Te Whatu Ora
Health New Zealand
Southern

MQSP ANNUAL REPORT

JAN 2021 - DEC 2022

TE WHATU ORA - SOUTHERN

CONTENTS

ACKNOWLEDGEMENT

We would like to acknowledge and thank the dedication and hard work of all Te Whatu Ora - Southern staff including members of the senior leadership team, clinical staff both midwifery and obstetric, service managers, general managers, health care assistants, administration, and cleaning staff during the unprecedented times we have experienced over the past two years and in particular the ongoing dedication to quality and safety improvement work that they have contributed to and that the following pages detail.

Champion roles are undertaken by many staff across all settings (primary, secondary, and tertiary) usually in addition to their rostered FTE. It is these people who are instrumental in ensuring the success of many of the MQSP local and national projects including audit, education, policy and guideline review, development and implementation, consumer representation and feedback, infection, prevention and control, health and safety, maternal wellbeing, breastfeeding, and child protection as well as smokefree to name but a few and we acknowledge their contributions here.

We would also like to acknowledge Jane Wilson (Chief Nursing & Midwifery Officer) executive sponsor of the MQSP governance group for her time and dedication to maternity quality and safety. Equally we acknowledge Karen Ferraccioli for her inspirational leadership and support for the programme, Michelle Archer, and Sara Evans for their adept and dedicated coordination of the programme, as well as Mel Rackham for her contribution to the development and release of this report.

For all those individuals who have and continue to contribute to the important mahi that is MQSP – thank you.

MESSAGE FROM THE CHIEF NURSING & MIDWIFERY OFFICER – MQSP SPONSOR

Tēnā koutou

The Southern Maternity Quality and Safety Programme continues to build on its earlier work with some significant achievements highlighted in this report. One of the most important roles that the MQSP plays is to ensure effective use of governance to monitor maternity outcomes and identify priorities for improvement. Despite the challenges of the last two-three years, the pursuit of high quality and safe care and a commitment to continuous improvement has not wavered. Refreshed terms of reference and renewed MQSP membership has enabled 'fresh eyes' to question and ensure greater transparency and accountability. Although there is more work to do to improve outcomes, the programme is strengthening year on year and resulted in several new initiatives you can read about in this report. I applaud the work of all those involved and their relentless energy and commitment to improving maternity services in the Southern district.

Ngā mihi maioha
Jane Wilson
Chief Nursing & Midwifery Officer

MESSAGE FROM THE DIRECTOR OF MIDWIFERY

Kia ora koutou

In October 2021, I had the privilege of joining the Southern district's whanau and continue my career journey in one of the most beautiful parts of Aotearoa. Te Waipounamu welcomed my family and I with all its beauty and natural integrity. Its Alps and lakes remind me of my native land in the Northeast of Italy, and I began to feel at home. Since I moved, this whenua/land and its people have generously talked to me with pride and open hearts about their community needs and desires and inspired me with their values and resilience. Southern encompasses a variety of geographical realities and challenges, rural and remote needs, increasing populations in underserved areas, and the highest midwifery workforce vacancy in the country. However, access to care and safety has been a priority to everyone involved in maternity services, and when resources have been lacking, people have found creative ways to support and care.

Southern maternity services have been committed to equity, inclusivity, quality and safety and better outcomes for our people. This report is an acknowledgment of the resilience and strength of Southern maternity teams and midwifery leadership which went the extra mile to keep whanau, women, and pregnant people safe, during the Covid-19 pandemic, with extremely limited workforce resources, and while the country was starting the Pae Ora Act 2022 implementation.

It is also a celebration of the passion and achievements of our maternity services, and wider network and their commitment to excel.

Noho ora mai
Karen Ferraccioli
Director of Midwifery

THE MQSP TEAM

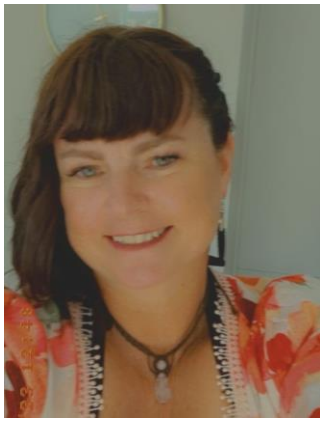
Karen Ferraccioli (She-Her) – Director of Midwifery

Karen is an accomplished change leader, equity advocate, strategic thinker, and people-centric Director of Midwifery. Karen has a more than 30-year history of working within maternity settings both overseas in Europe as well as in New Zealand. Karen came to New Zealand with a passion for midwifery and a mandate to engender people-centric equity within all aspects of her work. Since 2014, Karen has undertaken midwifery leadership roles from Taranaki to the Hutt Valley and finally here in Southern. As well as her midwifery calling Karen advocates for equitable childbearing pathways for the LGBTQIA+ community, and she is involved in national child protection networks. Karen contributed to the MERAS-midwifery union as a union representative and chair of the NRC also. She is an inspirational leader, role model and change agent who is perfectly placed to oversee innovation, intervention and change within the Maternity Quality Safety Programme by ensuring strategic alignment and the progression of national, regional, and local quality and safety projects.

Mel Rackham (She-Her) – Midwifery Advisor-MQSP

Mel came to MQSP in late November 2022. Mel's passions and experience sit firmly within maternity, education, practice and professional development, quality, and safety arenas. As a member of the MQSP governance Team, Mel's role incorporates ensuring collaborative programme delivery alongside developing and facilitating the strategic direction of MQSP across primary, secondary, and tertiary maternity settings that aims to improve clinical outcomes for pregnant women/wahine/people and their pēpi/babies. Mel's passion for equitable outcomes and leadership makes her a great addition to the MQSP team.

Michelle Archer (She-Her)- MQSP Coordinator



As the Maternity Quality and Safety Programme (MQSP) Coordinator it has been Michelle's role to coordinate the operation of the Maternity Quality and Safety Programme Governance Group. Michelle provides meaningful liaison with all stake holder groups internal and external and is dedicated to meeting the expectations and requirements of people accessing maternity services. Michelle assures that consumer engagement within the MQSP structure is valued and ensures that quality improvements are undertaken in a respectful and equitable manner across the service. Michelle feels honored and finds her role rewarding particularly being a part of MQSP and looking at our maternity service with a quality and safety lens, ensuring the best possible care.

Sara Evans (She-Her) – MQSP Coordinator

Sara trained and qualified as a midwife in Cardiff, Wales in 2014. After completing her preceptorship year Sara spent 4 years as a community midwife in Newport, Wales. She moved to Invercargill in 2019 and started her New Zealand midwifery life as a core midwife in Southland Hospital. In 2021 Sara moved into MQSP, following her passion for quality and governance. In 2022 Sara was appointed Clinical Midwife Manager at Southland Maternity Unit, which has also helped to focus those same passions at a local level. Sara continues to live in Invercargill with her husband, daughter, two cats and numerous foster kittens.

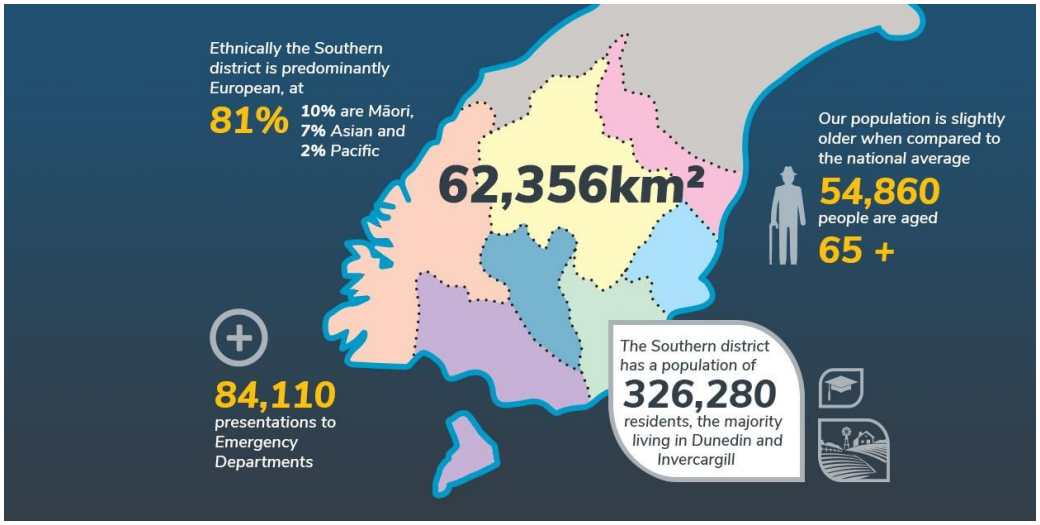
Kay Baldock (She-Her)- MQSP Administrator

Kay has had a varied working life that has included everything from NZ Post (Bonus Bonds), Administration at Otago Polytechnic, becoming and adult student studying IT to a Mobility Taxi Driver. Following enforced time off during Covid Kay decided to apply for a number of roles that looked interesting, one of which was an administrator role in Queen Mary Maternity and from there she accepted the dual position of Management Assistant to the Director of Midwifery and Administrator of the Maternity Quality and Safety Programme (MQSP).

Kay has found maternity to include far more than "women having babies" and has come to appreciate the hard work and dedication that the maternity workforce, whether hospital staff or independent LMC's, put into every day. MQSP sees both the best, and the worst, of the maternity journey which never fails to leave Kay appreciating the work that the MQSP team puts into ensuring that, whatever the outcome, they have made it the best possible one it could be.

INTRODUCTION

Situated in the heart of Te Waipounamu, Te Whatu Ora – Southern incorporates some of the most diverse terrain in the motu from snowy mountains to vast lakes and rushing rivers located South of the Waitaki River and encompassing Southland, Clutha, Dunedin, Central Otago, Waitaki and Queenstown Lakes districts. Southern therefore serves the largest geographic region, caring for over 326,000 New Zealanders. From Sothern's smaller rural hospitals, to one of the motu's largest trauma centers, Southern provides stand-out facilities with passionate, supportive, and highly professional, friendly teams that have strong community-connectivity that enables everyone across our district to live well, and access the right care when they need it, by delivering high quality, patient-centered and equitable health services to our diverse communities.



To achieve our maternity and broader population health goals we work in partnership with Iwi, primary care and community providers, rural trust hospitals and education and research partners across the district. Te Whatu Ora - Southern receives government funding of over $900 million per annum, approximately half of which is applied to traditional hospital and mental health services while the other half is applied through contracts with a range of primary and community health providers including primary maternity facilities.

Te Whatu Ora's statutory purpose is to:

- Improve, promote, and protect the health of our population.
- Promote effective care and support for people in need of personal health or disability services.
- Reduce health outcome disparities.
- Manage national strategies and implementation plans.
- Develop and implement strategies for the specific health needs of our local population.

OUR PATHWAY

The Southern District occupies a vast landscape that houses resourceful and capable people that have built healthcare structures, systems and processes that enable us to take care of each other. With a staff of approximately 4,500 the focus moving forwards is to bring all that is 'Southern' together into an integrated whole.

It is Sothern's integrated approach to care that has seen primary maternity settings providing highly valued, safe experiences for wāhine/women/people in which normal birth is facilitated, maximizing whānau involvement and enabling choice and self-determination throughout the pregnancy journey.

Integrated maternity services within the Southern region have ensured care and support needs are met in an individualized way that leads to improved health literacy, outcomes, and experience of care. Collaboration within and between services has meant that service gaps, changing needs as well as improvement opportunities are identified in ways that facilitate quality and safety enhancement for our birthing population.

OUR SOUTHERN VALUES

Our values describe how we expect everyone who works in Southern to look after each other including patients, whanau, colleagues, providers, and other organisations – they apply to all of us, no matter our role or level.

Kind - Manaakitanga

Looking after our people: we respect and support each other. Our hospitality and kindness foster better care.

Open - Pono

Being sincere: we listen, hear, and communicate openly and honestly, and with consideration for one another. Treating people how they would like to be treated.

Positive - Whaiwhakaaro

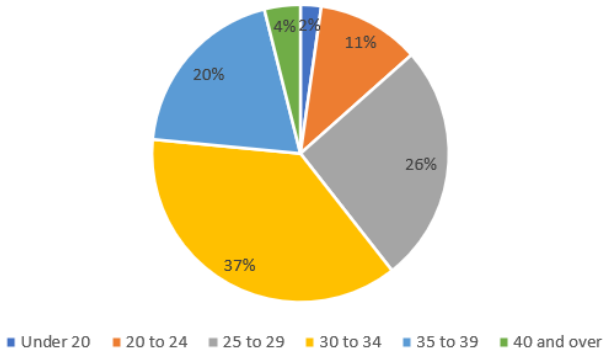
Best action: we are thoughtful, bring a positive attitude and are always looking to do things better.

Community - Whānaungatanga

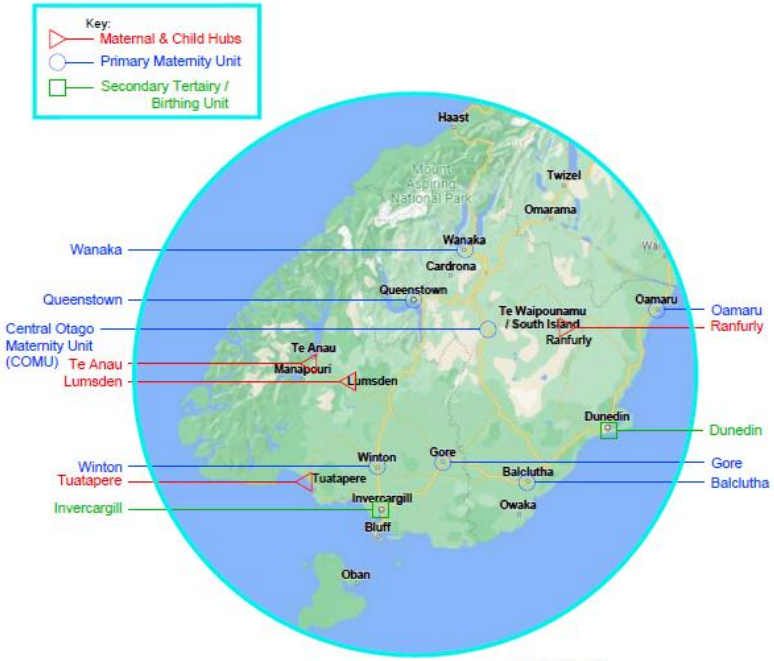
As family: we are genuine, we nurture and maintain relationships to promote and build on all the strengths in our community.

MATERNITY DEMOGRAPHICS

WOMEN OF BIRTHING AGE 2020



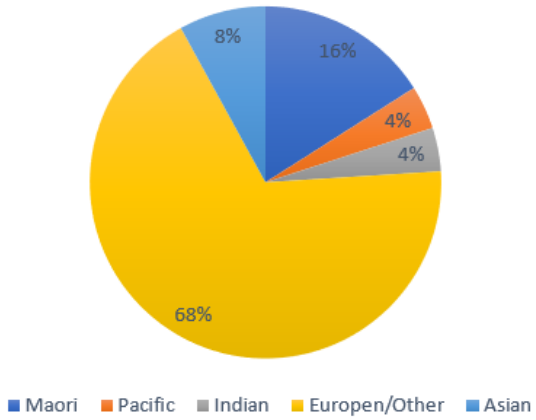
In Southern the population we serve is diverse in both age and culture. As a service we acknowledge the importance of providing patient centered culturally appropriate care to all our service users. As our population grows and changes, we adapt our service to the needs of our users. All staff at Southern attend cultural safety and humility training, incorporating the principles of the Te Tiriti o Waitangi.



62,356Km^2
Te Whatu Ora - Southern has the largest geographical area in New Zealand with approximately 3300 births per year.

In Southern we have seven primary birthing units and two base hospitals.

BIRTHING WOMEN/PEOPLE ETHNICITY 2020



Over the last couple of years there has been a growth in our Indian and Asian population with other ethnicities remaining at approximately the same level.

In 2020 we had:

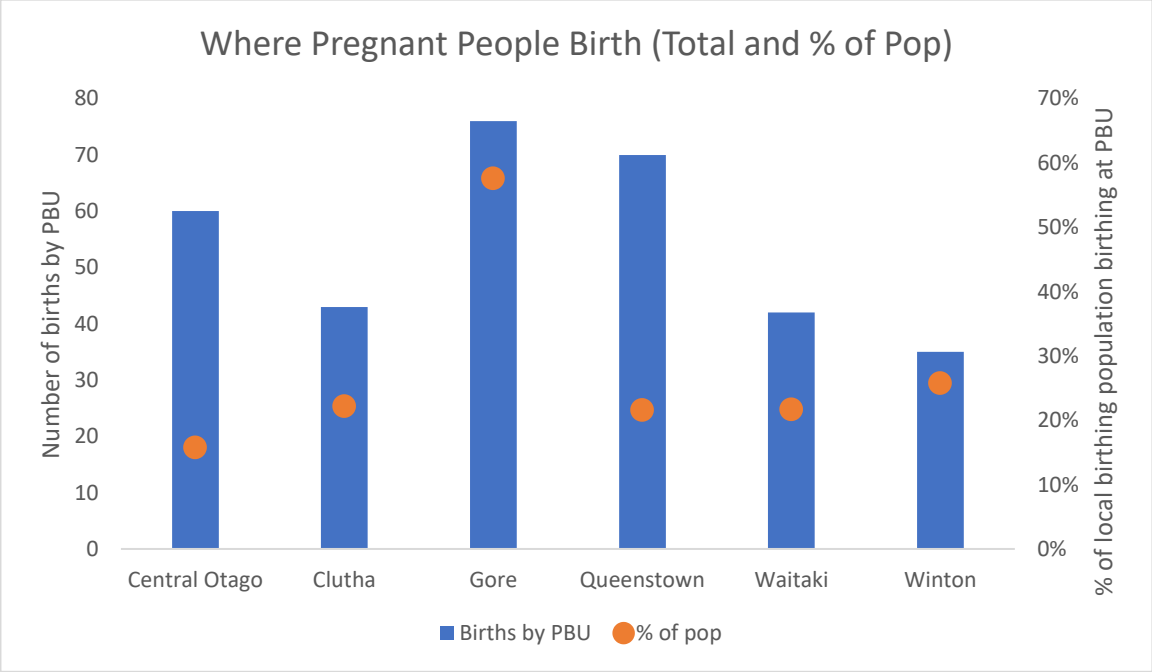
1498 births in our Tertiary facility (Dunedin)

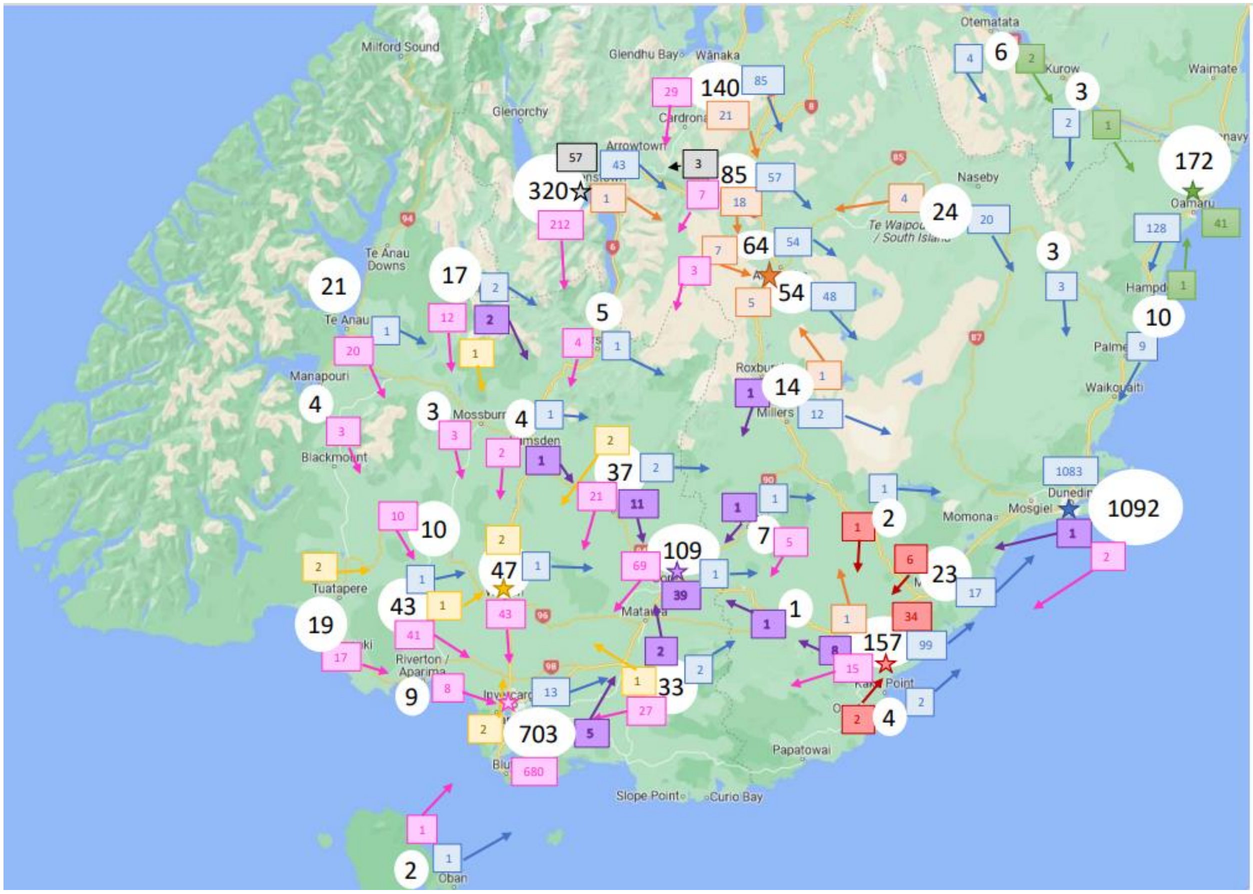
1129 births in our Secondary facility (Southland)

195 births in our primary birthing units

Primary Birthing Units are strategically placed across Southern to provide closer to home care for our rural communities. On average 20 – 30% of the pregnant population births in one of our Primary Units, the exception being Gore and the surrounding regions where nearly 70% of the community opt for a primary unit delivery. In addition, the Primary Birthing Units provide inpatient postnatal care for approximately 2 nights post birth to between 40 and 100% of their surrounding community. During their stay whanau can get one-on-one support in areas such as breastfeeding and parenting. Additionally, it is typical to see many parents deciding, or requiring, to birth in the secondary and tertiary centers, then returning to a Primary Unit for their postnatal care.


WHERE WOMEN/PEOPLE LIVE BY REGION AND YEAR
350
300
250
200
150
100
50
0
Central Otago
Clutha
Gore
Queenstown
Wanaka
Waitaki
Fiordland
Winton
2018/19
2019/20
2020/21
2021/22


Where Pregnant People Birth (Total and % of Pop)
Number of births by PBU
80
70
60
50
40
30
20
10
0
70%
60%
50%
40%
30%
20%
10%
0%
% of local birthing population birthing at PBU
Central Otago
Clutha
Gore
Queenstown
Waitaki
Winton
Births by PBU
% of pop



Key

COMU	60
QM	1694
Oamaru	42
Kew	1234
Winton	35
Gore	76
Balclutha	43
Queenstown-Lakes	70

CONSUMER REPRESENTATION

Southern is privileged to have four consumer representatives; Deli Diack, Catkin Bartlett, Danika Tauri and Megan Kane who are dedicated to bringing the consumer voice to our maternity services and quality and safety initiatives across the region. We are grateful for their membership and input.

Deli Diack (She-Her)

Employed at Awarua Whānau Service (AWS) since 2018, Deli supports wāhine /women and whānau/family through their haputanga/pregnancy. As a qualified Childbirth Educator, Deli facilitates Mama & Pēpi Services, providing 1-1 education, information, and support from haputanga/pregnancy to 6 weeks post birth. Deli offers a Traditional Māori Birthing Program – Te Whare Tangata twice weekly and quarterly Weekend Wananga. Additionally, Deli coordinates and facilitates Community Parent Hubs as well as weekly Playgroups in Bluff and AWS Invercargill.

Bluff South Sprouts and AWS He Taonga te Mokopuna focus on culturally appropriate Positive Parenting strategies with a Maternal and Infant Mental Health and Wellbeing lens, focusing on the first 2000 Days. Deli is passionate about breastfeeding and travels throughout the Motu/Country as a dual BFHI and BFCI Māori and Consumer Auditor for the New Zealand Breastfeeding Alliance (NZBA). Supporting local wāhine as an active Māori Breastfeeding Peer Supporter allows Deli opportunities to improve breastfeeding rates in Murihiku/Southland. Deli fosters, maintains, and sustains, connections with the wider Te Kohanga Reo collective, Kura Kaupapa, Runaka, Māori community service providers and is a member of Arahi Māori Women's Welfare League all of which enable and enhance meaningful relationships, contributions and consultations that result in positive outcomes for whānau Māori.

As a Parent, a Taua, and a member of her community, Deli welcomes opportunities that ensure there is a local voice, and a collective community perspective for positive outcomes and equitable change.

Catkin Bartlett (She-Her)

As a maternity consumer representative Catkin tells us that many of her insights into community, whanau and wellbeing originated from growing up in an unremarkable and wonderfully nurturing, small village in rural Buckinghamshire, England and from extensive travel through Africa, Asia, Europe, and Australasia. Catkin worked as a specialist community nursing practitioner in inner city London and as an expedition medic in Mongolia. Catkin is now very settled living in the spectacular Wakatipu with her four children, kiwi husband and a rather unruly, bountiful garden. Since becoming a mother (14 years ago) Catkin's primary occupation has been to develop the Breastfeeding Peer Support Programme for Central Otago and Whakatipu. Catkin now describes her role as a community builder aiming to ensure that services are designed and implemented with whanau and community at their core.

Ecosystems are central to everything Catkin does, whether it is gardening, nurturing her whanau, looking after herself, or advocating for and working within communities. Each ecosystem relies on diversity, adaptation, responsiveness, nurturing, creativity, challenges, negotiation, and inclusion. To relate this to whanau maternity experiences and the first 2000 days Kaupapa Catkin works with diverse organisations, institutions, and communities with the intention of facilitating the development of services and to assist in creating an environment that enables whanau and whanaungatanga.

Catkins current workstreams include developing and implementing a strategy for the Breastfeeding Peer Support Programme, developing a volunteer family support network for the Whakatipu, establishing a forever postpartum positive pelvic health programme as well as generating a collegial local network of peer support, lived experience programmes.

Catkin is a founding Trustee of Central Lakes Breastfeeding Charitable Trust, member of Te Wai Pounamu Breastfeeding Working Group, Presiding Member of School Board of Trustees, member of Headlight (Goodyarn) Steering Group as well as having been a consumer representative on the former Southern District Health Board Maternity Quality and Safety Governance Group for seven years, since my youngest baby was 6 months old.

Catkins other passions include biodiversity regeneration, dance, literature, exploring new places and sociable nutrition (cooking for people that appreciate it!).

LMC REPRESENTATION

Southern is privileged to have two LMC representatives (Fiona Heares and Janelle Carse) who dedicate time and effort to ensuring an LMC voice forms part of the maternity quality and safety programme.

Fiona Heares (She-Her)

Fiona joined the MQSP governance group as an LMC representative approximately one year ago, bringing with her eleven years of LMC experience encompassing practice across a spectrum of socio-economic and cultural groups.

As a midwife Fiona actively participates and regularly attends New Zealand College of Midwives (NZCOM) meetings as well as having previously held a position on our regional NZCOM. Fiona also hosts a Facebook midwifery research page to disseminate research that informs midwifery practice.

Fiona's personal focus is on primary birth which, in Dunedin, most commonly occurs within the tertiary Centre and means that Fiona works extremely hard to protect primary birth within the hospital setting.

Fiona takes a keen interest in maternity politics and has made submissions on various documents including maternal mental health and ACC maternal birth injuries.

Fiona brings the birthing population and LMC voices to the table with the aim of working collaboratively on areas highlighted through practice incidents, national groups/reports, consumer feedback, (i.e.,

PMMRC, Ministry of Health, national clinical indicators, consumer feedback etc.) to improve outcomes while making a real difference for wāhine, pregnant people and their whānau in the community.

CORE REPRESENTATION

Part of our governance structure requires core midwifery representation from primary, secondary and tertiary settings and we are both privileged and grateful to have Jan Scherp represent primary core midwifery in this arena. Representation in our secondary and tertiary spaces continues as a work in progress.

MQSP GOVERNANCE

Maternity quality and safety programs (MQSP) have been operating throughout the motu since 2012 and act to monitor, improve, and maintain maternity quality and safety outcomes for wāhine /women/people, babies, whānau and service providers within the Southern District. MQSP programs identify improvement priorities through collaboration with maternity stakeholders and thereby improve maternity services by promoting best practice, accountability and strengthens underpinning operational processes.

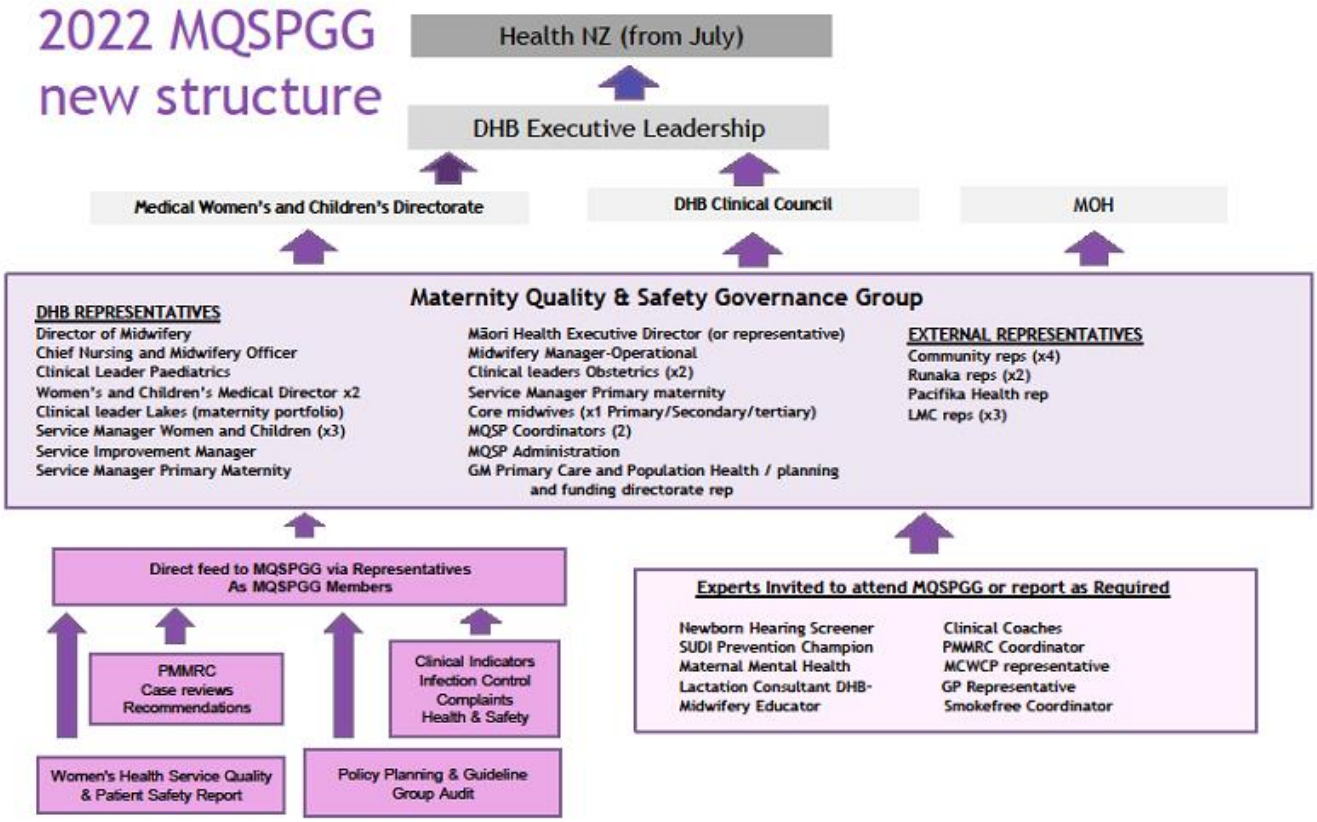
In 'usual' times this report would have been delivered annually, however with the unprecedented circumstances that eventuated due to the Covid-19 pandemic this report details the quality and safety activity that has taken place during the past two years (2021; 2022) despite adversity in all aspects of service provision.

The MQSP Governance Group (MQSPGG) provides oversight of the program through a forum where clinicians, managers, and community representatives, including consumers, can collaborate and provide advice and recommendations that inform the strategic direction of Maternity Services.

The requirements of MQSP are fulfilled by:

- Ensuring robust clinical governance processes are in place for maternity services of the Southern District.
- Ensuring representation of community-based providers and consumers, which reflect the local birthing population and demographic, in quality and safety activities.
- Ensuring recommendations from national bodies, such as the Perinatal and Maternal Mortality Review Committee (PMMRC), Health and Disability Commissioner (HDC) and the National Maternity Monitoring Group (NMMG) are implemented.
- Ensuring that National Guidelines are implemented and that policies are consistent across the district.
- Prioritising service quality improvement in the program of work.
- Analyzing, auditing, and evaluating local maternity outcomes that inform ongoing and future improvement projects.
- Providing strategic input to key organisational decision-makers regarding the planning and delivery of maternity services.
- Ensuring that funding for the MQSP is managed in an open and transparent way.

See below for MQSPGG new structure.



CONSUMER ENGAGEMENT

Following is a report from Catkin Bartlett, a consumer representative, who presents insights on behalf of herself and other consumer colleagues regarding their experiences of participating in the MQSP programme providing input, oversight, and governance from a consumer perspective.

2022 challenges

Whanau and communities have been thrown some extraordinary challenges over the last year and of course maternity care and associated providers are also represented in these whanau and communities. For many the effects of Covid "rebound" have been profound. It is clear that the challenges of distressing birth experiences, unsatisfactory preparation for parenthood, uncertainty about accessing care and increasing parental and whanau emotional fragility and vulnerability have had a significant effect on whanau wellbeing.

History of Consumer representation on the MQSP

As an MQSP Consumer representative for the last 7 years I have participated in and observed the evolution of a maternity health care governance approach for the South Te Wai Pounamu. This MQSP

has made considerable progress to embed consumer perspectives in healthcare governance. I have also observed an enlightening that is moving from a culture of reacting to situations, concerns and events to a culture that responds to risks and is pursuing a generative approach to risk that attempts to explicitly focus on whanau and their experiences. Membership of our MQSP has significantly changed over the last year and I hope that new members have felt welcomed, and their contributions valued, respected, and easily made. I would also like to acknowledge the work and contributions of previous consumers and other members; you have made significant contributions to the futures of our whanau. Ngā mihi nui ki a koe, I have learned from you all, yet there is still much work to be done.

Reflections from a consumer representative

The Governance Group has mana and is well respected. For example, when services are invited to present to the group it is clear to me that they value the opportunity and put a lot of work into giving an account of their successes and challenges. Those presenting are increasingly active in seeking and listening to the questions and feedback from the group and individual group members. Group members demonstrate that the group is productive and worthwhile; they are engaging with the group, attending regularly and actively participating in discussions in collegial and respectful ways and making pragmatic whanau focused decisions.

The group is developing ways of working effectively and managing some of the challenges of being so widely dispersed across our extensive region as shown by the high attendance at our meetings either in person or video conference. This sustained high level of engagement suggests that the clinicians, managers, leaders, consumer all feel valued and value this work.

The role of Consumer reps for 2022

The oversight and chairmanship since the inauguration of the group in 2016 has consistently advocated for and ensured that the voices and perspectives of consumers have been valued, respected, and considered. Consumers are involved in all aspects of the general decision-making process of the MQSP and also in some MQSP operational matters, such the policy and procedure group (PPG). Consumers have robustly contributed to MQSP initiatives, such as Parental Mental Health workshop and developing a tool to assist with place of birth selection for whanau.

Challenges as an MQSP Consumer Rep include practical ones such as using the same IT system as Te Whatu Ora staff. I think this simply reflects that traditionally hospital and non- hospital communication wasn't great because the systems didn't support it. For the future I look forward to when Te Whatu Ora Southern has IT systems that enable inclusivity reflected by the way partnerships and collaboration with communities, other providers and whanau evolve, develop, and are maintained.

A consumer representatives' aspirations for the future of the MQSP

- MQSP group matures to the point it can easily identify the purposeful governance work streams. There remains a strong temptation get stuck into more operational matters. The risks blurring objective perspectives rather than maintaining creative focus on how we can influence and enable the operational matters to do what we as consumers know need to happen to ensure that care is provided, where, when, by whom, and how it is needed.

- Review the definition or title of consumer representation to ensure that it reflects individual and whanau lived experiences.
- Exploring how to embed consumer and/or community perspectives in more aspects of maternity and Kahu Taurima provision, such as locality-based healthcare governance or maternity unit governance.
- Kahu Taurima, maternity care and the first 2000 days providers develop partnerships between Te Whatu Ora Southern, Primary Care, Community Providers and Communities as this will enable true partnership between whanau and providers.

MQSP PRIORITIES

PMMRC

The PMMRC is a sub-committee of the Health Quality and Safety Commission (HQSC). Due to the impact of Covid-19 on normal operations in healthcare over the last three years, the PMMRC nationally has not held annual conferences and workshops, so the focus of this report will be on the local context.

The role of the PMMRC is to collect and analyze data surrounding death in the pregnancy and neonatal periods. For the purposes of review a stillbirth is defined as birth after 20 completed week's gestation, where the baby shows no signs of life. If gestation is not known, a baby weighing 400g or more is deemed to fit this criterion. Neonatal death is any baby which was born after 20 completed weeks gestation and showed signs of life but then died within 28 days. Maternal death is defined as death from any cause, at any gestation of pregnancy and includes up to 42 days following birth.

This data collection begins at the time of death, with Rapid Reporting. This is an overview of the data around the birth and death, which must be entered onto a database within 48 hours of the event.

Each region is required to appoint local coordinators to follow up on each of these events. They collect data to enter into a national database. They then examine these data, determining a cause of death, and write a detailed report for submission to the national database. In this way common themes surrounding fetal loss and maternal death can be identified, and hopefully solutions or interventions found to reduce the likelihood of further losses.

In the Southern region the local coordinators include two registered midwives, 3 clinical midwife managers 2 SMOs (1x obstetric, chair and 1x paediatric), and a pathologist. Te Whatu Ora Southern also utilises the local coordinators to convene Morbidity and Mortality (M&M) meetings. There is some misunderstanding that these are separate and distinct functions.

More populous regions see higher numbers of fetal loss, and therefore, often employ fulltime Bereavement Midwives. Sometimes these midwives are also PMMRC local coordinators. In Southern Dunedin our bereaved parents are cared for by core midwives. The rapid reporting component is managed by Tracey Morris and Sarah Pezaro on an ad hoc basis. These two midwives are then given one day per calendar month in order to complete statutory requirements around detailed death reporting. This day is also used for M&M meeting preparation and presentation.

ACTIVITIES

In the 2020/2021-year activities at a national and local level were disrupted due to Covid-19 lockdowns and restrictions.

In the 2021/2022-year disruptions to normal tasks due to staffing crises at a local level were noted.

In 2022, activities resumed:

- Local coordinators attended Coordinator Workshop convened in Wellington. Focus on culturally appropriate care for bereaved Tangata Whenua. Focus on correct classification cause of death and contributing factors. Networking and support nationally.
- Regular M&M meetings resumed, with introduction of TEAMS based access for offsite stakeholders. This had long been requested by rural providers, however legal questions regarding privacy persist.
- Acquisition of a regular supply of caskets suitable for burial or cremation approved for purchase by Te Whatu Ora Southern. This has been a vexed issue. Local coordinators have lobbied for some years to stop relying on volunteer-made, donated items to receive and transport remains. Procuring an established supply is a significant improvement.
- Ongoing liaison between Queen Mary Maternity Centre (QMMC), Mortuary services and perinatal pathology. This has resulted in refining processes alongside increased consumer satisfaction.
- Ongoing liaison between QMMC and Te Ara Hauora services/Māori Health Directorate. This has resulted in the production of Kauwhaiwhai signage for the unit notifying staff and visitors of parents undergoing bereavement/loss. Work continues in the pursuit of wairua cleansing bowls for placement in QMMC unit.
- Representation on hospital new-build committee to design an appropriate space for care provision to bereaved whānau.
- Local coordinators are seen as a resource and role models for provision of care to whānau going through loss. They maintain and refine the fetal loss packages kept on the birthing suite as well as other associated supplies (cards, pamphlets, inkless print kits).

FUTURE DIRECTIONS

Kylie Fraser (clinical coach) has volunteered to create a one-day workshop for midwives and nurses providing bereavement care. PMMRC local coordinators have been invited to present at this day to increase understanding of their role.

- LMC role within the Local PMMRC to be scoped and formalised.
- PMMRC to be restructured within the National Mortality Review Committee (NMRC) as of 1 July 2023.

It is anticipated that the appointed local coordinators will continue in their current roles throughout 2023.

SMOKEFREE

The following information details the activity undertaken to support Smokefree babies:

- In-services/smokefree updates offered to all clinical staff across the primary, secondary and community sector.
- Smokefree Champion roles encouraged in all wards/sites.
- Resources and information packs available for staff to access on support services available.
- Provision of reports across all hospital admissions in Southern district against the Better Help for Smokers to Quit health target to all inpatient units on a regular (monthly) basis.
    - Summary report for 2022 for all inpatient maternity units attached.
    - NB: 2022 report across all inpatient maternity units in the Southern District show that less than 5% of admissions of pregnant women were recorded as current smokers.
    - National average (Te Hiringa Hauora report) is 13% of pregnant women smoke tobacco.

Southern Stop Smoking Service (SSSS) have local coaches who work with hāpu māmā/people and their whānau/family to consider their smoking behaviour. Coaches provide free NRT (where appropriate) and work with people to use it effectively. They also provide behavioral support to address triggers and develop coping mechanisms.

SSSS also have two financial incentive programs:

1. **Smokefree Pregnant Women**: as well as providing the above support, women/pregnant people have the opportunity to access 3 x $60 Warehouse vouchers on achieving set targets throughout their pregnancy, and a further $120 of vouchers if their stay smokefree after baby is born.

As part of this program, coaches also provide safe sleep and gentle handling messaging, including access to wahakura or other safe sleep devices, and information on breast-feeding and supports available.

2. **Smokefree families**: primarily targeted at families who smoke in the primary home of a child who has recently been admitted to hospital for tobacco associated health issue e.g., respiratory infection or glue ear, whānau may access 3 x $60 vouchers on achieving set targets.

Partners or other whānau within the home of pregnant people engaged in the above incentive program may also be eligible for this incentive program.

Referral to SSSS is electronic via Consult Requests on Pulse https://intranet.southerndhb.govt.nz/net/Clinical/ConsultRequest/Current.aspx or can be made through their website https://nkmp.maori.nz/stop-smoking-referral-form/

Vaping in Pregnancy:

It can be difficult to quit smoking. For pregnant people who are struggling to become tobacco free, nicotine replacement therapy (NRT) should be considered. For information about the risks and benefits of vaping to quit smoking, talk to a doctor, midwife, or stop smoking service is recommended.

For further information please refer to: https://vapingfacts.health.nz/the-facts-of-vaping/vaping-and-pregnancy.html.

Preliminary data from 1.1.21 – 31.12.22 (age 15 and over) is presented below:

Smokefree Pregnancies	5,250 (**95.94%**) of 5,472 total discharges in the Southern Region	National average of pregnant people smokefree **13%** per HPA/Hiringa Hauora report:

Discharge Ward	Smokers	Discharges	% Smokers	Number ABC	% ABC	# missed
Clutha - CMAT Clutha Maternity	7	124	5.65%	7	100%	0
Dunedin - ANTE Antenatal*	24	421	5.70%	14	58.33%	10
Dunedin - DEL Delivery Suite*	21	322	6.52%	13	61.90%	8
Dunedin - QM Post Natal*	61	1482	4.12%	52	85.25%	9
Oamaru - OMMAT Oamaru	3	138	2.17%	3	100%	0
Other - COMDEL Central Otago	1	35	2.86%	1	100%	0
Other - COMMAT Central Otago	1	279	0.36%	0	0%	1
Gore Maternity	8	314	2.55%	7	87.50%	1
Lakes - Maternity	1	453	0.22%	1	100%	0
Southland - Maternity Services	95	1904	4.99%	58	61.05%	37
Total	**222**	**5472**	**4.06%**	**156**	**70.27%**	**66**

All Southern District Maternity Units

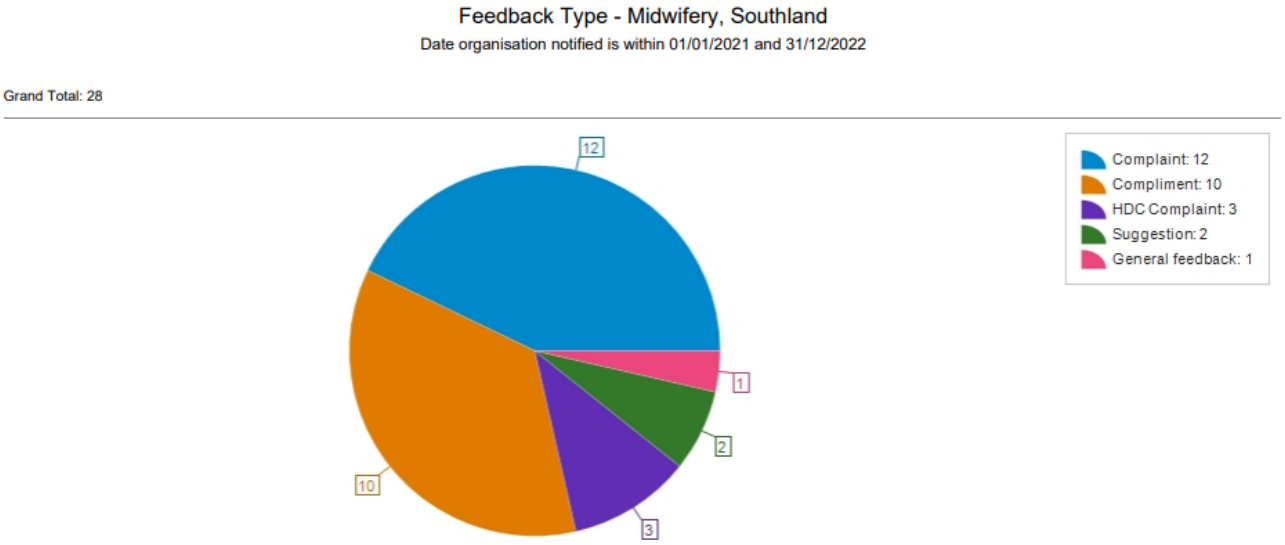
Month	Smokers	Discharges	% Smokers	Number ABC	% ABC	# missed
Jan-22	21	448	4.69%	14	66.67%	7
Feb-22	16	452	3.54%	13	81.25%	3
Mar-22	30	409	7.33%	23	76.67%	7
Apr-22	21	408	5.15%	14	66.67%	7
May-22	30	528	5.68%	21	70.00%	9
Jun-22	15	614	2.44%	11	73.33%	4
Jul-22	20	463	4.32%	12	60.00%	8
Aug-22	17	472	3.60%	15	88.24%	2
Sep-22	19	400	4.75%	12	63.16%	7
Oct-22	9	432	2.08%	5	55.56%	4
Nov-22	9	431	2.09%	7	77.78%	2
Dec-22	15	415	3.61%	9	60.00%	6
	222	**5472**	**4.06%**	**156**	**70.27%**	**66**

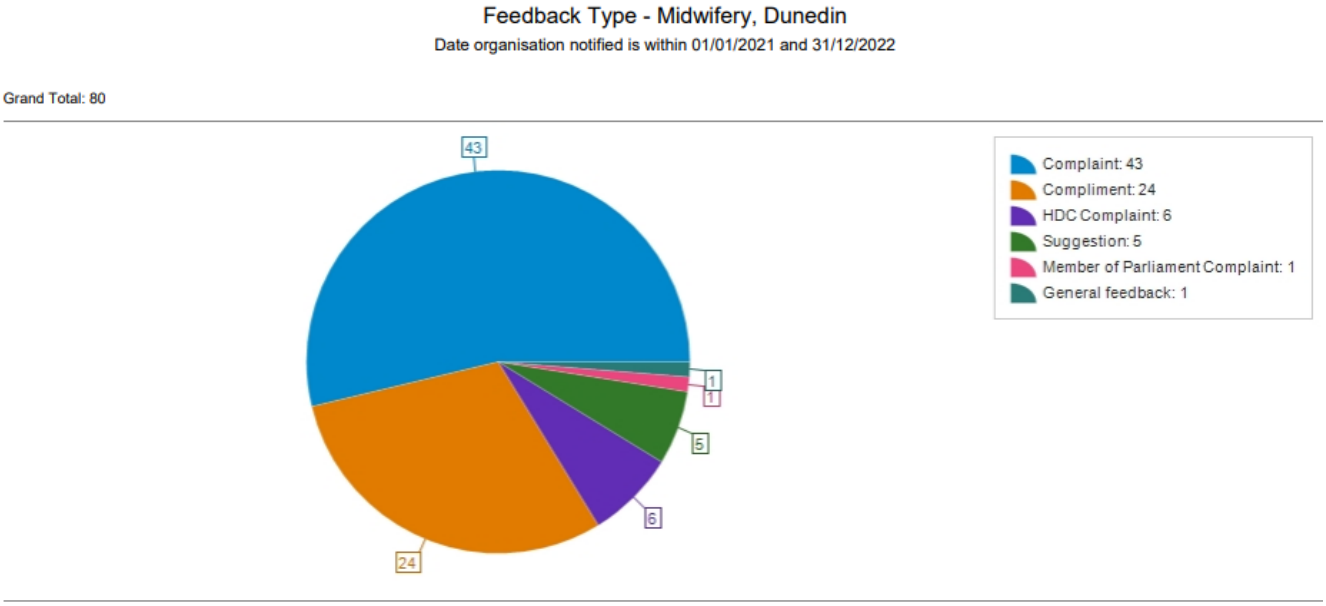
*Dunedin/Queen Mary combined	Smokers	Discharges	% Smokers	Number ABC	% ABC	# missed
Dunedin - ANTE Antenatal	24	421	5.70%	14	58.33%	10
Dunedin - DEL Delivery Suite	21	322	6.52%	13	61.90%	8
Dunedin - QM Post Natal	61	1482	4.12%	52	85.25%	9
Total Dunedin Hospital/QM	**106**	**2225**	**4.76%**	**79**	**74.53%**	**27**

AUDIT

October 2022 saw the completion of both Newborn Hearing Screening and Newborn Metabolic Screening audits, and although a formal feedback report has yet to be received the informal verbal feedback was extremely positive. Two recommendations for improvement were advised and these included development of a process to track courier envelopes containing the blood spot cards alongside a robust process for recording consent for the procedure.

COMPLAINTS





The above pie charts illustrate the types of feedback received for the two-year period covered by this report for Southland maternity and Queen Mary. The pandemic had a big impact on our staffing through vaccine mandates and attrition during this time. The theatre redevelopment project as well as the relocation of the antenatal clinic to make way for a covid 'red' area, in particular, resulted in an increase in complaints. These shifts adversely affected our ability to provide single rooms and was evident in the number of complaints we received relating to our ability to enable support people staying in the units overnight.

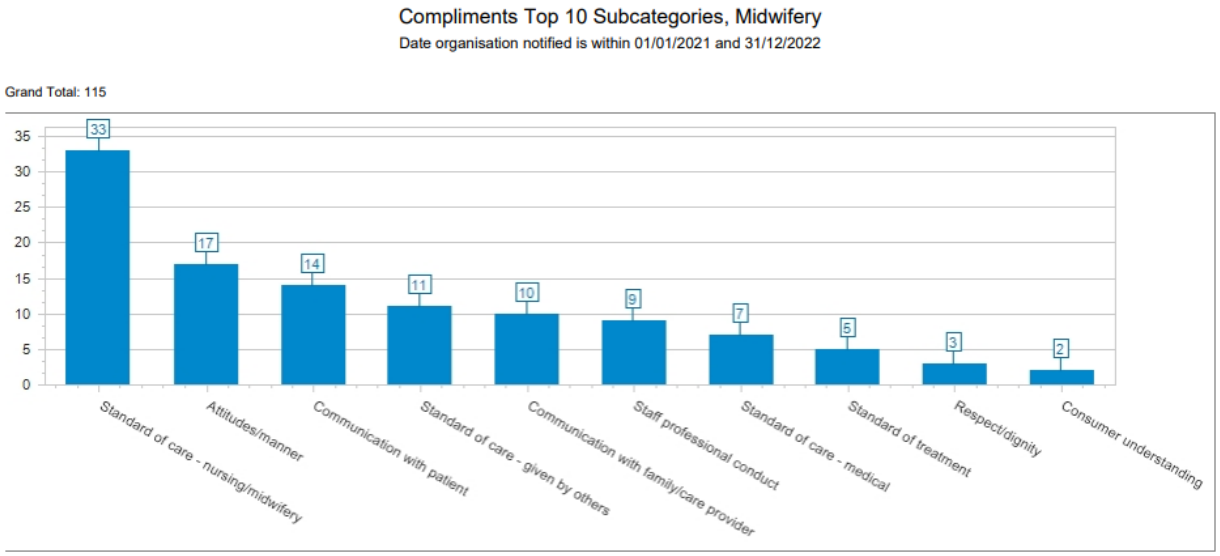
The most common complaint themes focused on standards of care and communication. A cluster of those focused on the induction of labour processes and women not feeling supported adequately, either by not having support people able to remain with them or the perception that one to one care was not facilitated in appropriate quantities.

To address the issues the ward manager met with a consumer who reported experiencing a dissatisfactory induction of labour experience and as a result, a group of midwives and obstetricians reviewed the induction of labour model of care. A new method of induction was introduced which enabled induction of labour to commence in the mornings rather than evenings. They were commenced in a birthing room, where possible, rather than on the ward. This enabled support people to stay from the very beginning and this positively contributed to the experience of our patients.

Other key contributors to positive improvements were the introduction of clinical coaching and clinical midwife manager (CMM) roles. Clinical coaching facilitated wrap around support to all midwives while the introduction of CMMs enabled 24hrs clinical coordination and management of the shop floor with both leading to improved clinical safety and support at all levels of service provision.

On balance it is encouraging that 30% of compliments received focused on positive standards of care while another 35% of compliments were related to attitude & communications with women and their whanau.

Despite the very challenging times, positive developments have continued with changes to improve staff and patient experience evidenced and continuing to occupy a high priority.



Clinical Indicators

The New Zealand Maternity Clinical Indicators present comparative maternity interventions and outcomes data across a set of 20 indicators for pregnant people and their babies, by maternity facility and district health board (DHB) region for 2020.

Many of the indicators compare results for "standard Primiparae"; pregnant people who would be expected to have a similar outcome across all places of birth throughout the country. These have been abbreviated to SP on the clinical indicator table.

Standard Primiparae:

- aged 30-34 years old.
- giving birth for the first time
- carrying one baby
- at term 37 – 41 weeks gestation
- cephalic (head down) presentation
- no obstetric complications

We acknowledge that these clinical indicators statistics are now outdated and may no longer be clinically relevant. However, they are the only source available to us without an electronic system available across all Southern localities.

Where did we do well in 2020 indicators?

Indicator 1. 81 % Registration with a lead maternity carer within the first trimester

This clinical indicator shows a continuing upward trend since 2018 (79%). We have identified workforce challenges due to the midwifery staffing crisis nationally. Some local women/pregnant people have struggled to find a midwife to care for them. In response to the shortage of lead maternity providers, Southern DHB set up an Outreach Clinic where women were able to access maternity care.

Indicator 3. SP who undergoes an instrumental delivery - 17.5%

This clinical indicator shows a positive downward trend from 2018 (19.2%).

Indicator 5. SP who undergoes induction of labour - 7.7%

This clinical indicator shows a positive downward trend from 2018 (9.5%), especially with the implementation of the National Induction of labour guidelines, promoting evidence-based practice.

Where we can improve

Indicator 2. SP who has a spontaneous vaginal delivery - 60.0%

There has been a decline from 63.9% however, it is expected that there will be an increase in spontaneous vaginal deliveries with the adoption of the National Induction of labour guidelines as evidence-based practice.

Indicator 4. SP who undergoes a caesarean section - 21.2%

Southern recognizes this clinical indicator has a variance of 3.6% from the national average. With the implementation of misoprostol inductions of labour and the National Induction of labour guidelines as evidence-based practice Southern has made a commitment to reduce variations in practice.

Indicator 6. SP with an intact lower genital tract (no 1st – 4th degree tear or episiotomy) - 24.8%

Southern did not achieve the national average of 26.7% which means that more people birthing within our region experience lower genital tract trauma. As a consequence, we will continue to monitor this clinical indicator and consider as well as implement improvement initiatives that will aim to assist in reducing the rate of trauma experienced by birthing people within our region.

Indicator 7. SP undergoing episiotomy and no 3rd or 4th degree tear - 19.4%

We acknowledge that this has increased from 16.6% in 2018 with a variation of 6.7 % against the national average. We will continue to monitor this indicator and are committed to reducing variations in practice.

Indicator 17. Preterm birth - 9.4%

Our preterm birth rate is 1.5 % higher than the national average (7.9%). Maternal tobacco use is associated with higher rates of pre-term birth. National average (Te Hiringa Hauora report) is 13% of pregnant people smoke tobacco. The 2022 report across all inpatient maternity units in the Southern District shows that less than 5% of admissions of pregnant women were recorded as

current smokers, therefore there is an expectation that the preterm birth rate will be positively affected and decrease accordingly.

Indicator 19. Small babies at term at 40 -42 weeks gestation - 36.8%

Southern recognizes that this clinical indicator has the greatest variance of 17.2 % against the national average. With the implementation of the nationally endorsed Growth Assessment Programme (GAP) across the district this indicator has been addressed.

C1	Description	National 2020	Southern 2020	Desired position
1	Registration with a lead Maternity Carer within the first trimester	74.1	81.0	Above national average
3	SP who undergoes an instrumental delivery	19.2	17.5	Below national average
5	SP who undergoes induction of labour	9.2	7.7	Below national average
13	Diagnosis of eclampsia during birth admission	0.0	0.0	At national average
14	Peripartum hysterectomy	0.0	0.0	At national average
15	Women admitted to ICU requiring ventilation during pregnancy or postnatal period	0.0	0.0	At national average
20	Babies born at 37+ weeks gestation requiring respiratory support	2.7	1.3	Below national average
8	SP sustaining a 3rd or 4th degree perineal tear an no episiotomy	4.3	4.2	Below national average
9	SP undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear	2.1	1.4	Below national average
10	Women having a general anaesthetic for caesarean section	7.8	8.5	Above national average
11	Women requiring a blood transfusion with caesarean section	3.4	3.1	Below national average
12	Women requiring blood transfusion with vaginal delivery	2.4	1.9	Below national average
16	Maternal tobacco use during postnatal period	8.6	8.8	Above national average
18	Small babies at term	3.0	2.3	Below national average
2	SP who has a spontaneous vaginal delivery	62.1	60.0	Below national average
4	SP who undergo caesarean section	17.6	21.2	Above national average
6	ith an intact lower genital tract (no 1st – 4th ee tear or episiotomy)	26.7	24.8	Above national average
7	SP undergoing episiotomy and no 3rd or 4th degree tear	26.1	19.4	Above national average
17	Preterm birth	7.9	9.4	Above national average
19	Small babies at term born at 40 – 42 weeks gestation	29.6	36.8	Above national average

*SP Standard Primipara

C1	Description	National 2020	Queen Mary	Southland
1	Registration with a lead Maternity Carer within the first trimester	74.1	78.4	84.8
2	SP who has a spontaneous vaginal delivery	62.1	48.5	53.1
3	SP who undergoes an instrumental delivery	19.2	23	19.8
4	SP who undergo an caesarean section	17.6	26.7	25.9
5	SP who undergo an induction of labour	9.2	8.5	11.7
6	SP with an intact lower genital tract (no 1st – 4th degree tear or episiotomy)	26.7	15.7	17.5
7	SP undergoing episiotomy and no 3rd or 4th degree perineal tear	26.1	27.8	19.2
8	SP sustaining a 3rd or 4th degree perineal tear an no episiotomy	4.3	5.1	6.7
9	SP undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear	2.1	2.5	0.8
10	Women having a general anaesthetic for caesarean section	7.8	9.8	7.1
11	Women requiring a blood transfusion with caesarean section	3.4	4.1	1.7
12	Women requiring blood transfusion with vaginal delivery	2.4	1.8	2.5
13	Diagnosis of eclampsia on birth admission	0.0	0.0	0.0
14	Women having a peripartum hysterectomy	0.0	0.0	0.0
15	Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period	0.0	0.0	0.0
16	Maternal tobacco use during the postnatal period	8.6	7.6	10.5
17	Preterm birth	7.9	12.2	8.9
18	Small babies at term born at (37 – 42 weeks gestation)	3.0	2.5	2.8
19	Small babies at term born at 40 – 42 weeks gestation	29.6	27.8	44.8
20	Babies born at 37+ weeks gestation requiring respiratory support	2.7	1.6	0.6

*SP Standard Primipara

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

Source: https://www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2020

PRIMARY MATERNITY

The maternity service welcomed the employment of a new Director of Midwifery, Karen Ferraccioli, in October 2021. Followed by the Project Manager (Primary Maternity Strategy Implementation) stepping into an acting Primary Maternity Service Manager role in February 2022. The appointment of the Director of Midwifery has seen the establishment of quarterly Primary Maternity Huis (all Primary Maternity stakeholders) and weekly Midwifery leadership network.

The vast majority of innovation in Primary Maternity has been driven by Co-design to identify the needs of pregnant people and their whānau in our rural communities. This process of collective gap and solution finding has enabled us to focus on improving equity in the rural Primary Maternity space, as well as boosting the profile of our Primary Maternity Units. The programmes of work contributing to these two aims are described briefly below.

TECHNOLOGY SUPPORTED

A key project for 'closer to home care' has been the establishment of telehealth in our Primary Units and Child and Maternal Hubs. This service enables whānau to remain in the community to receive many routine secondary care appointments that they would previously have had to travel into Dunedin or Invercargill for. This service has been rolled out to Queenstown, Wanaka, and Central Otago Primary Units, with conversations happening to also bring Lumsden Child and Maternal Hub on board with the telehealth service in 2023.

Changing service models meant that existing patient management systems were no longer fit for purpose. Expect Maternity System was introduced in 2022 to enable staff timely and secure access to digital information for clients booked under the care of Te Whatu Ora case loading teams. Roll out of this system is happening now in Queenstown-Lakes, Wanaka, and Central Otago.

SERVICE INTEGRATION

Stakeholder engagement has begun to highlight the gaps experienced by rural communities in maternity care. Scoping of service requirements in Wanaka and Central Otago has been undertaken to ensure the Primary Birthing Units under construction are able to meet the needs of localities under Te Whatu Ora, including co-location of care for both child and maternal wellbeing.

Queenstown and Fiordland are the next two areas identified for this work to be expanded into. The underlying principle being that each region leads the development of their own priority areas.

NEW PRIMARY BIRTHING UNITS

The business case for the build of two new Primary Birthing Units, one in Clyde and the other in Wanaka, was approved by the Ministry of Health on 1 December

2021. This was followed by a tender for Architectural providers which closed at the end of January 2022. The detailed design was due to be finalised towards the end of 2022.

As part of this project a Primary Birthing Unit facility has been purchased in Wanaka, with completion of the sale and resource consent for its use completed July 2022. This will need some minor renovations before it can be opened to pregnant people early in 2023. Two new purpose-designed birthing beds have been purchased to go into the completed buildings.

These facilities (pictured right) will provide both inpatient and outpatient space, enabling closer to home care for pregnant people within the Central Otago region. Providing the service associated with these facilities will improve patient experience related to pregnancy care.

We have a dedicated, enthusiastic, caring and compassionate team that work in the rural space some of whom are pictured here.

HUBS

Te Whatu Ora Child and Maternal Hubs have been a standout resource over the past two years of the Covid-19 pandemic. These hubs have shown the benefit of having local facilities equipped to respond to community needs. Each hub has worked on meeting the needs of the region they are positioned in. From the hubs that serve as emergency birthing spaces and central locations for distribution of resource such as PPE, through to those that provide space for telehealth access to secondary care, clinic rooms for midwives, and common access for essential equipment.

Morgan Weathington, Hub Co-ordinator in Wanaka, emphasised that the hubs enable clearer two-way communication between front line health providers and Te Whatu Ora service management. By providing a mouthpiece for more rural communities, the hubs enable the dissemination of equipment, communication on changes to policies and procedures, and pathways for support through to their midwifery population, whilst providing feedback on needs and challenges within the community to Te Whatu Ora leadership teams.

Overall, the hubs have shone a light on pieces of work which needed to happen regarding rural equity, and how equity not only supports better patient care, but also provides more sustainable work environments for front line health professionals. This has led to the next pipeline of projects around employment models, new service possibilities, and a broadening of potential care pathways.

DEDICATED RURAL EDUCATION PROGRAMME

An area identified as needing further support was education for midwifery professionals working in our rural areas. Funding has been ring-fenced to enable employment of a dedicated rural education coordinator. This will ensure Midwives receive mandatory education closer to home, as well as emergency skills training within their local birthing units.

MATERNITY SERVICES

EDUCATION

The vision for Education is to:

- Provide safe, responsive, intuitive maternity care in comfortable spaces for women/people and their whānau, by our valued team, specialized in their unique crafts.

To meet this vision, we strive for best practice, enabling staff opportunities to meet not only organizational learning needs, but also midwives own individual needs to extend their knowledge in areas of interest.

Due to midwifery shortages, the maternity settings have temporarily increased the nurse's ratio to support postnatal care. Therefore, nurses have been given the opportunity to attend midwifery emergency skills refresher days to inform collaborative response in emergency. This not only improves teamworking but facilitates an understanding of direction and delegation of tasks when obstetric or postnatal emergencies occur. Insights gained enable appropriate care delivered for the whānau and their new-born when transferred to the postnatal ward Additionally, midwives are also able to understand the skills and knowledge that a nurse brings to the maternity care setting within her scope and appreciate their place as part of the broader team.

PROMPT (PROFESSIONAL OBSTETRIC MULTIPROFESSIONAL TRAINING)

This is a quality initiative involving CORE, LMC & rural midwives, anesthetists, consultants, obstetric medical staff, nurses from theatres, emergency department staff, St John paramedics, Helicopters Otago paramedics and staff, as well as rural GP's. Feedback from these days is always positive, participants enjoy learning about obstetric emergencies and come away feeling more confident and competent. The importance of communication, documentation, and teamwork are emphasized, and appreciation gained. Pictured to the left is a day held at Helicopters Otago June 2022 which resulted in demand for this day becoming part of their annual education on and delivered on an annual basis. Women/people of Otago reap the benefits of these days with better outcomes, and emergencies managed in a timely manner.

RESUSCITATION COUNCIL NEWBORN LIFE SUPPORT TRAINING

Nursing staff within maternity are now attending newborn life support training to ensure they feel confident and competent working with ? deteriorating babies. Recent changes to the curriculum ensure a more 'hands on' course, that delivers best practice.

FETAL SURVEILLANCE EDUCATION PROGRAMME (FSEP)

Fetal surveillance training has been introduced to ensure that midwives are confident to interpret cardiotocography (CTG) for those women/people whose babies requires monitoring. The training covers the physiology driving what is seen on a CTG to ensure that interpretation and analysis are accurate, and action taken in a timely manner. It is anticipated that this training will become mandatory for all core midwives in the coming years, attending a face-to-face session tri-annually and undertaking on-line education annually in the intervening years. This initiative will improve/refresh practitioners knowledge base and enable support for those who are less exposed to CTG interpretation.

BREECH WITHOUT BORDERS

Held in Dunedin November 2022, this initiative delivered much needed education around safe delivery of a breech presentation that would alleviate the need for cesarean section and thereby improve birthing outcomes. The next step would be to purchase a training manikin to provide

ongoing teaching and opportunity to practice to improve confidence in breech delivery and manage complications.

Ideally the manikin will be set up in delivery suite with the teaching tools to recognise and resolve breech delivery complications, so that midwives and medical staff would have 24/7 access to practice maneuvers, become more competent and confident if they see and do/practice physiological breech birth.

MATERNAL MENTAL HEALTH

Maternal Mental Health requires greater investment with more education to increase midwives' confidence in assessing and recognising when women/people in their care are becoming unwell. This is especially important because the signs can be very subtle and sometimes missed. Collaboration with the maternal mental health team has led to education sessions being implemented within ongoing mandatory maternity study days, with planning afoot to extend the reach of this education to Oamaru and Alexandra.

THE KOWHAIWHAI TILE

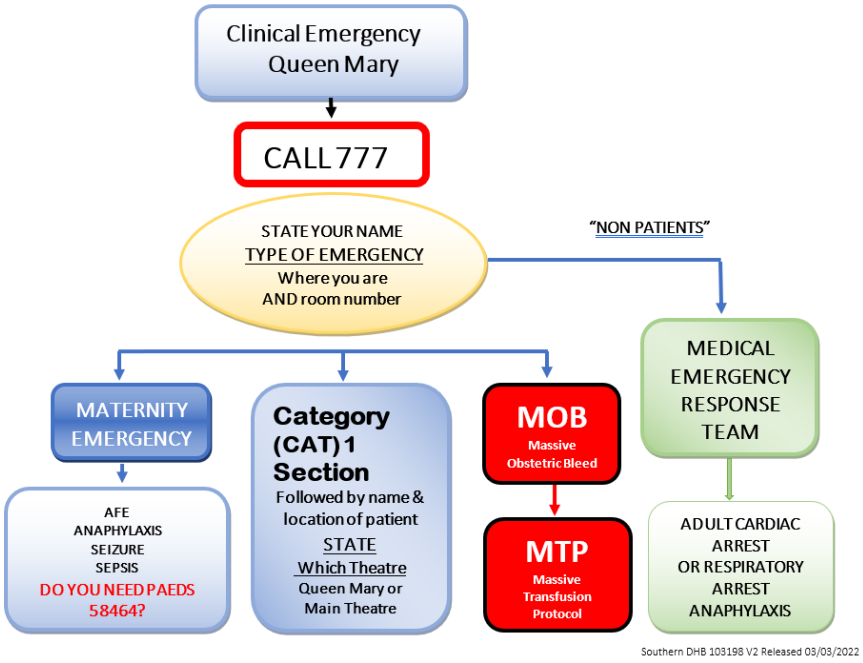
This quality initiative was established in collaboration with the Māori health unit to advise/raise awareness of people entering the maternity unit (i.e., medical & obstetric staff, midwives, nurses from all areas i.e., MOT, PACU, NICU, paediatrics, administration staff, allied health staff including physios, social workers, kitchen staff, cleaners, CSSD, venepuncture, building & property, and chaplains), of a passing/death, and facilitate thought regarding the sensitivities around this.

The Kowhaiwhai symbol resembles a purerehua which is a Māori tool of communication, and the design shows symbolizes the transition from birth to life to spirit. The tile is utilized with whānau consent and placed strategically both at the midwifery station and on the room door to ensure it is visible for staff on the unit as well as those who need to enter the room.

CLINICAL GUIDELINES

To ensure a safe and streamlined process the following flow chart was created alongside a guideline to ensure timely attendance of staff in an emergency on the Otago site.

Remember to Name your Emergency – Queen Mary (Otago)



Southern DHB 103198 V2 Released 03/03/2022

Who sits behind that Emergency Call?

MATERNITY EMERGENCY

INCLUDES PREGNANCY, BIRTHING, OR POST-NATAL EMERGENCY
DO YOU NEED PAEDS 58464?

Neonatal/Paed Reg on 5846
Obstetric consultant – cellphone
Obstetric registrar – 57442
Anaesthetist +/- tech
ACM/Coordinator – 57077
Orderlies x 1
House officer
After hours HO
HCAs - 57488

Category ONE (CAT 1) Section

On-call Obstetric consultant
Anaesthetist on-call - 57300
Anaesthetic tech – 57235
QM Shift Coordinator – 57055
Theatre Nurse Coordinator 57236
Or cellphone 027 262 3490
On-call Obstetric consultant – cellphone
Paediatric registrar – 58464
NICU CAN - 56000

MOB
Massive Obstetric

Orderly
Anaesthetic reg +/- tech
On-call Anaesthetic consultant
Main Theatre Coordinator
Duty manager
Sometimes MORPHS into

MTP
Massive Transfusion Protocol

ACM
Obstetric registrar
Blood Bank
ICU registrar
Duty manager
Security
Orderly

MEDICAL EMERGENCY

ADULT CARDIAC ARREST
OR RESPIRATORY ARREST
AFE
ANAPHYLAXIS

Medical Team
Medical consultant
Medical registrar
ICU registrar
House officers – Med & Surg
Duty manager
Orderlies x 2

Southern DHB 103198 V2 Released 03/03/2022

CULTURAL SAFETY

Te Tiriti o Waitangi and cultural humility concepts were introduced into maternity mandatory education in response to the need for equitable outcomes for women/wāhine/ people and their whānau. While there is lots of room for improvement in this space this education has 'planted the seed' with many participants wanting/seeking additional learning opportunities.

CENTRAL OTAGO EDUCATION

Charlotte Jean, as it was formally known, was taken over by the SDHB (now Te Whatu Ora Southern and renamed as Central Otago Maternity Unit (COMU) on the 1st of July 2021. In recognition of the need to provide education in the central Southern regions a business case subsequently culminated in permanently increased FTE for a dedicated education resource that includes coordinating and/or delivering education locally.

Regular communication with midwife and service managers enables timely assessment of educational needs, together with service planning that ensures skill competency alongside safety and quality of care delivery.

CLINICAL COACHING

The clinical coach role was established nationally through the Midwifery Accord as a strategy to support the midwifery workforce affected by the midwifery staffing crisis. The role of the midwifery coaches is to support midwives no longer practicing to return to practice, as well as international midwives to join New Zealand practice in a supported and supervised way.

In February 2022 three 'clinical midwife coaches' were appointed in Southern; two 0.6 FTE positions on the Otago site and one 0.4 FTE position on the Southland site with the intent of improving midwifery recruitment and retention, through support and supervision, across the district. Coaches' support is also offered to newly graduated midwives as well as existing staff to facilitate the development or uplift of clinical skills, improve standards of practice, instill confidence, and improve job satisfaction and staff retention.

As a result of the coaches' implementation, 22 new staff were orientated on the Otago site in 2022: 13 midwives and 9 Nurses with roles comprising both permanent and casual positions. Additionally, a number of new graduate LMCs also benefited from the coaching engagement ensuring they felt comfortable and confident coming into hospital settings to care for their clients.

Having the coaching roles has improved secondary/tertiary placements for final year midwifery students by enhancing the structure of their 5-week placement. In this way the coaches have not only provided an opportunity to build the new graduate midwifery workforce but also aid in attracting new graduates to work in the Southern region.

Coaching Goals for 2023:

- Continue to deliver personalised orientation to new staff.
- Build preceptor skills within the workforce.

- Participate in school careers events to promote midwifery career pathways and attract more Māori and Pacifica students into the profession.
- Attend Midwifery schools to promote new graduates in the Southern region.
- Provide optimal placements for final year student midwives to facilitate recruitment and retention.
- Continue to upskill existing staff regionally.
- Supporting midwives to ensure clinical competency.
- Develop a rural/tertiary placement.
- Suturing, cannulation, fetal loss support, PCA care, wound care.
- Work alongside the educator to support optimal education opportunities.

LACTATION CONSULTANT SERVICE

The Baby Friendly Initiative is a requirement for maternity and newborn services in New Zealand to Protect, Promote and Support Breastfeeding. Te Whatu Ora - Southern, as a BFHI accredited organization, has got an ongoing committed to support the 10 Steps to Successful Breastfeeding. To demonstrate our compliance with the 10 steps we are audited every 3 years and to assist with maintaining our exclusive breastfeeding rate of 75% and over we introduced the following in 2022:

Step 2. Breastfeeding education for all staff working on Maternity. Due to extreme staff shortages alongside covid constraints, online education was offered (in place of face to face) to ensure that education was completed by all staff.

A QR code was introduced to enhance consumer access to breastfeeding education/information resources easily as well as having the capacity to save the link in order to revisit information in their own time and/or at home.

The QR code provides information about:

*Breastfeeding Attachment (video)

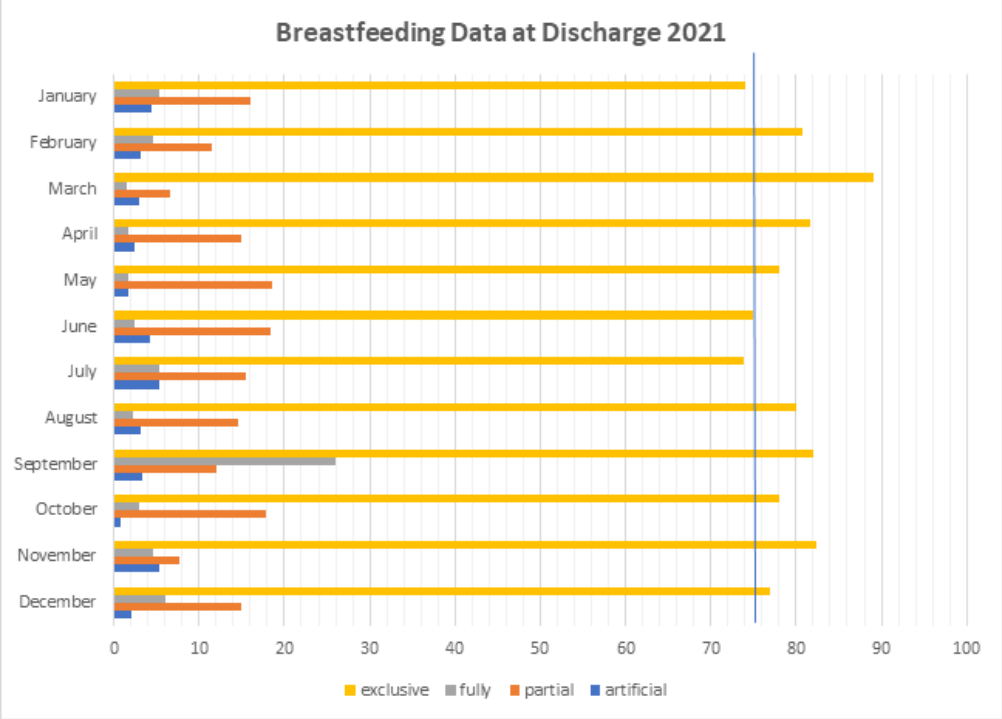
*How to make sure your baby is latched correctly

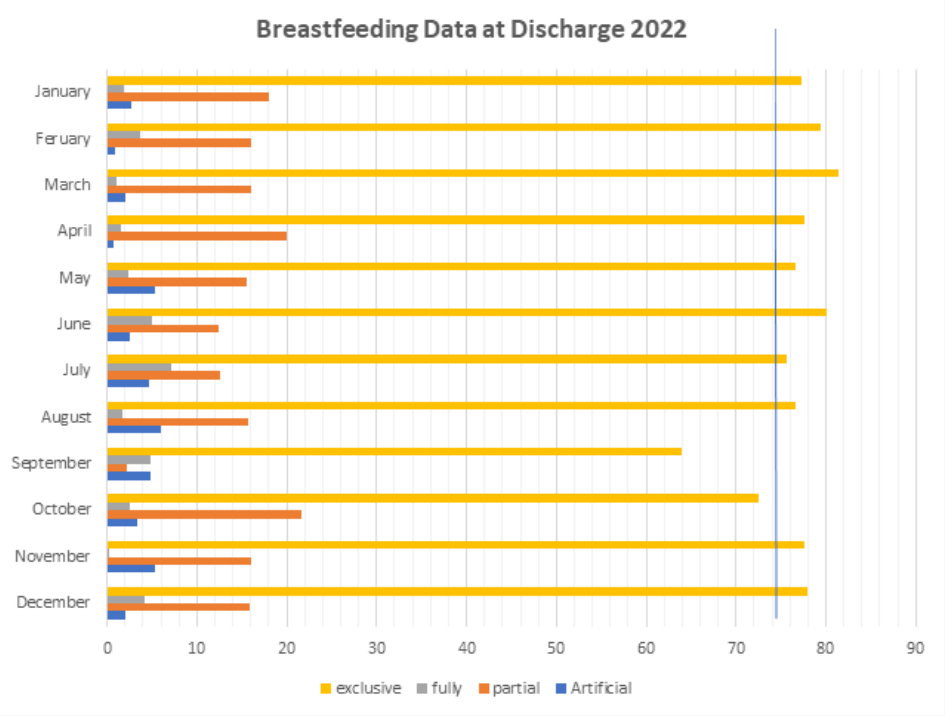
*Maximizing Milk production

*Ten Steps to Successful Breastfeeding

*Mama Aroha App

Despite service disruption due to covid, exclusive breastfeeding rates have only marginally been affected, highlighting the dedication and hard work of staff working with our breastfeeding population across our region.





*Blue vertical line marks the minimum expected 75% expected exclusive breastfeeding rate @ discharge to meet BFHI standard.

Improvement Initiatives

- The Lactation Star newsletter was commenced in September 2021 as a tool to communicate and inform staff. It includes 'formula use data' in graph form, reports on quality work and education, birthing and breastfeeding stats, areas of clinical work that need highlighting and updates on evidence.
- "Move from Milton" was implemented in December 2021. A system for cleaning infant feeding/expressing equipment that no longer used chemical sterilisation. This 'rinse, wash and steam sterilise' system is now fully established on the Otago site.
- Formula Use Data that has been collected for many years and is now collated each month and the resulting graphed data added to the newsletter for staff to see. This information also contains stats on methods of supplementation.
- Tongue tie release data is now collated electronically, and parents and babies followed up at 2 weeks.
- A change to the BTAT tool to assess tongue function has been established in line with other areas in New Zealand. It is a less cumbersome tool than the Hazelbaker tool formerly used. Study days were offered to update staff on the tool an associated paperwork.
- In 2022 two new guidelines were developed and 9 guidelines/resources were updated. This included a complete revision of the Mastitis guideline and the development of a 'cue card' for discussing the risks of formula use with parents.
- The system for hire of breast pumps to parents was updated and an option for online payments established. A process to manage overdue returns and outstanding payments was also implemented.
- Online breastfeeding education for staff was commenced in 2022 to the address the issues of staff not being able to attend face to face breastfeeding study days due to Covid related staff shortages/absence.
- Development of a systematic way to file outpatient visit clinical notes in a secure and ongoing manner has been established.
- Decommissioning of 30+ year old pumps undertaken with replacement of new lighter pumps on a rolling replacement program commenced.

MATERNAL CARE & WELLBEING & CHILD PROTECTION (MCWCP)

We have two coordinators working in the maternal care and wellbeing child protection multi-agency group space across our region. The purpose of this group is to enable the best possible outcomes for both wāhine, people, pēpi, and their whānau, as they journey through pregnancy and the early postnatal period. As such, wāhine, people and pēpi, are placed at the center of care. The aim of the work undertaken by this group is to strengthen whānau by enabling and supporting smooth transitions between primary, secondary and sometimes tertiary services. The safety of wāhine, people and pēpi is paramount therefore all planning aims to keep the dyad safe, while supporting healthy attachments.

There are increasing numbers of referrals to, and discharges from, the service each month, with weekly meetings held that alternate between face to face and virtual via TEAMS technology.

Achievements:

1) Networking with personnel from participating agencies and garnering information regarding the directions they see the group moving towards. It is encouraging to see a group of people so passionate about fully supporting women needing increased care.
2) Planning with relevant parties for inpatient stays, enabling care that is tailored to the individual whānau. This means whānau have a voice in what may help support them while staying in the maternity unit.
3) The design and implementation of a traffic light system – this allows discussion and planning at in-depth levels to occur for women identified as red alongside relatively less input for those who have great support already in place or triaged green. It also facilitates focus and direction and allows an understanding of the difference the MCWCP group is making.
4) A much-needed paper analysis that clearly showed deficits in services and enabled the deficits to be worked through.

MCWCP services strive for a partnership model with clients however currently this work is being undertaken by those agencies actively engaged with the whānau and not included the MCWCP coordinator. Stakeholders are all working hard to rectify this disconnect so that input from the coordinator can occur directly with clients in order to facilitate transparency of involvement in while also allowing for open discussion about referrals that may be of benefit. Additionally, work is being undertaken to ensure LMC's are kept up to date and included in discussions and plans resulting from meetings which has previously not occurred.

There is much excitement regarding work that has been achieved thus far but moreover what the next 12 months has to offer and where it will take this valuable group.

PATIENT SAFETY

The patient safety team has been working extensively with the Maternity teams across the Southern region to provide education and guidance in the use of Safety 1st and how incidents are managed. The service has gone from having one of the largest numbers of overdue severity assessment code (SAC) 3 and 4's to having no overdue files, this is due to the diligent work of the clinical midwife managers (CMM's) and midwife managers (MMs) who have worked to clear the longstanding backlog.

Other work includes facilitating the adverse event reviews of which many were significantly overdue. This process has meant that the overdue reviews are in the final stages of completion and with the Director of Midwifery. Extensive work has been done with the Directorate leadership team to put in place a robust process that recognises the trigger meetings and the expertise of midwives as well as the importance of a multidisciplinary team in completing reviews. The implementation of the trigger meetings has meant that any incidents are dealt in timely manner but most importantly information is fed back to staff on the floor who are beginning to see the value of the process.

The entire maternity team are acknowledged for the great work they are doing and particularly how they have embraced the changes and taken the opportunities to increase their knowledge.

INFECTION PREVENTION & CONTROL (IPC)

Throughout the '21/'22 period there has been a great deal of collaboration and joint working between maternity units and IPC to ensure the quality, safety, and appropriateness of patient care with the following projects identified and completed on the respective sites:

Dunedin

- Involvement in trial of waterproof laundry bags with Alsco and IPC - these bags have been introduced district wide.
- Development of covid red zone plan and ongoing review of operational plan based on risk management principles - this has resulted in seamless management of covid positive women/people and their whānau/family members.
    - Installation of ultraviolet lights in red zone/s
    - Processes that facilitate speedy isolation rooms opening and closing dependent on need that facilitate ongoing business as usual in the ward – relevant clear signage, workflow access pathways communicated.
- Replacement of chairs with non-intact coverings
- Appointment of 2 infection control representatives in late December to facilitate IPC projects.

Invercargill

- Ongoing Hand Hygiene auditing for the National Hand Hygiene Programme.
- Poor compliance of patient screening tools noted on the ward, for COVID screening questions and MDRO/D+V/other screening questions. Discussion had with the Midwife Manager who completed a spot audit 07/07/22, compliance rate was 0%. Education provided to staff. The midwife manager re-audited the ward 14/07/22, compliance rate increased to 90%.
- Setting up the maternity ward to safely care for COVID positive patients. Four rooms were converted to negative pressure with negative pressure units. HEPA filters were placed outside these rooms. Carpet was replaced with vinyl outside the birthing suite. Anterooms were created with Perspex doors. Signage, PPE trolleys, waste and linen receptacles, donning and doffing stations set up. Cell phones and tablets were provided to aid communication.
- COVID simulation set up on the ward 10/02/22. Scenario involved staff managing a known COVID patient in labour who required transfer to OT. IPC assessed the setup of the room, PPE donning and doffing, cleaning processes for all equipment, transmission risk factors particularly around the ward transfer, documentation processes, cleaning of the COVID room, waste, and linen management.
- Continuous education provided to the ward throughout the pandemic re policy changes, particularly around patient screening and testing, mask wear and support person policy changes.
- Environmental audit with IPC and ISS was completed 26/05/21, with a score of 94% from ISS.

- PPE train-the-trainer education undertaken.
- IPC education at maternity study day including donning and doffing training.
- Donning and doffing training on the ward
- Education at ward huddles re screening tool, PPE requirements and PCR testing.
- Support and advice provided regarding COVID positive patients and their support people (PCR testing, visiting rights, attending delivery on ward or in OT).

Queenstown Lakes & Central Otago Maternity Unit (Alexandra), Wanaka Maternity Unit:

- Review of Covid plan at Queenstown Lakes Hospital
- Installation of 1 UVC light in delivery room and 2 ceiling mounted HEPA filer units at Queenstown lakes Hospital
- Problem solving to identify and secure a compliant clean line storeroom at Queenstown.
- Pre-certification quality review at COMU
- Working with COMU to find solutions to non-compliant areas (laundry, hazardous waste, decontamination of sterile instruments); a new unit is in planning phase.
- Work completed to hand over management of placentae issues (identified across the district) to maternity staff at Dunedin and Invercargill.
- Work with Wanaka Maternity unit development group to reconfigure newly purchased property to meet compliance.

The following upcoming projects have been identified for ongoing collaboration in 2023:

- Installation of Ken sanitizers on the ward, with education for staff.
- Cleaning and disinfection audit for birthing baths.
- Ongoing HLD validation and review of process.
- Know your lines project.

MQSP INITIATIVES

MATERNITY EARLY WARNING SCORE (MEWS) (IMPROVING SAFETY & REDUCING HARM)

The Maternity Early Warning Score (MEWS) is a standardised chart that was rolled out nationally to assist clinicians in the early detection of patient deterioration. Developed as part of the Health Quality and Safety Commission (HQSC) patient deterioration programme, it addresses the unique physiology of pregnancy and the postpartum period. Specifically designed for use in pregnancy and the first 42 days after a birth event, use of the chart can aid clinicians to recognise early signs of deterioration, with the response based on an escalation pathway. Whilst the parameters of vital signs have been agreed nationwide, regardless of maternity setting, the escalation pathway allows individual settings to develop a localised escalation pathway.

The use of MEWS was initially rolled out in our Tertiary and Secondary Maternity settings (Queen Mary in Dunedin and Southland Maternity Unit in Invercargill). Education was included in study and emergency skills training days, with all staff completing an online training package prior to its

implementation. Over time, with the support of the MQSP Coordinators and Maternity Educators, primary birthing units adopted MEWS chart when transfer/transport required to a base hospital.

Following MEWS implementation, an audit tool was developed with assistance from ACC and the Te Whatau Ora Patient Safety team. This allows regular review of usage and adherence to the escalation policy, with the benefit of identifying and responding to training needs within a short time frame.

Initial audit results show that over 80% of MEWS charts in Southland and over 95% in Dunedin are utilised to their full potential, although work is still needed to ensure that documentation requirements are fulfilled, and that escalation follows the correct pathway.

NEWBORN OBSERVATION CHART (NOC) NEONATAL EARLY WARNING SCORE (NEWS) (IMPROVING SAFETY & REDUCING HARM)

> "The Neonatal Encephalopathy (NE) Taskforce was set up in November 2015 bringing together expert representatives from health care providers, clinicians, professional bodies, government agencies (including the Accident Compensation Corporation (ACC) and patient advocacy groups. The taskforce engages and works with these groups to design and establish an evidence-informed improvement programme to reduce the number and severity of avoidable NE cases in New Zealand."
>
> (Newborn Observation Chart (NOC) incorporating the Newborn Early Warning Score (NEWS) February 2020)

Implemented nationally in 2020 the purpose of NOC/NEWS is to have a standardised early warning observation system for all newborns born after 35 weeks gestation, especially those with identified risk factors such as:

- Meconium exposure
- Sepsis
- Low Apgar scores

Use of the chart allows clinicians to follow a pathway of observations based on identifiable risk factors at birth: babies with these risk factors require more frequent assessment and additional observations. The NEWS chart is now the central document to record newborn vital signs and observations, allowing it to be used as a communication tool, that can identify deterioration in the early stages and prompts a timely response to this. Responses, like the MEWS chart, are based on an escalation pathway which allows individual settings to localise it to their needs and services.

NOC/NEWS were first launched in our Tertiary and Secondary Maternity. Education consisted of online programmes and inclusion in our emergency skills training days, and it's use in now embedded in practice. Supported by the MQSP Coordinator and Maternity Educations, primary birthing units developed their own, localised escalation pathways.

Following implementation, an audit tool was developed by ACC and adapted with support from Te Whatau Ora Patient Safety team. This allows regular review of usage and adherence to the

escalation policy, with the benefit of identifying and responding to training needs within a short time frame.

An audit of 100 charts in both secondary and tertiary unit shows that over 75% of newborns in Southland and 95% in Queen Mary had a correctly completed risk assessments.

In Queen Mary, 6 newborns reached a defined trigger for escalation, and in Southland 9 newborns reached the same.

While use of the NOC NEWS is ingrained into practice, some work is needed to focus on the correct calculation of NEWS scores and early identification of risk factors.

MATERNITY EVENT TRIGGER FORM (REDUCING HARM)

The Maternity Event Trigger form was introduced in October 2022. Introduction of the trigger tool has enabled prompt reviews of any adverse events or outcomes within maternity services and informs ongoing practice and service provision.

Regular meetings across all localities within maternity services (weekly in Dunedin and Southland, with monthly meetings in our Primary units) have brought together a multi-professional team who review and collaborate on all cases so that improvement initiatives alongside positive feedback is shared across services. The team includes midwifery managers, obstetricians, patient safety team members, midwifery educators, senior midwives, the Director of Midwifery, and any other service required to conduct a thorough review of any case required at the time, i.e., paediatric team, external advisors.

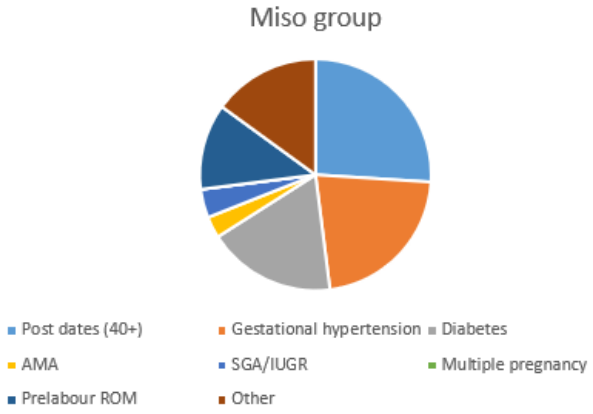
Embedding the trigger tool has enabled opportunities for education, streamlined and optimized service provision while building a positive reporting culture that results in services that are appropriately responsive and minimize harm.

MISOPROSTOL FOR INDUCTION OF LABOUR (IOL) (IMPROVING QUALITY/EXPERIENCE OF CARE)

The introduction of misoprostol for IOL has resulted in a regional approach that has tightened up the indications for IOL and assisted in addressing clinical indicator two (National Clinical Indicators), by reducing the number of inductions that take place unnecessarily. Therefore, this initiative has resulted in:

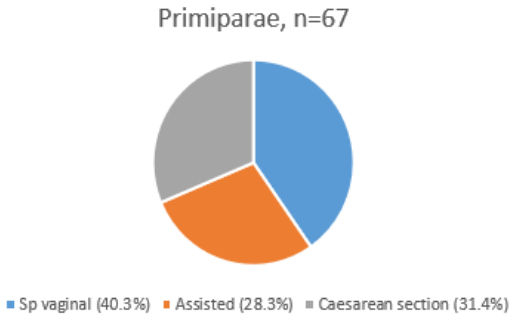
- An increase in the number of women/people going into spontaneous labour.
- Aligns evidence-based practice with national guidelines for IOL.
- Facilitates consistency of practice across services.
- Increased midwifery autonomy.
- Reduce length of induction time for women.
- Reduced length of stay.

- Increased maternal satisfaction with IOL process.
- Cost savings.
- A safe and effective method for IOL that reduces the chance of having a caesarean section (clinical indicator 4) following induction of labour when compared to prior methods.



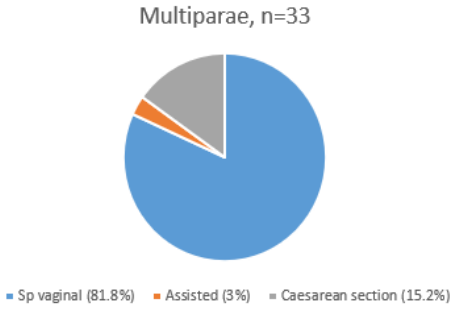
First 100 misoprostol IOLs (8/12/2021 – 13/04/2022)

Indications	Miso group
Post dates (40+)	26
Hypertensive disorder of pregnancy	22
Diabetes	18
AMA	3
SGA/IUGR	4
Multiple pregnancy	0
Prelabour ROM	12
Other	17



Vaginal delivery within 24hours: 89%

All deliveries within 24hours: 52%



SEPSIS BUNDLE (IMPROVING SAFETY)

Sepsis/mate whakatāoke, also known as blood poisoning/toto pirau, is a life-threatening condition which occurs when the body's immune response to infection damages its own tissues and organs and remains one of the leading causes of maternal and neonatal death worldwide. (HQSC, 2022; Sepsis Trust NZ).

In 2014, the Perinatal Maternal Mortality Review Committee (PMMRC) recognised the need to respond to the rising rates of maternal sepsis with work being ongoing ever since. Early recognition and treatment of sepsis is a component of regular training and education within maternity settings. The use of a district sepsis pathway and bundle enables a streamlined and combined approach to this.

Work on a sepsis care bundle commenced in 2022 with a multidisciplinary team developing/establishing:

- A district wide maternal sepsis pathway
- A policy on maternal sepsis, inclusive of signs, symptoms, and immediate treatment
- A sepsis pathway checklist
- A sepsis grab box and implementing a restocking process.
- Audit processes.

Pathways from the Sepsis Trust NZ Maternal Sepsis Screening and Action tool were utilised to create a district wide protocol, with the creation of a flow chart that can be applied to all women and people who are pregnant or up to 6 weeks postpartum, who present with clinical signs of infection or have clinical observations recorded on a MEWS chart that our outside normal parameters. Use of the flow chart allows clinicians to determine the risk factor for sepsis and start treatment if indicated. Risk factors include:

- Abnormal vital signs,
- Fetal tachycardia; and
- Dysuria/anuria

Treatment then follows the 'Sepsis Six plus 2' pathway:

1. Administer oxygen.
2. Take blood cultures.
3. Give IV antibiotics.
4. Give IV fluids.
5. Check serial lactates.
6. Get senior help.

Plus 2

1. Assess fetal state and consider delivery or evacuation of retained products of conception.
2. Consider thromboprophylaxis.

At time of writing, the clinical guideline has been written and is awaiting review by the newly formed Maternity policy and procedure group (PPG). Once ratified, a planned rollout including education, review and audit in all maternity settings will be undertaken.

GROW (REDUCING AVOIDABLE ADVERSE OUTCOMES)

The Growth Assessment Programme (GAP)

Fetal growth restriction is a frequent precursor of stillbirth and other adverse perinatal outcomes. Clinical case reviews in the UK show that the majority of small for gestational age (SGA) stillbirths were potentially avoidable and could often be attributed to factors such as a lack of training in standardized measurement, inappropriate use of growth charts and absence of policies and referral pathways. A general lack of audit to monitor performance and learn from adverse outcomes was also noted (Hugh et al, 2021).

GAP

The Growth Assessment Protocol (GAP) arose out of the need to address these issues, and was developed as a voluntary, licensed service that included:

- Multidisciplinary face to face education supported by theoretical and practical e-learning.
- Implementation of evidence-based guidelines and care pathways for risk assessment at booking, monitoring of fetal growth, investigation of suboptimal growth, and serial growth scans in high-risk pregnancies
- Customized growth charts, for plotting measurements of fundal height and estimated fetal weight.
- Calculation of birth-weight centiles adjusted for the constitutional characteristics of each pregnancy, baby's sex, and gestation at birth.
- Audit tools to record process and outcome of implementation, benchmarking, and monitoring of progress.

- Missed-case audit to establish the reasons why babies born SGA may not have been detected antenatally to be SGA.

GROW Charts

Customized charts using GROW (Gestation Related Optimal Weight) software, optimize the growth curve by excluding pathological factors affecting growth, and adjusting for constitutional variation including ethnic origin, maternal height, early pregnancy weight and parity. They are based on evidence that the known variation in fetal size and growth due to ethnicity as well as maternal size are physiological. Compared with population-based one-size-fits-all standards, SGA defined by GROW centiles is better related to adverse outcome, helps to reduce false positives, and improves identification of the fetus that is pathologically small.

Benefits

Implementation of GAP in the UK has been associated with a significant increase in the detection of SGA and a reduction in the rate of stillbirth. The GAP programme has been implemented across NZ and is being supported by ACC as part of its strategy to reduce Neonatal Encephalopathy (NE), based on evidence that SGA and NE are related, and that better antenatal detection of SGA is likely to reduce the burden of NE. A multidisciplinary working group has been set up to over-see the programme. The programme has been adapted for New Zealand and approved by NZCOM and RANZCOG. Benefits of implementation of GAP in New Zealand have been reported (Cowan et al., 2021).

Southland implemented GAP in November 2021, and it was subsequently rolled out in Dunedin and across the service in late June 2022. Since implementing the GAP across our services our detection rates in pregnancy have increased, in picking up Small for gestational age babies. In the last quarter for 2022 there has been over 80.9% completion of records, meaning specifically that over 80.9% of pregnant people have had a GROW chart in pregnancy and their baby has a customised birth weight centile completed. This represents a significant increase from 56% in the previous quarter. Out of the 80.9 % of completed birth centiles created only 12.6% were SGA babies below the 10th birth centile which sits below the national average.

Our SGA referral rate, however, is sitting below the national average, which presents an opportunity to analyze our data further to ascertain whether this is attributable to data accuracy requiring more education, or alternatively to scanning error. Implementation of GAP/GROW addresses clinical indicators 18 and 19 reduces risk, increases recognition and surveillance, and thereby reduces the stillbirth rate.

Initiatives across the region to improve engagement with GROW chart generation and centile completion include education alongside mandatory chart generation for booking acceptance at any facility across the region and while Southern isn't hitting 100% of pregnant people having a GROW chart generated, our performance in this arena is certainly improving with our centile generation rate going from 24% in the first quarter of 2022 to 81% in the last quarter. Making the recording of birth centile within our patient management system has also assisted with the increase in centile recording and certainly is a cause for celebration!

NEW STAFF APPRAISAL (IMPROVING EQUITY & WELLBEING)

A new appraisal was developed towards the end of 2022 that aimed to be more meaningful and validating for maternity staff. Alongside formal education opportunities in the cultural safety space, we included a cultural self-awareness tool within the appraisal process. Here staff can identify what they have done or are doing in this space as well as what they would like to do. Raising this awareness is imperative for longer term cultural sensitivity, appropriateness, and safety in order to make some advances towards equity within all healthcare environments and wider community settings.

Additionally, a wellbeing tool (Hua Oranga – Te Rau Ora) was also included in the new appraisal documentation. This focus on staff well-being encourages staff to identify how they apply or would like to apply self-care strategies to the way they live and work. It enables discussion and opportunities for support (both formal and informal) to assist in building a healthy, happy, and fulfilled workforce.

PLACE OF BIRTH TOOL (IMPROVING ACCESS, VISIBILITY & SAFE TRANSFER)

The need of a place of birth tool was identified in response to adverse events and consumer feedback. Consumer feedback informed, that transfer times from primary units to a base facility hospital, and service provisions that rural maternity localities offer in Southern are poorly communicated.

In response to consumer feedback, a Place of birth Tool is under development to prompt inform decision on where they would like to give birth and facilitate three-way conversation when needed.

The birth tool would promote visibility of all maternity services across the Southern region also. The tool will also have a QR code, allowing whanau to take a virtual tour of all our birthing facilities.

WORKFORCE & STAFFING (IMPROVING QUALITY & SAFETY OF CARE)

RETENTION

Several initiatives were introduced which provided a direct benefit to support the workforce and delivery of care during the period covered by this report.

1) In December 2021 Clinical Coaches were introduced to stabilize the midwifery workforce. They provided both clinical and pastoral support for all hospital midwives. With 2FTE across the district the coaches have a supernumerary clinical role to support midwives with the clinical demand and complexity of their work, particularly new graduate midwives, midwives returning to practice, new internationally qualified midwives (including those registered under the TTMRA) as well as other midwives with an identified need.
2) 24/7 Clinical Midwife managers (CMM) were appointed in Queen Mary Maternity through a change management process in November 2021. Prior to this, Clinical Midwife Managers were only supernumerary during the days Monday to Friday. The change process enabled the appointment of midwives working as shift coordinators to be appointed into Clinical Midwife Manager roles on the designated senior Midwifery pay scale. This enabled strong

clinical leadership across the 24hr period providing stability and enhancement of quality and equity of patient care. Out of hours the CMMs had a 50% lead 50% clinical component.

3) Actions to support the workforce issues in Southland maternity resulted in a recruitment drive supported by the union, to encourage midwives to apply for coordinator positions. The use of CCDM data revealed a need for a swing shift senior midwife to support induction of labour work during the day. All quality roles that were officed away from the Maternity floor were relocated back to the clinical area to provide an extra layer of clinical support availability in an emergency. Engagement with MMPO enabled the use of locum midwives to enhance the level of midwifery support available to improve safety issues. Reaching out to casuals & providing flexible working arrangements were initiated.
4) November 2021 saw the provision of a retention allowance based on MERAS recommendations for all Southland & Dunedin employed midwives, in the secondary & tertiary services. This encouraged some casual midwives to return to the permanent workforce.
5) In October 2022 a new role in Southland, clinical midwife manager (CMM), was introduced to provide clinical leadership and support to the coordinator and the midwife manager.
6) A service specification was introduced to ensure equitable remuneration as well as standardize the way Southern collaborates with LMC colleagues to provide secondary care.

The vaccine mandate further complicated service issues and culminated in the following initiatives being instigated:

1) A hospital wide call for support for critical shortages resulted in Gynaecology outpatients closing of services and utilizing their RN workforce within the maternity setting.
2) Support received from day of surgery to prep women for elective caesarean sections.
3) A recruitment drive for Nursing staff who would work under the direction and delegation of Midwives.
4) Extra Health care assistant resource to enable greater levels of service out of hours.
5) A Maternity Pod Annex (MPA) was stood up as a collaboration between surgical and women's and children's to address negative staffing variances.

Continuing strategies utilized once Covid lock downs ended throughout 2021 and 2022 to support the workforce included:

1) Increased administrative support out of hours in birthing suite and postnatal area.
2) Relocation of day assessment unit to relieve pressure on acute area.
3) Introduction of a two-year fixed term midwifery postnatal coordinator (MPC) to support the direction and delegation of registered nurses and health care assistants. The MPC also has a role of cross multi-disciplinary team collaboration and communication to ensure there are no near misses and gaps in care.
4) In December 2022 the maternity care assistant role was advertised; an initiative to enhance the level of support provided to the midwifery workforce by student midwives working in a casual 'as needs' capacity.

These new ways of working across the district all contributed to enabling a level of safety with staff all pulling together to continue to deliver safe midwifery care while ensuring women and pregnant people remained at the heart of our services.

SCHOLARSHIP

During and in response to the midwifery staffing crisis over the past two years a business case for a scholarship programme was developed to attract new graduate midwives to the Southern region. Approval is required to provide New Graduates with a $10,000 scholarship that included a robust orientation programme together with clinical coaching and educator wraparound support for the first year of practice in exchange for a two-year bond.

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC)

Long-acting reversible contraception is the most reliable form of contraception available. In terms of maternity care, a gap (but also an opportunity) was identified across our district, for women accessing LARCs prior to discharge from a maternity facility to enable and support appropriate inter-pregnancy intervals as well as avoiding unwanted pregnancies.

As a start Southern sought to train maternity staff to facilitate a train the trainer model of care. One trainer was duly trained alongside three staff (two Dunedin and one Invercargill based) who would become inserters of the various LARC devices. Currently the inserters require supervision to achieve independent sign off as inserters. Once this has occurred, point of care contraception will be more readily accessible to more post-partum people.

While post-partum LARC availability within our tertiary and secondary units is still in its infancy the broader vision is to train and support clinicians across the district to be able to offer this important service. Our LARC services are a 'work in progress' however we hope to formalize these throughout 2023.

ACCESS (IMPROVING ACCESS/SUPPORT)

Quotes for work to upgrade the disability bathroom situated on the ward have been undertaken as this area is not suitable for use currently and requires upgrading. As soon as quotes and provider are approved work will commence to improve accessibility.

Additionally, the doorbell at the postnatal entrance has been lowered to enable ease of access to all, reducing inequity and improving accessibility.

Finally access to support people staying in the postnatal ward has been facilitated by dividing a four bedded room into two separate areas enabling support people to stay with mama and pēpi overnight.

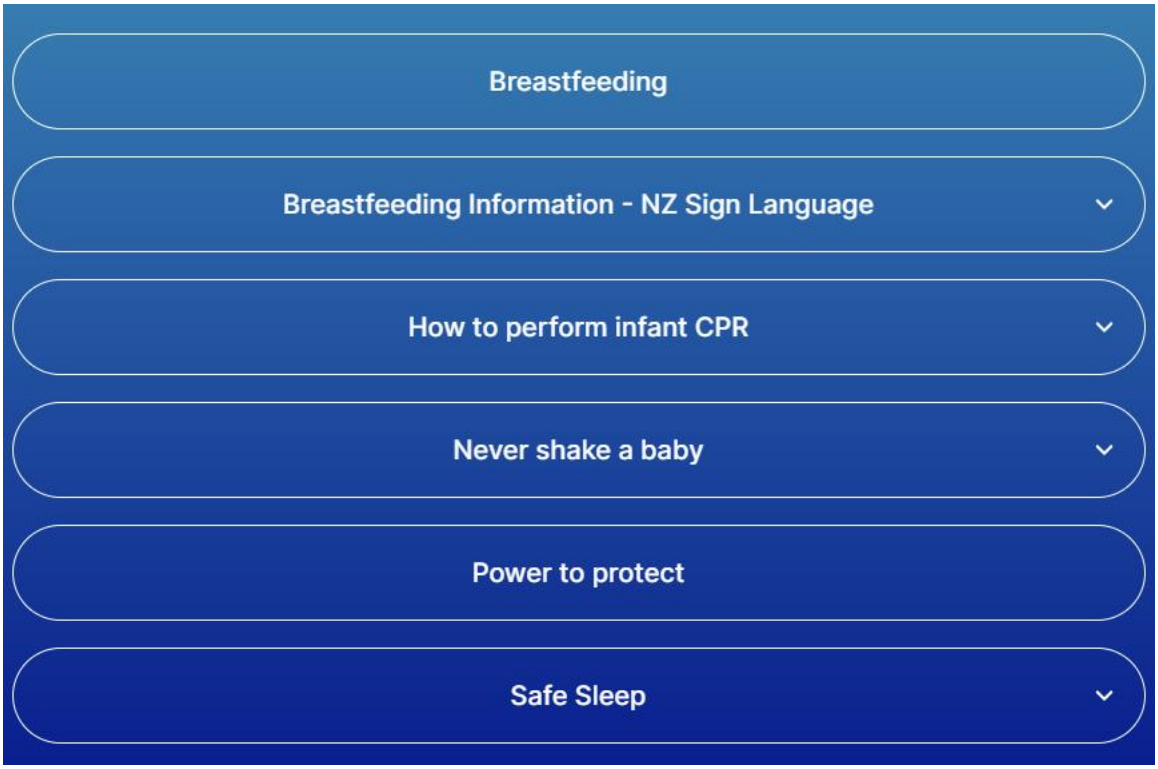
FEEDBACK

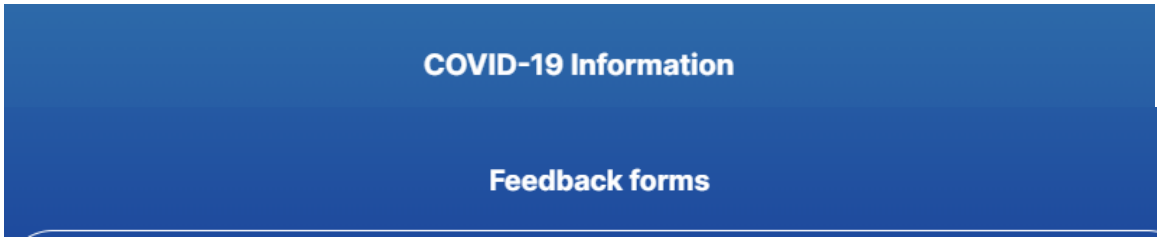
QR CODE IN Southland and Dunedin 2022

The QR Code is a link tree with resources for our hapu mama, pregnant women/people and whānau to access while inpatients on the ward or prior to discharge. The QR code has also been used for obtaining consumer feedback.

https://linktr.ee/SDHBMaternity?utm_source=linktree_profile_share&ltsid=37658b7a-f033-49c0-9599-35e85ee48903

Linktree





Shout Out Board

A shout out board has also been provided to anybody on the ward to be able to comment and show their appreciation to any staff members on the ward. The shout out board has provided a boost to staff morale as well as assisted in promoting a positive and supportive workplace culture.

FLEXIBLE WHĀNAU ROOM (PROMOTING EQUITY & DIVERSITY)

We have staff from the rainbow community who requested a gender-neutral change area. We now have a suitable changer area that can be locked, and we have redirected a scrubs supply to that area. This room additionally provides chairs and a fold out couch for whānau to comfortably wait or rest.

MATERNAL MENTAL HEALTH (IMPROVING OUTCOMES)

Mothers are the backbone of many whanau, therefore supporting good mental health can improve health outcomes, and the quality of maternal and child health services for all women/pregnant people by creating an environment where they feel safe to discuss any difficulties they are experiencing in a respectful and caring environment that is free from stigmatization.

Our focus on Maternal Mental health service improvement commenced with a Maternal Mental Health Hui late in 2022, that included maternity, women, and children's' health specialists service providers alongside consumers to start the journey by identifying services available across the region together with identifying gaps in service provision/availability.

Moving into 2023, in consultation with our midwifery leadership teams, mental health teams, local Māori Runaka representatives and consumers we will work towards developing one or more initiatives to start to address the gaps that exist to enable better and safer outcomes for our population.

CHAMPION ROLES

There are plenty of opportunities for midwives throughout the southern region to take on champion roles, some examples of champion roles offered at Southern are listed below.

Power to Protect	**Smoking Cessation**	**Audit Coordinator**
Manual Handling	**Policy & Guidelines**	**Medical Gases**
Violence Intervention	**Wound Care**	**Electrical warranty audits**
Safe sleep	**Tikaka**	**Health & Safety**
Infection Control	**Hand Hygiene**	**Union representatives**
Maternity Plus	**Customer Satisfaction**	

MQSP PRIORITIES/PROJECTS 2023

1. Reducing the Cesarean Section Rate
2. Reducing Perineal Injury rate
3. Improving Breastfeeding Outcomes
4. Development of a Neuro Diverse Community Pathway
5. Development of a Rainbow Community Pathway
6. Primary Unit Virtual Tours
7. Optimization of the maternal Inter-District Transfer process
8. Development of a Maternal Mental Health pathway

CONCLUDING REMARKS

It's been a very interesting and often times testing couple of years for maternity staff alongside women/wahine/people and their whanau birthing in our region. Despite the adversity, as a region we have risen to the challenge and worked some Southern magic, undertaking and completing various improvement projects that relinquish improved quality and safety of care outcomes.

Quality and safety work has continued while exceptional circumstances have taken us to places, we never quite envisaged. Quality and safety have been and remain pivotal in the services and care we provide, and we could not be prouder of the collaborative efforts that have made us appreciate one another for all that we are, all that we do and all that we have achieved during 2021 and 2022.

We look forward to improving experiences and outcomes moving into 2023 - a brand new, and bright MQSP year!