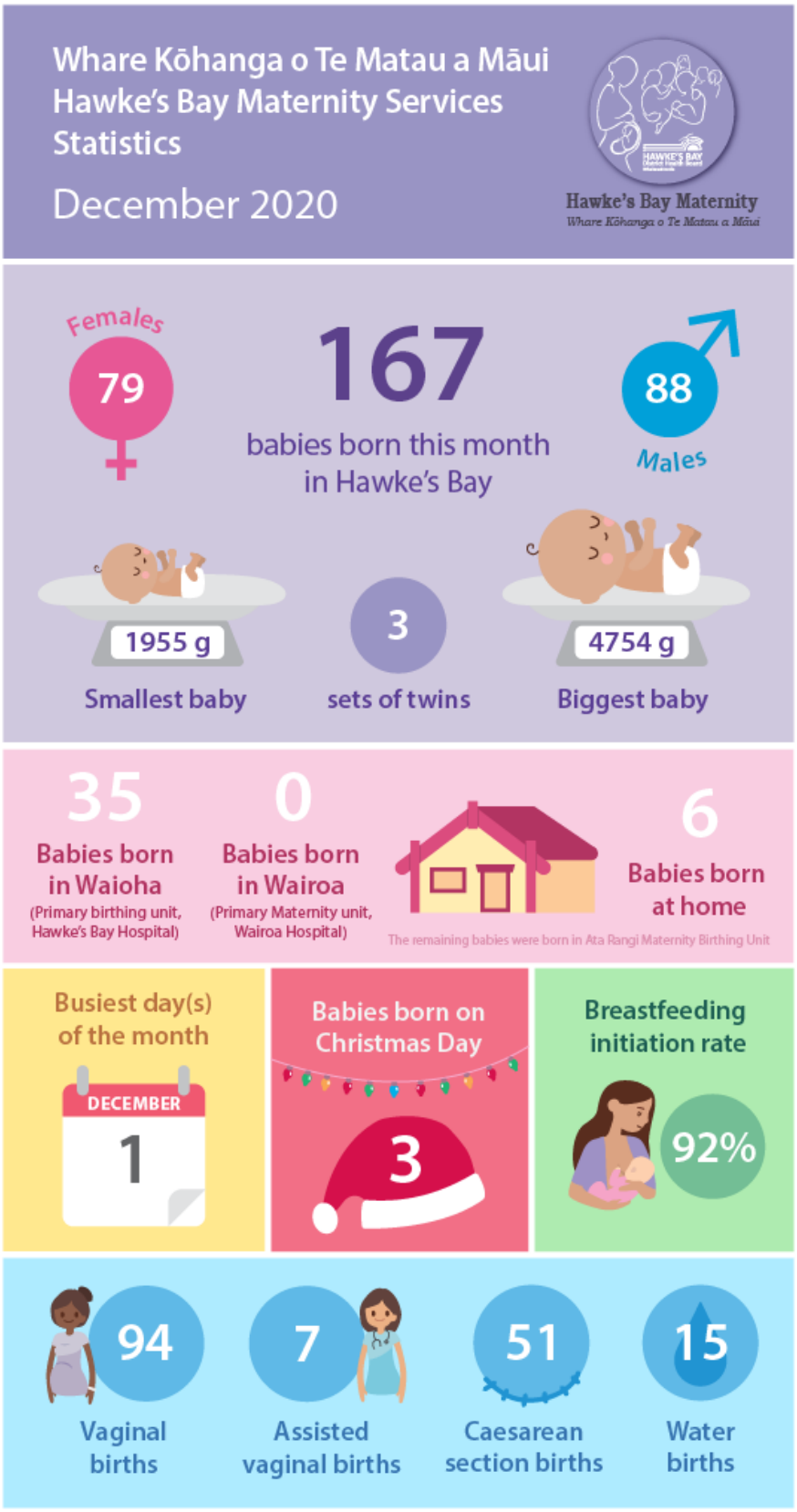
Ko wai au, he uri tĕnei o Porourangi,
ka puta ki waho ko Kahungunu.
Ko korongata taku marae
Kei korongata mātau me töku whānau e noho ana ā ko Whitney Ferris toku ingoa.

Consumer Representative Whitney Ferris

I am the Māori maternity consumer representative for HBDHB. I have experience as a health navigator, kaiawhina, working alongside our Māori and Pacifica whanau. Through this position I hope to be able to support educate and empower hapu mama so they can make the best decisions for them, their pepi and whānau. I look forward to the challenges ahead and finding solutions that best support the needs of our people through a Māori view approach.

Kei te mihi

A highlight for consumer engagement in 2020 was the development of a monthly birth statistics infographic, published on our maternity facebook page. This has fostered great engagement with our consumers and the broader community, generating much discussion and interaction.



'Excited to be part of December's stats!'

'This is a really interesting snapshot! Thanks for posting'

'Finally! can say that we were part of these stats!!'

'That was us guys!'

'Wow that's a big baby haha!'

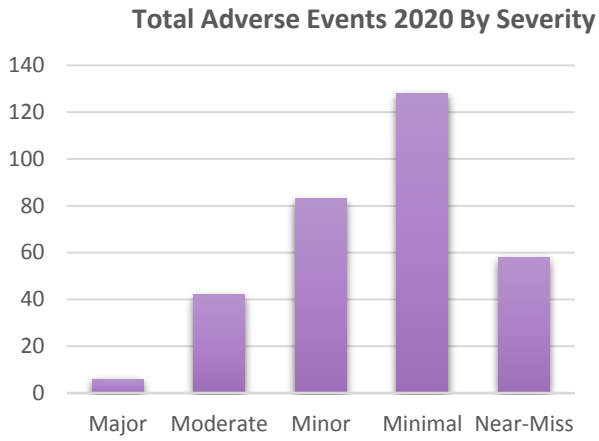
'Love this, so interesting!'

'Our boy arrived on the busiest day too!'

'This is so awesome... you guys are doing an amazing job'

IMPROVING SAFETY AND LEARNING FROM ADVERSE EVENTS

The Hawke's Bay maternity service is committed to improving the service we provide and learning from any adverse events occurring in our units. Over the past few years we have worked to fully implement the Health Quality and Safety Commission's (HQSC) Maternal Morbidity Review process. Our aim is to review each event in a compassionate way, looking at evidence and focusing on systems and processes rather than allocating blame. The section below outlines our process for reporting, triaging and reviewing adverse events in the Hawke's Bay Maternity Unit.



All incidents are reported on our online event reporting system by the staff involved. These events are reviewed weekly by the Head of Department for Obstetrics and Gynaecology, the ACMM and the MQSP coordinator. Events are triaged using the HQSC maternity severity assessment code (SAC) rating system.

SEVERITY ASSESSMENT CODE (SAC) ONE AND TWO

There were no SAC 1 events and six SAC 2 events investigated in the 2020 period. These events are allocated to the MQSP coordinator. The first step in reviewing an adverse event is to contact the wāhine/whānau to express our apologies if appropriate and offer our support. We want to ensure the wāhine/whānau voice is heard in the review process. Contact is maintained during the review process and we ensure whānau have a contact person in case they require further information or support. A full report is written using the wāhine story, clinical notes and clinical data systems, and shared with members of the multi-disciplinary team involved in the review. Following a multi-disciplinary meeting, recommendations are made and implemented to reduce the incidence of future maternal morbidity. The Health Equity Assessment Tool is used when developing the recommendations and actions. An anonymised copy of the review is shared with whānau and a debriefing meeting is offered.

SEVERITY ASSESSMENT CODE (SAC) THREE AND FOUR

Incidents with a SAC rating of 3 or 4 (Moderate to Near-miss events) are allocated to the CMM, ACMM and MQSP coordinator for review. These events are investigated and actions arising are documented in the events system. Themes from events are shared at the monthly MCGG meetings. Learnings and recommendations from events are shared with the maternity workforce through our monthly maternity bulletin, email and our Perinatal Morbidity and Mortality Review Committee (PMMRC) bi monthly meetings, an open forum for medical staff, nurses and midwives, LMCs and SCBU staff.

CASE REVIEW LEARNINGS AND RECOMMENDATIONS IMPLEMENTED

Some of the changes relating to clinical practice that have occurred as a direct result of our multi-disciplinary case reviews are:

- **Safety First Pathway**
  As documented in the Progress on National and Local MQSP Projects p.46. Learnings from a number of

case reviews led to the implementation of the Safety-First Pathway. This includes all clinicians completing the RANCOG FSEP training annually and all ongoing CTGs to be reviewed by a colleague every two hours.

- **Assisted Birth leaflet**
  Following an assisted vaginal birth event it was recognised that our antenatal information regarding assisted birth was lacking. In response to this a new 'Assisted Births- Forceps and Ventouse' pamphlet was written. This pamphlet will be available in the antenatal waiting room and circulated to all LMCs and antenatal educators for discussion with all wāhine. We are in the process of translating this leaflet into other languages.
- **Introduction of a 24/7 0800 number for maternity**
  An event which occurred in 2020 highlighted the need for a phone dedicated to wāhine who had concerns but were unable to contact their LMC. The maternity unit has always made its contact number public but we have never advertised a specific number for women with concerns. The 0800 number is attached to the coordinators phone which is manned 24/7. The number is available on our website, Facebook page and on our Maternity Unit Information Leaflet.
- **Risk assessment tool implemented in clinic**
  To ensure that all potential risks for women are identified and acted upon we introduced a new Maternity Risk Assessment form to be filled in by the doctor initially reviewing the woman in clinic.
- **New Place of birth policy**
  In order to support our LMC and DHB midwives ensure that wāhine give birth in the right place we produced a New Place of Birth Policy. The policy provides a framework for LMCs and DHB midwives regarding place of birth, transfer between the primary and secondary unit and the use of our primary birthing unit when acuity and demand in our secondary unit are high.
- **New documentation and swabs for perineal sutures**
  To assist in the checking and counting of swabs post suture/operation a new form is being designed. The swabs now being used are visible by X ray.
- **New pathway for collection of samples from clinic**
  Following an event were a wahine was admitted to our unit with PET after being seen in clinic earlier in the day. It was highlighted that there was a delay in sending samples to the laboratory from the antenatal clinic. This was rectified by having earlier collection of samples and reminding clinicians to follow up of samples they have ordered.
- **Increase in CMC hours**
  A review of the events in 2019/2020 indicated that many events happened when there was no CMC on duty. In order to try to rectify this and support our midwifery and obstetric staff CMCs are being trialled on Saturday and Sundays for eight hours a day.
- **New adult sepsis pathway**
  A new Adult Sepsis Pathway was introduced in 2020 to assist with early recognition and treatment of sepsis in our hāpu wāhine and mama.
- **New placenta/whenua form**
  To ensure that wāhine are fully consulted regarding keeping or disposing of their placenta/whenua and to clearly identify if the placenta/whenua was collected by the whanau or disposed of by the hospital a new form was designed and implemented.

LOCAL MATERNITY QUALITY IMPROVEMENT ACTIVITIES

Local maternity quality improvement activities			HB DHB status
Local activity title	**Fresh Eyes**		
	Rationale	To support midwives and doctors in the interpretation of CTGs. To support early detection of abnormal FHR patterns and early intervention to reduce fetal hypoxia and adverse neonatal outcomes To prevent risk of Neonatal Encephalopathy (NE) and admissions to SCBU	
	Actions	Fresh Eyes approach – 2 hourly review of CTG Annual completion of online RANZCOG FSEP programme, 3 yearly completion of full FSEP study day Refresh the obstetric escalation pathway to access senior clinician support	
	Measures	Diagnosis of NE is reduced in neonates Admission rate to SCBU for low apgar scores and fetal hypoxia will decrease evidence of access to early senior clinician support increases	
	Outcomes	Reduction in admission to SCBU for fetal hypoxia Improved team communication/functionality	
	Future	All maternity clinicians maintain educational requirement to support best practice in fetal surveillance and CTG interpretation Diagnosed NE rate in neonates will be below national rate	
Local activity title	**Anti D – implement RAADP**		
	Rationale	To prevent sensitisation to the D antigen for Rh-mothers	
	Actions	Implement Routine Antenatal Anti-D Prophylaxis (RAADP)	
	Measures	Anti-D prophylaxis given to all consenting Rh-women at 28/40 and 36/40	
	Outcomes	Evident reduction in Rhesus sensitisation due to implementation of prophylactic anti-D	
	Future	Continuation of programme Audit	

Local activity title	**Vaginal Breech Birth working group**		
	Rationale	To offer choice in birth mode for wāhine with term breech presentations	
	Actions	Identified a group of midwives with interest in vaginal breech birth and motivated to ongoing education. These midwives will be available for breech births and offer support and education to other midwives. To develop educational resource for pregnant women	🟡
	Measures	Number of vaginal breech births	
	Outcomes	Informed choice for wāhine Clinicians supported to maintain and upskill in the management of vaginal breech births	
	Future	Highly skilled midwifery and obstetric workforce in the option of vaginal breech birth	
Local activity title	**Improve the Induction of Labour (IOL) process for those requiring IOL**		
	Rationale	To improve wāhine's experience of IOL and reduce the IOL rate	
	Actions	New IOL policy New IOL booking form and pathway	🟡
	Measures	Audit number of women who have IOL and outcomes.	
	Outcomes	Potentially fewer IOL	
	Future	Reduction in the number of IOLs	
Local activity title	**Introduce wound care bundle**		
	Rationale	Reduce the number of wound infections and readmissions for wound management (caesarean and perineal)	
	Actions	Develop updated wound care bundle	
	Measures	Audit of wound infections	
	Outcomes	Reduction in readmissions for moderate/severe wound infection Reduction in the overall rate of wound infections	🔴
	Future	To reduce readmission to hospital with wound infections	

🟢 Work has been completed and/or business as usual phase
🟡 Work is in progress/underway and nearing completion
🔴 There is still a significant amount to achieve before completion

IMPLEMENTING THE GAP/GROW PROGRAM

The Perinatal Institute's Grow Assessment Protocol (GAP) programme aims to improve the detection rates of pēpi who have Foetal Growth Restriction (FGR) and/or Small for Gestational Age (SGA) thus leading to appropriate management during pregnancy, delivery and the postnatal period.

The Hawke's Bay DHB commenced using GAP in 2018 with the roll out of the GROW software (Gestation Related Optimal Weight). A customized growth chart is produced using the variables: maternal parity, ethnicity, height and weight, also showing previous pēpi centiles. Fundal heights and estimated foetal weights are plotted on the chart, with those pēpi that plot under the 10th centile considered to have not met their optimal weight for gestation. In 2020 we saw 120 to 279 charts produced each month and 123 (69%) to 161 (91%) centiles produced. Detection rates are slowly improving – the baseline audit (2017) detection rate antenatal period was 32%. Now in 2020 detection rate per quarter varies from 32% to 48%.

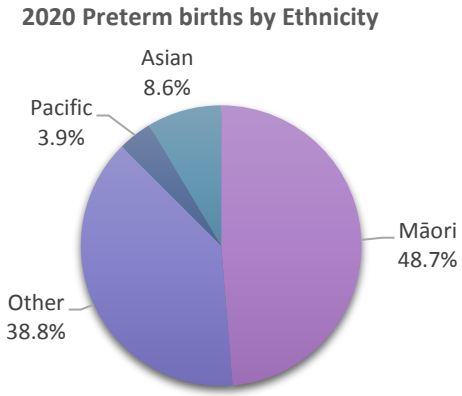
Supporting the programme, the Hawke's Bay DHB GAP Champion carries out teaching sessions with staff covering the use of customized growth charts, the implications of a baby being under the 10th centile and the guidelines for care. Over 80% of staff have now completed required face to face training.

PRIORITY AREA UPDATES

Priority areas identified by the National Maternity Monitoring Group (NMMG) for MQSP attention in 2020 were: Reducing the rate of preterm birth, maternal mental health, contraception and place of birth choice.

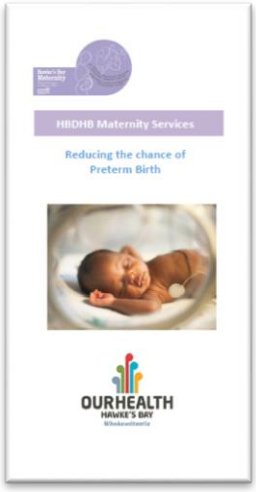
REDUCING THE RATE OF PRETERM BIRTH

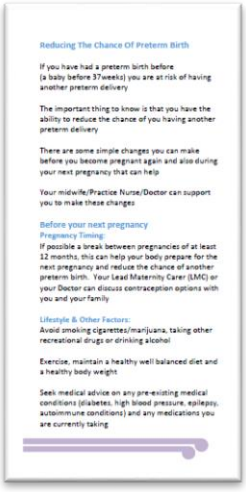
Preterm birth is a leading cause of morbidity and mortality for tamariki under five years of age as highlighted in the 2019 National Maternity Monitoring Group (NMMG) report. Our 2020 preterm birth rate (8.1%) reflects some improvement from 2019 (8.9%), but remains above the 2018 National rate of 7.5%.



In response to this we have:

- Developed a pathway whereby all wāhine experiencing preterm birth are given information regarding future pregnancies and what they can do to reduce the risk factors of another preterm birth.
- Produced the 'Reducing the Chance of Preterm Birth' leaflet for these wāhine which outlines reducing risks and knowing the signs and symptoms of preterm birth.
- Produced a new Premature Labour Pathway which helps to identify at risk wāhine and recommendations for prevention and treatment.
- Wāhine identified as at risk of preterm birth are seen in the antenatal clinic ideally before 12 weeks.
- Worked with Te Haa Matea Hawke's Bay's Smokefree Service to increase the number of wāhine and whānau becoming smokefree.





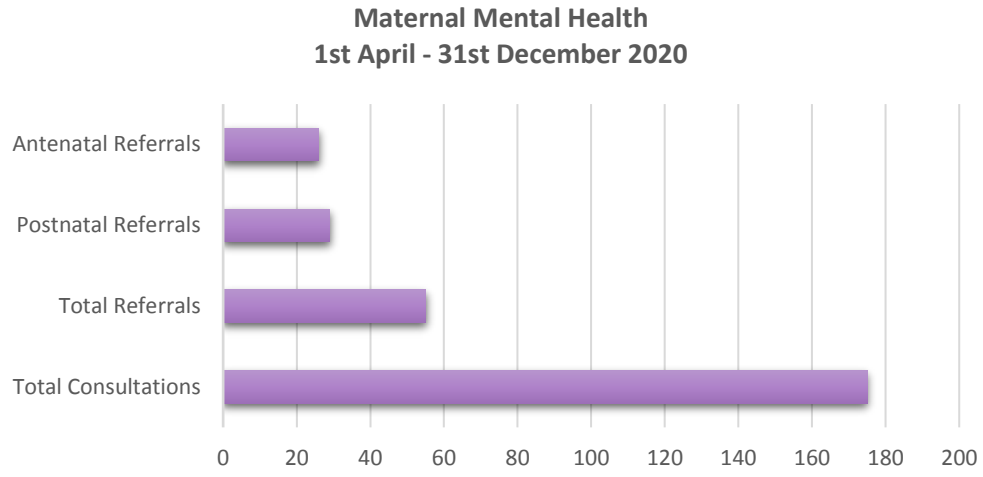
MATERNAL MENTAL HEALTH

The Maternal Mental Health (MMH) Outpatient Service has grown in the last year with the addition of another Specialty Clinical Nurse and a Psychiatrist joining the team. This is the first time the team has been fully staffed since 2019. Our one Specialty Clinical Nurse along with the support of a psychiatrist have managed the service with limited FTE for a long period of time so it is exciting for us all to be able to meet the need of more whaiora in our community.

In November 2019 the Maternal Mental Health Service was transferred to sit alongside the Te Ara Manapou team (a service for pregnant women experiencing drug and addiction issues). The COVID19 pandemic slowed the progress of recruitment and the availability of our new psychiatrist who was emigrating to New Zealand from the United Kingdom. We were privileged to welcome Dr Coccia into the service in July 2020. Dr Coccia brings with her a wealth of knowledge working in the MMH field and we have been fortunate the Mental

Health and Addiction directorate has allowed the Maternal Mental Health (MMH) team to utilise her 0.4 FTE to help develop the service.

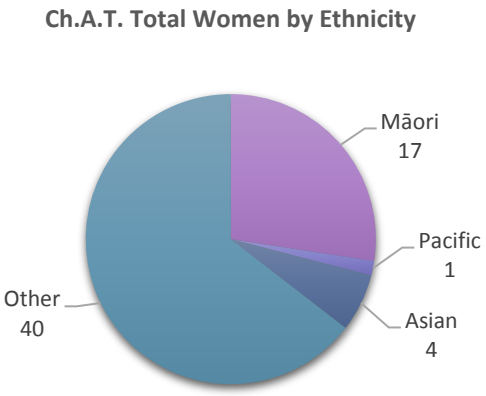
The MMH team now triage their own referrals and this allows the team to liaise with referrers and recommend other community supports if the referral does not meet the moderate to severe secondary criteria of MMH. Whilst nearly 50% of the referrals come from the wāhine's GP we are seeing a range of other referrers from internal Mental Health service, midwives and the ChAT (Chidlbirth After Thoughts) service. The MMH service has also been allocated funding to train and support the Primary Care Sector. Dr Coccia is leading this training and it is hoped to start rolling this out in February/ March 2021. With the new primary care model for GP's having health improvement practitioners and health coaches it is hoped that the training can support the workforce in the mild to moderate space to ensure all wāhine are supported. It is exciting to be able to continue to develop a service to ensure not only the wellbeing of our wāhine but also their pēpi.



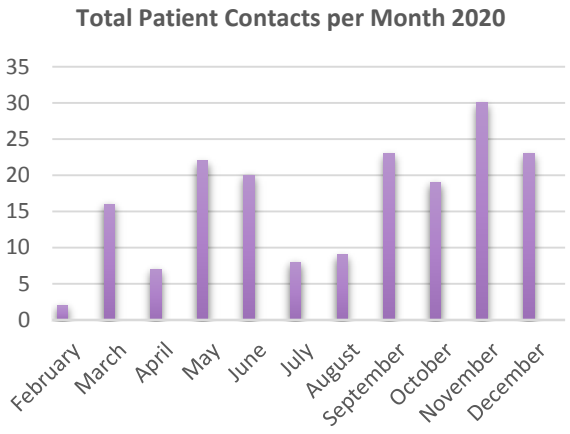
CHILD BIRTH AFTER THOUGHTS (CHAT)

The Childbirth After Thoughts Service (ChAT) has been operating at Hawke's Bay DHB for 12 months. We currently have a midwife working 0.4 FTE in this role. It was set up to enable wāhine who have been distressed by an unexpected birth related incident or trauma to have a platform to process their thoughts and understand the physical symptoms of their survival/fear response.

The service has been well received and is firmly ensconced in the maternity culture, with many referrals coming from the DHB Obstetric and Gynaecology (O&G) clinics as well as staff, LMCs, Tamariki Ora and Plunket nurses and the wāhine themselves.



Each woman receives an initial phone interview and is followed up by face to face meeting in her own home or at the maternity service. Most wāhine take the opportunity to engage in the full five sessions but others feel they have been able to work through their experiences in only three sessions. Useful insights are uncovered in the time together to understand her thoughts around the distressing birth memories; reading her notes, learning the limbic system, identifying core beliefs and using Cognitive Behaviour Therapy techniques (CBT) to rationalise her self-defeating mind-set around her birth experience. Feedback has been positive with 100% of survey responses saying they found it beneficial and would recommend the service to their friends and whānau.



Our ChAT midwife has presented the ChAT service by Zoom on the national forum, Perinatal Anxiety and Depression Aotearoa (PADA) and face to face at New Zealand College of Midwives (NZCOM) region's education day, to our rural midwives in Wairoa, to the Community Mental Health Team, to Taiwhenua O Heretaunga Tamariki Ora service and to Plunket. The referrals as a result have rapidly increased to currently 5-7 per week. Seeing a maximum of four wāhine each week results in the waiting list being approximately one month. Wāhine requiring further help are referred to their GP, Maternal Mental Health Service, Napier Family Centre, Birth-right and/or the DHB social workers.

Further work is being done in 2021 to extend this valuable service.

CHAT A WOMAN'S STORY

March 20th, 2019 is a day that will be etched into my memory forever. It was a day of devastation, heartbreak, confusion and yet still infused with so much love and moments of joy.

Our much wanted and loved babies who came early into this world before they were ready.

We were blessed to have some time with them while they were alive, their little hearts beating before they passed over in our arms.

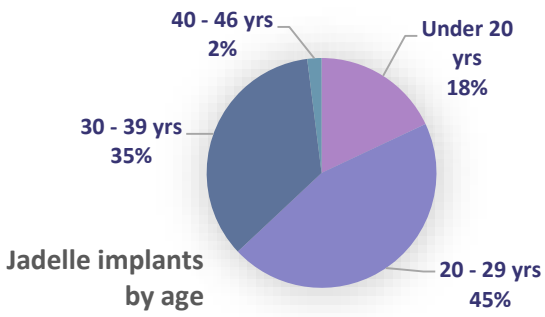
Nothing can ever prepare a parent for a moment like this and it takes you on a rollercoaster of a journey that will most likely last a lifetime.

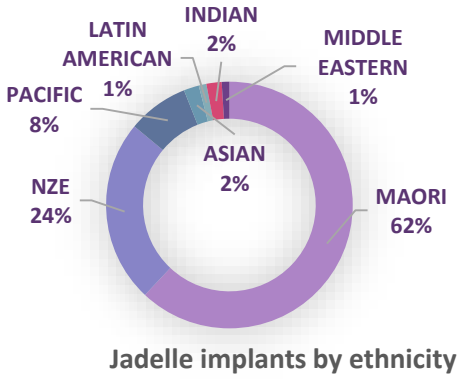
I spent most of my subsequent pregnancy using avoidance to help deal with fear of the pregnancy and of the impending labour and birth. Then I was referred to ChAT (Childbirth After Thoughts) to help me work through my labour and birth trauma with the triplets. Without the help of ChAT, alternative forms of therapy plus an amazing team of wāhine including a very special LMC and hospital midwives, I wouldn't have had the positive birth experience I did. It really was a team effort to get me across the line emotionally.

The support I received from ChAT enabled me to push through my fears, to birth in the same room I lost my babies in, to feel comfortable with the labour and birth process and to find joy in the birth of my daughter, something I wasn't sure would be possible.

CONTRACEPTION

Equitable access to long acting reversible contraception is one of the four priorities as set out in the NMMG's 2019 work programme. All wāhine should have free access to contraception for the immediate postpartum period and to this end the Hawke's Bay DHB continues to train clinicians in the insertion of Jadelle (Levonorgestrel Implants). We now have a combination of 11 midwives and nurses trained to insert Jadelle contraceptive implants in the postnatal period. In 2020 a total of 154 Jadelles were inserted in Ata Rangi postnatal ward and in Waioha Primary Birthing Unit. We do not have data on Jadelle removal as this is done in the community.





PROVISION OF JADELLES IN WAIROA RURAL BIRTHING UNIT

An identified gap in access to long acting reversible postpartum contraception (LARC) in Wairoa prompted a proposal for this service. This proposal was also supported by a one-year audit of the birthing population in 2017 which indicated evidence of high unmet need for contraception, high birth rate for under 20-year-old wāhine, frequent short birth interval spacing (Wairoa Birth Stats 2017 & 2018) and high fertility rate (personal communication, Statistics NZ 2018).

DHB caseload midwives provide maternal healthcare in Wairoa and surrounding districts. Along with the Clinical Manager at Wairoa Hospital they supported initiation of a midwife led Jadelle placement service. One midwife in the team had the appropriate skill set to provide this service for post-partum wāhine. In 2020 15 Jadelle implants were provided for Wairoa wāhine.

WAIROA JADELLE IMPLANTS 2020			
86% identified as Māori Ethnicity	**20% were 20yrs age or younger**	**46% were 21-29yrs age**	**46% birthed first baby**

PLACE OF BIRTH

During 2020 our home births increased from 86 homebirths in 2019 to 161 in 2020, an increase from 4.5% to 7.7% of all births. This was mainly due to the COVID-19 pandemic which influenced wāhine to birth at home.

Waioha, our stand alongside Primary Birthing Unit, was repurposed to our Covid-19 isolation area in Lockdown Level 3 & 4 and therefore our birth rate in our primary unit has been impacted in 2020.

A HOME BIRTH STORY - HINE, TRENT, BABY CHARLIE AND KERRI SMITH LMC MIDWIFE

When first meeting Hine in her first trimester, she mentioned she was thinking about homebirth. Most women having their first babies aren't thinking about it so early, so I knew she was confident and brave from the start. She was also healthy, well-informed, had a supportive partner and a home of their own to live in. In between this initial plan and the time baby Charlie was ready to be born, the whole world changed: We were in level 4 lockdown and suddenly many more women were wanting to birth at home now.

Hine blogged and journaled throughout her pregnancy and labour, so captured the experiences herself:

"I planned a homebirth from the very beginning. I hadn't thought about this prior to becoming pregnant and I'm not sure what exactly made me want to do it. I just knew I wanted to birth my baby in the comfort of my own home, in my own space where I felt safe and secure."

"Wednesday, 7pm. After 36 hours of prelabour I am FINALLY in active labour, with contractions now every 1-3 minutes. Kerri is assisting at another birth so I have another midwife here. Kylie turned up about 8pm. At this stage I was breathing deeply, in the pool, listening to hypno-birth recordings. I found this really helpful, and Trent (my partner) said it helped him to feel calm too!"

"I'm in and out of the pool, can't be comfortable, back and forth from pool to toilet. Contractions getting stronger and I'm vocalising strongly. A second midwife (Sarah J) has turned up."

"I'm feeling really defeated and upset. I asked for pain relief even though I know we don't really have any. I wanted to give up. I started to doubt I was ever going to give birth and the emotions were high! It's funny because I read the midwife notes and they wrote that I was coping well and relaxing between contractions."

"I request an examination: 9cms. I was frustrated and wondering why I was still in labour! Charlie's head was low and tight against my cervix. They all encouraged me to carry on. My waters hadn't broken yet. I kept changing positions but nothing felt right. 1130pm, is this EVER going to end? I'm absolutely wrecked. Contractions have spaced out." Kerri - Hooray, I was finished at the other birth and on my way to Hine and Trent!

"1240am, My Saviour has arrived. Kerri has come to attend mine. I feel a sense of relief upon her coming in. I'm propped up against the couch. Kerri gives acupuncture and some homeopathics. I feel a spontaneous urge to push. Finally, my waters break and we have obvious gushes of fluid." Kerri. I was not her saviour in any way. She had done it all already on her own power and had amazing midwives with her.

"Thursday, 1.05am. 41 hours and OMG I'M FULLY DILATED. I'm lying on the couch and we can see her head now. It's all go. With each push, her little head is only peeping ahead by the millimetre. I'm so exhausted but the end is near. Midwives suggest I sit on Trent's lap (like a birth stool) so that gravity can help. I'm hardly coherent so just do as they say. Here I am straddling Trent on a dining chair in the lounge."

"1.44am she was born ☺ A sense of relief like no other. The pain, the journey, the walk into the unknown. We had made it to the end. My baby was on my chest, cord attached and pumping. A head full of hair and the most beautiful face I had waited long months to meet."

I am so proud of this family. This birth was hard work. I think maybe people feel that those who have homebirths just breeze through them, but that's not how it is. At any time Hine could have changed her mind and gone in to hospital if we had any worries about Hine or baby Charlie, or if she needed a break or stronger pain relief. Birth is not a contest. We can birth any way and be proud and successful. We are so lucky that women can choose to birth where they want, and are funded to have this choice in New Zealand.

PROGRESS ON NATIONAL AND LOCAL MQSP PROJECTS

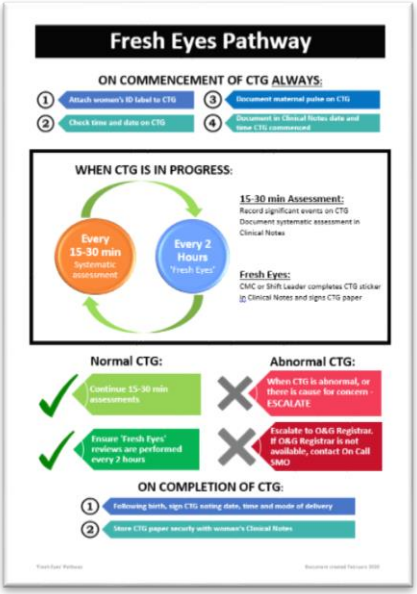
Project type			HBDHB status
Local Project	Title	**Safety First Campaign**	
	Rationale	To reduce the number of events occurring because of poor CTG interpretation and reduce the number of babies admitted to SCBU	
	Actions	Implementing of mandatory yearly online FSEP course completion with face to face study day every three years. Implementing the "fresh eyes" campaign with 2 hourly review of all CTGs by CMCs/shift leaders	🟢
	Measures	Reduction in SAC events with misinterpretation of CTGs and babies transferred to NICU for cooling	
	Outcomes	Improved interpretation of CTGs Reduction in infants with NE as diagnosis	
	Future	Continue campaign with annual completion of FSEP training Ongoing practice learnings shared and implemented	
National Project	Title	**Implementation of MEWS**	
	Rationale	National programme to increase the recognition of the deteriorating maternal patient	
	Actions	Create local escalation pathway Implement MEWS observation chart Educate all clinicians	
	Measures	Audit use of the chart, reduction in numbers of patients admitted to ICU	🟢
	Outcomes	Improved and early recognition of the deteriorating maternal patient	
	Future	Audit of the chart continues Continued dissemination of findings and ongoing clinical best practice and updated care pathways	
National Project	Title	**Implementation of NOC/NEWS**	
	Rationale	To reduce the numbers of babies/ pēpi who develop neonatal encephalopathy	
	Actions	Create local escalation pathway and customise chart Implement chart Educate all clinicians	🟡
	Measures	Audit use of the chart, increase in detection of unwell baby/ pēpi.	
	Outcomes	Improved recognition of deteriorating baby/ pēpi.	
	Future	Implemented February 2021	

🟢 Work has been completed and/or business as usual phase
🟡 Work is in progress/underway and nearing completion
🔴 There is still a significant amount to achieve before completion

SAFETY FIRST

As a result of reviewing adverse events in 2019 several themes emerged. The most concerning and recurrent theme was that of misinterpretation of CTGs. As a result of this mandatory completion of the fetal Surveillance Education Program (FSEP) online CTG interpretation training annually was introduced for all midwives, O&G Senior Medical Officer (SMOs), Registrars and SHO, we also strongly advised all LMC clinicians to complete this course. The full day course is to be completed every three years. All courses are provided free of charge to all midwives.

As well as the CTG training it is now expected that all practitioners follow the "Fresh Eyes" approach of reviewing CTGs whereby all CTGs are reviewed by a CMC/shift leader or member of the O&G team at 2 hourly intervals. Along with the changes a new CTG sticker and algorithm was produced.



IMPLEMENTING THE MATERNITY EARLY WARNING SCORE (MEWS)

The Health Quality and Safety Commission developed the Maternity Early Warning System (MEWS) in order to support staff in providing safe and consistent care to wāhine. The MEWS chart allows for earlier identification of the deteriorating wāhine in the antenatal and the 42 days post-partum period.

A working group was established and charter written in August 2019. Following this, consultation with senior obstetricians, anaesthetists and midwives allowed for an escalation pathway to be written. Education then followed via our on-line model and via routine study days and the PROMPT course. Midwives and nurses were asked to trial the chart and comment before the chart was finalised and introduced in our base maternity unit and stand alongside primary birthing unit in November 2019. The MEWS chart was introduced into our rural Wairoa unit in February 2020 and hospital wide in March 2020

Audit of the MEWS chart in Ata Rangi and Waioha indicate that the chart has been well received and is being well used. We begin audit of the use of the MEWS in our rural unit and hospital wide in January 2021.

IMPLEMENTING THE NEWBORN OBSERVATION CHART/NEWBORN EARLY WARNING SCORE

The new-born observation chart/new-born early warning score (NOC/NEWS) is a nationally used chart which standardises early warning observations and recording of vital signs for new-borns. The aim of the NOC/NEWS chart is to recognise those new-borns who are deteriorating and need extra care in particular those pēpi at risk of neonatal encephalopathy. Earlier identification of these risk pēpi improves escalation and treatments times which can significantly improve their health outcomes. The chart is used in conjunction with the GAP/GROW tool.

We have been working in partnership with ACC since September in order to introduce the NOC/NEWS into our units. A working group was convened, escalation pathway refined and education implemented into our online education system. The NOC/NEWS were introduced in December in Ata Rangi and Waioha. Our rural primary birthing unit in Wairoa is expected to be on board in March 2021.

OUR MATERNITY DATA

CLINICAL INDICATORS

The National Maternity Clinical Indicators are a selection of 20 indicators, which are useful for Maternity services to identify and flag possible variances in their service that may need investigation, quality improvement or special focus. Of the 20 indicators, 8 relate to all wāhine giving birth in HBDHB, 8 relate to Standard Primipara (SP) – wāhine aged 20-34 years birthing their first baby with no history of pregnancy complications, and the remaining 4 relate to babies.

HB 2018 and NZ 2018 data are verified from the Ministry of Health's National Maternity Report, published September 2020. All HB 2019 and HB 2020 data is provisional data, based on HBDHB facility data only, not accounting for HB domiciled women who may have birthed elsewhere.

	NZ Maternity Clinical Indicators	HB 2018 %	HB 2019 %	HB 2020 %	NZ 2018 %	How we compare
1	Register with LMC in 1st trimester (ALL)	76	60.2	54.5	72.7	×
2	Spontaneous vaginal birth (SP)	67	73.2	68.2	64.7	✓
3	Instrumental vaginal birth (SP)	20.7	12.9	11.9	17	✓
4	Caesarean section (SP)	10.4	13.2	17.6	17.2	✓
5	Induction of Labour (SP)	7.1	9.5	9.4	7.8	×
6	Intact perineal (SPV)	38.6	33.8	31.5	26.5	✓
7	Episiotomy and no 3rd or 4th degree perineal tear (SPV)	20.9	14.9	15.8	24.6	✓
8	3rd or 4th degree perineal tear and no episiotomy (SPV)	2.5	7.1	6.2	4.5	×
9	Episiotomy with 3rd or 4th degree perineal tear (SPV)	1.8	1.1	1.2	2.1	✓
10	General anaesthetic for caesarean section (ALL)	12.5	10.3	7.4	8.5	✓
11	Blood transfusion with caesarean section (ALL)	1.9	2.9	2.4	3	✓
12	Blood transfusion with vaginal birth (ALL)	1.8	2.2	2.1	2.1	✓
13	Eclampsia at birth admission (ALL)	0.09	0.0	0.0	0.03	✓
14	Peripartum hysterectomy (ALL)	0.09	0.1	0.0	0.06	✓
15	ICU with mechanical ventilation during pregnancy or postnatal period (ALL)	0.0	0.2	0.2	0.03	×
16	Postnatal maternal tobacco use (ALL)	16.8	20.0	18.9	9.4	×
17	Preterm births (under 37wks gestation) (ALL)	7.3	8.9	7.2	7.5	✓
18	Small babies at term (37-42wks gestation)	2.6	3.5	3.2	3.1	✓
19	Small babies born at 40-42wks gestation	32	36.1	20.0	29.9	✓
20	Babies born at 37wks+ gestation requiring respiratory support	2.6	2.9	4.2	2.1	×

ALL = All wāhine SP= Standard primipara wāhine SPV= Standard primipara wāhine giving birth vaginally

NZ Maternity Clinical Indicators by Ethnicity 2020

		Māori %	Pacific %	Asian %	NZE %	Other %	DHB average
1	Register with LMC in 1st trimester (ALL)	43.7	37.1	66.5	63.4	62.7	54.5
2	Spontaneous vaginal birth (SP)	81.4	81.8	47.8	64.5	69.2	68.2
3	Instrumental vaginal birth (SP)	6.2	0.0	17.4	15.2	11.5	11.9
4	Caesarean section (SP)	11.3	18.2	28.3	18.1	19.2	17.6
5	Induction of Labour (SP)	9.3	36.4	8.7	8.0	7.7	9.4
6	Intact perineal (SPV)	47.7	0.0	16.1	27.7	22.7	31.5
7	Episiotomy and no 3rd or 4th degree perineal tear (SPV)	8.1	0.0	19.4	21.4	18.2	15.8
8	3rd or 4th degree perineal tear and no episiotomy (SPV)	2.3	0.0	19.4	7.1	0.0	6.2
9	Episiotomy with 3rd or 4th degree perineal tear (SPV)	0.0	0.0	0.0	1.8	4.5	1.2
10	General anaesthetic for caesarean section (ALL)	11.8	8.6	6.6	5.6	4.2	7.4
11	Blood transfusion with caesarean section (ALL)	1.2	2.9	3.9	2.4	4.2	2.4
12	Blood transfusion with vaginal birth (ALL)	1.2	2.8	4.1	2.4	3.1	2.1
13	Eclampsia at birth admission (ALL)	0.0	0.0	0.0	0.0	0.0	0.0
14	Peripartum hysterectomy (ALL)	0.0	0.0	0.0	0.0	0.0	0.0
15	ICU with mechanical ventilation during pregnancy or postnatal period (ALL)	0.4	0.0	0.0	0.1	0.0	0.2
16	Postnatal maternal tobacco use (ALL)	38.0	9.2	1.2	9.0	1.4	18.9
17	Preterm births (under 37wks gestation) (ALL)	9.8	5.0	7.8	7.3	3.9	7.2
18	Small babies at term (37-42wks gestation)	4.6	1.0	2.5	2.3	2.2	3.2
19	Small babies born at 40-42wks gestation	22.6	100.0	0.0	15.8	0.0	20.0
20	Babies born at 37wks+ gestation requiring respiratory support	4.8	5.1	3.8	3.8	3.7	4.2

ALL = All wāhine SP= Standard primipara wāhine
SPV= Standard primipara wāhine giving birth vaginally

	NZ Maternity Clinical Indicators for Birthing Wāhine under 20 years 2020	15-19 years %	DHB average
1	Register with LMC in 1st trimester (ALL)	41.0	54.5
2 - 9	Not applicable (SP only)	-	-
10	General anaesthetic for caesarean section (ALL)	12.5	7.4
11	Blood transfusion with caesarean section (ALL)	6.3	2.4
12	Blood transfusion with vaginal birth (ALL)	1.2	2.1
13	Eclampsia at birth admission (ALL)	0.0	0.0
14	Peripartum hysterectomy (ALL)	0.0	0.0
15	ICU with mechanical ventilation during pregnancy or postnatal period (ALL)	1.0	0.2
16	Postnatal maternal tobacco use (ALL)	34.6	18.9
17	Preterm births (under 37wks gestation) (ALL)	10.7	7.2
18	Small babies at term (37-42wks gestation)	3.4	3.2
19	Small babies born at 40-42wks gestation	33.3	61.8
20	Babies born at 37wks+ gestation requiring respiratory support	10.1	4.2

RESPONSE TO CLINCIAL INDICATORS

Direct comparison between our 2020 clinical indicators and 2020 NZ national averages is not possible due to the two-year reporting lag of national figures, hence where small differences occur between our 2020 data and NZ 2018 data we have not commented. However where significant variation from the 2018 NZ figures exists, we address each of these clinical indicators below:

CLINICAL INDICATOR ONE – REGISTRATION WITH LMC IN 1ST TRIMESTER

Our 2019 and 2020 provisional data appears to show a large drop in LMC 1st trimester registrations from our 2018 rate. However, as provisional data is obtained only from our DHB facilities and does not include LMC data sent directly to the Ministry of Health (MOH), we anticipate the figures will increase once MOH national reports for 2019 and 2020 are released. This pattern was observed previously with our provisional 2018 rate increasing from a low 65.1% to 76% (above the national average) once nationally adjusted.

Even so, the provisional data does suggest that early LMC registration rates have reduced over 2019 and 2020, and are particularly low in priority population groups of Māori wāhine (43.7%), Pacific (37.1%) and young māmā (41%). We continue to promote early registration through our 'Top Five for my Baby to Thrive' campaign, featured prominently on social media, DHB website and signage. Also the increase to 53 LMC midwives now accessing our units, will enable better access to and early engagement with an LMC for pregnant māmā in our region. With the appointment of our new Māori Consumer Representative in late 2020, a focus will be on consumer promotion of early LMC registration directly to our priority population groups in 2021.

CLINICAL INDICATOR THREE – INSTRUMENTAL VAGINAL BIRTH FOR STANDARD PRIMIP

Our rates for instrumental vaginal births for standard primips have continued to decrease over the last three years and we are pleased to see that our rate is now considerably below the national average at 11.9%. This may be partially explained by our slight raise in our caesarean section rate. However, despite our slight raise in caesarean sections for standard primp we are still within the national range for these births.

CLINICAL INDICATOR FIVE – INDUCTION OF LABOUR

An initial jump in rate of induction of labour for standard primips from 7.1% in 2018 to 9.5% in 2019 has reduced slightly for 2020 at 9.4%, yet remains above the national rate of 7.8%. Having identified this unfavourable indicator, a considerable body of work has taken place to improve our Induction of Labour

pathway by our Obstetric Head of Department. A new Induction of Labour Pathway is to be introduced in the near future.

CLINICAL INDICATOR SIX – INTACT PERINEUMS FOR STANDARD PRIMIP GIVING BIRTH VAGINALLY

Although we have seen a decline in our intact perineum rate for standard primips giving birth vaginally over the last three years we are pleased to see that we are still well above the national average for this indicator. We continue to work on engaging wāhine early in their pregnancy to give them the best chance of education and information about their health and pregnancy to increase favourable outcomes.

CLINICAL INDICATOR EIGHT – 3RD OR 4TH DEGREE PERINEAL TEAR WITH NO EPISIOTOMY

Our rate of 3rd or 4th degree perineal tear without episiotomy peaked in 2019 at a high 7.1% before reducing to 6.2% in 2020, though still higher than the 2018 national average of 4.5%. When sorted by ethnicity, it is evident that while Māori and Pacific māma show favourably low rates of 3rd or 4th degree perineal tear with no episiotomy, a particularly high rate is experienced by Asian Māma at 19.4% of standard primip vaginal deliveries. This significantly higher rate can be attributed somewhat to a small population size of just 31 women in this group, which may skew the percentage, however our data also shows this same population group experiencing a high rate of instrumental deliveries (17.4% in 2020) a known contributing factor to perineal trauma. In order to further investigate this outcome, an audit of 3rd or 4th degree perineal tears is planned for 2021 to establish cause and risk for this trauma.

CLINICAL INDICATOR SIXTEEN – POSTNATAL MATERNAL TOBACCO USE

Tobacco use among Hawke's Bay hāpu wāhine has historically been high. A region with significantly high rates of deprivation; a known factor influencing tobacco use; 43.6% of our wāhine hāpu in 2020 resided in deprivation quintile 5 areas. When sorted by ethnicity, the rate of tobacco use is also significantly higher in our Māori wāhine population group, with 40.1% not smokefree at time of booking. The efforts of Te Haa Matea, the Hawke's Bay smokefree team, in tackling this issue is outlined in the section 'Stop Smoking Service' on p.19. Despite the Covid 19 lockdown period, the slow but steady reduction in the rate of wāhine using tobacco in the postnatal period continues, 18.9% for 2020. Although considerably higher than the national rate of 9.4%, it represents a reduction of 5% over the previous five-year period from a high of 24.8% in 2016. We hope to build on this result in 2021 as we continue to focus on smokefree pregnancies as a priority in collaboration with both Te Haa Matea, and community colleagues at Tuai Kōpu, He Korowai Aroha, Te Ware Pora, and teen parent schools.

CLINICAL INDICATOR NINETEEN – SMALL BABIES BORN AT 40-42WKS

The national average for small babies (defined as babies less than the 10th percentile for birthweight for gestational age on intergrowth charts) born at 40-42 weeks is 29.9%. Our data shows a very pleasing result, with rates for 2020 dropping to 20% from the previous rate of 36.1% in 2019. This large reduction is mainly attributed to the successful implementation of the GAP/GROW Programme – see section 'Local Maternity quality improvement activities" p.39. The GAP/GROW midwife has worked hard to ensure all medical staff, midwives and LMCs have received education and training to use the customised growth charts proficiently. Increased detection of

small pēpi has meant these at-risk pēpi are monitored and delivered before 40 weeks of pregnancy for the best clinical outcomes.

CLINICAL INDICATOR TWENTY - BABIES BORN AT 37WKS+ GESTATION REQUIRING RESPIRATORY SUPPORT

An audit to review term (37wks+) admissions to SCBU was conducted during 2020. Results confirmed that there has been both an increase in respiratory support required and an increase in duration of support for term infants. Reasons for the increased rate remain unclear and a further audit to specifically investigate respiratory admissions has been recommended. Pleasingly, it was found that the rate of admissions from our primary birthing unit Waioha were low.

MEASURABLE OUTCOMES

These Measurable Outcomes relate to all births in HBDHB, irrespective of parity.

MEASUREABLE OUTCOMES RATES ALL WĀHINE 2020				
Spontaneous Vaginal Birth 67%	Instrumental Birth 5.7%	Elective Caesarean Section 10.9%	Emergency Caesarean Section 16.0%	Total Caesarean Section 26.9%
Caesarean Section under GA 7.4%	Induction of Labour 17.5%	Episiotomy 4.8%	3rd or 4th Degree Perineal Tear 2.2%	Epidural 12.8%
Postpartum Haemorrhage 7.2%	Postnatal Blood Transfusion 2.0%	Wāhine Living in Deprivation Deciles 8-10 58.4%	Neonatal SCBU Admission 17.5%	Exclusive Breastfeeding 70.8%
Homebirth 7.7%	LMC Registration in 1st Trimester 54.5%	BMI ≥ 35 at Booking 6.6%	Premature Birth (<37weeks) 7.2%	ICU Admission 0.2%

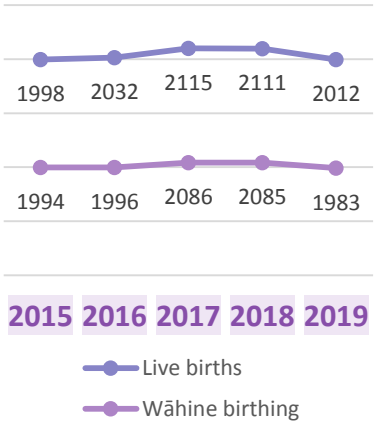
MEASUREABLE OUTCOMES MĀORI WĀHINE 2020				
Spontaneous Vaginal Birth 76.7%	Instrumental Birth 2.9%	Elective Caesarean Section 7.6%	Emergency Caesarean Section 12.1%	Total Caesarean Section 19.7%
Caesarean Section under GA 11.8%	Induction of Labour 16.2%	Episiotomy 2.2%	3rd or 4th Degree Perineal Tear 1.2%	Epidural 9.4%
Postpartum Haemorrhage 7.3%	Postnatal Blood Transfusion 1.1%	Wāhine Living in Deprivation Deciles 8-10 71.7%	Neonatal SCBU Admission 17.8%	Exclusive Breastfeeding 66.7%
Homebirth 7.9%	LMC Registration in 1st Trimester 43.7%	BMI ≥ 35 at Booking 8.1%	Premature Birth (<37weeks) 8.9%	ICU Admission 0.4%

MEASUREABLE OUTCOMES WĀHINE 15-19 YEARS 2020				
Spontaneous Vaginal Birth 75.7%	Instrumental Birth 9.9%	Elective Caesarean Section 1.8%	Emergency Caesarean Section 11.7%	Total Caesarean Section 13.5%
Caesarean Section under GA 12.5%	Induction of Labour 15.3%	Episiotomy 6.3%	3rd or 4th Degree Perineal Tear 4.5%	Epidural 14.4%
Postpartum Haemorrhage 12.6%	Postnatal Blood Transfusion 1.8%	Wāhine Living in Deprivation Deciles 8-10 75.7%	Neonatal SCBU Admission 22.3%	Exclusive Breastfeeding 68.5%
Homebirth 4.5%	LMC Registration in 1st Trimester 41.0%	BMI ≥ 35 at Booking 2.7%	Premature Birth (<37weeks) 10.7%	ICU Admission 1.0%

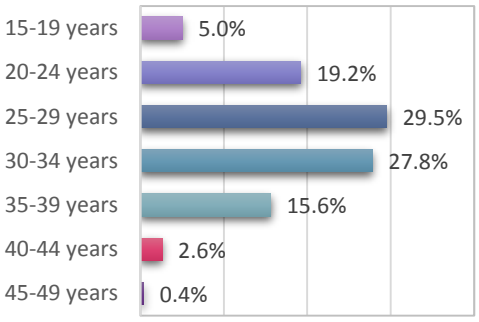
APPENDIX ONE – 2019 MATERNITY OVERVIEW

MEASUREABLE OUTCOMES RATES 2019				
Spontaneous Vaginal Birth 67.4%	Instrumental Birth 4.9%	Elective Caesarean Section 8.7%	Emergency Caesarean Section 16.9%	Total Caesarean Section 25.6%
Caesarean Section under GA 10.3%	Induction of Labour 15.5%	Episiotomy 4.0%	3rd or 4th Degree Perineal Tear 2.1%	Epidural 11.8%
Postpartum Haemorrhage 7.2%	Postnatal Blood Transfusion 2.2%	Women Living in Deprivation Deciles 8-10 60.5%	Neonatal SCBU Admission 15.6%	Exclusive Breastfeeding 76.9%
Homebirth 4.3%	LMC Registration in 1st Trimester 60.3%	BMI ≥ 35 at Booking 8.2%	Premature Birth (<37weeks) 8.4%	ICU Admission 0.2%

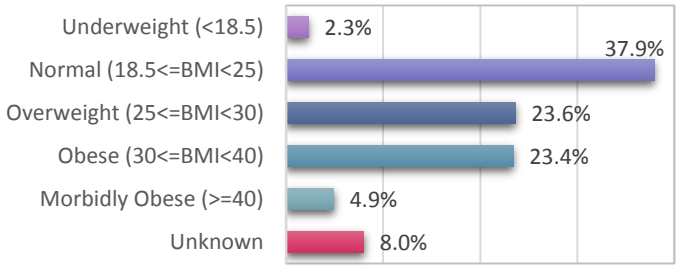
Yearly Birth Numbers



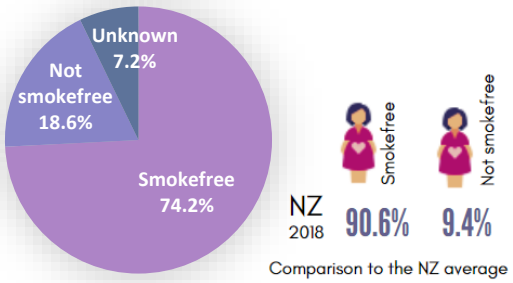
Age of Wāhine Birthing



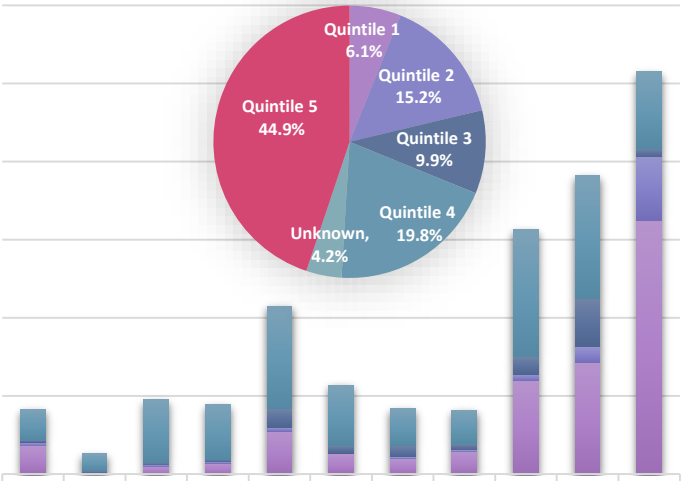
BMI of Wāhine Birthing



Smokefree status at discharge



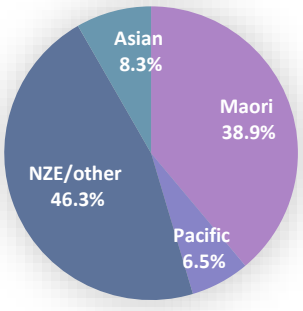
Deprivation of Wāhine Birthing



	Unknown	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
NZE/other	39	21	80	70	131	77	47	43	163	157	98
Asian	3	4	3	3	24	10	15	8	22	62	11
Pacific	5	1	2	2	5	1	2	2	8	20	81
Maori	36	0	10	14	55	26	20	29	120	143	325

Ethnicity of Wāhine Birthing

Hawke's Bay has a proportionately higher rate of Māori wāhine giving birth than the NZ 2018 average of 25.1%



APPENDIX TWO – UPDATE ON ALL NATIONAL RECOMMENDATIONS

2019/2020 PMMRC Recommendations	Hawke's Bay DHB progress
Monitor key maternity indicators by ethnicity to identify variations in outcomes & improve areas where there are differences in outcome	Ongoing. See clinical indicators.
Co-design models of care to meet the needs of Indian women	For 2021
Co-design models of care to meet the needs of wāhine <20 years	For 2021
Interdisciplinary foetal surveillance education for all clinicians involved with intrapartum care	FSEP implemented as part of Safety First Project.
Cultural competency workshops for all Maternity Service staff	Complete. Study day for all staff ongoing
Implementation of HQSC maternal morbidity review tootkit and SAC rating (maternal & NE case review)	Complete. HQSC review toolkit and SAC rating system fully implemented

2019/2020 MMWG Recommendations	Hawke's Bay DHB progress
MEWS audit and case review Morbidity review identified through trigger tool	Audit ongoing.
Implementation of Hypertension guideline, with a review/re-stock of medications to ensure easy availability in acute care settings	Complete
Use of the Health Equity Assessment Tool (the HEAT) to assess services for the impact of health equity	On going
Establish a clinical pathway for wāhine with identified placental implantation abnormalities	For 2021
Establish septic bundle kits to address human factor components, such as stress in high-acuity settings	On going
Establish clinical pathways across primary and secondary/tertiary care to enable earlier recognition and treatment of sepsis	On going

2019/2020 NMMG Recommendations	Hawke's Bay DHB progress
Encouraging low-risk wāhine to birth at home or in a primary facility Promotion of primary birthing facilities	Top 5 For My Baby To Thrive campaign. Promotion of Waioha Primary Birthing Unit.
Equitable access to post-partum contraception, including regular audit	11 nurse/midwife clinicians fully trained and competent in Jadelle insertion. Audit to commence 2021.
Equitable access to primary mental health services. Maternal mental health referral & treatment pathway	ChAT service fully implemented Maternal Mental Health Service in place.
Reduce preterm birth and neonatal mortality	Reducing the Chance of Preterm Birth Leaflet produced and available. New Premature Labour Guideline in place. Te Haa Matea smoke free service engaged with wāhine hapu. Early engagement with a Midwife Campaign in progress

APPENDIX THREE – FUTURE MQSP PROJECT PLAN

MQSP PROJECT PLAN (2020-2023)

Objective	Status	DHB Priority	PMMRC	MMWG	NMMG
Implement and continue to embed national projects	In progress			●	
MEWS • Continue monthly MEWS audit and socialise learnings. • Commence six month audit of MEWS in Wairoa 02/21. • Commence hospital wide audit of MEWS. NOC/NEWS • To be implemented Jan'21. • For weekly audit April 2021 • To establish an escalation pathway for Wairoa and implement NOC/NEWS in Wairoa.	SEPSIS • Maternal Sepsis policy complete and in use. • Ongoing audit of sepsis management to commence Jan'201. HYPERTENSION • Policy in progress. • Working group to be established to complete this work GAP/GROW • Education of staff ongoing. • Ongoing audit of missed small for gestational age audit every 6 months ongoing				
Improve equity for priority groups – Māori, Pacifica and Indian women. Also, young women, women living in high deprivation and those living rurally	For 2021			●	
• Work with Business Intelligence to identify where inequality exists is evident in our health outcomes. • Ensure we have consumer representation from our priority groups. • Work with maternity consumer representatives to engage and communicate with our consumers. • Continue to work in partnership with Tuai Kōpu navigator to increase engagement with our service and help us better meet our consumer's needs. • Continue to work in partnership with our Māori service providers. • Work with He Korowai Aroha in our rural setting to better engage with hapū wāhine in Wairoa. • Use the HEAT tool in all initiatives to support equitable health care decisions and service planning/design. • Continued support for local maternity HUBs to enable earlier access to midwives for wāhine. • Work with our LMC colleagues to increase early engagement with a midwife. • Continue the identified connections with Te Haa Matea programme to enable wāhin and their whānau to become smokefree.					
Promoting low risk women to birth at home or in our primary birthing facilities	In progress				●
• Updated Place of Birth policy 2019. • ACMM now working with Primary Birthing in Waioha portfolio. • Ongoing support and education for our rural midwives to increase the birth rates for healthy women in our rural unit.					
Equitable access to Long Acting Reversible Contraception (LARC)	In progress				●
• Provide ongoing education and support for practitioners to insert Jadelles. • Identify a contraceptive champion in our unit. • Continued support for our rural midwives to provide Jadelles in the postpartum period.					

Provide equitable access to primary mental health services.	In progress				●
• Continue to embed ChAT service. • Secure sustainable funding for ChAT service. • Monthly audit of ChAT in progress. • Work with Maternal Mental Health service to provide an equitable Maternal Wellness pathway for women requiring ongoing support.					
Implement Maternal Morbidity Review Toolkit	In progress			●	
• Draft HBDHB framework and TOR form national guidance for consultation. • Pilot Case Review checklist form complete. • Form working group to finalise maternal morbidity review tool kit. • Implement formalised framework and review process					
Reduce Pre-term birth rates	In progress				●
• Promote early engagement with a midwife. • Embed Prevention of Pre-term birth pathway including education for at risk women. • Ensure early referral for specialist consultation for at risk women. • Provide smokefree support and referral to community support as required.					
Maintaining a Safety-First attitude in our unit (Safety First campaign)	In progress		●		

• Ongoing FSEP education as per current programme
  ○ Annual completion of FSEP training.
  ○ Completion of FSEP study day every three years.
• "Fresh eyes" 2 hourly review of every ongoing CTG audit of compliance to be commenced
• Ensuring completion of partogram in labour. Audit to commence Jan'21
• Ensuring completion of Placenta/whenua form. Audit to commence Jan'21					

Ensure a culturally safe and sustainable workforce across maternity services.	In progress	●			
• National participation in identification and development of immediate/medium and long term strategies and actions to address workforce shortage. • Use of Trendcare and CCDM tools to assess workforce needs. • Finalise DHB midwifery workforce career pathway in conjunction with national development. • Participate in the Leading Empowered Organisation (LEO) programme and support projects/emerging leaders identified in this programme. • Develop Tuakana teina pastoral care programme for undergraduate and new graduate Māori midwives. • Turanga Kaupapa training embedded for all maternity workforce.					
Support Vaginal Breech Birth	In progress	●			
• Establish working group to support term vaginal breech birth. • Provide education to upskill midwives. • Midwives to form on call roster to support other midwives to facilitate vaginal breech births. • Dissemination and education of midwives to feel confident with breech birth. • To establish/adopt vaginal breech care pathway – work in partnership with obstetric SMOs					

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