Southern District Health Board
Piki Te Ora

Southern Maternity
Quality and Safety

ANNUAL REPORT

Jul 2019
to
Dec 2020

Kind
Manaakitanga

Open
Pono

Positive
Whaiwhakaaro

Community
Whānau ngatanga

CONTENTS

SECTION 1

INTRODUCTION

Foreword

In the 18-month period from July 2019 to December 2020, and through unprecedented times, the Southern Maternity Quality and Safety Programme (MQSP) continued to build upon its earlier achievements.

Through effective use of governance, MQSP monitors maternity outcomes and identifies priorities for improvement. We also collaborate with maternity stakeholders to improve maternity services across the district for women and whānau in our region, promoting best practice and accountability, whilst strengthening its operational processes.

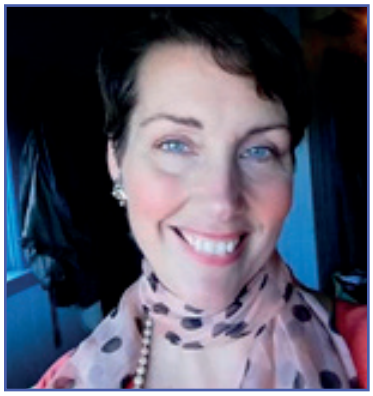
Jane Wilson and Catkin Bartlett
Co- Chairs
MQSP Governance Group

The Primary Community Directorate has continued with the significant project work determining the best configuration and location of primary facilities for the Central Otago/Wanaka areas, leading to the Southern District Health Board endorsing the recommendation of two primary maternity units at Dunstan Hospital and Wanaka. The Maternity and Quality Safety Programme (MQSP) have played an active advisory role in the process.

Lisa Gestro
Executive Director - Strategy, Primary and Community
Southern District Health Board

A year in reflection

Director of Midwifery Heather LaDell reflects on 2020.



Midwives pulled together across the district to provide the best care possible to mothers and babies through unprecedented challenges. Even as our International Day of the Midwife and International Year of the Midwife celebrations were disrupted, midwives all worked at light speed to adapt and pivot to provide safe care to our District's mothers and babies.

This year has been my first as Director of Midwifery. Who would have thought in 2019 that we would face a lockdown of the entire country, with midwives among the only professionals still providing in-person and in-home care? Together we figured out the what when and how of PPE, completely reconfigured how we delivered care and how hospital-level maternity care worked, while we prepared for being "ground zero" of Covid-19 in New Zealand. Thank you midwives and maternity staff for keeping yourselves and your colleagues safe and continuing to put the needs of pregnant women and babies at the forefront.

We all learned the ins and outs of Zoom video meeting etiquette – and probably all had some screen fatigue as well. It was an essential tool to keep in touch though, and I appreciated everyone's flexibility to adapt. It sure makes me appreciate face-to-face korero even more than usual!

We managed to have some achievements to celebrate in 2020, beyond just surviving Covid-19.

A brief list:

- New birthing pool installed at Lakes Maternity (see page 38).
- New permanent charge midwife in Southland Maternity.
- Two new Midwifery Coordinators, Fleur Kelsey and Liz Whyte, appointed for the Maternal and Child Wellbeing and Child Protection programme (see page 41).
- Two new Coordinators, appointed at Southland Maternity
- New Associate Director of Midwifery position signed off and advertised.
- Trialled a Reflective Learning circle in Dunedin with experienced clinical supervisor Morag Macaulay (see page 41).
- Rolled out the Maternity Early Warning Score, and prepared for Newborn Early Warning Score roll out (see page 44).
- Implemented the Variance Response Management plan in Dunedin, which increases visibility of when we don't have enough resources to match the demand at our tertiary unit (see page 44).
- Secured Board approval for two new purpose built primary maternity facilities in Wanaka and Central Otago (see page 17).
- Five new graduate midwives applying for Midwifery First Year of Practice positions for 2021 at Southern.

We are building toward a District-wide network of high-performance teams who trust each other, have a positive learning culture, and provide the highest quality of midwifery care in the world.

A thank you

From MQSP Coordinator Sarah Clark R.M.

I am proud to have compiled this Maternity Quality & Safety Programme Annual Report 2019/2020, on behalf of Southern District Health board.

The clinical indicators are from the 2018 dataset released October 2020, and the statistical data covers 2019 and the first six months 2020, where possible. This has been extended out to December 2020 based on local data.

The narrative is for the 2019/2020 period.

I would like to thank everybody who works for the maternity service across the district and the stakeholders for their ongoing commitment to provide quality care for wāhine, pèpè and whānau.

Recognition

The Maternity Quality and Safety Programme (MQSP) wishes to acknowledge the huge commitment from all the staff across the district who enable the maternity service to run efficiently and with its strong quality focus.

Many of the staff in the tertiary, secondary and primary settings take on champion roles that work alongside MQSP and are key to local and national quality projects succeeding, such as consumer feedback, manual handling, policy and guidelines, audit and education.

Other champion roles are related to patient safety such as falls' prevention, infection control, health and safety, maternal child wellbeing child protection, newborn life educators, safe sleep and smokefree champions who all enable practitioners to be the best they can be and educate and support women and whānau through their journey and time within the service.

Southern District Health Board (SDHB) and MQSP also formally acknowledge and thank all the senior leadership teams in the primary, secondary and tertiary settings for maternity and obstetric services that align multi-disciplinary teams to provide the safest care and support to all users during the antenatal, intrapartum and postnatal period.

The primary maternity units continue to provide a highly valued safe setting, for normal low-risk birthing, that maximises whānau involvement with their home-from-home experience. Secondary and tertiary services offer both low- and high-risk specialists for normal and complex care situations.

There are a significant number of community-based providers in the district operating many programmes to support healthy māmā and pēpē, meeting social and health needs. Your collaboration and approach to delivering integrated services in 2019/2020 across the SDHB ensured women and whānau got the care and support they needed, when it was needed. Your contribution meant we were all better able to respond to the individual needs of women to support improved outcomes. By working together, we have increased health literacy and awareness of gaps, opportunities and changing needs. This approach also enabled an ongoing focus on quality improvement across the sector. Your contribution is acknowledged and very much appreciated, especially by those receiving services.

SDHB and MQSP also recognise the important role primary care has within our maternity health system. Primary care continues to be one of the first points of contact for women who suspect they may be pregnant. General practice provides pregnancy testing, offers initial maternity advice to women and resources to link a woman to Lead Maternity Carer options. In some of our rural areas they support Lead Maternity Carers with urgent/emergency support to enable safe transportation as required, an integral element to the overall picture of integrated maternity services.

Strategic alignment

The following documents inform our primary maternity care.

- **National Maternity Standards**
- **National Maternity Monitoring Group Annual Report 2018**
- **Perinatal and Maternal Mortality Review Committee Thirteenth Annual Report**
- **Maternity Morbidity Working Group Third Annual Report**
- **Southern Primary & Community Care Strategy (Southern District Health Board and WellSouth Primary Health Network)**
- **Creating an Integrated Primary Maternity System of Care across the Southern District**
- **New Zealand Maternity Clinical Indicators 2018**
- **Report on Maternity web tool**
- **Primary Maternity Services Notice 2007**
- **Maternity service specifications**

Our pathway

The Southern District is a vast landscape, where resourceful and capable people have built health care structures to enable us to take care of each other. Now we need to bring it all together.

Our pathway towards enabling
Better health, better lives, Whānau Ora

What have our people asked for?*

Southern Future
It's up to us

- better coordinated care across providers, with less wasted time
- care closer to home
- communication that makes sense and is respectful
- a calm, compassionate and dignified experience
- high quality, equitable health services.

*Southern Future listening sessions, 2016

THE SOUTHERN STRATEGIC HEALTH PLAN

How will we get there?

Improving experience and outcomes:

Creating an environment for health
The environment and society we live in supports health and wellbeing.

Primary & Community Care
Care is more accessible, coordinated and closer to home.

Clinical service re-design
Primary and secondary/tertiary services are better connected and integrated. Patients experience high quality, efficient services and care pathways that value their time.

Enabling success:

Enabling our people
Our workforce have the skills, support and passion to deliver the care our communities have asked for.

Systems for success
Our systems make it easy for our people to manage care, and to work together safely.

Facilities for the future
Including Dunedin Hospital, Lakes District Hospital redevelopment and community health hubs to accommodate and adapt to new models of care.

By 2026:
We work in partnership to create a truly integrated, patient-centred health care system

A health-enabling society, within which we deliver:

More accessible, extensive primary and community care with the right secondary and tertiary care when it's needed.

So that our people:

- are healthier and take greater responsibility for their own health
- stay well in their own homes and communities
- with complex illness have improved health outcomes.

Southern Health
He hauora, he kuru pounamu

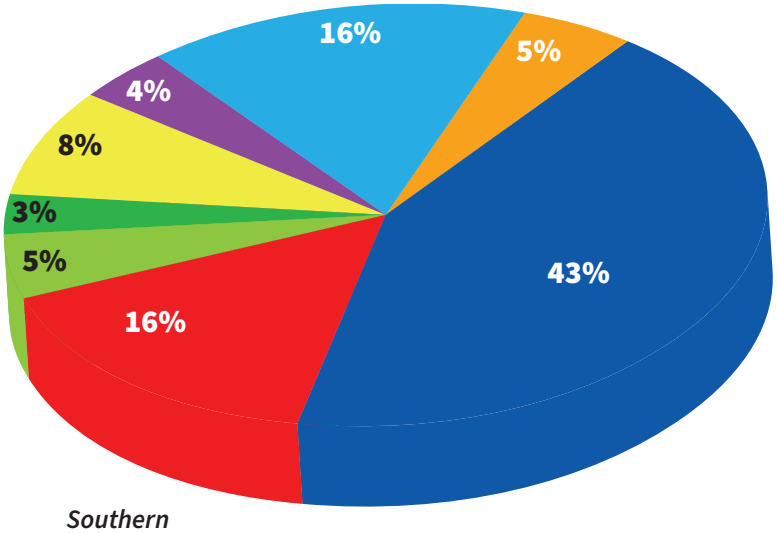
Kind - Manaakitanga | Open - Pono | Positive - Whaiwhakaaro | Community - Whanaungatanga

POPULATION & ENGAGEMENT

SECTION 2

Maternity demographics

Women of Birthing Age (15-49 years' old) by district %



2019

Source: Southern District Health Board coding data 2019 and MoH Qlik Data (accessed 13/01/2021)

In 2019

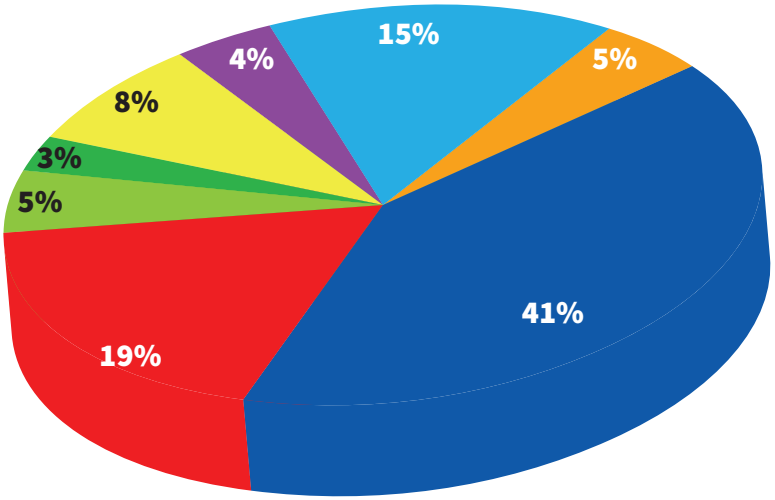
3392

women gave birth

Around

9

babies were born on average each day



2020

In 2020

3143

women gave birth

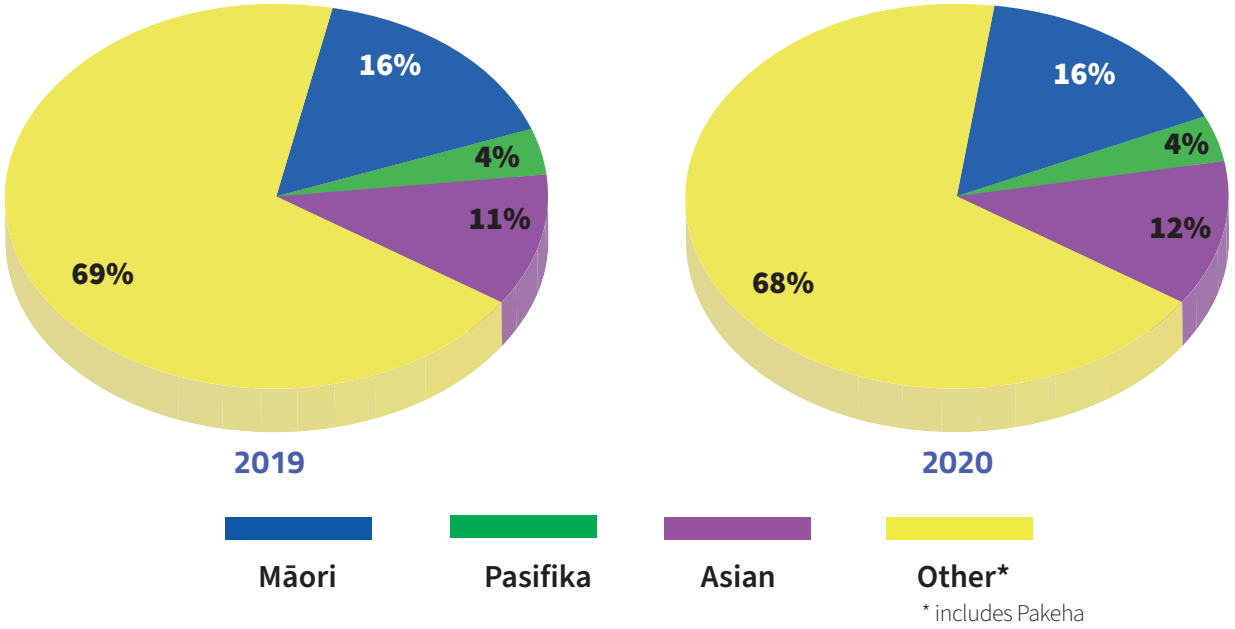
Around

9

babies were born on average each day

Dunedin | Queenstown Lakes | Central Otago | Gore | Southland | Clutha | Invercargill | Waitaki

Birthing Women Ethnicity %



Source: Southern District Health Board coding data 2019 and MOH Qlik Data (accessed 13/01/2021)

Primary Maternity Facilities Jan-Dec 2019

	Births	Transfer in for postnatal care	Total inpatient	Intrapartum transfer out to base hospital
Oamaru	75	68	143	19
Clutha Health First	41	85	126	8
Charlotte Jean	68	146	214	18
Gore Hospital	90	87	177	33
Lakes District Hospital	75	132	207	27
Winton Hospital	22	190	212	8
Total for primary maternity units	**371**	**708**	**1079**	**113**

Primary Maternity Facilities Jan-June 2020

	Births	Transfer in for postnatal care	Total inpatient	Intrapartum transfer out to base hospital
Oamaru	27	39	66	10
Clutha Health First	13	36	49	3
Charlotte Jean	43	49	92	4
Gore Hospital	40	27	67	10
Lakes District Hospital	32	31	62	33
Winton Hospital	16	49	65	4
Total for primary maternity units	171	231	401	64

Source: Primary maternity units

Clinical indicators

The New Zealand Maternity Clinical Indicators present comparative maternity interventions and outcomes data across a set of 20 indicators for pregnant women and their babies, by maternity facility and district health board (DHB) region.

Since 2012, DHBs and maternity stakeholders have used national benchmarked data in their local Maternity Quality and Safety Programmes (MQSP) to identify areas warranting further investigation. To support further investigation, the Ministry of Health provides unit record clinical indicators data to DHB MQSP coordinators (MoH, November, 26. 2020).

Many of the indicators compare results for "standard primiparae"; women who would be expected to have similar outcomes across all places of birth throughout the country. These have been abbreviated to SP on the table on page 11.

The definition of "standard primiparae' is:

- aged 20-34 years old
- giving birth for the first time
- carrying one baby
- at term 37-41 weeks' gestation
- cephalic (head down) presentation, and
- no obstetric complications.

Southern DHB recognises that clinical indicator 19 (small babies at term born at 40-42 weeks' gestation) has the greatest variance (3.9%) from the national average. We plan to implement the nationally endorsed Growth Assessment Protocol New Zealand (GAP-NZ) by March 2021. This programme targets fetal growth restriction and small-for-gestational-age babies, associated with stillbirth, neonatal death and perinatal morbidity. The implementation will address training and accreditation of all staff involved in clinical care, adoption of evidence-based protocols and guidelines and auditing and benchmarking performance.

There are also plans to reduce the number of standard primipare undergoing an instrumental birth (clinical indicator 3). Induction of labour is on the Southern DHB radar, with auditing occurring across both the secondary and tertiary units from late 2020 to early 2021. It is hoped that the long-awaited finalisation and release of *National Induction of Labour Guidelines* will be quickly adopted to help promote evidence-based practice and reduce variations in practice.

Pre-term birth (clinical indicator 17) is a strong focus in the next the MQSP tri-annual work plan, with initial plans for an audit of our tertiary facility, which has a higher-than-average rate compared to other tertiary facilities across the country. The results of the audit will assist us in making plans for targeted quality improvements. As maternal tobacco use (clinical indicator 16) is associated with higher rates of pre-term birth, there will be potential to link in with existing community stop-smoking programmes.

Clinical Indicator comparison of where Southern DHB Maternity sits against the national average 2018

CI	Description	National 2018	SDHB 2018	Desired position
1	Registered with a Lead Maternity Carer within the first trimester	72.7%	79.2%	Above national average
4	SP who undergo caesarean section	17.2%	15.5%	Below national average
7	SP undergoing episiotomy and no 3rd or 4th degree perineal tear	24.6%	16.6%	Below national average
10	Women having a general anaesthetic for caesarean section	8.5%	8.3%	Below national average
11	Women requiring a blood transfusion with caesarean section	3%	2.9%	Below national average
12	Women requiring a blood transfusion with vaginal birth	2.1%	1.5%	Below national average
13	Diagnosis of eclampsia during birth admission	0%	0%	At national average
15	Women admitted to ICU requiring ventilation during pregnancy or postnatal period	0%	0%	At national average
18	Small babies at term	3.1%	2.5%	Below national average
20	Babies born at 37+ weeks' gestation requiring respiratory support	2.1%	1.1%	Below national average
2	SP who have a spontaneous vaginal birth	64.7%	63.9%	Above national average
8	SP sustaining a 3rd or 4th degree perineal tear and no episiotomy	4.5%	4.6%	Below national average
9	SP undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear	2.1%	2.4%	Below national average
14	Peripartum hysterectomy	0.1%	0.09%	Below national average
3	SP who undergo an instrumental vaginal birth	17%	19.2%	Below national average
5	SP who undergo induction of labour	7.8%	9.5%	Below national average
6	SP with an intact lower genital tract	26.5%	24.9%	Above national average
16	Maternal tobacco use during postnatal period	9.4%	10.9%	Below national average
17	Preterm birth	7.5%	8.8%	Below national average
19	Small babies at term born at 40-42 weeks' gestation	29.9%	33.8%	Below national average

Favourable and/or better than national average
Equivalent and/or up to 1% of reaching national average
> 1 % away from national average

Source: https://www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2018

Hospital-based maternity service birth outcomes

Our two base hospitals provide specialist care for women and babies (obstetric and neonatal services) as well as providing midwife-led care for healthy, well women.

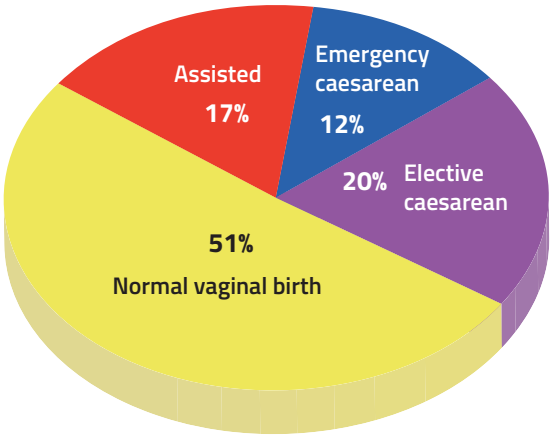
The interprofessional maternity team includes community midwives, staff midwives, registered nurses, lactation consultants, healthcare assistants, kaiāwhina, mental health workers, social workers, chaplains, obstetricians, paediatricians, anaesthetists and anaesthetic technicians, theatre nurses, physiotherapists, cleaners and the reception administration team.

In 2019, 1692 women gave birth in Dunedin Hospital and 1230 in Southland Hospital. In the first half of 2020, 782 women gave birth in Dunedin Hospital and 564 in Southland Hospital.

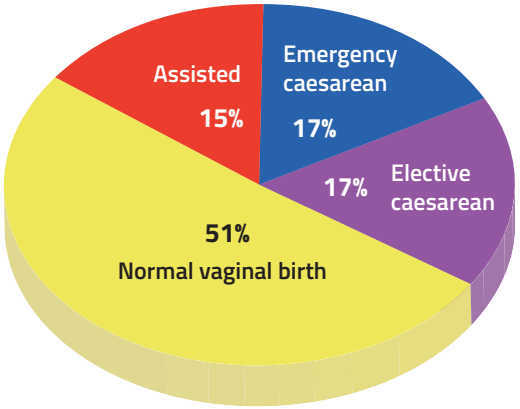
How women gave birth

Normal vaginal birth, with assistance using forceps or ventouse, caesarean section in labour or planned caesarean section

Queen Mary tertiary unit, Dunedin

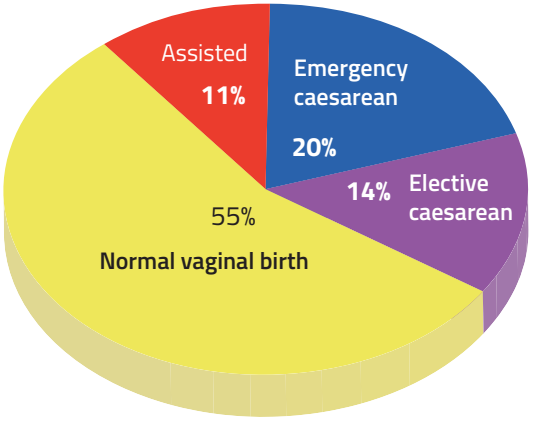


2019

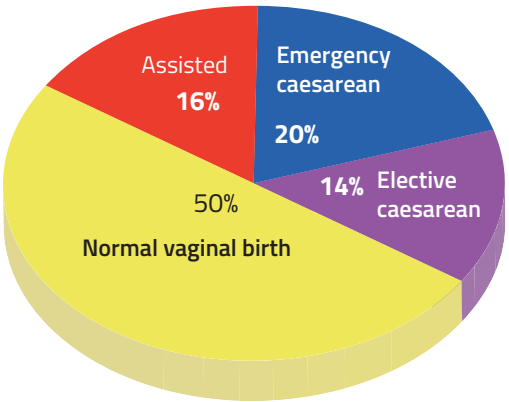


2020

Southland secondary unit, Invercargill



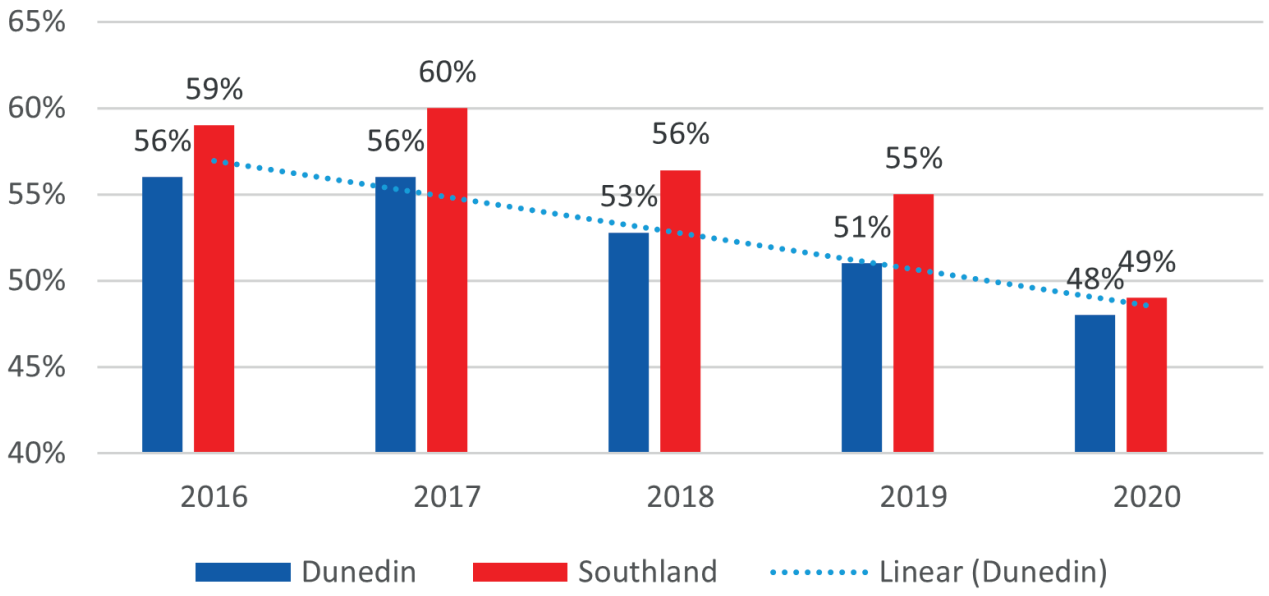
2019



2020

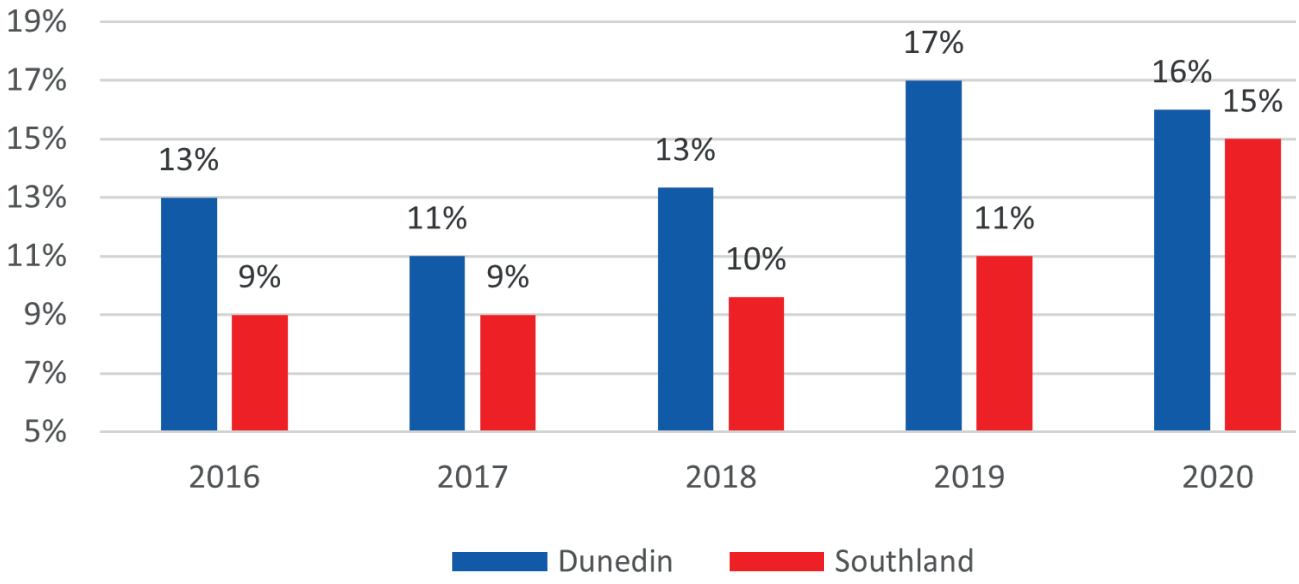
Normal vaginal birth - by percentage of all births

Healthy women having a well pregnancy with their first baby are a low-risk population.



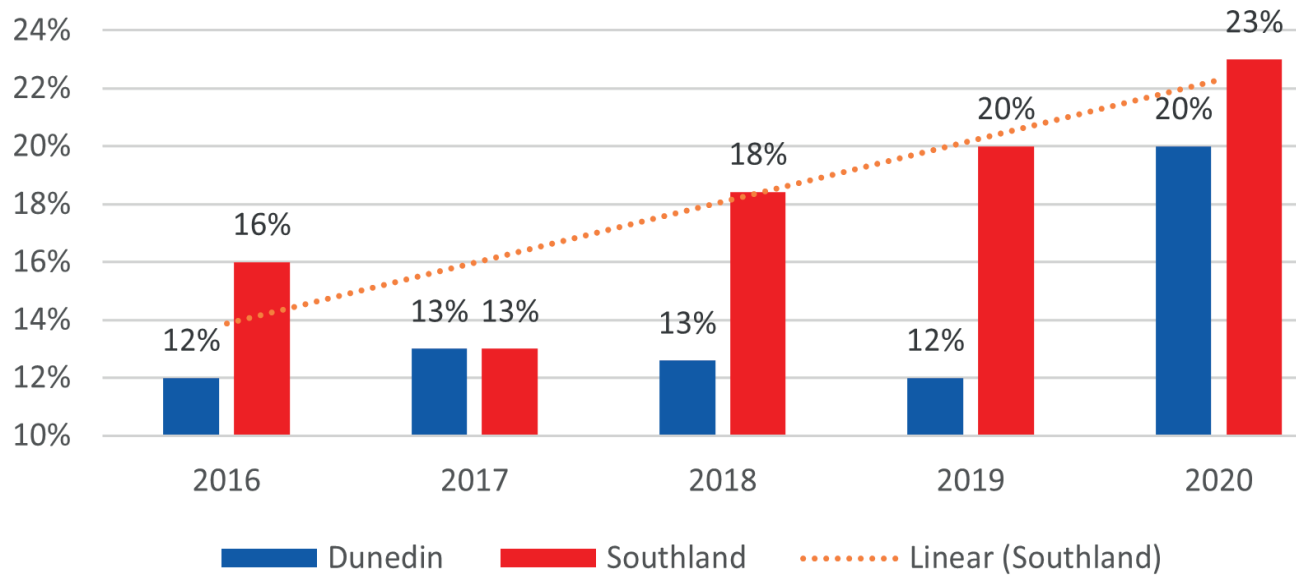
Assisted births by percentage of all births

Women who require assistance with vaginal delivery (the use of instruments such as ventouse, kiwi cup and forceps)

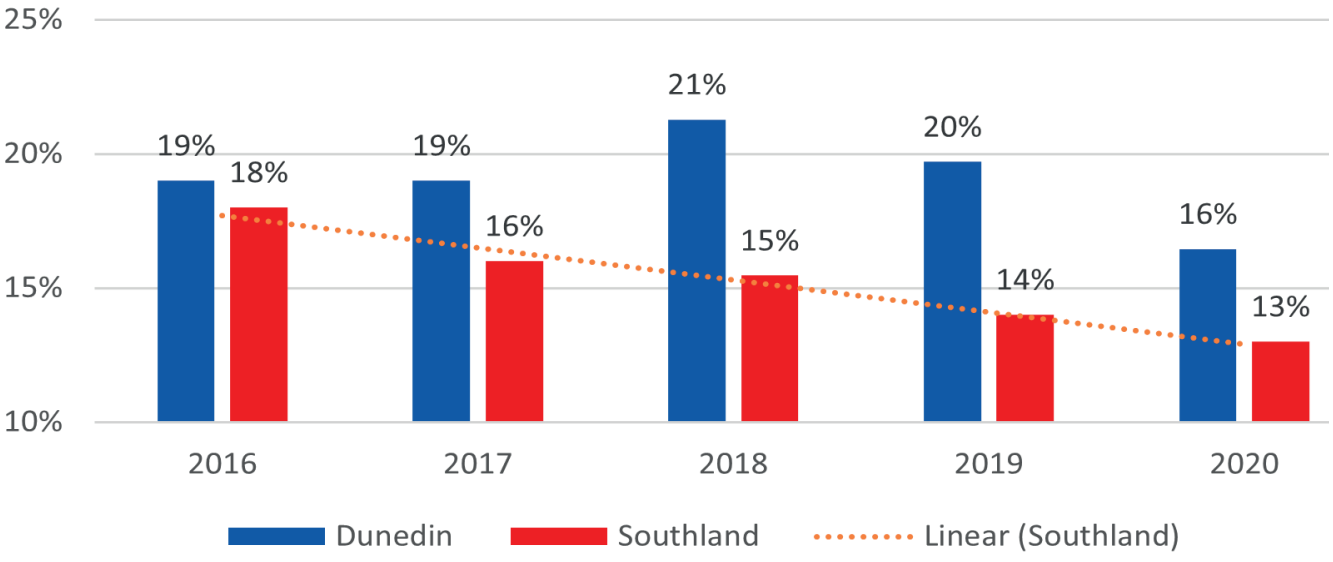


Emergency caesarean section - by percentage of all births

Emergency caesarean sections refer to caesarean sections carried out when the woman is in labour and had been planning a vaginal birth. There is a higher risk to mother and baby in an unplanned caesarean section, compared to a normal vaginal birth or a planned caesarean section. Complications can include bleeding.

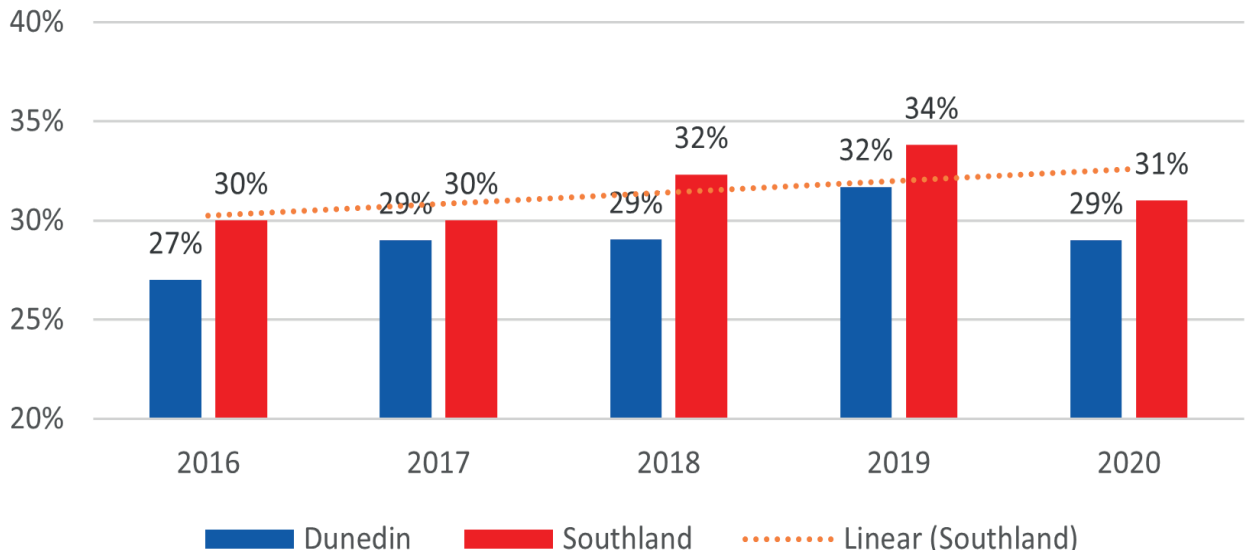


Planned caesarean section - by percentage of all births



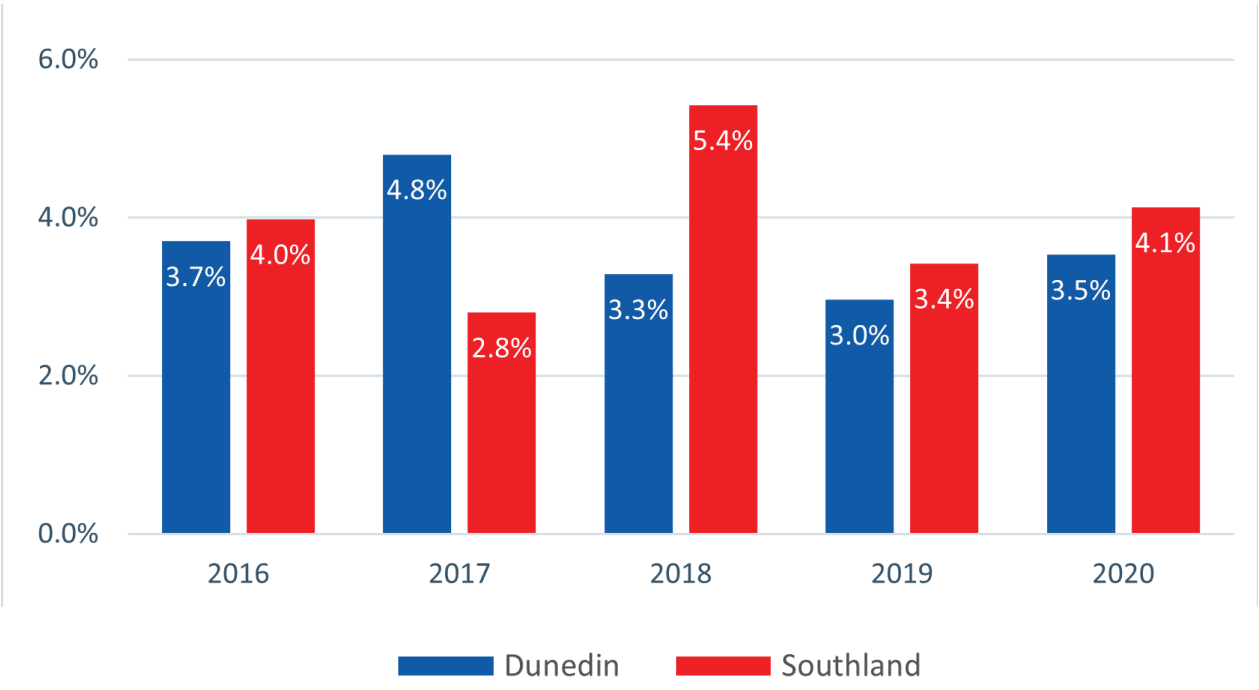
Labour started by induction - by percentage of all births

Quality improvement work has commenced in improving induction of labour rates across the district. This is in addition to the MQSP tri-annual work plan.



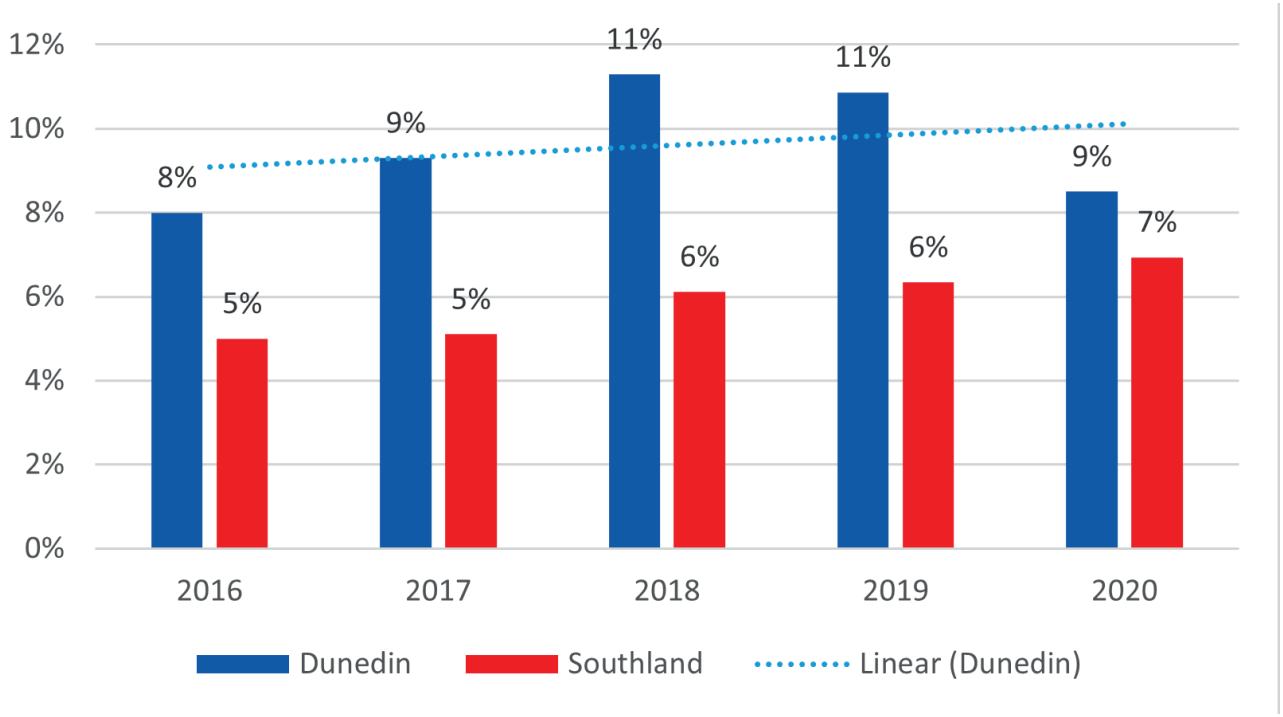
Severe tears by percentage of all births

Severe tears in childbirth are uncommon but can have a significant impact on women. This indicator compares severe tear rates in childbirth for healthy women having their first babies. Southern's Clinical Indicator result in this area was significantly higher than average in 2014. Quality improvement work commenced in 2016 and improvements are being monitored.



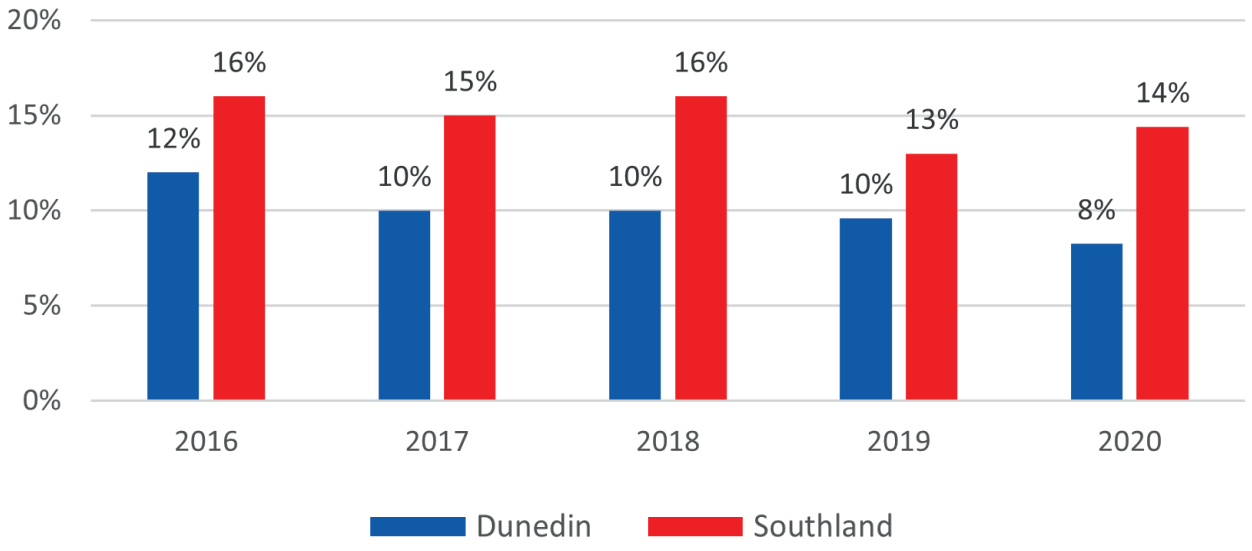
Bleeding following birth - by percentage of all births

% PPH 1000+ ml/all births



Mothers using tobacco on admission to maternity ward by percentage of all births

Smoking in pregnancy and postnatally increases risk to mothers and babies. Increases risk of pre-term birth, placental abruption, low birth weight, neonatal mortality, SUDI and long-term respiratory problems. Maternity providers work with Southern Stop Smoking Service (Nga Kete Matauranga Pounamu Trust) to provide high-quality and effective support for smokefree whānau .



Primary Maternity System of Care

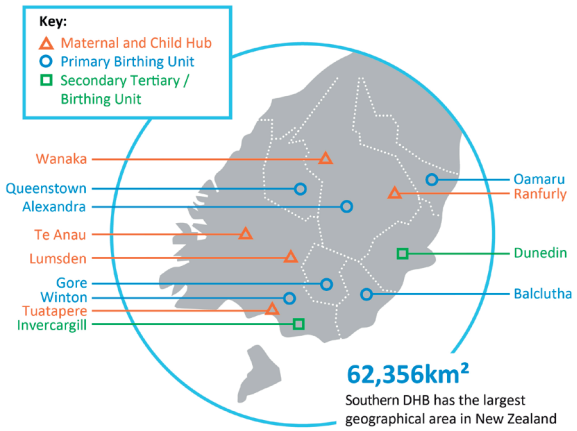
Southern District Health Board has had a strong focus on the ongoing implementation of the Integrated Primary System of Care, particularly the best configuration and location of primary birthing facilities for Central Otago/Wanaka areas.

The main objectives of the Integrated Primary Maternity System of Care are:

- equitable access to care across the district and equity for disadvantaged communities
- providing a maternity infrastructure
- providing services that meet the Ministry of Health birthing population standards and ensuring there is a viable sustainable workforce, supported by a transfer/transport system, and
- acceptable travel distances to a facility.

The introduction of maternal and child hubs provides an additional layer of support for remote rural midwives in Wanaka, Te Anau and Lumsden, with five hubs operating by the end of December 2019. By reducing some midwives' costs and providing ongoing sustainability payments, the remote rural LMCs (lead maternity carers) workforce has been strengthened to support the service they offer to women and babies.

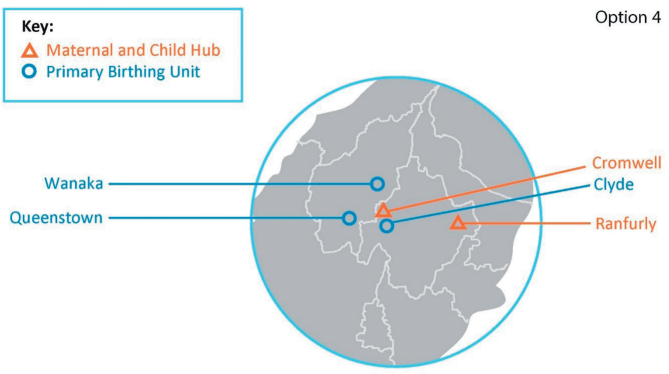
Proposed Model of Primary Maternity Services in the Southern Distict



The geographical spread of the Southern District provides a challenge for primary maternity care provision.

In early 2020, work began on determining the best location of the primary maternity facilities for the Central Otago/ Wanaka region. A Central Locality Network team worked with the DHB project team and initial rounds of public consultation resulted in over 330 submissions. The public consultation and other discussions with relevant stakeholders resulted in four potential options for configuration of services and a second round of consultation began in June 2020. The Maternity Quality and Safety Group (MQSP) played a key role in the assessment of these options and in providing advice and guidance to the DHB project team. This work will continue to be an important focus for MQSP throughout the implementation time frame over the next three years.

At the time of going to press, a recommendation -- option four below -- was put to the board to have two primary units, one at Dunstan Hospital in Clyde and one at Wanaka, which have been endorsed subject to caveat.



A Facebook advertisement calling for views on the best configuration of primary maternity services in Central Otago.

Projects

Project 1: Increase the percentage of women from priority populations who book with a midwife in first trimester (equity priority)

Why?

- Low percentages of young, Māori and Pasifika women booked with their LMC midwife in the first trimester, compared with the overall Southern District Health Board population average of 77.9% (2016).
- Encouraging early engagement can help the partnership focus on physical, spiritual, mental and whānau health needs, provide high-quality care and education for the best start for a healthy pregnancy and impact positively on maternal and neonatal outcomes.
- Geographic areas in Southern District with the highest numbers of priority populations are Invercargill, Gore and Waitaki (Oamaru).

Aims for 2019/2020

- Carry out ongoing partnership building with community providers in Invercargill, Gore and Waitaki who work with Māori, Pasifika and youth, to improve relationships and links with midwifery services.
- Work with primary care to ensure high-quality early pregnancy care at first contact and that pregnant clients from priority populations are given extra assistance to book with an LMC midwife.
- Offer maternity-specific (Turanga Kaupapa) cultural-competency training.
- Communicate the importance of early pregnancy care to the community and introduce the *Pregnant? See a midwife* leaflet.
- Improve online access to resources.

Our target

By June 2020 we wanted to increase the percentage of first trimester bookings by 10% with a focus on increasing the rates for Māori, Pasifika and women under 20 years.

Achievements from January 2019 to June 2020

- We completed the leaflet to promote early engagement with a midwife – *Pregnant? See a midwife* – following consultation with key stakeholders and community representatives.
- We began targeted leaflet distribution to community-based providers, including rūnaka, churches, schools and NGOs at the beginning of 2020. The Covid-19 pandemic disrupted distribution, but it recommenced in mid-2020.
- We made community visits and connections, achieving further progress in identifying barriers to accessing care.
- Improved online resources allow more consistent, accessible information for women and families.

Our results

- In 2019, we achieved 80.1% overall registrations in the first trimester, an increase of 2.2% on 2016 (*Qlik App, Ministry of Health accessed 30.11.2020*).
- In 2019, we had not increased our Māori or Pasifika population registration rate in the first trimester and we acknowledge a small decrease.

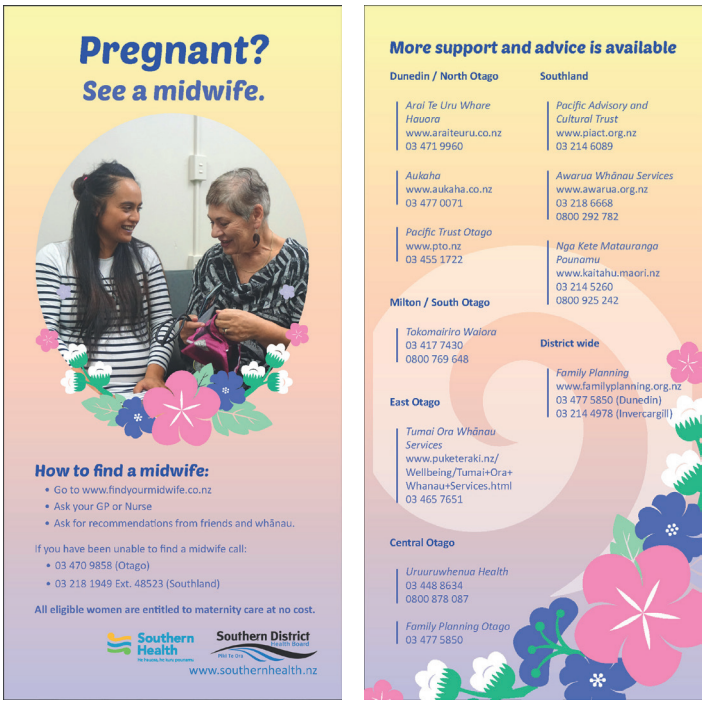
Summary

We have a higher-than-national-average rate of women who engage with a midwife in the first trimester of pregnancy. In 2018 our rate of engagement was 79.2% compared to the national average of 72.7% (*Report on Maternity, 2018*, released Oct 2020) and 2019 live data continues to show ongoing improvement.

The project was delayed by staffing on the Maternity Quality and Safety Programme and Covid-19 restrictions in 2020. It is disappointing we did not achieve greater gains in the expected timeframe for our Māori and Pasifika populations. However, we have a sound standing for ongoing improvement work and community relationship building in 2021.

Moving forward

Offering maternity-specific (Turanga Kaupapa) cultural-competency training is incorporated into the 2021-2023 workplan.



We began distributing this newly completed leaflet in 2020.

Project 2: Increase the number of LMC midwives providing care in key rural shortage areas (access priority).

Why?

- More than 700 women (20% of the overall birthing population) residing more than two hours away from a base hospital had babies in Otago and Southland in 2017.
- There were acute LMC midwifery shortages in 2018 in rural Otago and Southland, resulting in some women not being able to access LMC midwifery care or needing to seek care far from home.

Aims for 2019/2020

Combined with the Integrated Primary Maternity System of Care, the focus has been on:

- strengthening project management
- redirecting resources to increase the reach of maternity services by setting up community maternal and child hubs, which support the rural workforce by providing basic midwifery equipment, consumables and emergency equipment and a workspace for consultations, and
- ongoing investment into a sustainability package for LMCs supported by Southern District Health Board (DHB).

Our target

By June 2020:

- Wanaka: Increase from one to two LMC midwives.
- Queenstown: Increase from one LMC to four LMCs.
- Te Anau: Retain sole LMC in practice.
- Central Otago: Retain at least four LMC midwives.

Achievements from January 2019 to June 2020

- Southern DHB introduced a sustainability package for remote rural midwives in 2018, and these Midwifery Sustainability Payments continued into 2020. The aim was to provide financial and logistical support to this important workforce. The package recognised the urgent shortcomings in the Ministry of Health's remuneration and the specific challenges and responsibilities of performing duties in a rural environment. From 2018 to December 31, 2020, Southern DHB paid around $450,000 in sustainability payments to 37 midwives, across the district, who manage remote rural cases.
- We established five rural maternal and child hubs to provide an additional layer of support for rural midwives and women in remote and rural areas, with funded coordinators to support hub use and coordination. These hubs have been valuable in assisting rural midwives to reduce overheads and keep costs down for self-employed practice.

Our results

The sustainability package helped retain vulnerable midwives in Wanaka, Te Anau and Lumsden. We attracted new midwives into Queenstown and Central Otago.

- Wanaka: We achieved our target of two LMC midwives by June 2019. As of August 2020, we have three practising LMCs (with a fourth expected in February 2021).
- Queenstown: We achieved our target of four LMCs by June 2019. As of June 2020, we have 10 LMCs in Queenstown.
- Te Anau: We achieved our target of retaining the sole LMC in practice by June 2019.
- Central Otago: We achieved our target of retaining at least four LMC midwives by June 2019. We currently have five LMCs providing care at Central Otago.

In summary

The additional sustainability package and the maternal and child hubs helped retain the rural midwives in the remote areas of Lumsden, Wanaka and Te Anau and moved them from a fragile to a growing workforce. The package acknowledged the inequities in the work required of rural midwives compared to their urban counterparts.

Moving forward

The Southern DHB and the Ministry of Health have been working to develop longer-term approaches to support the sustainability of the midwifery workforce and maternity services in our rural communities. Southern DHB has reviewed the sustainability package introduced in 2018 and found that there have been significant enough changes to Section 88 funding to warrant stopping the Midwifery Sustainability Payments at the end of 2020. The DHB will re-invest the funding to help other initiatives supporting the sector.

Project 3: Decrease the level of unnecessary intervention in childbirth (quality and safety priority)

Why?

- Unnecessary intervention in childbirth contributes to increased morbidity for women and decreased birth satisfaction, without significant benefits for newborns (World Health Organisation (WHO), 2018).
- There is no primary maternity facility in Dunedin.
- Birthing in secondary and tertiary settings places women at increased risk of unnecessary interventions.
- Clinical indicators show that standard primiparae are less likely to have a normal birth outcome in a tertiary facility than in a primary maternity setting (NZ Clinical Indicators, 2018).

Aims for 2019/2020

- Communicate with communities, providers, women and whānau to make informed place-of-birth decisions.
- Communicate WHO recommendations for a positive childbirth experience to pregnant women, families and all maternity providers.
- Provide an annual update to PPE educators about current best practice recommendations.
- Develop and implement "Keep the First Birth Normal" programme for maternity providers and women and whānau who birth in secondary and tertiary facilities.
- Support The Royal Australian and New Zealand College of Obstetricians and Gynaecologists and New Zealand College of Midwives' "Choose Wisely" campaign to support women to make informed decisions about their care in pregnancy and childbirth.
- Explore the feasibility of a primary maternity facility in Dunedin.

Our target

To increase the percentage of standard primiparae women who have a spontaneous vaginal birth at Queen Mary (Dunedin tertiary facility) from 59.2% (*Clinical Indicator 2, 2016*) to 62%.

Achievements/results from January 2019 to June 2020

- We formed a Primary Birthing in Queen Mary Working Party but the project was put on hold for some of 2019, due to urgent theatre upgrades required at Queen Mary. The working party was re-established in the second half of 2020.
- We completed the birth options information leaflet (*Your options for place of birth and postnatal stay in Otago & Southland*) and mailed 500 to LMCs as a tool to use when discussing birth planning with women. People can also find the leaflet on the Southern District Health Board (DHB) website, allowing easy access when women, their partners and health professionals consider place-of-birth choices.

Our results

In 2018, clinical indicator 2 showed that Queen Mary (Dunedin tertiary facility) had dropped from 59.2% in 2016 to 50.9% for its standard primiparae who have a spontaneous vaginal birth. This project did not meet its desired outcome.

Summary

Southern DHB acknowledges that tertiary units do not often reach the same levels of normal birth rates as primary and secondary facilities. When compared to other tertiary facilities Queen Mary is at the average point for these units. Southern DHB and the Maternity Quality and Safety Programme realise the importance of keeping birth normal and are continuing the "Normal Birth in a Tertiary Unit" work in the next MQSP tri-annual work plan.

Moving forward

The new Dunedin Hospital build has approved plans for a primary birthing unit alongside the main hospital. It will function separately, following the primary facility service specifications as set out by the Ministry of Health. This will give Dunedin its own defined primary birthing space where there is optimal opportunity for a normal birth outcome and greater satisfaction levels for women (WHO, 2018). The estimated completion date is 2026, so it is important that work in this area continues in the meantime.

Southern District Health Board
Piki Te Ora

Talk to your midwife about what's right for you

Talk to your midwife about what's right for you. If you need input from a specialist doctor, they will give you advice about where to plan to have your baby.

Birth outside of hospital is a safe option for healthy women having straight-forward pregnancies. Women who plan to birth at home or in a local Primary Maternity unit are more likely to have a normal vaginal birth and are less likely to need pain relief.

If you need specialist care during labour and birth, most likely you will be advised to birth at a base hospital. Common reasons this is recommended include: carrying more than one baby, going into labour early, or having a medical condition such as high blood pressure or diabetes.

If you birth in hospital, you may wish to plan for a postnatal stay at a Primary Maternity unit closer to home.

Contact Us:

southernhealth.nz
contactus@southerndhb.govt.nz
03 474 0999

We aim to uphold these values when providing care to you:

- Kind Manaakitanga
- Open Pono
- Community Whanaungatanga
- Positive Whaiwhakaaro

Southern Health
He hauora, he kuru pounamu

Southern District Health Board
Piki Te Ora

Your options for place of birth and postnatal stay in Otago & Southland

You can decide where you want to give birth – at home, in a local primary maternity unit, or at a base hospital.

This leaflet is a useful tool when making a place-of-birth decision.

Primary Maternity Units

These units provide a home away from home environment. They are a good option for planned place of birth for women with uncomplicated pregnancies. Like home birth, women who choose a Primary Maternity Unit are more likely to have a normal birth and are less likely to require medical interventions. They are also a good option for postnatal care closer to home, even for women who give birth in hospital.

Your care in labour and birth will be from your LMC midwife, supported by the maternity unit staff. You are entitled to up to 48 hours of postnatal care following birth (or more when required) and will receive care from the maternity unit staff during your stay. If you develop a complication during labour or after you have your baby, you will transfer to one of the base hospitals for medical care. Staff are well trained to assist with establishing breastfeeding and to deal with complications and transfers to base hospital.

Home

Home birth is a safe choice for many women. Women who have home births require less pain relief and are more likely to have a normal vaginal birth than women who give birth in hospital. If you want to know more about this choice talk to your midwife and/or doctor. You can find out more on the Home Birth Aotearoa website.

At a home birth your midwife will have another midwife there to support you and her during and after the birth. Your midwife will stay with you for at least 2 hours after the birth. Postnatal care at a Primary Maternity Unit is also an option.

Oamaru Maternity
Serving the Waitaki community

Two birth rooms and three postnatal rooms.
www.oamaruhospital.co.nz/services

Lakes Maternity
Serving the Queenstown Lakes region

One birth room and three postnatal rooms.

Balclutha
Serving the Clutha community

One birth room and three postnatal rooms.
www.cluthahealth.co.nz/pages/maternity-centre

Gore Maternity
Serving the Southland region

One birth room and two twin postnatal rooms.
www.gorehealth.co.nz/maternity

Charlotte Jean Maternity Hospital, Alexandra
Serving the Wanaka/Central Otago region

One birth room and three queen-size postnatal rooms. Partners are encouraged to stay.
www.charlottejean.co.nz

Winton Maternity
Serving the Southland region

Two birth rooms and four queen-size postnatal rooms. Partners are encouraged to stay.
www.winton.co.nz/listing/58/Winton-Maternity-Centre

Hospital Maternity Care

If you have medical complications in pregnancy it will be recommended that you birth in hospital where you can receive input from the specialist and/or neonatal team in addition to your LMC midwife. If you have an uncomplicated pregnancy you can also birth at a base hospital under the care of your LMC midwife and supported by the staff midwives.

Southland Hospital Maternity Service is part of Southland Hospital in Invercargill. Queen Mary Maternity Centre is located on Level 2 of Dunedin Hospital. Both hospitals have specialist antenatal clinics Monday to Friday. Lactation Consultant service provides support for women experiencing complex challenges with breastfeeding. After giving birth women can choose to stay at the base hospital for inpatient care, or transfer to a primary maternity unit closer to home for post-partum recovery.

Southland Hospital has a Neonatal Intensive Care Unit (NICU) providing level two neonatal and intensive care to babies born prematurely (from 30 weeks gestation) and for newborn babies to three months of age who require intensive care.

Dunedin Hospital's Neonatal Intensive Care Unit (NICU) provides tertiary level (highly specialised) care to babies born prematurely (from 23 weeks gestation) and for newborn babies to three months of age who require intensive care.

WWW

www.health.govt.nz/your-health/pregnancy-and-kids/services-and-support-during-pregnancy/where-give-birth

www.maternity.org.nz

Project 4: Continue to decrease the percentage of women who sustain severe perineal harm during childbirth (local priority)

Why

- Historically, Southern District Health Board (DHB) had the highest level among all DHBs of third- and fourth-degree tears with no episiotomy for first-time mothers. The severe-perineal-harm rate was 6.8% in 2014 (Indicator 8, NZ Maternity Clinical Indicators, 2014) so we began work on the "Reducing Severe Perineal Harm" quality improvement project, which included a multi-disciplinary review study and delivered an evidence-based practice recommendation education programme.

Aims for 2019/2020

- Following implementation of the *Perineal Harm Strategy* in 2017, we aimed to increase support to midwives and obstetricians in secondary and tertiary facilities to fully implement harm reduction practice recommendations.
- Communicate perineal harm reduction strategies to women and all maternity providers.
- Perineal harm decreases to the point where we need only consider it as "business as usual".

Our target

Decrease the percentage of women who sustain a third- or fourth-degree tear during vaginal birth to 3.15% by June 2020.

Achievements from January 2019 to June 2020

- Covid-19 stalled pro-active ongoing education in 2020. However, reducing perineal harm practice continues throughout the maternity service.
- Severe perineal harm dashboards are part of the ongoing quarterly clinical governance reviews.

Our results

- Southern DHB severe perineal tear data (MQSP Report and Primary Data 2019, accessed Dec 2020) supports that we are on target as a district and have achieved sustained severe perennial tear reduction. See page 15 for a five-year comparison.

Primary	0.5%
Secondary	4.14 %
Tertiary	3.95%
Overall	**2.86%**

Summary

Overall across the district, our rates of severe perineal harm are decreasing, although ongoing review through the clinical dashboard will help monitor the continuing effectiveness.

Moving forward

Southern DHB hopes to re-visit the "Reducing Perineal Harm" project annually, as an update session on any planned midwifery education study days.

Project 5: Decrease the distance women need to travel to access obstetric consultation in pregnancy (access priority)

Why?

- Due to our geographical spread, women in remote rural destinations who require specialist obstetric input must undertake up to a seven-hour round trip for an obstetric appointment.

Aims for 2019/2020

- Build on the success of a Wanaka telemedicine clinic set up in late 2018.
- Assess the need for similar services elsewhere to bring specialist care closer to home.

Our target

- At least 40 women, who would have otherwise had to travel to a base hospital, will receive an obstetric consult through the virtual telemedicine clinic.
- Evaluate the need for additional telemedicine clinics and set up where needed.

Achievements/results from January 2019 to June 2020

- More than 40 women in Wanaka received telemedicine consultations in 2019 and Telehealth Wanaka reached 26 local clients in the first six months of 2020.
- Telehealth services are operating in Queenstown.
- We planned a further telemedicine clinic for Central Otago by April 2020, but it was delayed due to Covid-19.
- The majority of antenatal clinics during the Covid-19 shutdown were performed remotely where possible.

Summary

- Southern District Health Board (DHB) achieved its targets and continues to provide a rural telehealth option. Telemedicine became a key component in delivering obstetric consultation during the Covid-19 pandemic and lockdown in early 2020. The Southern DHB is actively growing the use of telehealth technology throughout the district.

Moving forward

- Work continues in the area of telehealth to strengthen the service and provide more options and opportunities and choices for women to connect with maternity services across the district.

Covid-19 response

The Southern District Health Board's Maternity Quality and Safety Group (MQSP) undertook a review of the experiences of our members and some stakeholders for the period of the Covid-19 lockdown during 2020.

The lockdown was an opportunity to do many things very differently, while adapting under considerable stress. Some of those adaptations worked out well for whānau and staff, and some did not. The aim of this review was to find out what did, and did not, work well so we know which questions to ask to ensure continual improvement and safety for whānau using maternity care. The review was not a critique of services or planning; it was looking at what happened. We see it as an opportunity to learn from positive experiences and how to mitigate for factors outside of anyone's control.

The process of compiling the review also contributed to improving communication and cohesion for the MQSP, which is a positive outcome in itself. The feedback was thematically arranged with questions, MQSP recommendations and learnings for stakeholders.

Covid-19 Maternity impact theme overview (Maternity Quality and Safety Programme, 18 May 2020)

HOME

Observations

- LMCs reported an increase in requests for information on home birth.
- Delivery of services was significantly altered, eg virtual access for services such as obstetrics, labs, ultrasound, LMC, breastfeeding support, general practitioner, Well Child Oranga Tamariki, lactation consultant and pregnancy and parenting programme.
- Consumers reported a decrease in face-to-face contact with LMC midwives.

MQSP suggested action

Analyse data from National Minimum Data Set, eg rate of emergency transfer from home birth.

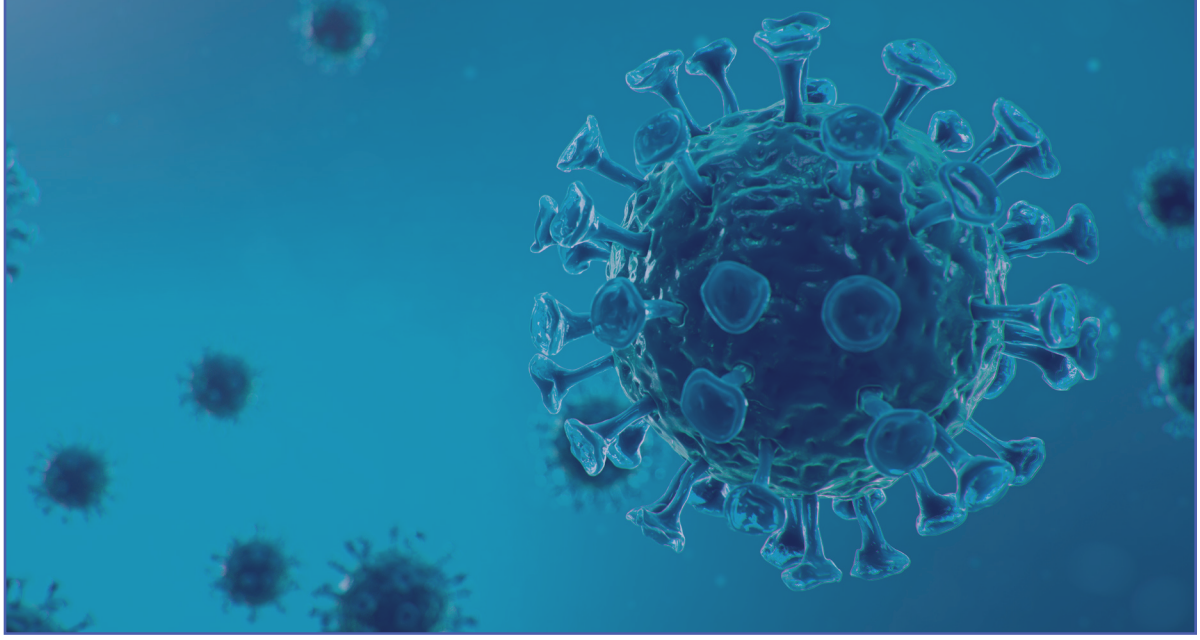
COMMUNITY PROVIDERS

Observations

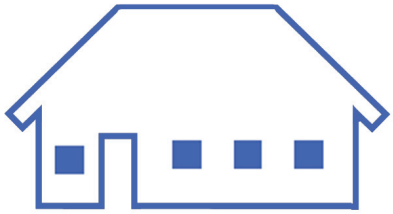
- New Zealand College of Midwives (NZCOM) reported a 26% increase in LMC midwife workload.
- NZCOM undertook an impact survey with LMC midwives.
- There was a large volume of changing practice recommendations, and there were variations in practice between individual providers and groups of providers (WCTO and LMC midwives).
- There was an unknown impact on NGO (non-governmental organisation) partners who work with and represent specific target population groups.
- Wanaka LMCs reported a 50% home birth rate during the Covid-19 lockdown. Initial statistics showed a district increase from 3.8% to 10.7%.
- The midwife coordinators of the maternal and child hubs in Wanaka and Lumsden provided valuable communication and coordination to the LMC midwives in their areas.

MQSP suggested action

Monitor impact on community breastfeeding rates at six weeks.



PRIMARY MATERNITY UNIT



Observations

- Reduced use due to no transfers in from base hospital for postnatal care.
- Covid-19 restrictions to visitor policies affected families.
- Positive feedback came from women's experiences in relation to uninterrupted breastfeeding and bonding.
- Lakes had a physical re-location, resulting in inadequate facilities.
- Variations in organisational capacity resulted in inconsistencies and inequities of service provision and the ability to respond to the rapidly changing situation.
- Implementation of Primary Maternity Strategy was paused, eg Wanaka hub development and consultation on the location of a primary maternity unit (PMU) for Central Otago.

MQSP suggested action

Collate data on birth outcomes and emergency transfers for January to May for all PMUs.

SECONDARY/TERTIARY HOSPITAL

Observations

- Many women went home from postnatal units earlier (length of stay reduced from 3.48 to 2.48 days in Queen Mary and from 2.25 to 2.0 in Southland Maternity).
- There were fewer shifts, with understaffing to workload ratio. (Negative variance reduced from an average of 11.3 shifts to 4.0 in Queen Mary and from 8.3 to 2.0 in Southland.)
- Units were less full (bed use went from 56.5% to 46.8% in Queen Mary and from 62.9% to 50.2% in Southland).
- The Obstetric Antenatal Clinic consult model of care changed to virtual consultation, delivered in the home.
- Staff reported a quieter unit.
- Leadership staff exceeded their normal working hours.
- There were no medical or midwifery students.
- The number of visitors was restricted due to Ministry of Health guidelines and we received complaints about this policy.
- Working practices constantly changed, and staff planned and implemented changes while also providing care.
- Reduced on-site obstetrics resources in Queen Mary, while maintaining a constant workload, generated increased stress.

MQSP suggested action

Analyse:

- consumer feedback and complaints
- data from MQSP dashboard on rates of interventions, and
- adverse events during Level 3 and 4.

District-wide maternity system

COMMUNICATION

Ensure clear communication of information for providers and wider community.

STRATEGIES

Primary Maternity & Maternity and Child Wellbeing annual review with Covid-19 in mind.

DECISION-MAKING PATHWAY

- Use a validated decision pathway for key changes and adaptations to maternity provision that reflects Te Tiriti o Waitangi obligations, includes affected stakeholders and considers the impacts of changes on all providers and service users.
- Use Te Whare Tapa Whā framework when considering the impact of proposed changes.

LEARNING

- Ensure we gather stakeholder responses for:
  - What worked well?
  - Where were there inequities?
- Are there examples of excellence?
- Which practices/new ways of working need to endure?

PARTNERSHIP WITH COMMUNITIES

Work with NGOs to enable new approaches to meet needs that recognise the capacities of their community.

PROFESSIONAL RELATIONSHIPS

- Recovery plan focus on restoring and preserving relationships, wellbeing and building trust.

Suggestions for improvement

HOME

Work with NZCOM and LMCs to identify what the barriers are for women to access.

Conduct a needs assessment to understand the recovery needs of priority populations including Māori, Pasifika, refugees and rural families, using Te Whare Tapa Whā framework and inviting feedback from individuals, community groups and independent providers.

Develop a survey that captures what the women's experience has been during Covid-19, exploring:

- where whānau got their information
- the intention/motivation around a decision
- mental/emotional wellbeing
- whānau relationships, and
- parental confidence.

COMMUNITY PROVIDERS

Request reporting from contracted providers to evaluate efficacy and effects of changes to service delivery and implications for their staff/contractors.

PRIMARY MATERNITY UNITS

Develop a tool for PMUs to complete a self-assessment on the impact of their response to Covid-19, with consideration given to consumer feedback, the impact on models of care and which factors enabled the PMU to adapt effectively.

Ensure key stakeholders are included in significant decision-making and that those decisions are effectively communicated to stakeholders and the wider community.

SECONDARY/TERTIARY HOSPITAL

Conduct a staff survey on the impact of Covid-19 with respect to their care delivery, consideration of the impact of the revised visitor policy and staff safety during alert levels.

Develop quality and safety outcome measures for obstetric consultation so we know how service changes influenced outcomes.

Ensure key representation during significant decision making and transparency when communicating those outcomes.

Ensure recovery plan includes attending to individual and team wellbeing.

Recognise the impact of the rise in stress for women and families and consider early engagement with social work/mental health referrals.

Monitor rates of neonatal retrievals.

Quality improvement initiatives

1. Improving the transfer pathway from secondary and tertiary facilities back to primary maternity units.

Issues and problems identified when transferring women and babies back to primary maternity units (PMUs)

- Late transfers
- Incomplete clinical information
- Communication challenges
- Lack of consistency
- Potential for increased risk for women and babies
- Communication breakdown between units
- Varying levels of efficiency

Further exploration demonstrated that women were not well informed of their postnatal stay options or the transfer process. There was late identification of those women choosing to stay at PMUs and no defined transfer process.

Proposed solutions

- Booking forms to include postnatal stay intentions
- Booking confirmation letters to include postnatal care options and process of transfer
- A primary unit transfer checklist for base hospital
- A *Record of Verbal Clinical Handover Form*, for use at the primary unit
- The birth options leaflet
- Bed-side boards that identify postnatal stay intentions
- Improve efficiency of the service

Work carried out

We carried out work on a new transfer checklist and a new *Record of Verbal Clinical Handover Form*, with a new associated *Hospital to Primary Maternity Unit Transfer Guideline* circulated for feedback. We delivered presentations and set up education boards in base hospitals.

The improvement project stalled in later 2019 and was re-launched in 2020 and the positive audit results, using a repeated PDSA methodology, have already demonstrated significant reduction in clinical omissions in Southland, with ongoing work in 2021 for Queen Mary.

2. Improving the maternity mortality and morbidity process and providing multi-disciplinary approaches to review.

Issues and problems with mortality and morbidity review process in Southland

- Inconsistent multi-disciplinary involvement
- Issues with the existing terms of reference, with regard to structure and consistency to case selection
- A need for greater engagement with professional groups
- Potential for bias in review
- No feedback to wider maternity service on learnings
- No feedback mechanism to clinical governance on potential process changes

Proposed solutions

- Multi-disciplinary working group to improve participation and engagement
- The Perinatal and Maternal Mortality Review Committee Review toolkit to be adopted
- Updated terms of reference to address the process of consistency and case selection
- Multi-disciplinary presentations, investigations and reviews
- New process for feedback to clinical governance on process change requirements
- New process for feedback to health professionals on learnings

Work carried out in 2020

We have formed a working party consisting of LMCs (lead maternity carers), core midwives and obstetric resident medical officers to provide a multi-disciplinary approach to case review, presentation and selection. Terms of reference have been prepared for wider consultation. While we have made progress with the multi-disciplinary approach, staffing shortages have led to slow progress and the need for ongoing project work through 2021.

Governance and Consumer engagement

SDHB Maternity Quality & Safety Programme Governance Group Members 2019/2020 are listed below.

Co-chairs

- Chief Nursing and Midwifery Officer, Jane Wilson
- Breastfeeding Peer Support Programme Coordinator and consumer representative, Catherine (Catkin) Bartlett

Consumer representation

- Former Chair and Trustee Home Birth, Aotearoa, Sian Hannigan
- Midwifery Standards Consumer Reviewer, Anna Walls

Iwi consumer representatives

- Araiteuru Rūnaka, Ria Brodie
- Murihiku Rūnaka, Sumaria Beaton

Southern District Health Board

- Director of Midwifery, Heather LaDell (2020), Jenny Humphries (retired 2019)
- Māori Health Directorate representatives, Nancy Todd and Gilbert Taurua
- Obstetric representative, Southland, Kate Coffey (2020), Lena Clinckett (2019)
- Obstetric representative, Otago, Jana Morgan
- Charge Nurse Manager, NICU (Dunedin), Juliet Manning
- Charge Midwife Manager, Queen Mary Maternity Centre (Dunedin), Fiona Thompson

Primary maternity facility representation

- Charlotte Jean Maternity Hospital, Sue O'Brien

Primary providers

Midwifery

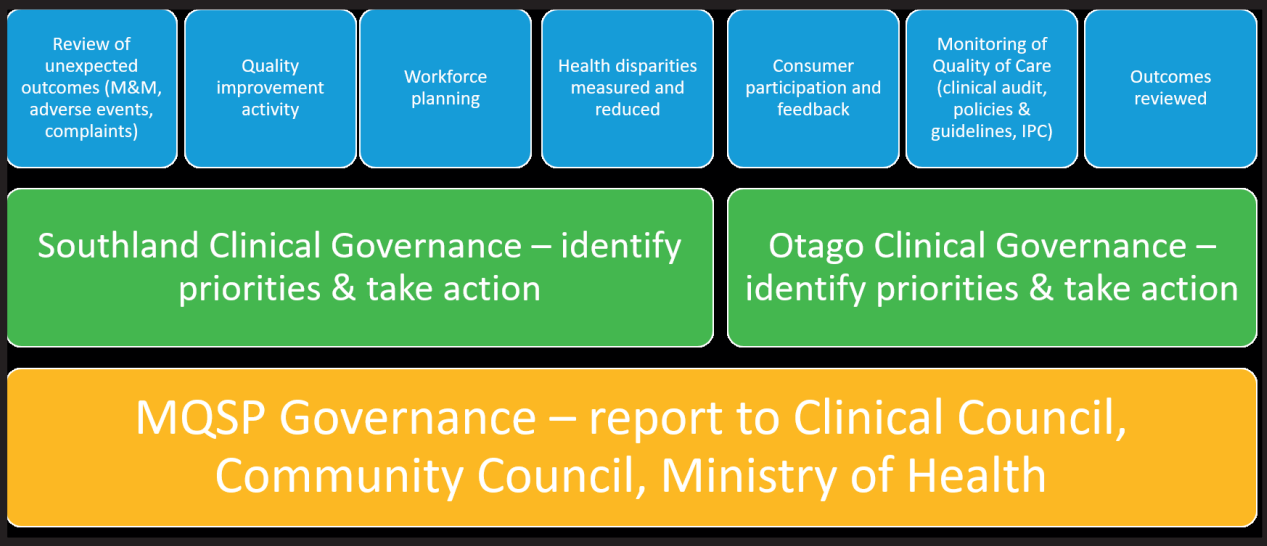
- NZ College of Midwives, Otago, Emma Medeiros. Sheridan Massey
- NZ College of Midwives, Southland, Nicky Pealing/ Tash Baillee
- NZ College of Midwives, Central/Lakes, Morgan Weathington

PHO

- WellSouth representative (shared role) Wendy Findlay, Nursing Director and Katrina Braxton, Clinical Manager (both resigned from Governance Group in 2020)
- WellSouth Practice Relationship Manager, Helen Ramsay (from 2020)

- **Programme Coordinator** Sarah Clark (2020), Pauline Moore (2019)

Maternity Clinical Governance Structure



Governance update

Following a successful recruitment programme, registered midwife Sarah Clark was appointed Maternity Quality and Safety Programme (MQSP) coordinator in 2020. Sarah continues the great work of her predecessors.

During 2020, the clinical governance groups in both Invercargill and Dunedin continued to evolve and feed into the MQSP Governance Group. However, the interaction and nature of our business began to highlight that the MQSP Governance Group itself needed to evolve, recognising it had taken on more of an advisory role. Work is now underway formalising a new revised structure, that will incorporate clinical governance for primary maternity units. There are also plans for a revised membership in 2021 to reflect the increased levels of accountability.

Consumer representatives will continue to have a strong focus, not only at governance-group level, but also at clinical-governance level, providing a wider consumer voice. We are proud to have two consumer representatives actively participating on the group and one consumer representative as a co-chair. We also have two iwi representatives on our MQSP Governance Group. We hope a new Pasifika consumer can be recruited in 2021 to widen cultural representation and better serve the local birthing population.

Our consumer community co-chair, Catkin Bartlett, has brought an invaluable perspective and unique qualities to the Governance Group.

MQSP profiles

MQSP Governance Group community co-chair Catkin Bartlett

I joined Southern District Health Board Maternity Quality and Safety Programme (MQSP) four-and-a-half years ago as a consumer representative, with my youngest pēpi in tow.

As the mother of four children I have, until recently, always had a pēpi in tow. Having babies present helps me focus on our priorities and assist with building relationships. It also represents trust that I trust, respect and value the kaupapa to share my precious baby.

I have a specialist community nursing background. This provided me with insights into how healthcare priorities are determined and an understanding of the perspective of those both leading and making change happen. However, there was no formal avenue for involving consumers in those discussions, hearing in a constructive way what their experiences of care were and having a voice in decision-making and priorities. Consumer representation at this level of healthcare governance is fundamental to making improvements and change that is sustainable and real.

As the Breastfeeding Peer Support Programme coordinator for Central Otago and Wakatipu with WellSouth for the last 10 years, I have had the privilege of hearing hundreds of unique whānau stories, many of which have never been told to anyone before. As a consumer representative I don't represent specific individuals, groups or whole communities, but I do know a lot about families, whānau, mothers and communities. I have a different perspective, voice and insight to the other members, and it is that perspective which I bring.

I am excited about the changes we are introducing to Southern MQSP to ensure that the platform for the voices of consumer representatives, and especially Māori and Pasifika are embedded in every level of maternity care provision, review, planning and governance.

MQSP Governance Group consumer representative Anna Walls

I came to the governance group through my work with the New Zealand College of Midwives with the Midwifery Standards Review process I have undertaken for the past 18 years.

This work has given me insight into some of the extraordinary challenges faced by women and maternity providers. I am passionate about good maternity care, as it has such a significant influence not just on mothers' and babies' physical wellbeing but also on our bonding and ongoing emotional health.

My advocacy in the maternity field has included work on maternal morbidity for the Health Quality Safety Commission and I am involved as a consumer advisor for secondary maternity in the Dunedin Hospital rebuild. I believe the wellbeing of our maternity workforce is very important to the provision of care that is supportive of whānau.

I am blessed to be the mother of five but have sadly lost recent pregnancies. I enjoy breeding dairy goats and ponies. I originally trained as a civil engineer and am now owner-building an eco-house. I have a PhD in qualitative research. I grew up next to a marae, which sparked my interest in Māori perspectives, and I endeavour to be supportive of our rūnaka representatives.

My personal experiences have contributed to my understanding of challenges that can be faced by mothers. As an advocate I strive to consider how systems and policies can impact on different people so everyone can have good maternity care that meets their particular needs, regardless of their socioeconomic situation or ethnicity.

MQSP Governance Group consumer representative Sian Hannagan

As a mother of two, I have experienced birth across both hospital and home settings. I bring experience from my work with Home Birth Aotearoa, the La Leche League and the School of Midwifery to inform my work.

I am an advocate for maternal choice and supporting whānau through maternity. I have a strong focus on diversity and making sure the right voices are heard.

Consumer feedback and communication

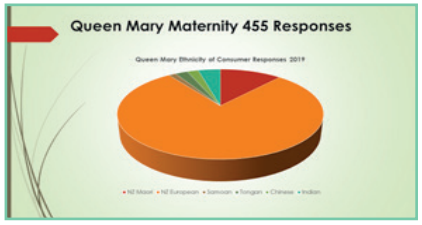
Tablet-based consumer feedback for secondary and tertiary units

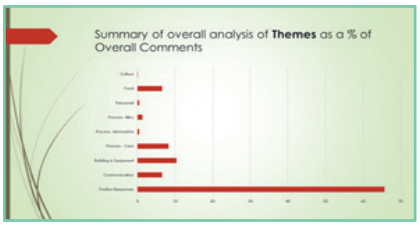
In 2018, tablet-based consumer feedback surveys were implemented across the secondary and tertiary settings.

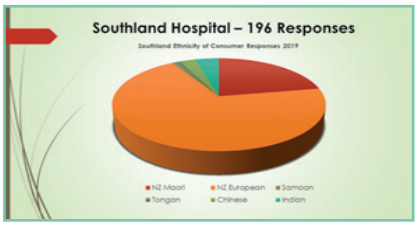
All women who have an inpatient stay are invited to provide feedback. We have also put essential information on the tablets, such as newborn resuscitation videos, so that providing feedback is a normal part of the discharge process. The questionnaire is based on the National Maternity Survey.

In 2019 and 2020 we have been able to analyse the consumer feedback into themes, ethnicity, display feedback for staff and identify areas that need to improve.

The iPad feedback proved invaluable while collating data for specific periods, such as during the Covid-19 Level 3 and Level 4 alert levels.







LMC/stakeholder engagement and communication

We continue to produce regular e-newsletters, sent to maternity stakeholders featuring primary, secondary and tertiary features and useful updates as a way of connecting our workforce.

Wahakura Launch and SUDI Prevention Day

The launch of the Wahakura earlier this month, now provides not only a safe sleep device, but a local naturally woven alternative and treasured taonga and can be obtained through Kaiāwhina and Community support agencies along with recognised distributers that also provide safe sleep education to women and whanau.
Hapai Re Hauora, the organisation that has the SUDI contract for the Community, provide excellent SUDI education on their website the link is http://hapai.co.nz/national-sudi-prevention-coordination-service. It is recommended that health professionals working with Wahakura complete cultural competency and cultural safety training to inform their practice.
This service will run alongside the current Pepi-pod safe sleep device to give cultural options for women and whanau. .

Cultural Competency Education Opportunities

Otago Polytechnic and **SDHB** are to provide a Training Scheme: the **Certificate in Bicultural Competency (Level 4)** for the upskilling of staff, contractors and LMCs. This proposal is designed to assist SDHB to build bicultural competency across the organisation, and to enable verification of standard of practice for all staff. Enrolments opening in February 2020.

A section of one of the e-newsletters.

NMMG Priorities (*Annual Report, 2018*)

Pregnancy and birth/early parenthood can exacerbate existing mental health issues, or it can result in new (or previously undiagnosed) mental health issues. Better processes are required for sharing information and ensuring a consistent approach to care. Consistency in screening and consistency of maternal mental health access pathways are required.

(*National Maternity Monitoring Group Annual Report 2018*)

Southern District Health Board has four programmes to support various levels of maternal mental health conditions, ranging from the Brief Intervention Service for mild-to-moderate conditions to the Family Mental Health intervention for moderate-to-severe cases, working with whānau to provide a whānau-centred approach within the community.

The current pathways do not allow for specific LMC maternity referral – they use generic referral processes through community or inpatient services. There are challenges with district differences. In Otago, the Psychiatric Consultation Liaison Service provides expert advice to LMCs following a woman's admission to hospital. Women in Otago have access to the DHB's mental health service through community health teams 24/7. Meanwhile, Southland has a small maternal mental health team working with antenatal referrals. Southland also has a psychiatric consultant who runs clinics and can provide shared care with obstetricians for pregnancy and postnatal planning.

There are well-established networks with the regional hub and Mothers and Babies Mental Health Service, based in Christchurch, that also provide education directly to midwives. Referrals can be made to secondary mental health services for mental distress and mental illness via a triage and assessment process.

Review of the current maternal mental health process highlighted many opportunities for improvement. From an LMC perspective, with no direct referral pathway and no clear admission criteria, options can be confusing. The Maternity and Quality Safety Programme (MQSP) plans to work alongside the Mental Health Addictions and Intellectual Disability Service as part of the next MQSP tri-annual work plan (2021-2023), to ensure a consistent approach that is system- and district-wide for maternal mental health.

For the MQSP tri-annual workplan, MQSP will align with MHAID to consider how we can:

- achieve consistency across the region
- provide education on service availability, screening and support
- provide equitable and timely access
- update the referral process with inclusion criteria to secondary services and address challenges to access treatment pathways
- trackreferrals that are accepted/declined and unmet needs
- report on the facilities available for inpatient care and provisions for baby/whānau stay
- provide focus on the availability of service within primary care to support women with mild-to-moderate depression during pregnancy and postpartum, and
- ensure support to midwives for those who have women with complex mental health issues, who are experiencing suicidal tendencies or who have committed suicide

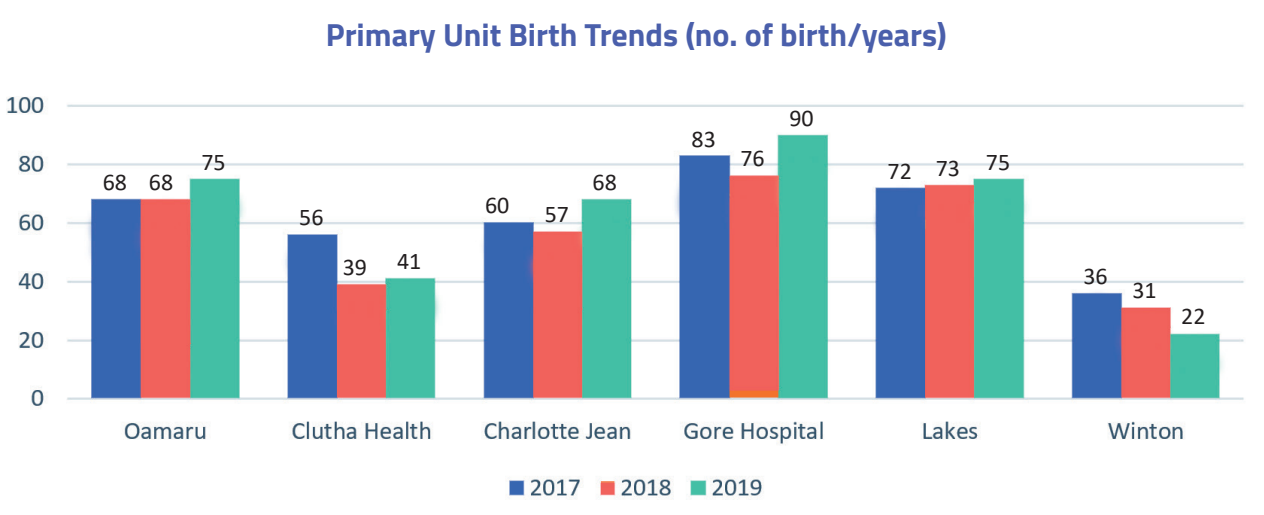
Our measure of success will be how many women are using the service and accessing the care they need after we have strengthened processes and improved health pathways and communications to health professionals, women and whānau.

Places of birth

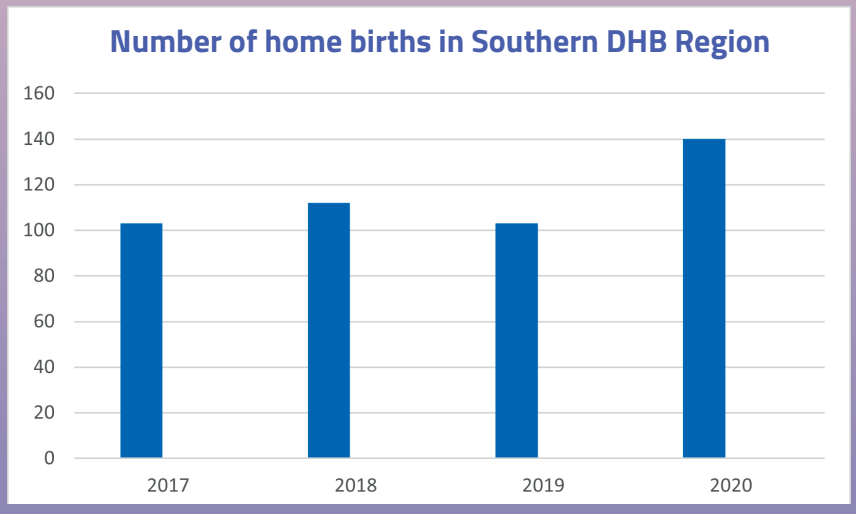
Evidence shows that, for a healthy woman and baby with no complications and low risk, birthing at primary birthing units is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Low-risk women birthing in secondary and tertiary units is economically unsustainable and often leads to poorer birth outcomes for these women. NMMG recommendations are consideration to promote the advantages for low risk women to birth in primary birthing units and how to support women who choose to birth at home.
(*National Maternity Monitoring Group Annual Report 2018*)

Across the district, maternity services consist of:

- **1** tertiary facility that provides a primary birthing option within the facility for the local population
- **1** secondary facility that provides a primary birthing option within the facility for the local population
- **6** primary birthing units across the district, and
- **5** maternal and child hubs (not for planned births), to support remote rural midwifery.



Five of our six maternity birthing units had increased birthing numbers between 2018 and 2019.
In 2019, the Maternity Quality and Safety Programme (MQSP) completed work on the birth choices leaflet (*Your options for place of birth and postnatal stay in Otago and Southland*). This key piece of work consolidated all the birthing options available for women and whānau across the district and the combinations of care packages available. It is an important discussion tool for LMCs explaining birth options for women to consider. It covers home and primary maternity settings, along with hospital care and postnatal services. The leaflet distribution involved personal presentations to community stakeholders and targeted mail-outs. **A link** to the leaflet is in the resources section of the newly designed, in-progress maternity website for Southern District Health Board (DHB).
Southern (DHB) acknowledges that primary birthing in secondary and tertiary facilities has a strong influence on whether women achieve normal birth. Dunedin will gain a primary birthing unit alongside the new tertiary hospital re-build, due for completion in 2026. MQSP plans to continue with its Normal Birth Project, started in 2019, within tertiary and secondary units. It includes education and expectations around normal birth, review of the physiological partogram as a tool and providing a woman-friendly birth space within the tertiary setting.
The *Integrated Primary Maternity System of Care* document identified the need for equitable access to care across the district and in 2020 work began on determining the best location for primary maternity facilities for the Central Otago/Wanaka region. At the time of going to press, Southern DHB had endorsed one of the four options for further exploration. The option chosen proposes a primary birthing facility at Dunstan Hospital in Clyde and also a facility at Wanaka.



Southern DHB is excited that the MQSP Workplan for 2021-2023 includes further promotion of primary and home birthing options, to raise the profiles of primary birth settings. This will include working alongside community organisations to promote, inform and educate parenting groups on normal birthing. Additional work on the new-look maternity website will provide a central point for resources and promotion.

Accessed QLIK, MoH 16/03/2021.

Equity of access

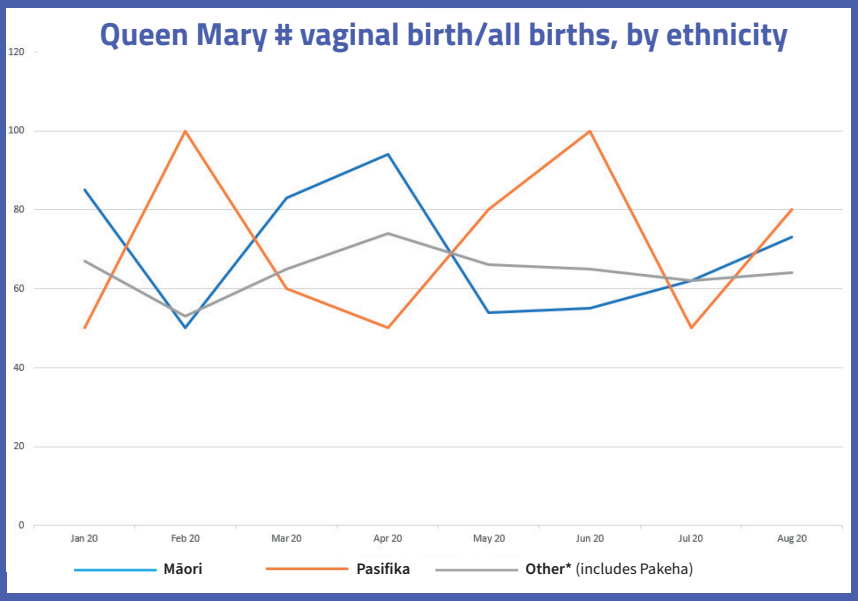
The PMMRC (Perinatal and Maternal Mortality Review Committee) recommends that regulatory bodies require cultural-competency training of all individuals working across all areas of the maternity and neonatal workforce. Training should address awareness of, and strategies to reduce and minimise the impact of, implicit bias and racism. DHBs are to provide evidence of their efforts to engage with and ensure equity of access to services for all consumers (particularly Māori, Pasifika, Asian, Middle Eastern, Latin American and African women, women with disabilities and young women).

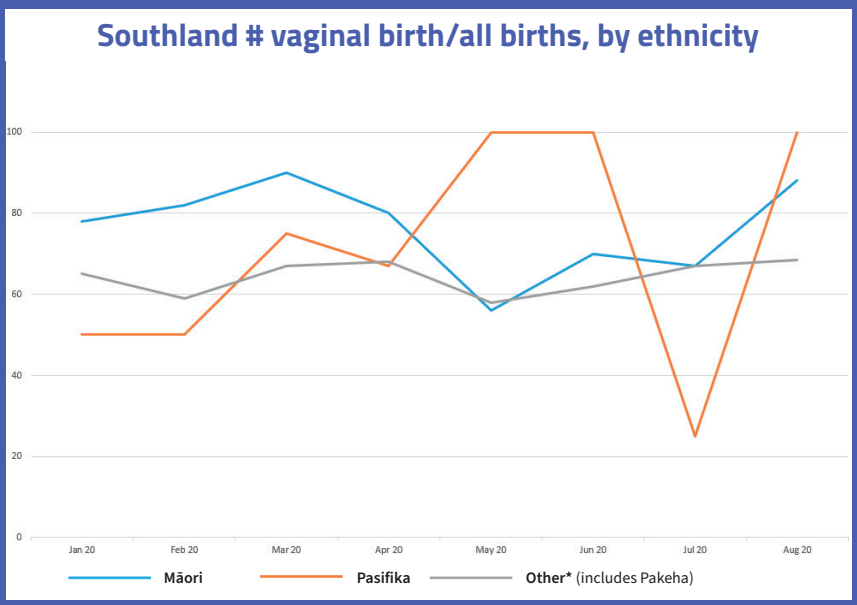
(*National Maternity Monitoring Group Annual Report 2018*)

Southern District Health Board (DHB) integrates cultural workshops into the mandatory orientation of all new staff to the DHB, with three-yearly Māori Health updates. Maternity services plan to align with the Māori Health Directorate to provide te reo Māori in *Health, Cultural Safety (Tikaka)*, *Te Tiriti o Waitangi* and *Cultural Humility*, and orientation will take place on marae. The next Maternity Safety and Quality Programme (MQSP) three-year plan includes maternity-specific education days to cover hospital and community practices around tikanga at birth and available local community support services. The MQSP is also focused on additional cultural quality improvements surrounding the maternity environment at the facilities.

MQSP governance is privileged to have diversity within its governance group and is planning to enlist a Pasifika consumer when the next vacancy comes up.

Southern DHB has the capacity to manually report on diversity of ethnicity in its clinical dashboards and this will become mainstream when we adopt the Power Bi system in 2021. The DHB will also address integration of primary maternity unit data via ethnicity reporting and present this information quarterly through clinical governance.





Local data (MQSP reporting, 2020) suggested that 3.9% of our birthing population in 2019 identified as Indian. MQSP has conducted a variance analysis of the Indian population against the 2018 Maternity Clinical Indicators, and this is under review. Southern DHB hopes the implementation of the GAP/GROW programme in early 2021 will help to reduce the prevalence of stillbirth, by increasing the detection of small-for-gestational-age babies within the high-risk Indian population.

Equitable access to contraception - LARC

Only 1/3 of women are using contraception postpartum. A birth-to-pregnancy interval of < 12 months is associated with increased risk of adverse health outcomes for the mother and child.

(*National Maternity Monitoring Group Annual Report 2018*)

District Health Boards (DHBs) are to report on the LARC (long-acting reversible contraception) service they are providing to their postnatal women and what steps they are undertaking to improve the equity of access to this form of contraception.

Auditing of LARC insertion occurs in the GP/nurse-practitioner space. Southern DHB currently does not track data from maternity services.

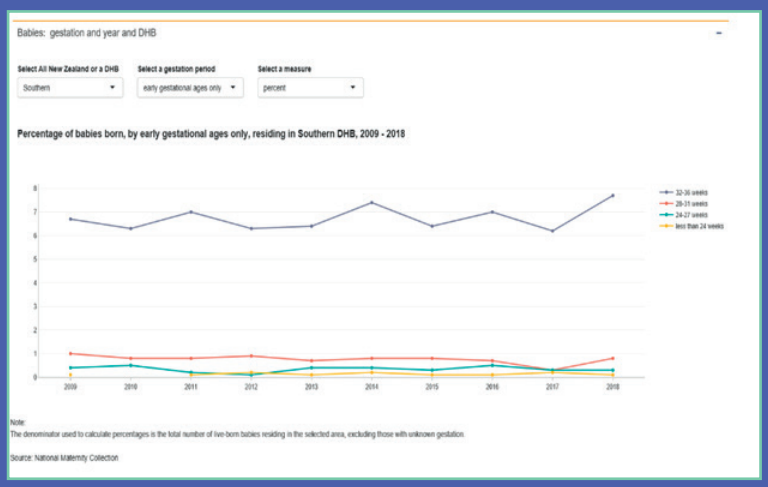
The Maternity and Quality Safety Programme (MQSP) has identified that monitoring insertions/removals and equitable access are areas that require significant work. MQSP is proposing, in its next MQSP tri-annual work plan, to perform a review of existing maternity services, conducting an audit to look at the requirements and adopt quality improvements that come from that work.

Implementation of the diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in New Zealand: A clinical guideline

This guideline was published in August 2018 and was adopted by Southern District Health Board (DHB) in 2018. When it was launched, Southern DHB rolled out initial education to introduce the guideline with teaching sessions held in the Queen Mary tertiary facility. The secondary facility and wider midwifery workforce received further education in 2019 through the compulsory Emergency Midwifery Skills days required for APC. The Southern midwifery leadership team completed additional work in early 2020 on a guideline to strengthen transfer of clinical responsibility highlighted during this process.

Future projects identified from this guideline work will involve consistency from the secondary and tertiary facilities with the pre-mix administration and review that primary maternity facilities are stocked with essential medications.

Pre-term birth



Southern District Health Board (DHB) data demonstrate an inclination in the birth rates at 32- to 36-weeks' gestation in 2018 to 7.7% compared to the national average of 6.2%.

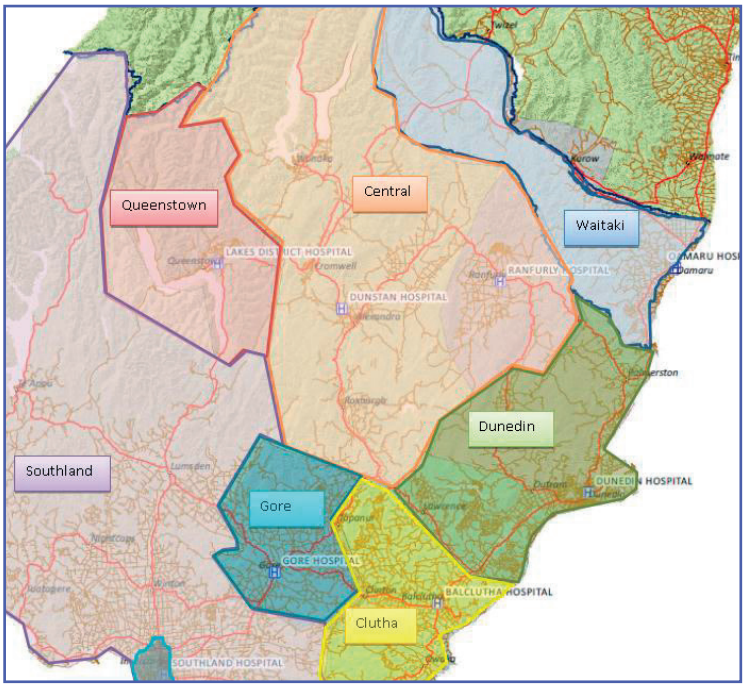
Southern DHB data include its tertiary facility in Dunedin, which specialises in the area of acute preterm birth management. The Maternity and Quality Safety Programme (MQSP) requires further work on auditing modifiable factors for preterm, with a multi-disciplinary approach to providing targeted measurable objectives and this is identified in the MQSP work plan for 2021-2023.

Maternity services

SECTION 4

Our facilities

At 62,356km in size, the Southern District Health Board (DHB) is the largest DHB by geographical area and serves a total population of 344,940 (as of October 2020).



Our district includes 8 territorial areas:

1. Central Otago district
2. Clutha district
3. Dunedin city
4. Gore district
5. Invercargill city
6. Queenstown-Lakes district,
7. Southland district, and
8. Waitaki district.

We have:

2 base hospitals in:

- Dunedin (Queen Mary)
- Southland (Southland Maternity)

They provide specialist care for women and babies (obstetric and neonatal), as well as midwife-led care for healthy, well women.

5 Maternal and child hubs provide basic midwifery equipment, consumables and emergency equipment and a workspace for consultations in:

- Lumsden
- Te Anau
- Wanaka
- Tuatapere
- Ranfurly

6 rural primary maternity units provide birth care for well women with uncomplicated pregnancies in the rural areas. These facilities provide postnatal care for birthing women and for women transferring from the base hospitals.

Oamaru Maternity
Waitaki community
Two birth rooms and three postnatal rooms.
https://www.waitakihealth.co.nz/maternity

Charlotte Jean Maternity Hospital, Alexandra
Wanaka/Central Otago community
One birth room and three queen-size postnatal rooms. Partners are encouraged to stay.
http://www.charlottejean.co.nz/

Gore Maternity
Southland community
One birth room and two twin postnatal rooms.
https://www.gorehealth.co.nz/maternity

Balclutha
Clutha community
One birth room and three postnatal rooms.
https://www.cluthahealth.co.nz/pages/maternity-centre/

Lakes Maternity
Queenstown Lakes community
One birth room and five postnatal rooms.

Winton Maternity
Southland community
Two birth rooms and four queen-size postnatal rooms. Partners are encouraged to stay.
https://www.winton.co.nz/listing/58/Winton-Maternity-Centre

PRIMARY MATERNITY UNITS

Oamaru maternity hospital

Oamaru Hospital Maternity Centre has been providing LMC midwifery care for the whole childbirth experience for 20-plus years. We have a birthing suite with water option and three postnatal beds in the unit and experienced midwives and nurses to care for women and whānau during their stay. Full antenatal and postnatal care is given to those women who are unable to birth locally.

They work collaboratively with our colleagues in Queen Mary to provide care for more complex pregnancies with between 60-100 births in our unit per year. We love to support birthing women in their centre and at home.

Thank you guys so much for your support and of course during the lockdown. It was such an overwhelming time to bring our baby unto the world. But we got through it!

To all you super-duper wonder women at the Oamaru Maternity Centre, thanks is not enough. You're awesome and your help, expertise and care has been so exceptional!

Clutha maternity centre

Clutha Health First (CHF) Maternity has had a good year, although it was challenging with Covid-19. There were 37 Clutha births and 73 postnatal transfers back from Queen Mary over this period, which is down on the last few years due to COVID-19. There was a great in-house breastfeeding education day in 2020. The team have worked steadily to increase our pepi-pod distribution in the South Otago area and are also now distributors of wahakura, which is exciting. We have implemented both SO2 screening of all newborn babies born at CHF, in conjunction with the Southern District Health Board and neonatologist and we also implemented the Maternal Early Warning Score system in line with the DHB.

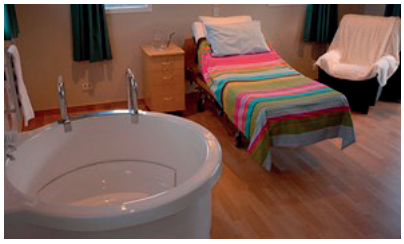
The team continues to have clinical governance meetings with the obstetric consultant who visits for antenatal clinics in Balclutha. There have been some great discussions and learning points that have come from those meetings. The employed LMC team have been working hard and 2021 bookings appear to be steady and on the increase.

Registered midwife Megan Pigou proudly reports that in 2021 the team will work on increasing primary birthing numbers and continuing to provide a high level of service to the South Otago community.

Amazing staff!!! Great support and care 24/7. Yummy food. Comfortable rooms and welcoming towards partner and visitors at all times. Great advice and help before going home.

Was impressed how staff always came around on shift change to introduce self, they would read notes before coming in so knew what was going on. So knowledgeable, loved my 2am chats with ward staff. Their knowledge was fantastic. Comfy bed, great meals. Nothing seemed to be a problem, didn't feel pressure to leave. Can't thank staff enough, they were all great.

Charlotte Jean Maternity Hospital



The number of births and postnatal stays at Charlotte Jean have continued to increase as Central Otago and Upper Clutha areas continue to grow and new LMC midwives promote primary birthing. There were 68 births in 2019 and 73 births in 2020.

Quality highlights have been the projects that resulted in completing an *Umbilical Cord Prolapse Guideline*, improving community pepi-pod distribution numbers and improved Anti-D administration processes. Continuing to provide breastfeeding education for staff as well as the wider community and maintaining a high standard of breastfeeding support to the whānau/families have continued to be a priority.

Quality coordinator Sue O'Brien says that despite the significant challenges of 2019 and 2020, the Charlotte Jean team is proud to have achieved the majority of their quality improvement goals.

I am so grateful to have birthed my second baby here. The quality and care you receive here is so beautiful!! To all the beautiful wāhine that helped me settle after giving birth, you all rock and the world needs more nurturers like you all. Happy New Year to you all here @ Charlotte Jean!! Blessed to have had baby #1 of the year @ CJ. Aroha tino nui Big loves.

We had our daughter during lockdown and we couldn't have had a more pleasant stay – we were well looked after, well fed and you wouldn't have known we were in lockdown. We are so lucky we have this facility. Thank you so much.

Lakes Maternity

Lakes District Hospital (LDH) had 65 births during 2020. This was down due to Covid-19, where home births increased dramatically in our region. LDH also had building work completed during 2020. The LDH maternity team achieved a very long-standing goal in 2020 of being able to provide a built-in pool for women to use during their primary birthing experience. We also added an additional shower and toilet to the ward. All the midwives and staff are super excited about this and the renovations completed as part of this project.

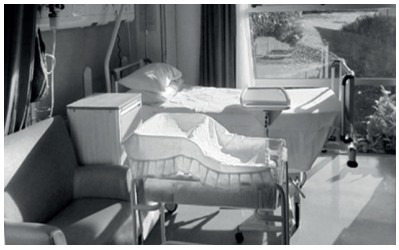
Midwifery coordinator Ann Mackay says it is lovely to have a new space and one that has been designed for the needs of the local women.

"The space is fresh and looks homely and welcoming."

The new birthing pool was a great relief to me during my labour. This made such a difference from last time! The midwives were so caring and looked after every need that my new family had. Thanks so much to everyone that cared for us, we will be back one more time!

To the LDH midwives, thank you so much for your wonderful help during the birth and days after our baby was born. We can't speak highly enough of the care received during our stay.

Gore Maternity



In 2019/2020, the Gore Health Maternity Unit was well supported by our community. There was an increase in birth numbers and in the number of families returning to the unit for ongoing postnatal care.

With support from the Countdown Kids Hospital Appeal and the community, we were able to replace the incubator with a new BabyPod20 Infant Transfer Device, used to transport babies in the ambulance to Southland Hospital. We were also able to replace the birthing bed with an AVE Birthing Bed – the first of its kind in Australasia. The ergonomic design allows mothers to find the optimum birthing position with support and comfort. Our birthing room now offers a modern and comfortable environment for families during labour.

The maternity unit is well supported by our team of midwives and nursing staff who work closely with the LMCs to ensure families enjoy their stay and feel well supported throughout their labour and postnatal period. Gore Health Maternity Unit has maintained our four-yearly Baby Friendly Hospital Initiative (BFHI) Certification and look forward to an audit from the New Zealand Breastfeeding Authority (NZBA) in 2021.

Quality improvement manager Glenda Maxwell, says that during the Covid-19 pandemic the teamwork was a real strength in the unit.

"We were successfully able to support families through this challenging time."

Everyone was so amazing, and you have a brilliant knack of knowing when to leave people to sort it out and when you need to come and help.

Thank you so much for a truly fabulous birth, your oozing confidence which boosted ours and your dedication to what you do. I really appreciate the way you have listened and advised – a big thank you to all the staff.

Winton Maternity

Winton Maternity Primary unit had 30 births in the 2019 contract year, potentially due to the closure of Lumsden Maternity. However, we continue to build on the momentum in 2020 and, despite Covid-19, we have continued to encourage low-risk women to deliver in our home-away-from-home facility.

A revamp of the inside of the building, with money from a local fundraising group, afforded new LED lighting, with painting and flooring to follow.

Following Covid-19, a change to shorter visiting hours has been beneficial to the mums, with more rest and focus on breastfeeding, improving their outcomes.

Nurse manager Debbie McDougall says the maternity centre worked well under Covid-19 lockdown, with great teamwork and communication from all staff.

Once again we have found Winton Maternity a fantastic transition from birth to home. We truly hope that the Southland people can enjoy this service for many years to come as it is a fantastic legacy for Winton and Southland! The care was great, the service, food and nurses were amazing.

To the lovely team at Winton Maternity. Wow, Southland is so lucky to have such an amazing facility on offer to parents. It was like home-away-from-home! Love the fact that we could all stay as a wee family and get fantastic support from all the nurses. It was certainly a great start for us as first-time parents and set us up well to go home. Thanks!!

SECONDARY MATERNITY UNITS

Southland Secondary Unit, Invercargill

Registered midwives, Sara Evans and Hilary Hoover, assisting in Covid-19 preparedness.

2019 and 2020 have been a rollercoaster, with midwifery workforce shortages and leadership changes due to retirements and pregnancies.

New nursing blood has certainly influenced the models of care used and the culture dynamics in the unit.

Using Trendcare as a tool became business as usual in 2019, allowing us to refine the process and data in 2020 and influence safe staffing.

New equipment came in the form of a fleet of latest-model Panda resuscitaires for the birth suites. With fundraising from Countdown's Kids Hospital Appeal, the unit secured two temporal thermometers and a jaundice screen tool for babies.

Reducing induction of labour rates in Southland began with some excellent audit work by staff and some short-term solutions included timed inductions and induction clinics. We also introduced balloon catheter inductions, allowing low-risk women the choice to go home for the first part of their labour.

Covid-19 meant a new way of working, and maternity rose to the challenge with ANC Telehealth a strong feature. PPE was distributed and "red zone" and "green zone" became the new normal.

The Maternity Early Warning Score is now operational, and the Neonatal Early Warning Score will be launched in 2021.

Queen Mary Tertiary Unit, Dunedin

A highlight for Queen Mary in 2020 was the start of the theatre redevelopment. It required the day assessment unit to move to the antenatal clinic area, enabling faster reviewing times and less waiting for our day assessment women. It is a much better experience being away from the acute area and lessens the pressure on our acute services.

The creation of a new administrative role for the birthing suite has enabled midwives to be released from administrative work to focus solely on midwifery care.

Charge midwife manager Fiona Thompson says the introduction of the Maternal Early Warning Score and the Variance Response Management Plan has enabled faster escalation of critical clinical issues and workforce variances to enable extra support for the team.

Our workforce

In its Annual Report 2018, the National Maternity Monitoring Group notes: DHBs should be responsible for their own workplace culture. Workplace culture affects staff both leaving and entering the workforce and also women receiving care. DHBs should be providing a positive and supportive working environment for maternity staff that is free from blame, bullying and harassment. Positive cultures are likely to improve retention and recruitment rates for staff.

Southern District Health Board (DHB) ran 28 staff-engagement workshops with groups across the DHB, including Lakes in 2019. Over 450 staff participated in these 30- to 45-minute sessions, which covered employee engagement and culture.
Following an overview of the survey results there was a short discussion and staff then voted or provided feedback on specific elements around our priorities and bullying. The sessions concluded with a short video encouraging staff to "speak up".
The results from the 450+ participants to date have ranked the priorities as listed in the table below.

Priority	Participants' rankings	Executive leadership and senior leadership teams' rankings
Eradicating rudeness and bullying	1	1
Addressing poorly managed people/HR processes	2	2
Enhancing professional development	3	6
Improving the way leaders communicate	4	4
Developing a high-performance culture	5	3
Embedding our shared values - Southern Future	6	5

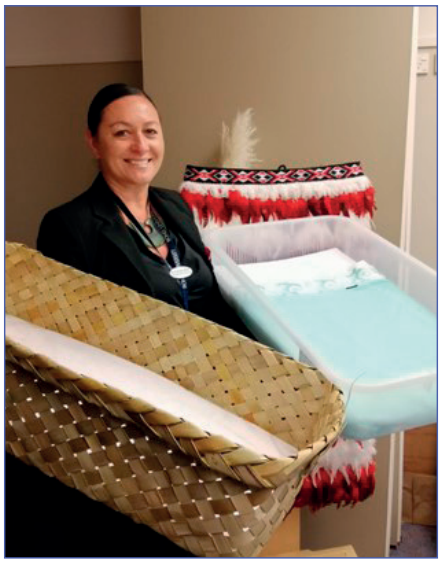
Priority	Action
Eradicating rudeness and bullying	*Speak Up/Above the Line, Below the Line* presentation is now included at orientation/Southern DHB welcome for all new staff. In addition, there have been workshops held continually throughout 2019 (*Speak Up/Above the Line*), including for maternity services.
Eradicating rudeness and bullying	We now provide online e-learning tools for addressing negative behaviours. April Strategy LLP's BUILD online tool launched on Ko Awatea for all staff. In November 2019, April Strategy LLP's Tim Keogh presented train-the-trainer sessions on the BUILD tool and how to use it in a training environment.
Addressing poorly managed people/HR processes	Mandatory training algorithms now ensure all staff have clarity regarding training requirements. This is now being looked at to see if we can integrate into HR processes.
Addressing poorly managed people/HR processes and enhancing professional development	Performance development reviews (PDRs) are now embedded in Essential Corporate Training, with revised PDR templates in place. Allied Health and SMO are still a work in progress. This supports the development of personal development plans for all staff.
Addressing poorly managed people/HR processes and improving the way leaders communicate	*Courageous Conversations* and *Performance Management* training are now part of Essential Corporate Training.
Improving the way leaders communicate	External contractor training was organised for leaders in 2019 on *Compassionate Assertiveness*. We will revisit this in 2020 with a new approach and new tools.

"Reflective education sessions" by registered midwife Morag MacAulay have been piloted in Dunedin to enable practitioners to have deeper reflective understanding within their complex work environments. The sessions have been aimed at providing support and developing resilience within the team.

Plans for maternity in 2021 include developing a culture and wellbeing programme and working closely with the Māori Health Directorate, in particular around the holistic employee wellbeing approach.

CULTURAL SUPPORT

Kaiāwhina Cultural Support, Te Huinga Tahi, Southland



Southland Hospital Kaiāwhina Andrea Jerry.

Andrea Jerry is a kaiāwhina (cultural support) in Te Huinga Tahi Māori Health Unit at Southern District Health Board (DHB).

The kaiāwhina addresses the cultural support for the physical element of health from Te Whare Tapa Whā in cultural assessments for māmā and pēpi/ whānau.

Andrea's work includes providing information; support with accessing community services and resources; social needs' assessment; assisting staff, whānau and patients as their needs require; and reducing Māori outpatient do-not-attend appointments.

Andrea has been prominent in pēpi-pod/wahakura engagement and distribution on behalf of Public Health South, identifying whānau Māori in the service who would benefit from this. As a trained distributor, from May 2019 to December 2020, Andrea provided 172 safe sleeping spaces at Southern DHB and continues to educate whānau in order to reduce SUDI rates for Māori. The Kaiāwhina will not only support the weavers of wahakura/ipu whenua (placenta container) in the future but will encourage whānau to weave their own. The pēpi pod will continue to be offered to whānau and it will be their decision what is best suited for the safety of their pēpi.

Andrea's vision is that appropriate tikanga Māori (customs) such as karakia, waiata or karanga could be offered or discussed with women, highlighting the need for tikanga Māori education/engagement of the whole maternity workforce. As part of the antenatal journey this could be factored into birth plans, including cultural support alongside the midwife/specialist in the delivery room or in theatre during a caesarean delivery and the kaiāwhina would be considered part of the multi-disciplinary team. Referrals for Māori clients to have cultural engagement should be offered by the LMC, preferably at the start of the relationship and thus would be honouring Article 2 of Te Tiriti o Waitangi.

MQSP has identified quality improvements with respect to Tikanga Māori and cultural education as part of the 2021-2023 workplan and are excited to work alongside the Kaiāwhina service.

Kaiāwhina Cultural Support, Te Ara Hauora, Dunedin

Kaiāwhina Wendi Raumati and Eleanor Russell gifting ipu whenua.

Wendi Raumati and Eleanor Russell are kaiāwhina at Te Ara Hauora in Dunedin.

"One of the most enjoyable aspects of our mahi here is being able to tautoko our māmā and pēpi when they come in to Queen Mary and NICU," Wendi and Eleanor say. "We have great communication and work very closely with our teams on the wards and always happy to explain tikanga to them."

Some of the services offered by our kaiāwhina in Dunedin to women, whānau and staff include:

- Cultural support kanohi ki kanohi
- Karakia
- Mate Māori
- Mihiwhakatau/powhiri
- Waiata
- Education related to Te Ao Māori
- Liaising within and outside the hospital.

Over the past four-and-a-half years the Kaiāwhina service has been providing ipu whenua to whānau when requested, as there was no supplier. In 2019, they held three workshops for staff to learn to make ipu whenua to be donated back to Southern District Health Board. Looking to the future, staff have the opportunity to attend a Mahi Raranga – Ipu Whenua Hui once a month where they learn tikanga around ipu whenua and weave them. Wendi and Eleanor are passionate about the service they provide and proud that their wahakura are woven by local kai raranga and are available to the new māmā.

NEW SENIOR POSITIONS

Requiring additional midwifery workforce members is often a theme that runs alongside FTE calculations. The challenge locally and nationally continues with ongoing vacancies in midwifery. But even in times of adversity, new senior positions have been created.

Two new senior midwife coordinator roles have successfully been recruited to Southland to provide support to the charge manager, to promote clinical midwifery professional standards and effective daily coordination and provide another layer of support and safety for the women and whānau in Southland.

Queen Mary in Dunedin has had new administrative roles for the birthing suite approved and recruited, and this has enabled midwives to be released from the administrative side of their role and focus solely on the valuable midwifery care.

In 2021, a new associate director of midwifery role will be recruited to focus on the safe delivery of midwifery and maternity care and operational services within the maternity units in Dunedin and Southland.

Southern District Health Board also reviewed the Maternity Care Wellbeing and Child Protection (MCWCP) multi-agency group following concerns about how the groups run. The review resulted in a series of recommendations, one of which addressed the need for midwifery coordinators to engage with LMCs and primary maternity units. Funding was successful and Liz Whyte and Fleur Kelsey (1.0 FTE total MCWCP midwifery coordinator positions) have been successfully recruited to address the issues and implement operational frameworks. Their work will result in support and the best outcomes for women and their families who have been identified as having vulnerabilities during the maternity care period.

MCWCP Coordinator Fleur Kelsey, RM.

Fleur has worked as both a rural LMC and a core midwife and has a keen interest in supporting wāhine and whānau who are experiencing mental health, addiction and family harm challenges in their pregnancy. Fleur is completing a Masters of Social and Community Work to extend her knowledge.

MCWCP Coordinator Liz Whyte, RM.

Liz has recently been appointed as the Southland midwifery coordinator for the MCWCP multi-agency group. Having been both an LMC and a core midwife, Liz has some understanding of the complexities women referred to the group bring. Often several different agencies are involved with the woman and her whānau, and Liz sees her role as coordinating the care to ensure each woman has the resources and support she requires to negotiate this vulnerable time.

Ongoing national midwifery workforce shortages, and those experienced by the Southern District Health Board, have meant that a unit staffed with only midwives is not yet achievable. Being able to utilise the valuable nursing resource has enabled those with special interest to work in the maternity setting. A bespoke training programme was devised to upskill the nurses in the needs and requirements of postnatal woman and baby cares, provide breastfeeding education and expand their skillset under the supervision of the midwife. 2019 saw the recruitment of the first Nursing Entry to Practice nurse (NETP) on to a maternity ward in the Southern District. NETP is the 12-month support programme for new graduate nurses.

Our own rising star in Southland Maternity, registered nurse Khellsey Atley.

Khellsey Atley was the first NETP registered nurse in maternity and reflects on the challenges of her role in Southland's maternity ward: "I was thrown in the deep end of learning a whole new language of obstetric health. I had no idea what 'gravida' and 'parity' meant, but now they are in my day-to-day vocabulary. Just as I was starting to find my feet, Covid-19 hit. Study days stopped, vulnerable staff were made to stay home, and patient contact was done with physical barriers in the form of PPE. But we muddled through together. We have struggled with staffing levels most of the year and have had a high ward acuity. Some days this has pushed me to the edge. The downside to this is less time being able to be spent with each patient, because it is not only one patient in each room, but two. Some days, I leave work to head home with an empty cup. Adjusting to the shift work and giving so much of myself to patients has often left me exhausted at home. I have struggled with finding the energy to maintain my physical health."

As part of Khellsey's support network, a Registered Nurse mentor on the ward provided professional and emotional support and guidance during the many challenges Khellsey adapted to.

Khellsey also shared the more positive aspects of her year: "I have seen the growth in myself and my practice. There has been a lot of reflection, feedback and learning undertaken, all for the better. I was lucky enough to be able to attend Ara Institute in Canterbury to do a child health paper to develop my neonatal assessment and resuscitation skills. I was also nominated for the Rising Star Southern Excellence Award, which was a humbling experience. I have set myself the goal of remembering to not just take time, but make time for myself. We have started this by team dog walks and starting a maternity ward book club. One of the best things about my year-to-date is the incredible people I have met along the way. I have made some amazing friends! I feel so privileged to work among such a nurturing and kind team of people and they certainly make the days a bit more fun. I have loved meeting all of the patients and their babies and, most of all, I have had the privilege of being a part of the start of their new journeys. I had the opportunity to move on to another ward at the end of my NETP new grad year, but there is nowhere else I'd rather be."

QUALITY OVERVIEW

SECTION 5

Care Capacity and Demand Management

Over the past 18 months there has been a strong focus by Southern DHB to have its Care Capacity and Demand Management (CCDM) fully implemented within the hospital maternity setting.

Care Capacity and Demand Management includes initiatives to support safe staffing in wards. Its components include the acuity software element, Trendcare; a Variance Indicator System (VIS); and Variance Response Management (VRM).

Trendcare is already operational, reflecting the work of midwives within in-patient settings. Acuity is now visible to the rest of the hospital. Work went into fine-tuning the accuracy of data through consistency and inter-rate reliability testing.

The VIS and VRM elements have now been successfully implemented across both secondary and tertiary settings, allowing escalation pathways to be developed that assist with decision-making on elective work, a core data set, staffing methodologies and FTE calculations.

Benefits

With the additional layer of visibility, the tool highlights when additional support is needed and resources can now be deployed from other areas, FTE can be adjusted based on Trendcare data and the process provides recognition of the work midwives do.

Queen Mary charge midwife manager Fiona Thompson says the introduction of the Maternal Early Warning Score (MEWS) and the VRM plan has enabled faster escalation of critical clinical issues and workforce variances to enable extra support for the team.

Early warning score

Towards the end of 2019 and throughout 2020, Southern DHB rolled out the Maternity Early Warning Score (MEWS) in our secondary and tertiary units.

This national programme allows for early detection of clinical deterioration and MEWS can be used on all hospitalised antenatal and postnatal women to recognise the potential need for a higher level of care.

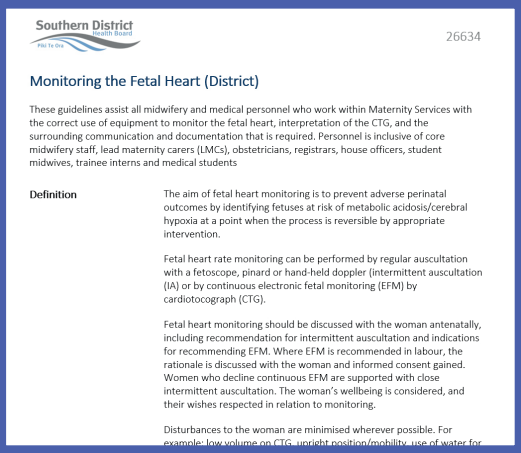
MEWS required roll-out of a national standardised form, education and escalation pathway. Auditing starts in 2021 with an ongoing plan to roll out to the primary maternity units in the district by March 2021.

Theatre redevelopment

In addition to dealing with Covid-19 and lockdown in 2020, our attention turned to the theatre redevelopment in Queen Mary. The aim was to improve the environment and patient flow from theatre to post-anaesthetic care. Once completed, we will have a modern theatre with furnishings that meet infection prevention control standards and an overall better working experience for peri-operative and midwifery staff. Work is expected to be signed off in early 2021.

Quality Improvements following case review

A new *Monitoring the Fetal Heart (District Guideline* and cardiotocograph (CTG) sticker came directly from such recommendations. The new guideline assists with identifying the correct use of equipment to monitor the fetal heart, interpretation of the CTG and the communication and documentation required.



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Monitoring the Fetal Heart (District)

These guidelines assist all midwifery and medical personnel who work within Maternity Services with the correct use of equipment to monitor the fetal heart, interpretation of the CTG, and the surrounding communication and documentation that is required. Personnel is inclusive of core midwifery staff, lead maternity carers (LMCs), obstetricians, registrars, house officers, student midwives, trainee interns and medical students

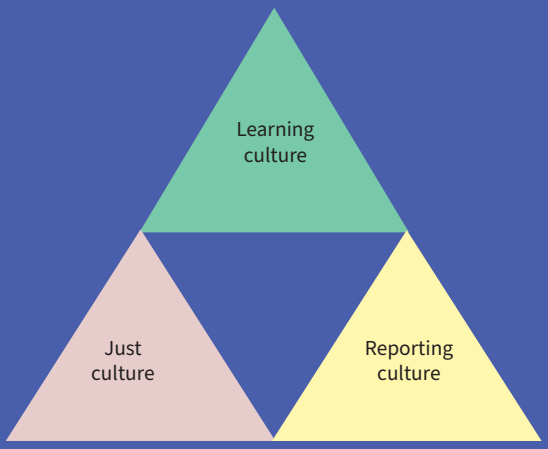
Definition

The aim of fetal heart monitoring is to prevent adverse perinatal outcomes by identifying fetuses at risk of metabolic acidosis/cerebral hypoxia at a point when the process is reversible by appropriate intervention.

Fetal heart rate monitoring can be performed by regular auscultation with a fetoscope, pinard or hand-held doppler (intermittent auscultation (IA) or by continuous electronic fetal monitoring (EFM) by cardiotocograph (CTG).

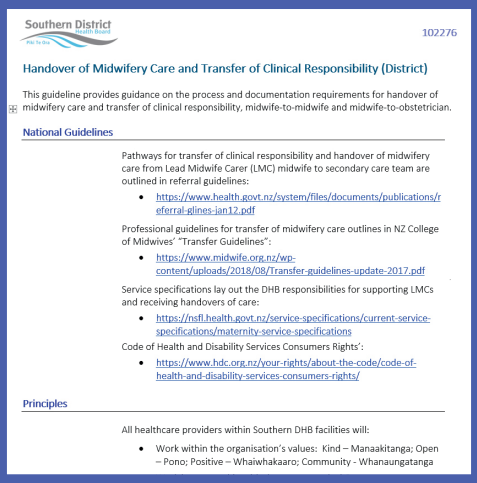
Fetal heart monitoring should be discussed with the woman antenatally, including recommendation for intermittent auscultation and indications for recommending EFM. Where EFM is recommended in labour, the rationale is discussed with the woman and informed consent gained. Women who decline continuous EFM are supported with close intermittent auscultation. The woman's wellbeing is considered, and their wishes respected in relation to monitoring.

Disturbances to the woman are minimised wherever possible. For example: low volume on CTG, upright position/mobility, use of water for



Following the launch of the new sticker and guideline, Southern DHB increased awareness of the requirements for all staff involved in CTG interpretation to have undertaken the Fetal Surveillance Education Programme and plans for this to be mandatory by 2021. Another recommendation was a clear guideline around the transfer of clinical responsibility of midwifery care. This document was developed to ensure we have clearer communication and documentation with each other about clinical responsibility and to ensure women and whānau understand when there is a change of clinical responsibility, whether it be from midwife to midwife or midwife to obstetrician. Making reference to the national guidelines (*S88 Referral Guidelines*, *New Zealand College of Midwives' Transfer Guidelines*, service specifications and *Health and Disability Service Consumer Rights*) clarifies the clear expectations of Southern DHB with respect to transfer of clinical responsibility, handover of midwifery care, roles and responsibilities and documentation.
The Safety First System, is the electronic risk-management system process identified to record incidents. Classification of these incidents allows clinical risk to be identified and brought through the Clinical Governance Group as dashboards, to monitor investigations, potential process changes and trends.

CARDIOTOCOGRAPH (CTG):			Antenatal ☐	Intrapartum ☐
Date:	Time:	Maternal pulse:	Gestation: / 40	*Fetal movements: Y / N
Risk	Indication for CTG:			
Contractions	None Irregular	Regular Mild Moderate Strong		.....in 10min
Baseline rate .....bpm	110 -160	100 -109	>160 Rising baseline Y / N	<100bpm for >5mins Rising baseline Y / N
Variability	6 – 25 bpm		Reduced (3-5 bpm)	Absent (< 3 bpm)
Accelerations	Present	*The absence of accelerations with an otherwise normal trace is of uncertain significance*		
Decelerations	1. None	1. Early 2. Variable without complicating features	1. Complicated variable 2. Late 3. Prolonged (> 90sec but < 5min)	1. Bradycardia > 5 min 2. Complicated variable with reduced variability 3. Late with reduced variability 4. Sinusoidal
Overall assessment	**Normal**	**Abnormal** **Unlikely** associated with significant fetal compromise	**Abnormal** **May be** associated with significant fetal compromise	**Abnormal** **Very likely** associated with significant fetal compromise
Determine action	Most abnormal feature determines **'ACTION'** below			
Action	No action required	☐Correct reversible causes* ☐Second opinion	☐Correct reversible causes * ☐Urgent referral to Senior colleague	☐Correct reversible causes* ☐Urgent referral to Senior colleague
Plan	(e.g. FBS, Tocolysis, continue CTG):			
Print name:			Signature:	
'Fresh Eyes' / Second opinion: document CTG analysis in clinical notes below or use another CTG sticker.				
Acknowledgement: CDHB		*Refer to Queen Mary MIDAS Document Monitoring Fetal Heart (District)		



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Handover of Midwifery Care and Transfer of Clinical Responsibility (District)

This guideline provides guidance on the process and documentation requirements for handover of midwifery care and transfer of clinical responsibility, midwife-to-midwife and midwife-to-obstetrician.

National Guidelines

Pathways for transfer of clinical responsibility and handover of midwifery care from Lead Midwife Carer (LMC) midwife to secondary care team are outlined in referral guidelines:

- https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf

Professional guidelines for transfer of midwifery care outlines in NZ College of Midwives' "Transfer Guidelines":

- https://www.midwife.org.nz/wp-content/uploads/2018/08/Transfer-guidelines-update-2017.pdf

Service specifications lay out the DHB responsibilities for supporting LMCs and receiving handovers of care:

- https://nsfl.health.govt.nz/service-specifications/current-service-specifications/maternity-service-specifications

Code of Health and Disability Services Consumers Rights':

- https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

Principles

All healthcare providers within Southern DHB facilities will:

- Work within the organisation's values: Kind – Manaakitanga; Open – Pono; Positive – Whaiwhakaaro; Community - Whanaungatanga