MATERNITY QUALITY AND SAFETY PROGRAMME

Te Whatu Ora Waitaha

Pūrongo-a-tau

Annual Report

2021 - 22

Te Whatu Ora
Health New Zealand

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A big thank you to the whānau/families, staff, LMC's and consumers that so kindly gave their permission to use their photographs to illustrate our Annual Report. A special thank you to Angela Jones for use of images **https://www.angelajones.co.nz/**

ACKNOWLEDGEMENT OF GENDER

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

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DISCLAIMER

While every effort is made to ensure the accuracy of the information contained in this report, Te Whatu Ora Waitaha cannot guarantee this based on the variation and completeness of data supplied.

Te Whatu Ora Health New Zealand Maternity Clinical Indicators are compiled using a range of sources such as the Lead Maternity Carer (LMC) claim forms, Department of Internal Affairs, Statistics New Zealand, and the National Minimum Data Set for hospital inpatient admissions. Te Whatu Ora Health New Zealand information will also include homebirths and private birthing facilities (such as St. Georges Maternity Facility). Data may be 'cut' based on birth location, district of domicile of the mother, or district of domicile of the baby, which may differ to the mother depending on what was recorded at the time of birth. Depending on the measure reported Te Whatu Ora Health New Zealand data may also include all stillbirths/terminations greater than 20 weeks or may only include standard primiparae. If a segment of data is missing from the Maternity Dataset (MAT), then the record may be excluded from the data set, denominator or numerator completely - this is particularly applicable to those women who may have birthed under the care of the hospital team and therefore did not have LMC registration data.

Where Neonatal Intensive Care Unit (NICU) information is reported this may not be all babies who have spent time in NICU but only those admitted in or depending on the measure may only be birth events here, transferred to and discharged from NICU. The caveats applied to the measure can change the data quite considerably.

Te Whatu Ora Health Waitaha information includes data for those women birthing, and babies born in Waitaha facilities only. The organisation continues to strive for data accuracy and integrity at each step along the way - from LMC forms, Patient Information Care System and Health Connect South data entry, clinical coding, system configuration, transfer into the Data Warehouse, maintenance and reporting.

Data should be used with caution, and in consultation with the Te Whatu Ora Waitaha Decision Support team as caveats are applied to each and every figure and table that may or not be transferrable to the context in which a user may wish to apply the data. We ask that you gain quality assurance that data is contextualised accurately when using this information to inform service improvement or funding decisions.

FOREWORD

Kia ora koutou

Te Whatu Ora Waitaha Canterbury is pleased to present the Maternity Quality and Safety Programme Annual Report for 2021/2022.

Despite the ongoing impact of COVID 19 and then the change to our health legislation to Pae Ora (Health Futures) Act (2022) on July 1, 2022 and the accompanying dissolving of the District Health Boards, we have continued to build on work from the past few years which had a focus of equity following the agreement on the Maternity Strategy for Waitaha. We have been specifically increasing the work we do with the community and ensuring their voices are becoming louder and also working to reflect our Te Tiriti obligations in all that we do. This culminated at the end of 2019 with a Maternity Strategy signed off by our then Board. This taonga was developed and led by Tangata Whenua and endorsed by Pasifika and others. Having this framework has provided us with an anchor and a vision for our māmā, pēpi and whānau for the first 1000 days of life. We now have Te Pae Tata and one of the Pou within that of Kahu Taurima. As we realign our maternity system we need to meet the requirements of Pae Ora and Kahu Taurima and the expectations from both Te Aka Whai Ora and Te Whatu Ora. When we focus on the community and what they are telling us, then as a system we are listening to their stories and can respond accordingly with an equity focus to provide a maternity service that works for them.

In the past the focus for much of Maternity Quality and Safety has rested with the specialist services part of health. Our Maternity Strategy required us to reorient ourselves and Te Pae Tata insists that we do, specifically relating to our obligations under Te Tiriti o Waitangi and hear what whānau/ families are telling us. Our health system is now rearranged into Hospital and Specialist Services, Community and Public Health. Importantly, in time, we will identify the horizontal expectations that will link all of these pillars together.

Whilst this new health system has been occurring the Maternity Quality and Safety programme in Waitaha has continued to operate against the work programme we agreed. We have continued to strengthen the Clinical Governance of this work and also the input from our Whānau Representative Group currently known as the Women's Health Consumer Advisory Council.

We continue to have in the past two years, increasing demand both in our specialist service facility, Christchurch Women's, and in our neonatal intensive care service. At many times we have seen both over capacity as we see increasing acuity related to underlying health conditions such as obesity, diabetes, and hypertension often worsened by the effects of poverty and poor housing as well as the other social determinants of health. We have noticed a rise in maternal mental health issues particularly anxiety and acknowledge that in the new world occupied by COVID – 19 this has added to the already burgeoning concerns our whānau have.

Our community maternity units continue to focus on the care of whānau who are local to them and are increasingly building LMC practices around each of these units, who then respond to their local populations. Within central Christchurch we continue to have a contract with St. Georges Maternity. During this time we have also had sign off for Kurawaka: Waipapa which is a refurbished building, to be converted into a 20 postnatal and 4 birthing room community unit. We have had significant

engagement in the development and planning for this facility so, it and the staff who work in it, practice to, reflect and embody Te O Māori frameworks when it opens.

We were also fortunate in 2022 to open Oromairaki which is a new purpose-built community maternity unit within a larger health facility space. Waitaha worked with the Selwyn Council to design this 10 bed and 2 birthing room maternity unit within the Selwyn Health Hub - Toka Hāpai. The local runanga, Te Taumutu Runanga were involved in the progress of this unit and contributed to ensuring this unit reflects their whānau needs. With the opening of this unit the Lincoln Maternity unit which was over 100 years old, was closed.

Workforce has continued to be challenging. This was especially noticeable with the vaccine mandates, the opening of the borders and several of our older staff members who continued to work during the pandemic but then retired once things started to settle after winter 2022. The pipeline from ARA is not able to provide enough graduates for our maternity facilities. The good news is that graduates are going to work in the community as LMCs, but we also need them to work in the maternity units. Our Obstetrics and Gynaecology workforce similarly has had significant impacts over the past few years which has made it challenging to cover our specialist service at times.

There are always things we could have done better during the pandemic, but we were all striving to do our best each day for women and their whānau. This was an especially challenging time. We linked frequently at this time with our whānau representatives, LMC forums and staff with a number of webinars exploring the impacts for hapū people when they had COVID 19, the latest variants and the latest pathways. These webinars were widely shared and used according to feedback we received. There was also the need to visit MIQ facilities when hapū people returned to Aotearoa, often receiving little to no care before they left the country they were living in. Many thanks to our clinic team for arranging these visits with our Infection Prevention and Control colleagues and managers of MIQ. Thank you also to our LMCs and core staff who provided care for these people often with very little history available and also continued to care for whānau when at times we all were struggling with how to provide care safely.

Our quality frameworks and feedback from staff though the Safety1st system, consumer feedback through satisfaction surveys and complaint processes and then our reviews at Incident Review meetings means we continue to work to ensure that the quality cycle is completed. We develop maternity guidelines including the wider community of practitioners and also involve our consumers. Again, with a focus on our community, we review the evidence and together develop pathways to guide referrals, provide education and simulation teaching sessions that reflect common scenarios.

Our Consumer Advisory Council has become an essential part of our maternity quality system and clinical governance. The members of this council far exceed those able to attend meetings and we are indebted to them for the sage advice they provide us on a wide range of topics. We have also ensured that the Chair of our council sits on the clinical governance of the Women's and Children's Division of hospital and specialist services.

We want to take this opportunity to thank everyone for all their mahi which at times has been over and above. The pride and professionalism shown by all is very much appreciated.

Thank you also to the members of our Consumer Advisory Council who always keep us on the right path and again big thanks to our MQSP Coordinator Sam Burke and our excellent maternity quality team. They all keep us motivated and focused on improving our maternity services in Te Whatu Ora Waitaha Canterbury.

We hope you enjoy reading our report.

Norma Campbell

Executive Director of Midwifery and Maternity,
Te Whatu Ora Waitaha Canterbury

Emma Jackson

Clinical Director, Obstetrics and Gynaecology,
Te Whatu Ora Waitaha Canterbury

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OVERVIEW

BACKGROUND

This is the eighth Maternity Quality and Safety Annual Report since the establishment of the Ministry of Health (MOH) Maternity Quality and Safety Programme (MQSP) in 2011.

The National Maternity Monitoring Group (NMMG) came into operation in 2012, as part of this programme, to oversee the maternity system in general and the implementation of the New Zealand Maternity Standards.

The high-level strategic statements of the New Zealand Maternity Standards (MOH, 2011) are:

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

AIMS AND OBJECTIVES

Te Whatu Ora Waitaha is committed to improving the quality and safety of maternity services for consumers.

Te Whatu Ora Waitaha maternity services' aims and objectives are to:

- Provide person-centred maternity care that meets the needs of the population
- Continue to implement, review and establish as required, systems and processes to support the provision of quality and safe care
- Take a whole of systems approach towards improving the health of women/wāhine and children/pēpi as guided by the Te Whatu Ora Health New Zealand goals and targets
- Align the maternity workforce to meet the needs of the population
- Align and strengthen regional links

The Maternity Strategy visions and values are outlined on Page 17.

PURPOSE

The purpose of this report is to provide information about Maternity services in Te Whatu Ora Canterbury/Waitaha:

- Improvements in relation to the overall aims and objectives
- Achievements against the quality improvement goals
- Contribution towards addressing the priorities of the NMMG, Health Quality and Safety Commission (HQSC) and recommendations from the Perinatal and Maternal Mortality Review Committee.
- Performance in relation to the Te Whatu Ora Health New Zealand Maternity Clinical Indicators 2019 and 2020 – Te Whatu Ora - Health New Zealand (Zealand T. w., 2022)
- Response to consumer feedback and ongoing consumer involvement
- Quality initiative goals for 2023/24

GLOSSARY

Caesarean Section	An operative birth through an abdominal incision.
Episiotomy	An incision of the perineal tissue surrounding the vagina to facilitate or expedite birth.
Gravida	A pregnant woman.
Maternity Facilities	A maternity facility is a place that women attend, or are resident in, for the primary purpose of receiving maternity care, usually during labour and birth. It may be classed as primary, secondary or tertiary depending on the availability of specialist services (Ministry of Health 2012). This section describes women giving birth at a maternity facility.
Multiparous	Multiparous is a woman who has given birth two or more times.
Neonatal Death	Death of a baby within 28 days of life.
Parity	Number of previous births a woman has had.
Primiparous	A woman who is pregnant for the first time.
Primary Facility	Refers to a maternity unit that provides care for women expected to experience normal birth with care provision from midwives. It is usually community-based and specifically for women assessed as being at low risk of complications for labour and birth care. Access to specialist secondary maternity services and care will require transfer to a secondary/tertiary facility. Primary facilities do not provide epidural analgesia or operative birth services. Birthing units are considered to be primary facilities. Primary maternity facilities provide inpatient services for labour and birth and the immediate postnatal period.
Postpartum Haemorrhage	Excessive bleeding after birth that causes a woman to become unwell.
Primary Maternity Services	Primary maternity services are provided to women and their babies for an uncomplicated pregnancy, labour and birth, and postnatal period. They are based on continuity of care. The majority of these maternity services are provided by Lead Maternity Carers (LMCs).
Secondary Facility	Refers to a hospital that can provide care for normal births, complicated pregnancies and births including operative births and Caesarean Sections plus specialist adjunct services including anaesthetics and paediatrics. As a minimum, secondary facilities include an obstetrician rostered on site during working hours and on call after hours, with access to support from an anaesthetist, paediatrician, radiological, laboratory and neonatal services.
Standard Primiparae	A group of mothers considered to be clinically comparable and expected to require low levels of obstetric intervention. Standard primiparae are defined in this report as women recorded in the National Maternity Collection (MAT) who meet all of the following inclusions: • delivered at a maternity facility • are aged between 20 and 34 years (inclusive) at delivery • are pregnant with a single baby presenting in labour in cephalic position • have no known prior pregnancy of 20 weeks and over gestation • deliver a live or stillborn baby at term gestation: between 37 and 41 weeks inclusive • have no recorded obstetric complications in the present pregnancy that are indications for specific obstetric interventions. Intervention and complication rates for such women should be low and consistent across hospitals. Compiling data from only standard primiparae (rather than all women giving birth) controls for differences in case mix and increases the validity of inter-hospital comparisons of maternity care (adapted from Australian Council on Healthcare Standards 2008, p 29).
Stillbirth	A baby is stillborn when he or she dies during pregnancy (or in-utero/in the womb) after the 20th week of pregnancy or if the baby weighs more than 400 grams at birth. In New Zealand a stillbirth is legally defined as a dead fetus that: (a) weighed 400 grams or more when it issued from its mother, or (b) issued from its mother after the 20th week of pregnancy.
Tertiary Facility	Refers to a hospital that can provide care for women with high-risk, complex pregnancies by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. Tertiary maternity care includes an on-site, level 3, neonatal service.
Weeks' Gestation	The term used to describe how far along the pregnancy is. It is measured from the first day of the woman's last menstrual cycle to the current date.

ABBREVIATIONS

ACC	Accident Compensation Corporation
APH	Antepartum Haemorrhage
BBA	Born before arrival
BFHI	Baby Friendly Hospital Initiative
CS	Caesarean section
CWH	Christchurch Women's Hospital
CYMRC	Child Youth Mortality Review Committee
EDD	Estimated date of delivery
GP	General Practitioner
HIE	Hypoxic Ischaemic Encephalopathy
HQSC	Health Quality and Safety Commission
ICU	Intensive Care Unit
IOL	Induction of Labour
LMC	Lead Maternity Carer
MAU	Maternity Assessment unit
MIQ	Managed Isolation and Quarantine
MQGG	Maternity Quality Governance Group
MOH	Ministry of Health
MMWG	Maternal Morbidity Working Group
MQSP	Maternity Quality and Safety Programme
NE	Neonatal Encephalopathy
NEWS	Newborn Early Warning Score
NGO	Non-government Organisation
NICU	Neonatal Intensive Care Unit
NMMG	National Maternity Monitoring Group
NSU	National Screening Unit
NZNO	New Zealand Nursing Organisation
NZCOM	New Zealand College of Midwives
PMMRC	Perinatal and Maternal Mortality Review Committee
PPH	Postpartum Haemorrhage
PROMPT	Practical Obstetric Multi-Professional Training
RMO	Resident Medical Officer
SMO	Senior Medical Officer
SP	Standard Primiparae
SUDI	Sudden Unexpected Death in Infancy
WCDHB	West Coast District Health Board
W&CH	Women's and Children's Health

WAITAHA MATERNITY STRATEGY

OUR VISION

Waitaha maternity services provide for the maternity needs of all māmā and whānau as and when needed during their maternity journey in order to enable the best start to life for all pēpi and the ongoing wellbeing of mothers.

OUR VALUES

MANA TAURITE EQUITY

Every person has the opportunity to access culturally appropriate services. Those who work across the maternity system reflect the community in which we live, and understand, value and support cultural practices that may be different to their own.

WHANAUNGATANGA EVERYONE BELONGS

The whole whānau is included and important, with each person feeling comfortable and as though they belong. Interaction with the maternity system is a mana enhancing experience.

MANAAKITANGA RESPECT FOR ALL

The maternity system is hospitable through being welcoming, and respectful. We provide the utmost care for each other.

TINO RANGATIRATANGA EMPOWERING WHĀNAU

Whānau are empowered and supported to make their own informed decisions.

ORANGA TONUTANGA HEALTH AND WELLBEING

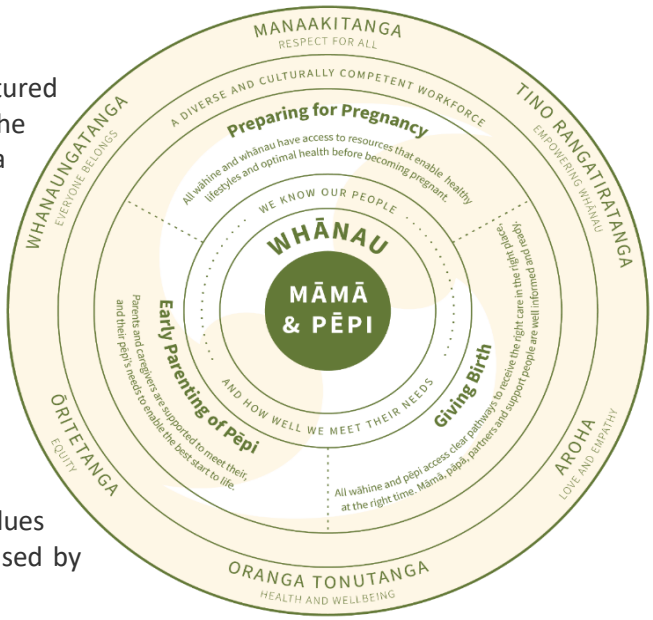
Whānau have optimal physical, mental, dental and sexual health before, during and after the birth of pēpi. People have the opportunity to enjoy clean smoke free air and clean water wherever they live, work and play (wai ora).

AROHA LOVE AND EMPATHY

Without bias every person[2] is treated with love, compassion and empathy.

2 When we say 'every person' this is inclusive regardless of sexual orientation, gender identity/expression, sex characteristics, ethnicity, age, religion, culture.

The Waitaha Maternity Strategy also known as the Canterbury Maternity System Strategic Framework (2019-2024) (CDHB, 2019) puts māmā and pēpi at the centre of what we do and what we want to achieve for our community.



The framework stands on three pillars and is featured throughout this MQSP annual report and is the foundation document for all Te Whatu Ora Waitaha maternity quality improvement work.

The vision statement within the strategy states that "Canterbury maternity services provide for the maternity needs of all māmā and whānau as and when needed during their maternity journey in order to enable the best start to life for all pēpi and the ongoing wellbeing of mothers".

The strategy also contains statements about our values and provides details about the framework to be used by Waitaha maternity services.

During development of the Maternity Strategy there was extensive consultation through hui with stakeholders from both within and outside of health. A list of partnerships are included in the published document at Canterbury Maternity Strategy .

In 2022 the Maternity Quality Governance Group (MQGG) approved the Maternity Strategy one year workplan which would sit under the umbrella of the MQSP from June for the 2022/23 year. The one year plan was developed from the overarching maternity strategy that was supported by the Waitaha leadership team in 2019.

The plan was developed with the support of a maternity oversight group and consumers. The plan took into consideration the current health climate, i.e. COVID -19 and the National health reform. It was approved in February 2022 while recognising that work would likely be delayed with the resurgence of COVID - 19 and reduced business as usual and capacity for new project work.

The workplan was also presented at the Te Whatu Ora Waitaha Child and Youth Workstream (2000 days) forum to align the project work in this space.

To ensure good governance processes and to follow progress the workplan is updated at each MQGG hui and also links in with the Women's and Children's Clinical Governance group.

OUR REGION

Te Whatu Ora Waitaha is the second largest district in the country by both geographical area and population size - serving an estimated 655,000 people (12.8% of the New Zealand population) Stats NZ Tatauranga Aotearoa (NZ, 2022) in 2022, and covering 26,881 square kilometres.

There are three separate divisions within Te Whatu Ora Waitaha responsible for providing the maternity services; Women's and Children's Health (W&CH), Ashburton and Rural Health services, which includes the Chatham Islands. Te Whatu Ora Waitaha also has a contract with St George's Hospital, Maternity Centre to provide inpatient maternity care.

WAITAHA AND TE TAI O POUTINI (WEST COAST) 'TRANSALPINE' RELATIONSHIP

Waitaha provides many services for the population of the Te Whatu Ora Te Tai o Poutini. This 'transalpine' approach to service provision has allowed better planning for the assistance and services Waitaha provides to Te Pai o Poutini/West Coast, so people can access services as close as possible to where they live.

Te Whatu Ora Waitaha also provides an extensive range of specialist services on a regional basis to people referred from other areas where these services are not available. This includes neonatal services.

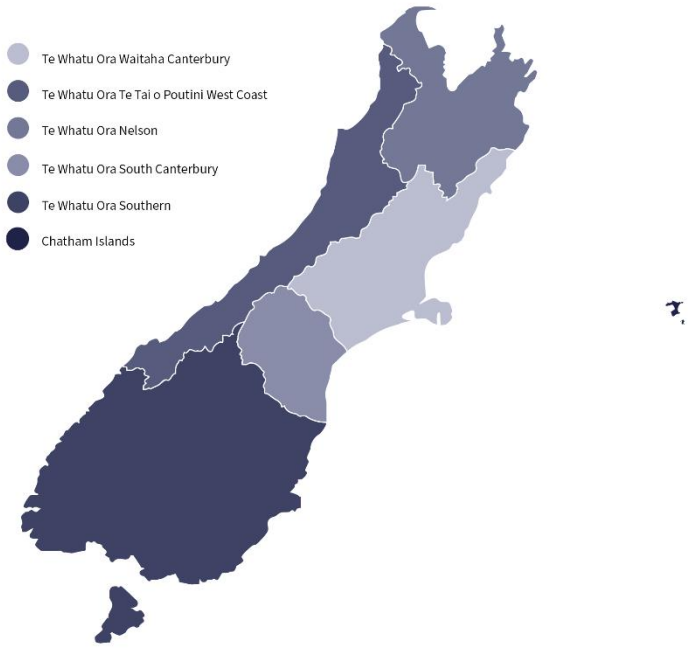
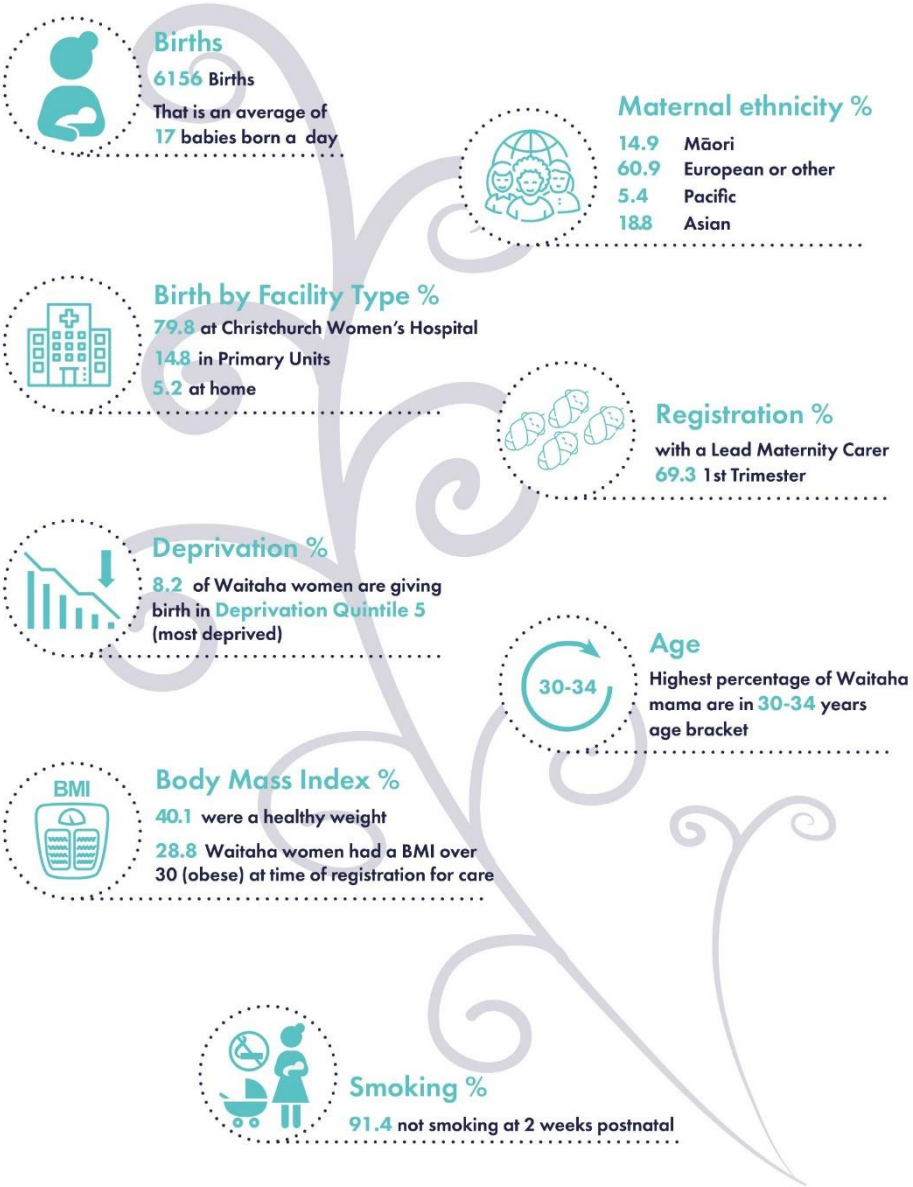


Figure 1. Te Waipounamu South Island District Boundaries

OUR COMMUNITY

Our community demographics are taken from the New Zealand Maternity Clinical Indicators 2020 (Zealand T. w., 2022), and the Report on Maternity web tool (2022). These are the latest published reports and have been used to provide a visual picture of health statistics for women giving birth in Waitaha in 2020 which pair with the data presented in the New Zealand Maternity Clinical Indicators and illustrated in this report.

Figure 2. Te Whatu Ora Waitaha Canterbury snapshot for women giving birth in 2020



OUR MATERNITY SERVICES

There are a range of Maternity facilities available to women in Waitaha (Table 1). Christchurch Women's Hospital (CWH) is the only tertiary facility and accepts referrals from Waitaha and the Te Pai o Poutini regions as well as throughout Te Waipounamu (South Island) for women who are presenting with complex pregnancies.

All referrals for tertiary care from Te Whatu Ora Te Pai o Poutini primary and secondary units and Waitaha primary units and homebirths go to Christchurch Women's Hospital.

Figure 3. gives a visual representation of where rural and remote rural women live and birth in Waitaha. It also provides an indication of women that birth in the tertiary centre from other areas. Women on the Chatham Islands have antenatal and postnatal care provided by a Lead Maternity Carer (LMC). This is a contracted service between Te Whatu Ora Waitaha and the LMC. Chatham Islands have a backup emergency service through the health centre in Waitangi. Almost all women leave the Islands to birth.

Table 1. Waitaha Maternity Facilities

	Women's and Children's Health Division	Ashburton	Rural Health Services
Primary	○ Lincoln Maternity Hospital (closed May 2022) ○ Rangiora Health Hub ○ St George's Maternity Centre (contract with Te Whatu Ora Waitaha) ○ Oromairaki Maternity Unit (opened May 2022)	○ Ashburton Maternity Centre	○ Chatham Islands (since 2015) ○ Kaikoura Health (Te Hā o Te Ora)
Tertiary	Christchurch Women's Hospital		

Figure 3. Place of residence for rural and remote rural women birthing in Waitaha Canterbury 2022

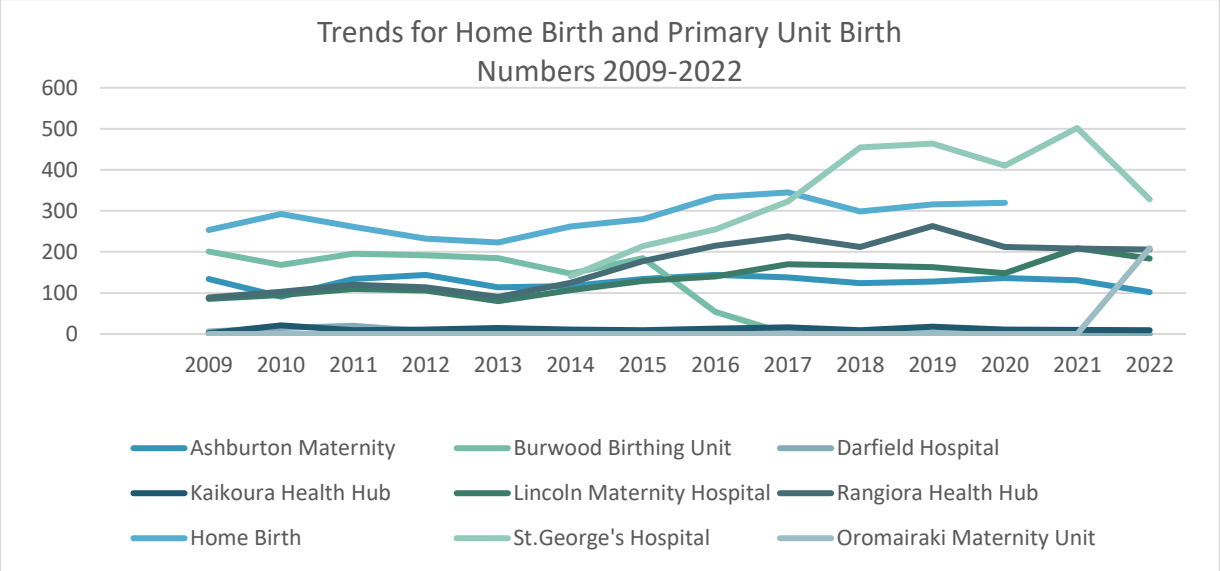


Figure 4. Waitaha Trends for Home Birth and Primary Maternity Unit Birth Numbers 2009-2022

A high proportion of our birthing women choose Christchurch Women's Hospital as their place of birth, 80.3% gave birth at the secondary/ tertiary maternity facility in 2022, with 19.7% birthing at a primary maternity unit. Work to increase birth numbers in our primary units has been active and ongoing since 2010, and it remains a priority within our maternity strategy.

Te Whatu Ora Waitaha have committed to providing care closer to home which has included purpose-built facilities to provide maternity care for women in their communities.

Figure 4 shows the consistent and upward trend in primary unit and home birthing since 2009.

In May 2022 the Oromairaki maternity unit opened in Rolleston to improve access to health services for the rapidly growing Selwyn population.

The name Oromairaki was gifted by Te Taumutu Rūnanga - ***The resonating sounds of the heavens***

The sounds of wonder, of welcome, of pain and of sorrow, they are the sounds of the heavens. Sounds which carry the resonance of joy and sadness. Sounds announcing life and death. They are earthly sounds, they are the sounds of the heavens receiving and echoing. They are sounds of ritual and blessing.
Whatua kā aho o te whare
Whiriwhiria, tuituia, kia tina.
Weave together the strands of the house
Weave them, bind them together and it is done.
Under the watchful eye of Hine-te-iwaiwa, the principal goddess of te whare pora, the weaving house, let the strands of life bind together, let the whare tangata prepare for new life and when it is done, let Hine-te-iwaiwa call them into te ao marama, the world of light.
Oromairaki celebrates the call of Hine-te-iwaiwa, the sighs of motherhood and the cries of new life. Oro means to resound, echo and resonate. It is a sound, a rumble and a note in music. Mairaki is a contraction of mai i te raki – from the heavens

WAITAHA MATERNITY HOSPITALS AND PRIMARY MATERNITY UNITS

Our Maternity facilities extend across Waitaha from Kaikoura to Ashburton. Despite the high birth rate at our main centre, Christchurch Women's Hospital, a significant proportion of women will transfer for postnatal care to one of our primary maternity units. The following information provides an overview of these facilities and their activity during 2021 and 2022 can be reviewed in Appendix 1.

CHRISTCHURCH WOMEN'S HOSPITAL

Overview:

Secondary/Tertiary Hospital - designed for women with complex maternity needs which require specialist multidisciplinary care.

- Day Assessment Unit
- Fetal Medicine Unit
- Maternity Assessment Unit located on the Ground Floor of Christchurch Hospital
- The 'Garden Room' is available for women experiencing fetal loss in the latter half of pregnancy
- **13** Rooms for labour and birth
- **2** Pools for water birth
- **2** Acute Observation beds
- **2** Multi-purpose rooms
- **5** Assessment rooms
- **2** Operating theatres
- **45** Antenatal / postnatal unit beds
- **16** Clinic rooms
- **11** Intensive care cots
- **30** Special care cots

"Very supportive all the time"

Christchurch Women's Hospital

RANGIORA HEALTH HUB

JEN CUNNINGHAM,

MIDWIFE MANAGER

Distance **35km, 41mins from Christchurch**

PRIMARY MATERNITY UNIT

3 Rooms for labour and birth

2 Pools for water birth

4 Assessment rooms

10 Postnatal rooms

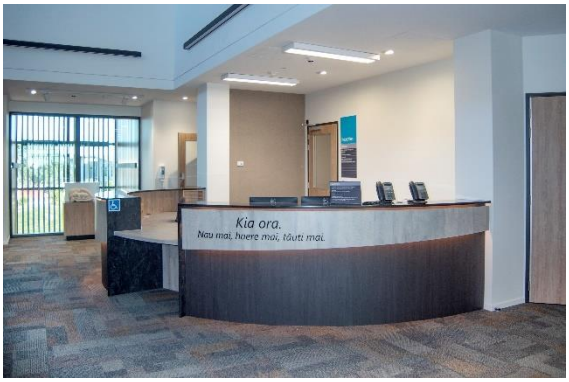
OROMAIRAKI MATERNITY UNIT

BRONWYN TORRANCE,

MIDWIFE MANAGER

Distance **23.1km, 28mins from Christchurch**

PRIMARY MATERNITY UNIT



Opened May 2022

3 Room for labour and birth

2 Pools for water birth

2 Assessment room

10 Postnatal rooms

Staff were prompt and super helpful. I did not have to hesitate to ask for anything that I needed. It felt like home.

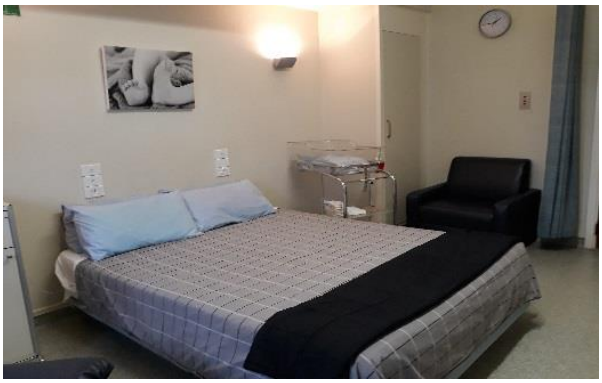
Rangiora Health Hub

ASHBURTON MATERNITY

JULIE DOCKRILL,

MIDWIFE MANAGER

Distance **87km, 1 hour 8mins from Christchurch**



PRIMARY MATERNITY UNIT

2 Rooms for labour and birth

1 Pools for water birth

5 Postnatal rooms

KAIKOURA HEALTH HUB (TE HĀ O TE ORA)

SIOBHAN CONNOR, LMC FOR KAIKOURA DISTRICTS

MARLISE VAN STADEN, CHARGE NURSE MANAGER

Distance **181km, 2 hours 10mins from Christchurch**

Overview:

PRIMARY MATERNITY UNIT

1 Room for labour and birth

2 Postnatal rooms

ST. GEORGE'S HOSPITAL

ANDREA ROBINSON,

CHARGE MIDWIFE MANAGER

Distance **5.1km, 12min from Christchurch Women's Hospital**

Overview:

PRIMARY MATERNITY UNIT

3 rooms for labour and birth – **2** with birthing pools

1 swing room (can be used for another birthing room or postnatal)

10 postnatal rooms

2 rooms for private stay

2 assessment rooms

5 rooms available - for use if required as "overflow" from surgical areas

LINCOLN MATERNITY HOSPITAL

BRONWYN TORRANCE,

MIDWIFE MANAGER

Distance **19.7km, 30mins from Christchurch**

Overview:

PRIMARY MATERNITY UNIT

Closed May 2022

2 Room for labour and birth

2 Pools for water birth

1 Assessment room

6 Postnatal rooms

OUR WORKFORCE

Waitaha maternity service is provided by our multidisciplinary team of midwives (Lead Maternity Carers (LMC's) and Te Whatu Ora Waitaha Canterbury employed midwives, obstetric doctors, General Practitioner's (GP's), physicians, nurses, lactation consultants, allied health and support staff.

Christchurch Women's Hospital, which is Canterbury's secondary/tertiary unit, provides antenatal clinic care, which includes specialised clinics for high risk pregnancies, diabetes, Ngā Taonga Pēpi and fetal maternal medicine. The outpatient clinic at Christchurch Women's Hospital also provides antenatal care for a small number of women unable to initially secure an LMC.

In line with our maternity strategy and Te Whatu Ora Waitaha Canterbury commitment to provide care closer to home, we provide some antenatal clinics at Rangiora Health Hub and Ashburton with the aim of improving access to our services and care closer to home.

A specialist obstetric clinic is also provided at Rangiora and the Chatham Islands.

We are also continuing to look at further opportunities to provide specialist consultation and care closer to home exploring the use of technology further to enable this. This continuing work is included in our MQSP priorities and action plan.

A day assessment unit provides observational care for women under the care of the obstetric team, reducing the need for inpatient care.

The Maternity assessment unit located on the ground floor of Christchurch Hospital, which opened in 2019 provides a dedicated and appropriate assessment space for hapu women. It also creates more capacity within Birthing Suite to deal with intrapartum care and acute presentations and improves the flow for women accessing unplanned antenatal care at CWH.

Christchurch Women's Hospital is an Obstetrics and Gynaecology teaching hospital providing a 24-hour service for consultation and acute care.

The medical team consists of:

- Clinical Director
- 20 FTE Obstetricians and Gynaecologists
- O.7 FTE Obstetric Physician
- 1 FTE Medical Officers
- 1 FTE Fellows
- 17 FTE Registrars (RMO)
- 9.5 FTE House Officers
- Anaesthetic cover 24/7

In 2022, 368 midwives identified Te Whatu Ora Waitaha Canterbury as the primary place of work as a midwife (MCNZ). This equated to 11.9% of the national workforce. This is both LMC and core midwives.

The head count of midwives and nurses employed by the Te Whatu Ora Waitaha Canterbury to work in the maternity setting fluctuates but is approximately 163, with a majority working at Christchurch Women's Hospital. The FTE for CWH is 62.0.

In addition to these midwives and nurses we have a senior midwifery team, which consists of:

- Executive Director of Midwifery
- Associate Director Midwifery
- 6 Midwife Managers
- 9 Clinical Midwife Managers (who cover the unit 24/7)
- 2 Clinical Midwife Coordinators
- 2 Clinical Coaches
- 2 Midwifery Educators
- 1 Baby Friendly Hospital Initiative (BFHI) Coordinator
- 1 PMMRC Coordinator

We also have approx. 70 ward clerks and hospital aids across the maternity service who are invaluable members of the team.

Five new graduate midwives were employed into the new graduate programme in 2021 and six in 2022.

OUR MATERNITY OPERATIONAL GOVERNANCE AND LEADERSHIP

GOVERNANCE STRUCTURE

The Te Whatu Ora Waitaha Maternity Quality Governance Group (MQGG) is comprised of members of the hospital interdisciplinary team as well as community facilities and consumer representation. This group develop, support and guide the operational quality work within the maternity service from several sources as outlined in Figure 5.

The group meet once a month either face to face or with videoconferencing and bring together staff from Women's and Children's Health, Ashburton, Rural Health services and St. George's.

QUALITY PLANNING AND REPORTING

Figure 5 below gives a graphic representation of the current and revised structure for the MQSP crown funding agreement for 2020 to 2023. It demonstrates the internal and external inputs that then informs and drives the Maternity Operations Group (renamed Canterbury Maternity Quality Governance Group) in developing an annual quality plan and MQSP annual report It also outlines the governance structure and reporting lines within Te Whatu Ora Waitaha which extend across the health system.

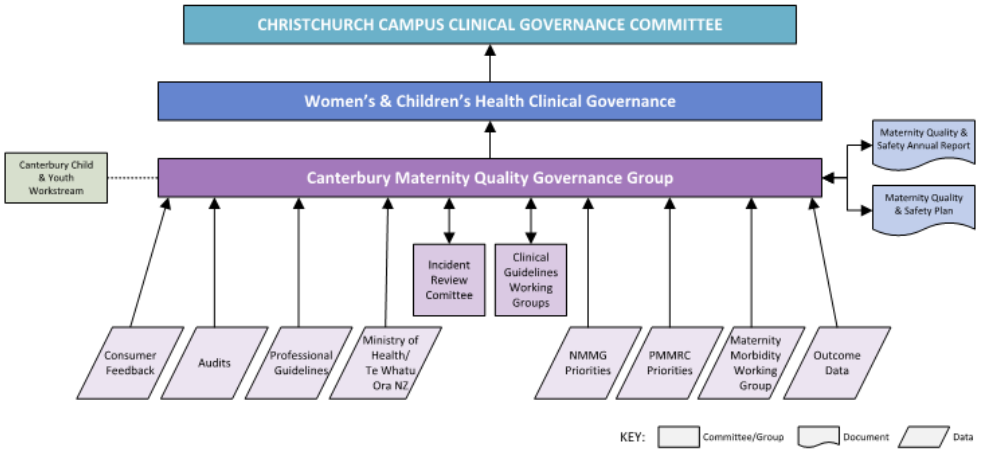


Figure 5. Governance Committee Structure and Reporting Lines in 2022

CONSUMER ENGAGEMENT

Engaging with our community through consumers of our maternity service continues to be one of the priorities of the Waitaha Maternity Quality and Safety Programme (MQSP). The Maternity Consumer Advisory Council has a large number of individual and NGO members who either attend meetings or receive the minutes and provide feedback on topics that they feel they can comment on.

The forum has continued to develop since 2017 and is now an essential part of the maternity system.

Consumer members represent the Advisory Council at different hui, for example, the Women's and Children's Clinical Governance, Maternity Quality Clinical Governance and the Baby Friendly Hospital Initiative (BFHI) steering group. Members do so as nominated by the council and are representative of all members and the groups they link into. The group provides the opportunity for information sharing, presentations, updates on maternity projects and networking. The meetings are held every six weeks and as a maternity service we actively seek feedback and consultation on quality mahi that we are reviewing or developing.

"Whakarongo ki o tatou māmā, Whakarongo mai to tatou whānau, in our consumer mahi this is the guiding factor of commitment, we have a responsibility to actively seek out & give safe spaces for our wāhine and their whānau to have a voice in the services they use within maternity and woman's health. Our consumer council in Waitaha has a significant presence within all levels of our houora system, from giving a voice within research studies, attending governance meetings and other groups that by their actions or involvement have touchpoints in health with the consumers we represent.

We have been able to be a big part of some initiatives that support our wāhine, the Birth Afterthoughts clinic has been established in Waitaha and is a direct result of the consumer voice telling us that there needed to be a mechanism to allow woman to talk through their birth in a safe way. We are incredibly proud of this project and see it as the start of something even bigger in the future that will continue to meet the needs of our birthing population and their whānau. We have made moves to make giving your experiences and seeking the rural and remote voice in this space a much easier process for our woman, with a view to better meet the needs of their community. We are currently actively seeking members to join our roopu from our ethnically diverse whānau, disability, rangatahi & other areas of our community so we are able to reach as deeply into our wider Waitaha whānau voice as possible. Our satellite group from Kaikoura continues to grow & give feedback to take into consideration.

One huge positive move for Aotearoa that has happened as a result of the new health reform is the clear directives of both Te Aka Whai Ora and Te Whatu Ora to seek out and listen to the consumer voice, our significant mahi in this area has us in a great position to support other parts of the system to be as active as we are in this space.

We look forward to seeing the consumer voice imbedded in to our wider hauora system as a whole, we are committed to being not only part of the change but leaders in the consumer voice within hauora".

Na mihi Mahana,

Lisa Kahu

Te Tai O Marokura, Health & Social Services, Kaikoura

Chairperson Woman's Health Advisory Council

STRENGTHENING AND SUPPORTING OUR MATERNITY TEAM

LMC LIAISON ROLE

SONYA GRAY
LMC LIAISON MIDWIFE

Hello, my name is Sonya Gray and I have been an LMC midwife since 2005.

I am the current LMC Liaison, a role I have held since Feb 2022. This is a contract position with Te Whatu Ora Canterbury Waitaha. I am a case loading midwife and an active member of the Canterbury West Coast Region of the New Zealand College of Midwives (NZCOM) and am supported by the region to be in this role.

I attend regular monthly meetings with the Director of Midwifery and Associate Director of Midwifery and the Regional NZCOM Chair. These provide a good way to communicate how both the community midwives and hospital are managing and addressing any concerns.

Within my role I attend the Maternity Quality Governance Group meetings which are held every 6 weeks, and fortnightly Incident Review group meetings to provide the LMC lens to incidents.

I am involved in the Kurawaka: Waipapa development group which is a multidisciplinary group overseeing establishment of the new Waitaha central city birthing unit.

I have also taken over from the previous LMC Liaison in attending the Child and Youth Workstream meetings.

Last year I was part of the team which worked to establish the Birth After Thoughts Clinic.

Last year we streamlined how information was sent out to LMC's to make sure they were not overloaded with emails, so I write an update of important information and this is then uploaded to the regional page of the NZCOM website and the link is sent out to all access agreement holders.

At the monthly Regional NZCOM meeting I provide feedback to the members; the members also know that they can email me with any concerns they have.

MIDWIFE CLINICAL COACH

CATHERINE KNOEF
MIDWIFE CLINICAL COACH, CHRISTCHURCH WOMEN'S HOSPITAL

The midwife clinical coach initiative began nationally in 2021. Christchurch Women's Hospital (CWH) was allocated 1.5FTE to the role by the Midwifery Council.

Under the oversight of the Midwife Manager, Dani Gibbs and I were provided time and space to develop the Clinical Coach role from the ground up and relished building it upon the principals of Manaakitanga (respect for all) and Whanaungatanata (belonging).

Our mission, broadly speaking, was to improve midwifery retention and recruitment at CWH, so from early on we set our sights on improving some key areas that were achievable for the short, medium and long term.

Some examples included extending the orientation period for new staff (new and experienced midwives as well as registered nurses) to 4 weeks, not including non-clinical mandatory onboarding (24 hours).

We took on the responsibility for providing 6 week and 3 month check-ins with new staff and began to closely oversee the orientation period to try ensuring that new staff got a broad exposure to as many areas in the clinical setting as possible whilst still being supernumerary.

A particular area of our coaching focus was and is to protect/support and nurture our new graduate midwives over the duration of their first year. We have delighted in witnessing the midwifery graduates settle, consolidate learning and grow in to their roles and responsibilities and confidence as midwives. We've celebrated with them over their wins, supported them through some hard times and have tried to remain available to drop everything and come to them for on-the-floor support or to provide a sounding board as they've been figuring out care plans and making clinical decisions.

Midwifery Council included in the clinical coach brief the supervision of Return to Practice (RTP) and Internationally Qualified (IQ) midwives which involves monthly meetings with those midwives, overseeing their Council RTP/IQ recertification requirements and reporting monthly to Midwifery Council.

The coaches have worked closely with our midwifery educators to update the midwifery/nursing orientation manuals/resources and have found that the coach and education roles have regular crossover points. We have been very well supported by the educators throughout the establishment of the clinical coach role which previously fell under the umbrella of the educators mahi.

All in all, it has been exciting, humbling and challenging to be part of this initiative. We continually look at the way we deliver coach support, adapt it to meet individuals and enjoy providing a warm welcome to our CWH whānau. We continue to evolve the role and adapt to the needs of each newly employed staff member with a strong focus on building strong connections/bonds that we hope will continue to make them feel that there is always someone to talk to through tough and good times

MQSP Annual Presentation day speakers 2022. Photo: Left to right: Erin Manning, Sam Burke, Esther Calje, Niranjala Hewapathirana, Liz Love, Norma Campbell, Jen Coster, Emma Jackson, Pelle Kempe (Mid Central DHB and Keynote speaker). Not pictured Lisa Kahu.

COVID – 19

During 2021 and 2022 COVID – 19 Alert levels continued to fluctuate depending on the number of COVID – 19 cases and risk for the community. As a maternity service and multidisciplinary team, we continued to navigate the changes which were sometimes rapid to ensure that our māmā and whānau had the best experience despite the imposed restrictions.

Following the Alert Level 4 lockdown in March 2020 we had taken the opportunity to gather feedback from our community to better plan for future pandemic planning and this lent itself well when considering changes to how we provided care and support, particularly around labour, birth and postnatal hospital care.

There was a huge amount of activity to further refine hospital pathways for any admissions (COVID – 19 vs non COVID – 19 cases). Communication was daily across the hospital campus and prioritisation tools were developed in case they were required given the anticipated impact of COVID – 19 on the workforce and non-clinical staff that held practising certificates were re-deployed to cover clinical roles

The Canterbury Hauora Coordination Hub was established, comprising of a number of agencies including health that could work collaboratively in response to COVID – 19. Key members of our maternity team worked alongside the hub, in particular our COVID – 19 liaison midwife.

Resources were continually developed to promote vaccination for māmā and whānau and to ensure accurate information on COVID -19. These were shared across districts, providing a variety of consistent health literacy for our different community groups.

COVID – 19 LMC LIAISON ROLE

CATHERINE RIETVELD
COVID – 19 LMC LIAISION MIDWIFE

The COVID - 19 Liaison Midwife (CLM) role was reinstated before widespread community infection and was brought up to speed quickly with the pandemic response requirements and able to answer questions from LMC's in a rapidly evolving environment.

Regular across sector meetings helped generate "one source of truth" and was remunerated for eight hours per week.

The 2020 experience had taught us about information overload, so we were keen to avoid this and we needed to share information in a timely manner, especially as recommendations changed as the realities of the pandemic emerged and the CLM was able to develop information sheets for LMC's to give to COVID – 19 positive māmā.

Collaboration between the local hospitals and the Regional New Zealand College of Midwives (NZCOM) was pivotal in the development of a safe platform for information sharing.

Regular interagency meetings (1-3 times a week) between all agencies meant that we were all sharing the same information.

During this time, the CLM & LMC Liaison midwife also produced a regular update which was published on the regional NZCOM webpage and sent to all access agreement holders.

A triage tool for the referral of COVID – 19 positive māmā was developed by the CLM with input from Directors of Midwifery and Obstetrics which was uploaded to both Expect and MMPO enabling LMC's to access and refer.

Referrals were emailed to maternity outpatient services at CWH where they were triaged according to gestation and comorbidity and a care plan was developed. It was Important for all COVID – 19 positive māmā to be referred as there was not a lot of data on the impact of the Omicron variant on pregnancy.

OVERVIEW OF MQSP PRIORITIES 2020/21

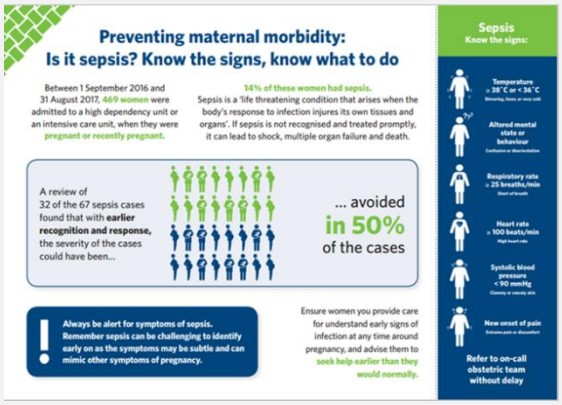
This table summarises the quality improvement work undertaken by our Maternity Services as planned and approved by the Maternity Clinical Governance Group for 2020/21. The work is the result of interdisciplinary collaboration and the involvement of consumer representatives.

- Indicates that the work has been completed and / or in business as usual phase
- Indicates that the work is in progress / underway and nearing completion
- Indicates that there is still a significant amount to achieve before completion

	Priority area	Progress Report	Status
1.	Implementation of NEWS/NOC as per national roll out *HQSC Patient Deterioration Programme. 2019*	The NEWS/NOC chart has been live in Waitaha since February 2021. Midwives and nurses have been appointed in all Waitaha maternity units as NEWS/NOC auditors; either as a part of their clinic portfolio or the Quality Leadership Programme/Professional Development and Recognition Programme. Having dedicated auditors has ensured that monthly audits are completed to monitor the post-implementation phase of the project and to continue to identify any areas for improvement or further education. Work has been underway to improve the current audit tool developed by the ACC as a part of the NE taskforce projects. To simplify the audit process we are now using Microsoft forms. Following a trial we commenced auditing using this application on the 1st July 2022 across all clinical areas. Audit results are reported regularly within the maternity and neonatal services at both clinical and governance level. The NOC/NEWS project has now been officially included in the MQSP programme of work.	● ● ● ● ●
2.	MEWS audit and case review Morbidity review identified through trigger tool *HQSC Patient Deterioration Programme. 2019*	Monthly audits of MEWS charts continue in all Waitaha maternity units. As with the NEWS/NOC audit process midwives and nurses have been appointed as MEWS auditors. Outcome measures post implementation are: - *Number of escalations to the emergency team or equivalent (excluding intra-partum calls) per month.* Any escalation or emergency calls captured by the main switchboard/telephone office are reviewed. - *Number of intensive care or high dependency unit admissions for pregnant or recently pregnant (within 42 days) women per month.* All ICU admissions are notified to the MQSP coordinator and a clinical review is completed.	● ● ●

	Priority area	Progress Report	Status
		- *Number of Safety1st (incident reporting application used in Te Waipounamu) reported regarding failure or delay in* escalating care All Safety1st submissions are reviewed by the Maternity Quality Coordinator and escalated to the incident review group as required. Audit results are reported regularly within the maternity and neonatal services at both clinical and governance level. There is continued work to rollout MEWS across the rest of the Waitaha clinical areas as national work on the maternity module for Patientrak progresses.	 ● ●
3.	Encouraging low-risk women to birth at home or in a primary facility Promotion of primary birthing facilities *MQSP 5 of 2019/20 priorities and action plan* *NMMG Work plan, 2019* *Canterbury Maternity System Strategic Framework, 2019*	Increasing birthing numbers and occupancy of our primary maternity units has and continues to be a principle focus for our service. In May 2022 the Oromairaki maternity unit opened in Rolleston to improve access to health services for the rapidly growing Selwyn population. Te Whatu Ora's new central city primary birthing unit (Kurawaka: Waipapa) is underway and project leads have worked extensively with user groups to complete the design of the internal layout of the unit that meets the needs of the community. The unit will be located 0.5kms from CWH, with four birthing rooms, 20 post-natal rooms, two whānau rooms, an education room and six assessment rooms. There has been a continued increase in primary and home birthing since 2013 as shown in Figure 4, page 21.	● ●
4.	Equitable access to postpartum contraception, including regular audit *NMMG Workplan, 2019*	An update on work in this area is given on page 49.	●
5.	Reduce preterm birth and neonatal mortality *NMMG Workplan, 2019* *PMMRC recommendations, 2021*	In 2021 and 2022 our pre-term birth rates were 16.4% and 16.0% respectively. As a service we continue to monitor these rates locally and report and reflect on the NZ Maternity Clinical Indicators. The Timing of Birth Assessment (TOBA) group formed in mid-2021 as a new multidisciplinary group with representation from midwifery, obstetrics, fetal maternal medicine, neonatal and with quality support, to review referrals for planned inductions of labour and elective caesarean sections. The objectives for commencing TOBA group were to review referrals and agree using a consistent, evidence informed approach (taking the views from all the team into consideration) in the decision about timing of the birth. This then created a clear pathway for pregnant wāhine.	 ● ●

	Priority area	Progress Report	Status
		In addition, the intention was: - To assist with capacity management of NICU in a multidisciplinary forum for timing of planned deliveries. - To apply consistency to timing of births for specific obstetric and fetal indications. - To assist Birthing Suite and Maternity Unit manage flow of wāhine/women. - To provide collegial support to all involved with the woman's care and shared accountability for recommendations and decisions. - Clarify pathways and provide an improved consistent service for māmā and pēpi. On completion of reviewing the referral, the management plan and recommended date is agreed, the case is booked into the Birthing Suite system at CWH and then communicated to the relevant referrer who advises/liaises with the wāhine/woman.	
6.	To continue to improve the screening and referral rates of women for family violence *MQSP 6 of 2019/20 priorities and action plan* *Canterbury Maternity System Strategic Framework, 2019*	Work in this area continues to improve family screening results for pregnant women. In 2022 we launched a family violence screening tool for Women's' outpatient's clinics, maternity assessment unit, day assessment unit and maternal fetal medicine unit. The poster is multilingual with ten languages identified as being the most common in our community.  Family violence resource boxes were also set up in all areas which contain a comprehensive range of resources and clear escalation for positive disclosures. In 2022 the maternity areas implemented Cortex (an app for iPhones and iPads) that digitises clinical documentation. As a part of this a family violence screening framework, consistent with paediatrics, was developed to further enable staff in screening and better capture data for audit.	

	Priority area	Progress Report	Status
7.	Monitor key maternity indicators by ethnicity to identify variations in outcomes & improve areas where there are differences in outcome Co-design models of care to meet the needs of Indian women *PMMRC Recommendation, 2021* *Canterbury Maternity System Strategic Framework, 2019* *CDHB District Annual Plan, 2021*	We continue to review local data and analyse using Level 2 ethnicity to determine our local outcomes and potential issues of health equity. We continue to work with our consumer group and community as we develop quality initiatives and implement projects. We encourage and support consumer representation at a national level in the development of clinical maternity guidelines that impact on our community groups, for example, Gestational Mellitus Diabetes.	
8.	Implementation of HQSC maternal morbidity review toolkit and SAC rating (maternal & NE case review) *MQSP 7/8 of 2019/20 priorities and action plan* *PMMRC Recommendations, 2021*	There is continued work to review current processes in place for reporting through to our incident management system - Safety 1st. We are also working to improve our team liaison regarding NE cases to ensure all are reported (including later diagnosis). We have explored adopting the HQSC maternal morbidity review toolkit through our corporate quality team, but at this stage we are awaiting the implementation of the new national Serious Adverse Event (SAE) Healing, Learning and Improving from Harm policy.	
9.	Use of the Health Equity Assessment Tool (the HEAT) to assess services for the impact of health equity *Maternal Morbidity Working Group, 2019*	Inservice education and workshops held to socialise using the HEAT tool both within our maternity service and the wider hospital campus. Currently trialling a localised Hauora Māori Equity Toolkit within our division (paediatrics) to meet the principles of equity of outcomes for our community groups. The toolkit provides a pragmatic approach to ensuring equity and outcomes are woven into the project planning.	
10.	Establish maternal sepsis bundle kits to address human factor components, such as stress in high-acuity settings Establish clinical pathways across primary and secondary/tertiary care to enable earlier recognition and treatment of maternal sepsis *Maternal Morbidity Working Group, 2019*	In 2022 sepsis bundles were introduced in all maternity and gynaecology areas including the primary maternity units and Chatham Islands. A report on this work is given on page 47.  	

OUR QUALITY INITIATIVES

Continued evaluation and improvement of our maternity services is vitally important to Te Whatu Ora Waitaha. It underpins our vision, values and goals for Women's and Children's Health and is encouraged to be a part of everyday business for the team. We are actively involved in the implementation of the wider organisations quality initiatives but also draw improvement projects from many sources, not limited to, but including:

- audit recommendations
- clinical case reviews
- incident investigation
- new evidence for clinical practice changes
- consumer feedback
- creating better health in our community

Our quality activities always strive to ensure the women's experience is optimal by reducing variation and being evidence based.

During 2021 and 2022 our team continued to work on many quality improvement projects, and for the purposes of our MQSP Annual Report we have chosen a handful to showcase our efforts and ongoing quality work.

SUPPORTING OUR COMMUNITY TO STAY WELL - ORANGA TORANGA

SMOKING CESSATION

RUTH TEASDALE
SERVICE DEVELOPMENT MANAGER, PRIMARY AND DISABILITY, PLANNING, FUNDING AND BUSINESS INTELLIGENCE

Te Hā – Waitaha Smokefree Support

Smoking cessation is a priority area for Te Whatu Ora Waitaha. Te Hā -Waitaha Smokefree Support has delivered a smoking cessation pregnancy incentive programme since 2017.

The programme provides support through a Quit Coach, who provides personalised support (either individually or in a group) and access to free nicotine replacement therapy, patches, gum, lozenges and QuickMist.

The Quit Coach also talks with pregnant women and their whānau about:

- remaining smokefree after the birth;
- safer sleep; and
- smokefree homes and cars.

Incentives to celebrate smokefree milestones include:

- Provision of a $50 voucher for all pregnant women who attend an initial session with Te Hā – Waitaha
- Further vouchers are provided for those who enrol in the programme when they reach certain points in their smokefree journey
- Pēpi pods encourage safer sleep and are available free to all pregnant women through the programme.

From January 2021 to December 2022 the service received 346 referrals of Hapū māmā. Over this time 244 Hapū māmā enrolled onto the programme, of which 188 made quit attempts. A total of 124 reached successful smokefree status.

Funding to upscale the programme with a specific lens on Hapū Whānau Māori and Pasifika was approved at the end of 2022. This has enabled the appointment of a health promoter/quit coach to drive this kaupapa. The goal is to engage with communities to encourage and invite those who have strong connections with these communities to refer and so collectively all support hapū whānau Māori and Paskifika towards their smokefree futures.

https://www.facebook.com/SmokefreeSupportCanterbury

SUDI PREVENTION

CANDICE CLEAVE
ORANGA TEAM LEADER, WHĀNAU MAI FACILITATOR,
TE PUAWAITANGA KI ŌTAUTAHI TRUST

Promoting safe sleep messages for pēpi and engaging with whānau continues to be a key focus for SUDI prevention. Referrals for a safe sleep space for pēpi are increasing. For the period 1January 2021 to 31 December 2022, we distributed 820 wahakura to whānau, not including those made at wahakura wānanga.

Te Puawaitanga ki Ōtautahi Trust has employed a Kairaranga (weaver) who now works directly with whānau to provide SUDI prevention messaging, as well as important tikanga around wahakura. Our Kairaranga attends sessions at Whānau Mai (kaupapa Māori antenatal education), Ūkaipō (community infant feeding and parenting support group), Whānau Whakapuawai Rākau Mauri session (maternal mental health) as well as with kaimahi of the Trust. These moments of connection all provide opportunities for SUDI prevention messaging across the spectrum of topics (breastfeeding, safe sleep, smoking cessation) to be discussed in a way that is honouring of whānau knowledge and experience.

There continues to be a low referral rate for whānau where smoking is occurring when we know that this group are at a significantly higher SUDI risk. Bed sharing continues to be the most commonly cited reason for referral. Referrals due to ‘No safe sleep space’ have increased. This highlights the financial challenges many whānau are facing. There has also been a increase in the numbers of whānau who have had minimal or no antenatal care. This is likely a reflection on the challenges whānau face trying to engage with midwifery care, especially for those with pēpi due around December/January.

Te Rā Mokopuna 2022 was the biggest event in the SUDI prevention mahi for 2022. The two day wahakura wānanga was held for 26 kaimahi, alongside 5 volunteer weavers. This wānanga was the first wahakura wānanga following covid. It provided an opportunity for kaimahi to learn the skills of making a wahakura as well as participating in SUDI prevention education and cross- organisation kōrero around how to support whānau in Waitaha. Major media outlets including Radio New Zealand and Te Karere covered the event providing a fantastic opportunity to share safe sleep messaging and this kaupapa with a national audience.

IMPROVING CLINICAL OUTCOMES

THE GROWTH ASSESSMENT PROTOCOL (GAP)

KATE CLAYTON
REGISTERED MIDWIFE /GAP EDUCATION MIDWIFE

The Growth Assessment Protocol (GAP) is an international, award winning program which aims to improve safety in maternity care with the predominant focus on identifying pregnancies at high risk of intrauterine growth restriction and improving the detection of small for gestational age babies. The programme consists of evidence based guidelines and risk assessment algorithms, education and accreditation of all staff involved in clinical care and rolling audit and benchmarking of performance. GAP is commissioned nationally by the Accident Compensation Commission (ACC). Thanks to a concerted effort by districts and clinicians including midwives, obstetricians and sonographers, all expectant mothers are now being cared for with evidence based maternity guidelines, including customised growth charts and birth weight centiles.

All districts in NZ have now implemented GAP. Each district has a champion midwife who is responsible for inviting clinicians to the workshops, completing 6 monthly audits of missed cases (Small for Gestational Age - not detected), disseminating the results and highlighting the learning opportunities.

Canterbury is fortunate to have an LMC champion Sharon Lindley, working alongside midwife Kate Clayton who works in Women's Outpatient Clinics. Kate has also recently been appointed by the Perinatal Institute as one of the new GAP education midwives, joining the NZ GAP Team. The Annual GAP report for July–Dec 2022 has recently been published by the Perinatal Institute and the themes, recommendations and statistics mentioned have been drawn from this. Missed case audits were undertaken in 326 cases throughout NZ.

GROW charts have been used widely in Canterbury for some time, but the generation of BW customised birth weight centiles was implemented in Canterbury in October 2021. A GROW chart and customised birth weight centile are linked by the chart ID and make a completed record for that baby.

Prior to going live, **13.9%** of records were complete, now they consistently sit above **90%** completion rate (rates of over 75% ensure that our data is reliable). However the recent NZ report identified that nationally 23% of GROW charts were created <30 days before birth, so a conscious effort needs to be made to generate only one GROW chart for each pregnancy.

Routine submission of a key set of items after each birth is an essential requirement of GAP and determines the accuracy of each unit's data, allowing them to monitor their performance in SGA detection and referral, as well as benchmarking against National GAP user averages. Nationally from

July-Dec 2022, the SGA detection rate was **43.4%**, which is **more than double** the pre GAP implementation rate baseline of **21%**. This statistically significant increase has occurred without an increase in obstetric intervention.

Detection rates for <3rd centile were 63.6%. Pleasingly, SGA detection rates in Māori and other groups were comparable if not better than national averages, despite Māori being at increased risk. TWO SGA detection rate comparably for <10th centile at the end of Feb 22 was **40.3%**. Detection of <3rd centile was **51.3%** but has been as high as 70% earlier in the year.

Nationally a substantial portion of the SGA pregnancies <10th centile and SGA <3rd centile respectively were undelivered at 40 and 38 weeks. Our statistics at end of Feb 2022 showed that 37% of <10th centile babies birthed at or after 40+0 and 76.3% of <3rd centile birthed at or after 38 weeks gestation.

The large variation between districts suggests a need for more targeted education and this is expected to be aided by the impending release of the new SGA guidelines. Currently we have approx. 200 midwives (LMC and core) 24 obstetricians and 4 nurses accredited. The expectation is that at least 75% of all clinicians attend a GAP interactive training workshop via ZOOM biannually, with an online self - directed refresher online in between.

FETAL MEDICINE NETWORK

NIC HARRISON
MIDWIFE – FETAL MEDICINE, TE WHATU ORA WAITAHA

Kia Ora my name is Nic Harrison and I am a core midwife working in the Fetal Medicine (FM) Unit at Christchurch Women's Hospital.

Fetal Medicine receives referrals from the LMC, GP and Obstetric specialist community within the Ōtautahi catchment area and accepts Senior Medical Officer (SMO) referrals from the remainder of the Te Waipounamu/ South Island excluding Nelson/Marlborough.

Our department cares for hapū wāhine and their whānau who are navigating a more complex pregnancy pathway. This can be due to high risk screening results, multiple births, complex history, structural fetal anomalies and maternal or fetal medical conditions that can negatively impact a baby in utero. Our service provides thorough assessment, screening, diagnostic testing and other specialist procedures and fetal therapies. Support and holistic care plus a high level of commitment are also integral to our services.

In 2022, our Christchurch FM unit carried out a combined total of 1327 appointments, comprising of 529 new patients and 798 follow up appointments. 124 invasive procedures for diagnostic screening were performed and we increased our midwifery appointments for low risk Non-invasive prenatal screening (NIPs) consultations. We carried out over 10 complex fetal therapies including: intra-uterine blood transfusions, intra-uterine pleural shunt insertions and amniotic fluid drainages which in many instances are live-saving fetal therapies.

In addition to this we undertook, fetocide procedures and co-ordinated medical and surgical terminations for major structural anomalies, chromosomal abnormalities and inherited genetic conditions. Informed parental choice is a large part of our work which leads to supporting whānau through very difficult decision-making processes.

FM facilitated 20 Video Conferences with Starship Hospital for complicated cardiac anomalies and arranged over 45 consultations with paediatric surgeons, neonatal doctors and other specialist disciplines. This approach ensures our whānau have more knowledge of fetal conditions, chromosomal abnormalities, surgical correction and treatment pathways/plans prior to the birth of their pēpi.

At a National level, The New Zealand Maternal Fetal Medicine Network (NZMFM) (Wāhi-Rua) was re-established in 2021 which is an exciting development for our specialty. This was following the formation of the National Advisory Group by The Ministry of Health (now called Manatū Hauora), with subspecialists from around the country including other allied medical disciplines. The National Leadership Group's (NLG) primary purpose is to implement the MFM Action plan and provide overall governance to the NZMFM (Wāhi-Rua) network, ensuring its members have full access to advisory support. The NLG will update Key Performance Indicators, clinical guidelines and aims to create a new webpage with evidence based clinical information and whānau focused content.

The NZMFM Operations Group (2022) has been formed to support the NLG with their objectives and I am very fortunate to be part of this working group along with MFM sub-specialists, midwives, radiologists, neonatal doctors, Māori health advisors and consumer members. We have been tasked with updating Clinical Recommendations of Practice which will ensure a consistent national approach to the management of complex fetal anomalies. Another focus is to implement quality national data collection practices, improve clinical triage turnaround and appointment waiting times which may eventually lead to a national referral pathway.

The Maternal Fetal Medicine network was very proud to be gifted the name Wāhi Rua by some of the Te Tai Tokerau Rangatira. The name describes of being in two spaces (Wāhi-space, rua-two) and the two spaces are in haputanga and birth and in Te Ao Marama and Te Ao Wairua. (A full explanation is available in Fetal Medicine).

The NZMFM Mission Statement is as follows:

The NZMFM Network is dedicated to delivering safe, equitable and sustainable Maternal Fetal Medicine services to the women, pēpi and whānau of Aotearoa New Zealand.

We will provide support for the MFM service to ensure nationally consistent outcomes, accessibility and collaborative care for all that enter into the service.

The NZMFM Network is dedicated to ensuring the ongoing clinical education of staff, promotion of evidence-based care and research, and the collegiality and ongoing wellbeing of practitioners within the Network.

Lastly, our Network is having its first National update and education day in Wellington in May 2023. This will provide a great platform for us to come together and strive towards achieving our National initiatives and objectives outlined above.

NEWBORN HEARING SCREENING

ANGELA DEKEN
UNIVERSAL NEWBORN HEARING SCREENING COORDINATOR, TE WHATU ORA WAITAHA

The 2021-2022 outcomes for the Canterbury Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP).

Approximately 1 baby per thousand (0.1%) is born each year in New Zealand with a moderate to profound hearing loss. Canterbury rate over this period is **0.2% of births**. That equates to up to 180 babies each year nationally. The first six months of a baby's life is a critical period for language development. Lack of exposure to language during this period, such as caused by a hearing loss, can affect a child's development, communication skills, and educational and career achievements. The early detection of hearing loss and the initiation of early medical and educational interventions has been demonstrated to significantly improve long-term outcomes for children with hearing loss and their parents/guardians/ whānau.

The aim of the programme is:

*Early identification of newborns with a hearing loss so that that they can access timely and appropriate interventions, inequalities are reduced and the outcomes for these children, their families and, communities and society are improved (*NSU, 2016).

New born hearing screening is offered to all new parents/whānau for babies born in the Canterbury District area regardless of place of birth. The goal is to complete screening by 1 month of age so if a clear result is **not** obtained the baby can be seen in audiology, so a diagnosis can be ascertained by 3 months of age. This means that support and habilitation can be put in place by 6 months of age. This is the goal of 1,3,6 from the NSU.

2021 to 2022 outcomes for babies and whānau in the Canterbury District UNHSEIP

Eligible babies 13511	Number born minus those babies who are deceased or transferred out of the Canterbury area.
Families/whānau offered hearing screening	99%
Babies who completed hearing screening	97.9%
Families/whānau who declined hearing screening	0.8%
Families/whānau who Disengaged/DNA/incomplete screening	1%
Families/whānau lost and missed to the programme	0 .1%
Babies referred to audiology	1.1% of completed screens
Babies requiring audiology Surveillance due to a risk of progressive hearing loss but who passed their hearing screen	0.8% of completed screens
Babies who had a Pass no follow up outcome from screening	98%

Audiology outcomes:

156 babies were referred to audiology in 2021/2022, of those:

77% completed audiology by 3 months of age

14 babies were not brought to audiology so were not diagnosed by 3 months and are being followed up in audiology but have been discharged from the UNHSEIP.

28.6% of babies referred to audiology have a confirmed hearing loss

54.4% of babies had normal underlying hearing but needed further audiology assessment due to middle ear dysfunction

16.9% of babies had normal hearing and were discharged from audiology

The Predictive value for babies having an issue with their hearing being either a temporary conductive loss or a permanent hearing loss: 83%

Audiology confirmed 39 babies who had a hearing loss.

Of those:

Bilateral Sensorineural hearing loss	13
Unilateral Sensorineural hearing loss	5
Bilateral mixed hearing loss	10
Unilateral mixed hearing loss	3
Bilateral Conductive hearing loss	1
Unilateral conductive hearing loss	6
Bilateral auditory neuropathy spectrum disorder	1
Unilateral auditory neuropathy spectrum disorder	0

Babies were Referred to	
23	Adviser on Deaf Children
36	Ear, Nose and Throat specialist services
31	Developmental Paediatrics service
27	Children's hearing aid service at University of Canterbury
5	Referred to Southern Cochlear implant programme
	2 babies have had cochlear implants, 1 has planned surgery for implant and 2 being currently reviewed

Risks factors for hearing loss:

Of the diagnosed babies:

- **43% had no risk factor**
- 20% had syndrome risk related to hearing loss
- 20% had a family history of hearing loss
- 15% had microtia/atresia

Waitaha [Canterbury] District UNHSEIP has identified a decrease in screening coverage for some ethnic groups and a slight decrease in the overall percentage of screening completion for 2021/2022. Anecdotally, this could be attributed to the impact of COVID-19, where parents possibly did not feel comfortable to leave their home or visit a hospital during the pandemic. A Māori screener has joined the UNHSEIP team who will focus on reviewing the disparities in screening completion rates for Māori. They will work with the rest of the UNHSEIP team and families to codesign the service delivery model to better meet the needs of Māori. One of strategies implemented to improve screening rates amongst Māori is to offer more home visiting than previously possible. We will be monitoring rates closely to see if this has a positive impact.

Overall the Waitaha [Canterbury] District UNHSEIP is mostly meeting the National Screening Unit's established outcomes. 2021/2022 has presented unprecedented challenges for the programme, particularly around staffing. Sincere thanks must be given to the Waitaha UNHSEIP screening team who with their commitment to the programme and flexibility has meant that the percentage of babies completed screening has been well over the NSU target of 95%.

KŌRERO MAI – TALK TO ME

SAM BURKE
MATERNITY QUALITY SAFETY PROGRAMME (MQSP) COORDINATOR, TE WHATU ORA WAITAHA

In October 2021 'Kōrero Mai -Talk to Me' family escalation process was implemented at Christchurch Women's Hospital. The rollout of the programme followed on from the paediatric areas at Christchurch Hospital, with the purpose of encouraging māmā and their family/whānau to speak up if they noticed a deterioration in their own or their pēpi condition.

The Health Quality & Safety Commission family escalation project, Kōrero Mai provides a clear, easy-to-use way to raise the alarm of a change in condition and can prevent delays in providing medical help.

Kōrero Mai is a three tier system that gives an increasing escalation pathway culminating in an 0800 number that is relayed through to the telephone office and triaged.

Māmā are referred to ICU Outreach and pēpi to NICU as required.

Posters are located at each bedside in our 45 bedded Maternity ward, Birthing suite, Acute observation unit, Day assessment unit and Maternity assessment unit.

Escalations to the 0800 number are captured by the telephone office for review and staff are encouraged to report any Kōrero mai escalations in our local incident management system – Safety1st. Any admissions to the intensive care unit are captured by the MQSP Coordinator and clinically reviewed for any learnings.

Orientation for māmā and whānau/family to korero mai is captured in Cortex (an app for iPhones and iPads) that digitises clinical documentation.

Maternity Kōrero mai launch day. Pictured: Shae Bishop, Midwife Manager, Maternity Ward with Corrie, Kingi and baby Maziah.

SEPSIS BUNDLES

SAM BURKE
MATERNITY QUALITY SAFETY PROGRAMME (MQSP) COORDINATOR, TE WHATU ORA WAITAHA

In September 2022 sepsis bundles were implemented in all maternity areas following recommendations from the HQSC Second Annual Report of the Maternal Morbidity Working Group (2017)

The MMWG recommended maternity areas:

1. *establish septic bundle kits to address human factor components, such as stress in high-acuity settings, within the next 18 months. The kit should include all requirements of the sepsis 6 + 2, and*
2. *consider establishing clinical pathways across primary and secondary/tertiary care to enable earlier recognition and treatment, while waiting for nationally consistent guidelines to be developed.*

This project has taken an extended amount of time due to the COVID-19 pandemic and the capacity for new work within the multidisciplinary team, in particular, our Antimicrobial Stewardship Committee who were pivotal to the success of this mahi.

As a part of this project there was a comprehensive review of the gynaecology (formerly puerperal sepsis guideline) to align with Best Practice Advocacy Centre NZ (BPAC) guideline (2018), Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) guideline (2017) and Maternal Morbidity Working Group (2017) findings and resources. This included liaison with Waitaha Canterbury Antimicrobial Stewardship Committee to standardise antibiotic regimens.

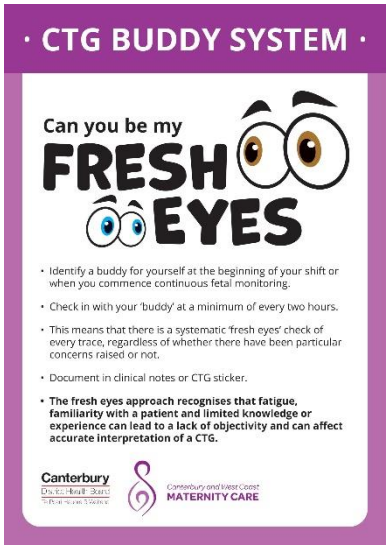
A sepsis pathway was developed for all pregnant women up to six weeks postpartum alongside 'quick grab' sepsis resource boxes for all maternity wards/units, Chatham Islands and gynaecology areas to enable rapid response to suspected sepsis.

National Sepsis Day September 2

FRESH EYES - CARDIOTOCOGRAPH (CTG) BUDDY SYSTEM FOR FETAL MONITORING

SAM BURKE
MATERNITY QUALITY SAFETY PROGRAMME (MQSP) COORDINATOR, TE WHATU ORA WAITAHA

It is well recognised internationally that fatigue, familiarity with a māmā, varied experience and knowledge can impact on the accurate interpretation of fetal monitoring and wellbeing.



In July 2022 Waitaha maternity services re-launched the CTG buddy system, a standardised approach for independent review and escalation, if needed of any fetal monitoring performed using a CTG.

The project work for this initiative included a review of the fetal monitoring maternity guideline and development of clinical pathways for both antenatal and intrapartum fetal monitoring, including escalation and/or referral processes for all maternity areas, including the primary maternity units.

All changes have been incorporated into our local documentation including the partogram used for recording observations during labour and birth.

This initiative is currently being audited to evaluate the effectiveness of the intervention.

OBSTETRIC RESEARCH UPDATE

CARLENE FARNHILL
RESEARCH MIDWIFE – UNIVERSITY OF OTAGO

Closing the Knowledge Gap: What Factors May Affect Cleft Lip and Palate?

Ongoing recruitment of cases and controls for this study.

A gene-environment study of risk factors involved in cleft lip and / or palate. Aiming to identify possible risk factors in terms of prevention, reoccurrence and knowledge of potential causes, which may benefit CL/P affected children and families.

Respiratory Syncytial Virus Vaccine

This is a phase 3, randomized, double blinded, placebo-controlled trial to evaluate the efficacy and safety of a Respiratory Syncytial Virus (RSV) Perfusion F Subunit vaccine in infants born to women vaccinated in pregnancy.

Recruitment now finished- study to be concluded at the end of this year.

C*STEROID

Ongoing recruitment for this trial.

The main aim of the C*STEROID Trial is to assess whether giving women antenatal corticosteroids prior to planned Caesarean Section at 35+0 to 39+6 weeks safely reduces the risk of breathing problems for baby after birth.

The C*STEROID Trial is a multi-centre, triple blind, placebo controlled, parallel, phase 111 trial with randomisation at participation level (1:1 allocation ratio). Participants in this study are assigned randomly to receive either the corticosteroid medication betamethasone or a placebo injection containing saline.

MaPINO

This study is to commence this year.

This study is focusing on whether inflammatory conditions, such as psoriasis, influence a child's development. Participants will have dedicated surveillance of their psoriasis, and all children will have a neurodevelopmental assessment at 2 years of age.

EQUITY - MANA TAURITE

IMPROVING EQUITY FOR LONG TERM CONTRACEPTION

RACHEL THOMAS
PORTFOLIO MANAGER, PLANNING & FUNDING, PRIMARY CARE AND DISABILITY TEAM

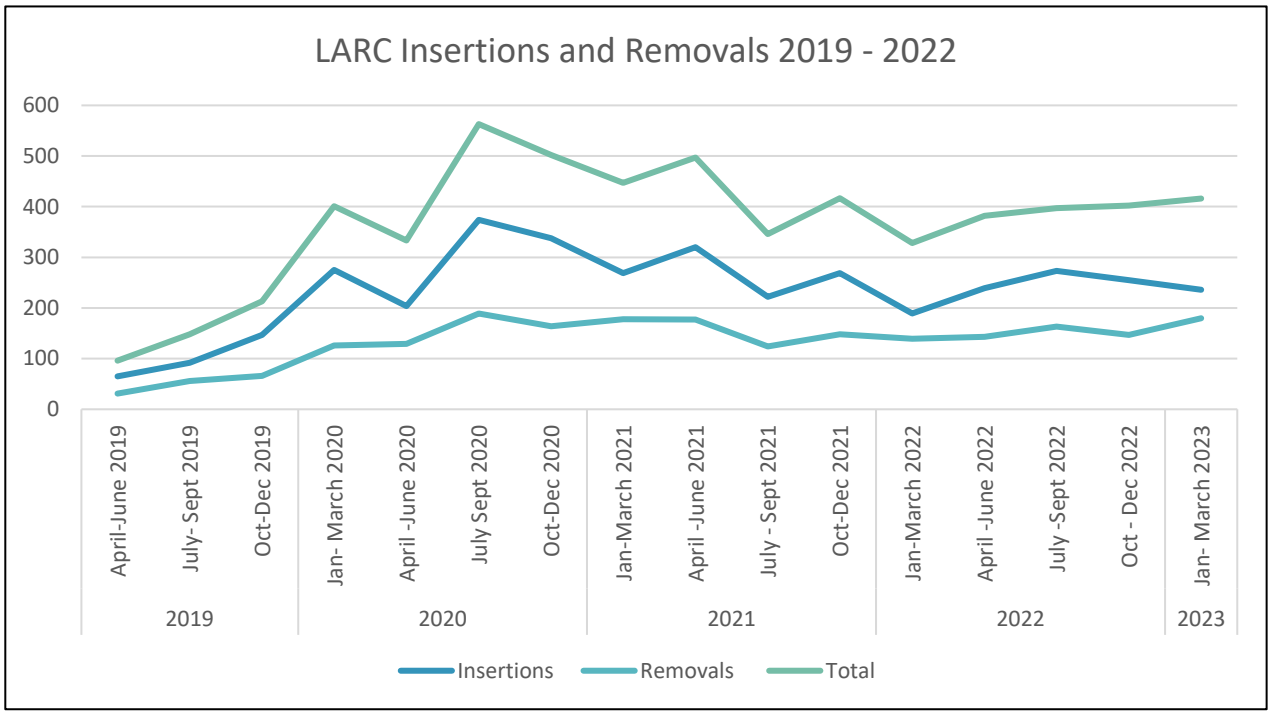
Long acting reversible contraception (LARC) are available via all general practices either at the clinic or via practice to practice referrals. The National training programme has been contracted to another provider but NZ Family Planning still has the online training modules available, practical training will be provided by the new provider. Training continues to be an ongoing problem.

ELIGIBILITY

Women, transgender men and non-binary people who have a uterus and;

- are a resident in the Waitaha Canterbury area and enrolled in a Canterbury General Practice and;
- hold a community services card; or
- are under 18-year-old; or
- Māori and Pacific; or
- alcohol or illicit drug dependent; or
- a high user of Maternity Services (hx of TOP, unplanned pregnancy or miscarriage in the last 5 years); or
- have a long term, severe mental health disorder including any psychotic disorder, BAD, severe depression.

1) **Free Long Acting Reversible Contraception (LARCs).** Free insertion and removal of funded LARCs for the eligible population. No additional charges for consumables or a co-payment may be charged.
2) **Very Low-Cost Consultations for Contraception.** A maximum $5.00 co-payment may be charged.



Outgoing Chair, Women's Health Consumer Advisory Council Jen Coster (2022).

OUR OUTCOMES

NZ MATERNITY CLINICAL INDICATORS ANALYSIS

The MOH data New Zealand Maternity Clinical Indicators 2019 and 2020 (2022) was published in October 2022. The publication shows key maternity outcomes for each area for 2019 and 2020 and is the most recent published Te Whatu Ora Health New Zealand data available for compilation of this Annual Report.

The analysis below shows Te Whatu Ora Waitaha performance and position in relation to both the indicators and national rate. Percentage figures are from either the area of domicile or the facility of birth, as indicated, and Clinical Indicators 2, 3, 4, 5, 6, 7, 8 and 9 are based on the standard primiparae only.

The "standard primiparae" (SP) make up approximately 15% of all births nationally.

The standard primiparae group are:

- Aged 20 – 34 years, with uncomplicated singleton pregnancies
- Birthing at full term with a cephalic presentation

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

The purpose of these indicators is to increase the visibility of quality and safety of maternity services and to highlight areas where quality improvement can potentially be made.

As a maternity service we have, and continue, to use these clinical indicators in developing our quality planning. As a service we have deliberated that the eight clinical indicators that apply the SP is not reflective of the total wider birthing population due to the narrow criteria and consequently small numbers. In order to better analyse these clinical outcomes, we have also reviewed our total birthing population as seen from page 59.

Of the remaining twelve clinical indicators, eight apply to all women giving birth in New Zealand, one to all babies born in New Zealand and three to babies born at term (between 37 and 41 completed weeks' gestation).

Findings from this work together with the clinical indicators have directed us in developing our one-year MQSP priorities and action plan for 2023/24.

Table 2. Te Whatu Ora Waitaha Clinical Indicator Analysis 2019 and 2020

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower national rate	National Rate
INDICATOR 1 - REGISTRATION WITH AN LMC IN THE FIRST TRIMESTER OF PREGNANCY (ALL POPULATION GROUPS)		79.3%	82.1%	85.3%	↑	74.1%
Comment: This indicator has continued with an upward trend overall since 2009 for all ethinc groups and as a district we remain above the national average (see Appendix 2). We continue to focus on opportunities for improvement; in particular equity of access to maternity services.						
Indicator	**Title**	**2018 Waitaha Canterbury Rate**	**2019 Waitaha Canterbury Rate**	**2020 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**National Rate**
INDICATOR 2 - SPONTANEOUS VAGINAL BIRTH (ALL POPULATION GROUPS)		SP 69.1%	SP 61.0%	SP 59.0%	↓	SP 62.1%
Comment: 2020 Standard primiparae rates were below the national average, there had been improvement since 2009, but a decrease in 2016 and all subsequent years (see Appendix 2). Action: This continues to be a focus for our service and remains a priority for our quality improvement action plan for 2023/24.						
Indicator	**Title**	**2018 Waitaha Canterbury Rate**	**2019 Waitaha Canterbury Rate**	**2020 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**National Rate**
INDICATOR 3 - INSTRUMENTAL VAGINAL BIRTH (ALL POPULATION GROUPS)		SP 20.2%	SP 21.2%	SP 21.4%	↑	SP 19.2%
Comment: Our rates remain higher than the national average and the rate has continued to increase since 2015 (see Appendix 2).						

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 4 - CAESAREAN SECTION (ALL POPULATION GROUPS)		SP 17.7%	SP 17.5%	SP 18.1%	↑	SP 17.6%

Comment: The SP rate had been consistently below the national average from 2012 – 2017 but has trended upwards since 2015 through to 2020 at 18.1%, (see Appendix 2).

The rate of caesarean section for Māori and Pacifica are 15.2% and 7.9% respectively with Māori showing an annual increase in rate since 2017.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 5 - INDUCTION OF LABOUR (ALL POPULATION GROUPS)		SP 6.3%	SP 6.3%	SP 9.9%	↑	SP 9.2%

Comment: Nationally there is a consistent increase in induction of labour rates. The SP group for the district remained relatively static after a sharp increase of 2.1% in 2016. 2020 rates show a sharp increase again of 3.6% (see Appendix 2).

Quality work in this area is underway and is included in our MQSP quality action plan for 2023/24.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 6 - INTACT LOWER GENITAL TRACT (ALL POPULATION GROUPS)		SP 24.9%	SP 26.6%	SP 27.5%	↑	SP 26.7%

Comment: The rate of intact lower genital tract for the SP group had remained static since 2009. From 2014 - 2017 the SP rate was higher than the national average but the rate had declined again in subsequent years. The last data set shows that we are now just higher than the national average.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 7 - EPISIOTOMY WITHOUT THIRD AND FOURTH DEGREE TEAR (ALL POPULATION GROUPS)		SP 27.2%	SP 27.1%	SP 27.1%	↑	SP 26.1%
Comment: The rate of episiotomy without 3rd and 4th degree tear for the SP group remains higher than the New Zealand rate and has been attributed to our instrumental rates. The rate has remained static since 2018.						

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 8 - THIRD OR FOURTH DEGREE TEAR WITHOUT EPISIOTOMY (ALL POPULATION GROUPS)		SP 4.5%	SP 5.6%	SP 5.6%	↑	SP 4.3%
Comment: Our rates for the SP group had continued to decrease since 2015, following quality improvements put in place as a part of the MQSP priorities and action plan. The last two years data shows an increase in rates again and has been identified to include again in our MQSP quality plan for 2023/24.						

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 9 - EPISIOTOMY WITH THIRD OR FOURTH DEGREE TEAR (ALL POPULATION GROUPS)		SP 2.1%	SP 2.7%	SP 3.2%	↑	SP 2.1%

Comment: This clinical indicator rate has continued to increase each year since 2017. This rate is now above the national average for the SP group. A repeat audit of our local data was carried out in 2021 to investigate further quality work that may be required in this area and several findings and recommendations were developed.

Action: We will continue to implement and evaluate our quality work in this area as discussed under clinical indicators 7 and 8.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 10 - GENERAL ANAESTHETIC FOR CAESAREAN SECTION (ALL POPULATION GROUPS)		4.7%	5.9%	4.2%	↓	7.8%

Comment: Canterbury rates for women having a General Anaesthetic (GA) for caesarean section remains lower than the national average.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATORS 11 AND 12 - BLOOD TRANSFUSION AFTER CAESAREAN SECTION AND VAGINAL BIRTH (ALL POPULATION GROUPS)		3.3% Caesarean 2.7% Vaginal	4.1% Caesarean 2.7% Vaginal	3.4% Caesarean 2.9% Vaginal	= ↑	3.4% Caesarean 2.1% Vaginal

Comment: This clinical indicator uses blood transfusion as a broad measure of excessive blood loss and a measure of severe, life threatening haemorrhage.

The rate for women requiring a blood transfusion following a vaginal birth has remained static but above the national average (see Appendix 2).

Action: Work on our local postpartum haemorrhage (PPH) rate remains one of the MQSP priorities. This work has included the:

- development of MBOP (Maternal Blood Optimisation) Guideline and Practice Improvement Strategy
- review of our PPH clinical guideline to include Misoprostol and Tranexamic acid for use in our primary units in consultation with the tertiary unit
- re audit of our PPH rates
- Multidisciplinary team project to identify ongoing quality work

Indicator	Title	2018 Waitaha Canterbury (n)	2019 Waitaha Canterbury (n)	2020 Waitaha Canterbury (n)	National (n)
INDICATOR 13 - DIAGNOSIS OF ECLAMPSIA (ALL POPULATION GROUPS)		(n = 0)	(n = 0)	(n = 0)	(n = 19)

Comment: This data refers to diagnosis of eclampsia during birth admission. Eclampsia was diagnosed 19 times in 2020 nationally, which is an increase of one in the previous report, there were no cases in Canterbury.

Indicator	Title	2018 Waitaha Canterbury (n)	2019 Waitaha Canterbury (n)	2020 Waitaha Canterbury (n)	National (n)
INDICATOR 14 - PERIPARTUM HYSTERECTOMY (ALL POPULATION GROUPS)		(n=4)	(n = 5)	(n = 3)	(n = 22)

Comment: In 2020 three cases of peripartum hysterectomy were reported. A review of local data is completed each year the MQSP report is prepared to ensure all cases are reported. These cases has been reviewed and appropriate management of care was noted.

Indicator	Title	2018 Waitaha Canterbury (n)	2019 Waitaha Canterbury (n)	2020 Waitaha Canterbury (n)	National (n)
INDICATOR 15 - MECHANICAL VENTILATION (ALL POPULATION GROUPS)		(n=3)	(n = 1)	(n = 0)	(n = 15)

Comment:

In 2020 no women were admitted to ICU and requiring ventilation during the pregnancy or postnatal period.

All Canterbury cases of pregnant or postnatal women requiring ICU admissions were reported via ICU to the MQSP coordinator. These notifications continue to be made and all clinical cases with an unexpected or adverse outcome are reported and reviewed through our Safety 1st incident management system.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 16 - TOBACCO USE DURING THE POSTNATAL PERIOD (ALL POPULATION GROUPS)		7.7%	7.0%	6.8%	↓	8.6%

Comment: This indicator monitors maternal tobacco use at two weeks postnatal. Our 2020 rate demonstrates that we are below the national average of 8.6%. The national rate has continued to decrease steadily as has Canterbury's rate.

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than national rate	National Rate
INDICATOR 17 - PRE-TERM BIRTHS (UNDER 37 WEEK'S GESTATION) (ALL POPULATION GROUPS)		7.0%	7.6%	8.0%	↑	7.9%
Comment: The rate of pre-term births for Waitaha has remained relatively static since 2009 (2009 = 7.9%, 2010 = 7.6%, 2011 = 8.0%, 2012 = 8.4%, 2013 = 8.0%, 2014 = 7.9%, 2015 = 8.2%, 2016 = 7.5%, 2017 = 7.8%) and this is comparable with other tertiary facilities in NZ.						
Indicator	**Title**	**2018 Waitaha Canterbury Rate**	**2019 Waitaha Canterbury Rate**	**2020 Waitaha Canterbury Rate**	**Higher or lower than the national rate**	**National Rate**
INDICATOR 18 - SMALL BABIES AT TERM (37 – 42 WEEKS GESTATION) (ALL POPULATION GROUPS)		2.3%	2.6%	2.4%	↓	3.0 %
Comment: Waitaha rates remain below the national average of 3.0% and remains consistent with previous data.						
Indicator	**Title**	**2018 Waitaha Canterbury Rate**	**2019 Waitaha Canterbury Rate**	**2020 Waitaha Canterbury Rate**	**Higher or lower than the national rate**	**National Rate**
INDICATOR 19 - SMALL BABIES AT TERM (BORN AT 40 – 42 WEEKS GESTATION) (ALL POPULATION GROUPS)		22.8%	34.4%	28.3%	↓	29.6%
Comment: The rate for small babies at term (40 – 42 weeks) for our district is lower than the national average. Quality work in this area has included development of the Timing of Birth (TOBA) guideline and implementation of the Growth Assessment Protocol (GAP).						

Indicator	Title	2018 Waitaha Canterbury Rate	2019 Waitaha Canterbury Rate	2020 Waitaha Canterbury Rate	Higher or lower than the national rate	National Rate
INDICATOR 20 - BABIES REQUIRING RESPIRATORY SUPPORT BORN AT 37+ WEEKS GESTATION (ALL POPULATION GROUPS)		1.6%	2.1%	2.5%	↓	2.7%
Comment: As noted in our previous MQSP annual report, as a district we have carried out a significant amount of work to investigate the discrepancy in neonatal data between local and MOH reported data. Further in the report we have reviewed and made comment on the locally collected data as reported to the Australian and New Zealand Neonatal Network (ANZNN) to identify any areas for improvement.						

Conclusion

The indicators show a high level of safety for both mothers and babies in Canterbury and that these continue to be above average for New Zealand. Data for almost all the indicators show continuing improvement compared to the previous 2018 figures.

A review of the maternity clinical indicators (both SP and total Canterbury population) and local data by the multidisciplinary team have identified areas for further review, and these are included in the 2023/24 priorities and action plan.

There is a need to carry on our work to reduce the number of caesarean sections, instrumental births, induction of labours and to continue with planned projects aimed at increasing our spontaneous vaginal birth rate.

LOCAL DATA ANALYSIS

The data in this section is from local Te Whatu Ora Waitaha maternity data sources and shows 2021 and 2022 in comparison, with percentage increase or decrease noted for the year where applicable. Data here is counted either in terms of all 'deliveries' which is a count of all mothers or in terms of 'births' which is a count of babies. The data relates to only births in Te Whatu Ora Waitaha facilities and so excludes data for homebirths or St. George's Hospital which is included as part of the overview of hospitals and primary birthing units in Waitaha Canterbury (page 22).

In previous MQSP reports we have reported on and reviewed our local data and aligned these clinical outcomes as closely as possible to the New Zealand Maternity Clinical Indicators series. These are shown from page 63.

For this 2021/2022 report we will also be using nine of categories from the Robsons Classification (WHO, 2017), which has been adopted by Waitaha following the implementation of Misoprostol for induction of labour (IOL) in October 2020. The reporting tool has been developed into a "live" dashboard using Power BI Data and Analytics Reporting and continues to be developed to better capture the data required for accurate analysis.

The Robson Classification was proposed by the World Health Organisation in 2015 as a global standard for measuring and comparing caesarean section (CS) rates across health facilities. The classification system is made up of 10 categories to provide a comprehensive tool for reviewing outcomes, see Appendix 4.

The Robson Classification report is also complimented by reviewing further clinical outcomes, with an analysis of the population groups that make up the Waitaha community. Analysis in this way enables us to determine our local outcomes, potential issues of health equity and areas for quality improvement.

QUALITY AND ANALYSIS OF ROBSON CLASSIFICATION REPORT DATA

As discussed previously, the development of this reporting tool is a work in progress, and it is anticipated that the validity of data will improve for future reports and we can better assess our CS rates. We have outlined the reasons for discrepancy in our disclaimer on page 4.

To make a robust analysis of the data the total number of CS and the total women birthing at Christchurch Women's Hospital should be identical (last lines of column 2 and 3). The data report shows a small amount of data is missing or incorrect (unclassified) and this accounts for 0.5% (2021) and 0.2% (2022) of women birthing.

Taking this discrepancy into consideration we can still make observations on the data reported using the Robson Classification Implementation Manual.

Indicators used to assess type of population and CS show:

- **A low ratio between Group 1 and 2 (less than 2:1) indicating a high induction/prelabour CS rate.**
- **Group 2 (2a and 2b) demonstrate a higher CS rate (usually consistent at 20-35%), 2021 data shows the CS rate for this group at 42.3% and 42.0% in 2022.**
- **Group 3 is higher than would be expected (no higher than 3.0%). It is suspected that women with previous caesarean sections have been incorrectly classified, but this would need further investigation.**
- **Group 5 (previous CS) contribute 25.4% (2021) and 21.8% (2022) respectively to the overall CS rate.**
- **Groups 1, 2 (2a and 2b) and 5 need to be investigated further for opportunities to reduce the overall CS rate.**
- **Group 9 should be 100% and so demonstrate opportunities for improvement in data collection.**

Findings from the analysis of Robson Classification identify further opportunities for quality improvement around data collection but also further exploration of the classification groups and areas that we can target to improve our CS rates.

Also, as the Robson Classification is adopted by more districts, we will have a consistent and standardised framework to look at CS nationally.

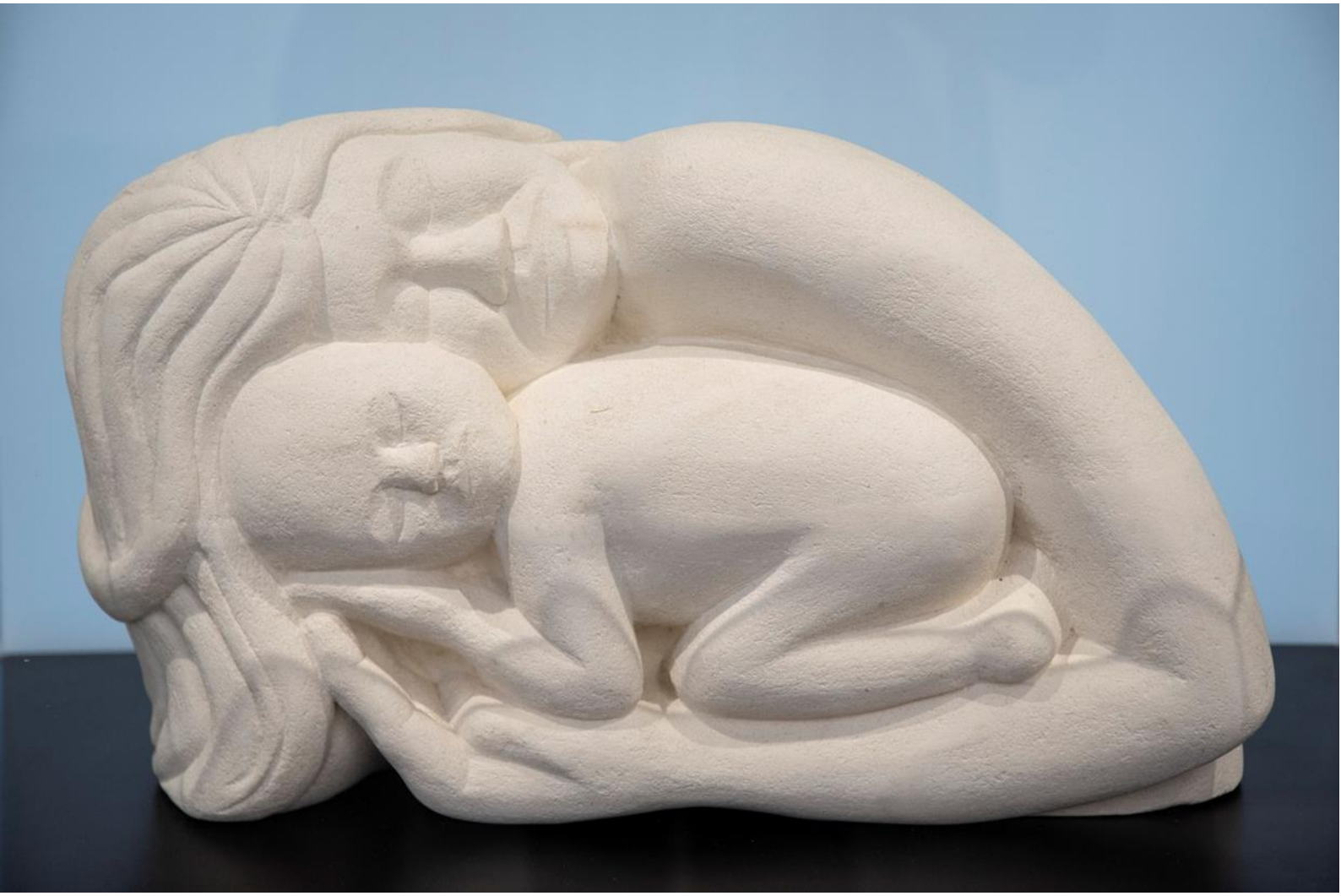


Table 3. Te Whatu Ora Waitaha Robson Classification report for 2021

Te Whatu Ora Waitaha Canterbury (CWH)		Period: January 2021 to December 2021				
Group	Number of CS in group	Number of women in group	Group size[1] (%)	Group CS Rate[2] (%)	Absolute group contribution to overall CS rate[3] (%)	Relative contribution of group to overall CS rate[4] (%)
1	284	1203	22.3%	23.6%	5.3%	13.5%
2	435	1027	19.0%	42.3%	8.1%	20.8%
3	131	944	17.5%	13.9%	2.4%	6.3%
4	297	830	15.4%	35.8%	5.5%	14.2%
5	531	692	12.8%	76.7%	9.9%	25.4%
6	110	116	2.1%	94.8%	2.0%	5.3%
7	81	88	1.6%	92.0%	1.0%	3.9%
8	57	101	1.8%	56.4%	1.0%	2.7%
9	26	28	0.5%	92.8%	0.5%	1.2%
10	131	323	6.0%	40.5%	2.4%	6.3%
Total*	2083 (n = 8 over)	5352 (n = 30 unclassified)	Total number of women delivered 100%		38.1%	99.6%

Unclassifiable: Number of cases and % [Number unclassifiable cases / (Total Number women delivered classified + unclassified) X 100]

1. Group size (%) = n of women in the group / total N women delivered in the hospital x 1

2. Group CS rate (%) = n of CS in the group / total N of women in the group x 100

3. Absolute contribution (%) = n of CS in the group / total N of women delivered in the hospital x 100

4. Relative contribution (%) = n of CS in the group / total N of CS in the hospital x 100

Table 4. Te Whatu Ora Waitaha Robson Classification report for 2022

Te Whatu Ora Waitaha Canterbury (CWH)			Period: January 2022 to December 2022			
Group	Number of CS in group	Number of women in group	Group size[1] (%)	Group CS Rate[2] (%)	Absolute group contribution to overall CS rate[3] (%)	Relative contribution of group to overall CS rate[4] (%)
1	250	1097	20.9%	22.8%	4.7%	12.5%
2	466	1110	21.1%	42.0%	8.9%	23.4%
3	109	960	18.3%	11.3%	2.0%	5.5%
4	333	877	16.7%	38.0%	6.3%	16.7%
5	435	563	10.7%	77.3%	8.3%	21.8%
6	121	123	2.3%	98.4%	2.3%	6.0%
7	73	79	1.5%	92.4%	1.4%	3.7%
8	52	77	1.5%	67.5%	1.0%	2.6%
9	27	34	0.6%	79.0%	0.5%	1.3%
10	125	334	6.3%	37.4%	2.4%	6.3%
Total*	1991	5254 (n = 1 over)	Total number of women delivered 100%		37.8%	99.8%

Unclassifiable: Number of cases and % [Number unclassifiable cases / (Total Number women delivered classified + unclassified) X 100]

1. Group size (%) = n of women in the group / total N women delivered in the hospital x 1

2. Group CS rate (%) = n of CS in the group / total N of women in the group x 100

3. Absolute contribution (%) = n of CS in the group / total N of women delivered in the hospital x 100

4. Relative contribution (%) = n of CS in the group / total N of CS in the hospital

Table 5. Gestation at Birth for total population 2021 - 2022 Te Whatu Ora Waitaha

Gestation at Birth	Number of Births 2021		Number of Births 2022	
Extremely preterm (<28 weeks)	40	0.72%	27	0.50%
Very preterm (28-31 weeks)	65	1.18%	25	0.47%
Moderate preterm (32-34 weeks)	118	2.14%	120	2.24%
Late preterm (35-36 weeks)	273	4.96%	269	5.03%
Term (37-41 weeks)	4931	89.76%	4867	90.99%
Prolonged (>42 weeks)	66	1.20%	66	0.77%
Total	**5493**	**100%**	**5349**	**100%**

Data in 2019 showed an increase of births <28weeks gestation, this has decreased for years 2021 and 2022. Other categories remain similar over the years with the exception of a continued drop in in prolonged gestation (>42 weeks) since 2018.

Table 6. Type of Labour for total population 2021 - 2022 Te Whatu Ora Waitaha

Type of labour	Number of deliveries 2021		Number of deliveries 2022	
Spontaneous	2732	50.63%	2549	48.34%
Induced	1636	30.32%	1709	32.41%
Did not labour	1027	19.05%	1015	19.24%
Total	**5395**	**100%**	**5273**	**100%**

Data for 2021 and 2022 shows a reduction in spontaneous vaginal birth and increase in induction of labour which is consistent with the local and also national trend.

Table 7. Method of Birth 2021 - 2022 Te Whatu Ora Waitaha

Method of Birth	Number of Births 2021		Number of Births 2022	
Vaginal	2396	44.41%	2376	45.06%
Vaginal Water Birth	95	1.76%	84	1.59%
Vacuum Extraction	371	6.88%	441	8.36%
Forceps	440	8.16%	382	7.24%
Caesarean Section	2093	38.80%	1990	37.74%
Total	**5395**	**100%**	**5273**	**100%**

Data shows a continued increase in the caesarean section rate since the last report which looked at years 2018 and 2019. There is also an increase in the rate of instrumental birth (vacuum extraction).

Table 8. Breech Births for total population 2021 and 2022 Te Whatu Ora Waitaha

Breech Birth	Number of Births 2021		Number of Births 2022	
No	5229	95.20%	5115	95.63%
Yes	264	4.80%	234	4.37%
Total	**5493**	**100%**	**5349**	**100%**

There was very little change in the percentage of breech births between 2021 and 2022.

Table 9. Anaesthetic for total population 2021 and 2022 Te Whatu Ora Waitaha

Anaesthetic	Number of deliveries 2021		Number of deliveries 2022	
None	1781	38.73%	1736	31.86%
Local	500	9.04%	527	9.67%
Pudendal Block	130	2.35%	105	1.93%
Epidural	1144	20.68%	1187	21.78%
Spinal/Epidural	232	4.19%	273	5.01%
Spinal	1637	29.59%	1510	27.71%
General	90	1.63%	97	1.78%
Mixed general/Epidural	11	0.20%	9	0.17%
Other	7	0.13%	6	0.11%
Total	**5395**	**100%**	**5273**	**100%**

A review of our 2021 and 2022 data shows similar rates since 2018. Our anaesthetic rates are also captured by our senior anaesthetist and reviewed regularly.

Table 10. Perineal Tears for total population 2021 and 2022 Te Whatu Ora Waitaha

Perineal Tears	Number of deliveries 2021		Number of deliveries 2022	
Intact	2908	53.90%	2749	52.13%
First Degree Tear	508	9.42%	505	9.58%
Second Degree Tear	992	18.39%	990	18.77%
3a Degree Tear	100	1.85%	88	1.67%
3b Degree Tear	58	1.08%	62	1.18%
3c Degree Tear	21	0.39%	17	0.32%
4th Degree Tear	13	0.24%	8	0.15%
Episiotomy	795	14.74%	854	16.20%
Total	**5395**	**100%**	**5273**	**100%**

The 2021 and 2022 data shows an increase in the episiotomy and 3b degree tear rates since the last report. These rates are also reflected in the New Zealand Maternity Clinical Indicators 2019 – 2020 where our rates are higher than the national average. These rates had been lower and indicative of quality work carried out in this area. This area has been included in the MQSP quality plan for 2023/24.

Table 11. Blood Loss at Delivery for total population 2021 and 2022 Te Whatu Ora Waitaha

Blood Loss at Delivery	Number of deliveries 2021		Number of deliveries 2022	
<1000mL	4675	86.65%	4543	86.16%
1000ml - 1500mL	489	9.06%	528	10.01%
>1500mL	231	4.28%	202	3.83%
Total	**5395**	**100%**	**5273**	**100%**

Overall there was no significant change in blood loss but the New Zealand Maternity Clinical Indicators 2019 – 2020 show an increase in blood transfusion and higher than the national average. There is also some exploraory project work happening in this area and it has been included in the MQSP quality plan for 2023/24.

Table 12. Blood Transfusion Required 2021 and 2022 Te Whatu Ora Waitaha

Blood Transfusion Required	Number of deliveries 2021		Number of deliveries 2022	
No	5102	94.56%	5085	96.43%
Yes	293	5.43%	188	3.56%
Total	**5395**	**100%**	**5273**	**100%**

There has been an increase in blood transfusions required as identified in the previous table.

Table 13. Feeding Method 2021 and 2022 Te Whatu Ora Waitaha

Feeding Method	Number of Babies 2021		Number of Babies 2022	
Artificial	196	3.57%	183	3.42%
Exclusive	3486	63.09%	3292	61.60%
Fully	100	1.82%	177	3.31%
Unknown status baby in NICU	534	9.71%	543	10.16%
Partial	1172	21.32%	1133	21.20%
Other	27	0.49%	16	0.30%
Total	**5497**	**100%**	**5344**	**100%**

Since 2018 there has been a continuous increase in the number of babies artificially and partially breastfed. Exclusive breastfeeding rates have decreased. These rates are reflective of a tertiary maternity facility, and it is expected that exclusive and fully breastfeeding rates will be higher in the primary maternity units.

NEONATAL DATA

The Waitaha Neonatal Intensive Care Unit collate a minimum data set which feeds into the Australian and New Zealand Neonatal Network (ANZNN). The ANZNN provides a collaborative network and a quality framework that can monitor care and outcomes using quality data. The following three data sets are taken from the data supplied to the ANZNN and provides a more accurate representation of neonatal activity than the MOH Maternity Clinical Indicators.

Comment: As a service we have in previous years spent time working with our analysts and liaising with the MOH to explore the discrepancy in data between local and MOH reported data. Reasons for the discrepancy are outlined in the disclaimer at the beginning of this report. We have focused on reviewing our locally collected data as reported to the Australian and New Zealand Neonatal Network (ANZNN) to identify any areas for improvement.

Table 14. Te Whatu Ora Waitaha Babies requiring respiratory support and admission to NICU by gestation 2021 – 2022

	Number of Babies 2021		Number of Babies 2022	
<26 weeks gestation	16	4.08%	9	2.02%
26 – 27 weeks gestation	15	3.83%	14	3.14%
28 – 31 weeks gestation	64	16.33%	32	7.17%
32 – 36 weeks gestation	118	30.10%	134	30.04%
≥ 37 weeks gestation	150	45.66%	257	57.62%
Total	**392**	**100%**	**446**	**100%**

Figure 6 demonstrates the number of babies requiring neonatal unit admission and respiratory support. The data was collated using the same criteria used for clinical indicator 20 of the MOH data New Zealand Maternity Clinical Indicators 2019 and 2020 (2022) and shows a steady increase in the rates of babies requiring neonatal admission and respiratory support at ≥ 37 weeks gestation.

Figure 6. Te Whatu Ora Waitaha Babies requiring support and admission to NICU by gestation 2013 - 2022

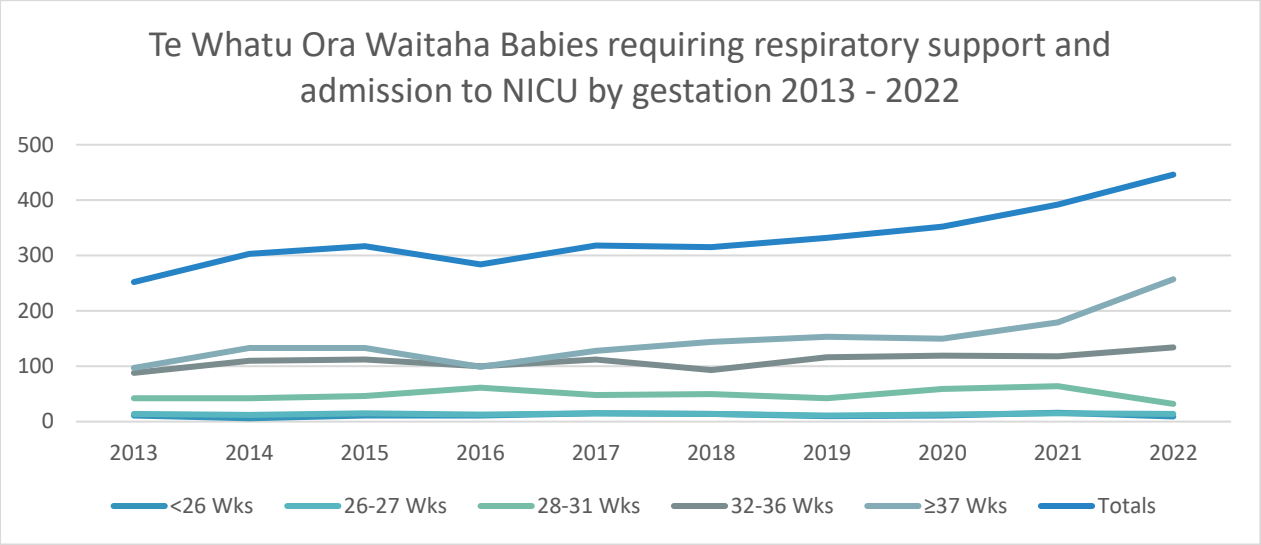


Figure 7 shows the percentage of steroid administration for babies <32 weeks gestation. The data is taken from the clinical record and verified on MedChart. The coding for this data set is:

- Code 0 – ***Unknown*** – Information not available
- Code 1 – ***None*** – Corticosteroids not ever given during this pregnancy at a time likely to enhance lung maturation
- Code 2 – ***Incomplete, less than 24 hours*** – First dose given less than 24 hours prior to the baby's birth
- Code 3 – ***Complete*** – More than one dose of corticosteroids given, and first dose was given more than 24 hours and the last dose less than 8 days before baby's birth
- Code 4 - More than 7 days – Steroids given more than 7 days before the baby's birth. If two courses given and 'one' is complete, use complete

Figure 7. Te Whatu ora Waitaha steroids administered for babies <32 weeks gestation 2017 - 2022 as % of total numbers born

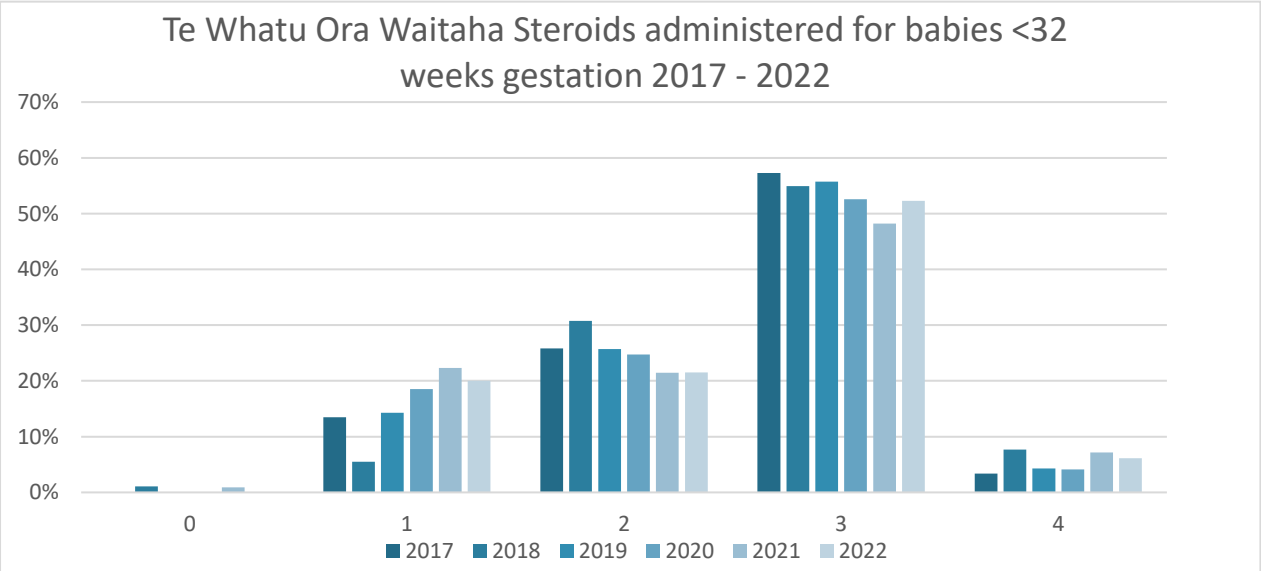
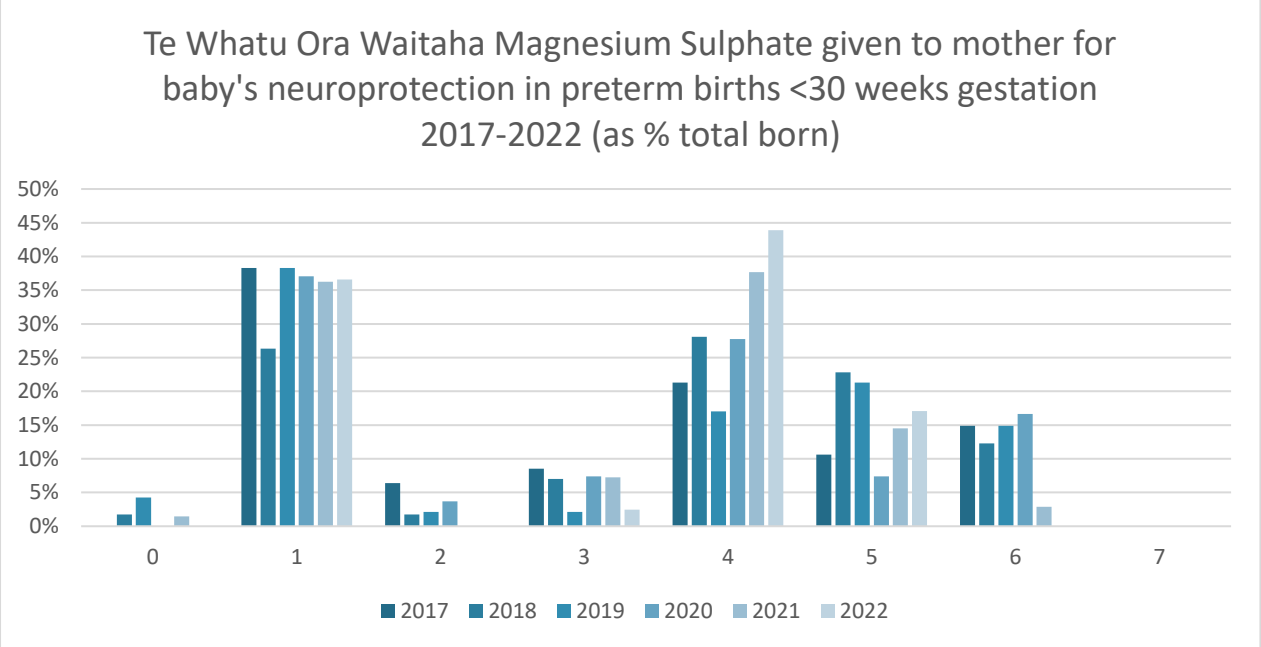


Figure 8 shows the percentage of Magnesium Sulphate given for baby's neuroprotection in preterm births <30 weeks from 2017 to 2022. As with the previous data set this is collected form the clinical record and verified on MedChart. The coding for this data set is:

- Code 0 – ***Unknown*** – Information not available
- Code 1 – ***Magnesium Sulphate not given at all***
- Code 2 – ***Magnesium Sulphate stopped >24 hours before birth***
- Code 3 – ***Magnesium Sulphate commenced > 24 hours before birth and stopped <24 hours before birth***
- Code 4 – ***Magnesium Sulphate commenced between 4 to 24 hours before birth***
- Code 5 – ***Magnesium Sulphate commenced within 4 hours of birth***
- Code 6 – ***Magnesium Sulphate given but details not known***
- Code 7 – ***Magnesium Sulphate/Placebo given for randomised trial***

Figure 8. Te Whatu Ora Waitaha Magnesium Sulphate given to mothers for baby's neuroprotection in preterm births <30 weeks gestation 2017 - 2022



Everyone was respectful, helpful, non-invasive, gave us our space and made me feel comfortable and safe in labour

Oromairaki Maternity Unit

MQSP PRIORITIES AND ACTION PLAN 2023/24

As a district we have identified MQSP priorities for 2023/2024 (see Appendix 5). We have taken into consideration the ongoing National Maternity Monitoring Group (NMMG) priorities for monitoring and investigation, as per the National Maternity Monitoring Group Annual Report 2019 (NMMG, 2020). We have also reviewed and included any priorities and recommendations from the Fifteenth Annual Report of the Perinatal and Maternal Morbidity Review Committee (PMMRC, 2022) and identified quality work to address our clinical outcomes following review of our local data.

As a district we have also committed to the Canterbury Maternity System Strategic Framework and ongoing work arising from the maternity strategy workplan.

We also acknowledge that Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority have published the Te Pae Tata: interim New Zealand Health Plan (2022), and that Kahu Taurima (Maternity and early years) are one of the six priority actions which will also shape our quality planning in the coming year.

These cumulated priorities were formed, supported and approved by the Canterbury Maternity Quality Governance group.

Oromairaki maternity unit postnatal room

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APPENDIX 1

BIRTH STATISTICS AND CLINICAL OUTCOMES FOR TE WHATU ORA WAITAHA PRIMARY COMMUNITY BIRTHING UNITS 2021 AND 2022

WOMEN BIRTHING AT RANGIORA HEALTH HUB 2021 AND 2022

2021 - 208 BIRTHS

- **52%** used water emersion for birth and / or pain relief
- **65%** of women were multiparous
- **35%** were primiparous
- **49%** did not require suturing

2022 - 206 BIRTHS

- **62%** used water emersion for birth and / or pain relief
- **62%** of women were multiparous
- **33.3%** were primiparous
- **68%** did not require suturing

Figure 9. Mode of birth for women planning to birth at Rangiora Health Hub 2021

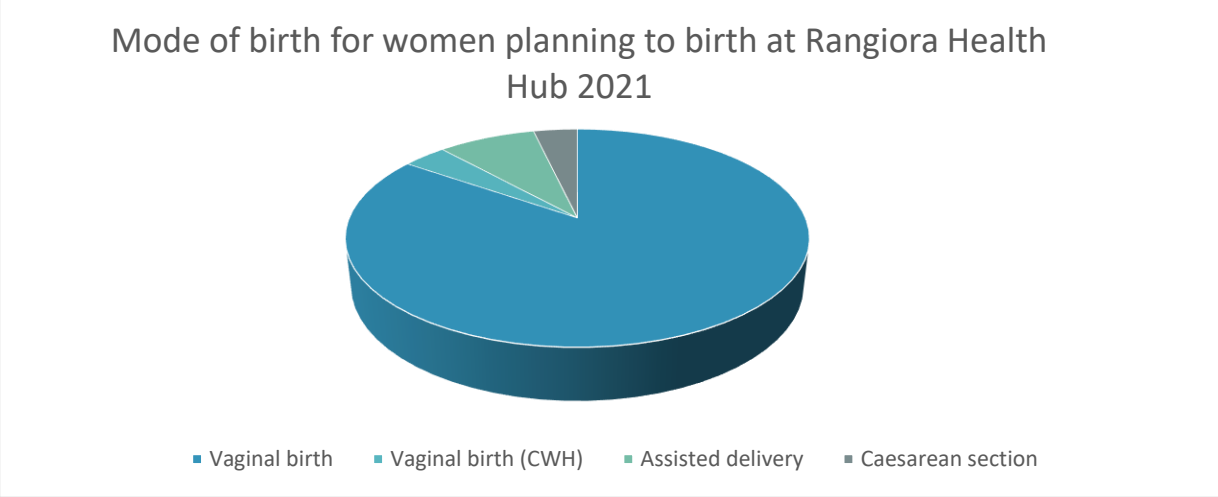


Figure 10. Mode of birth for women planning to birth at Rangiora Health Hub 2022

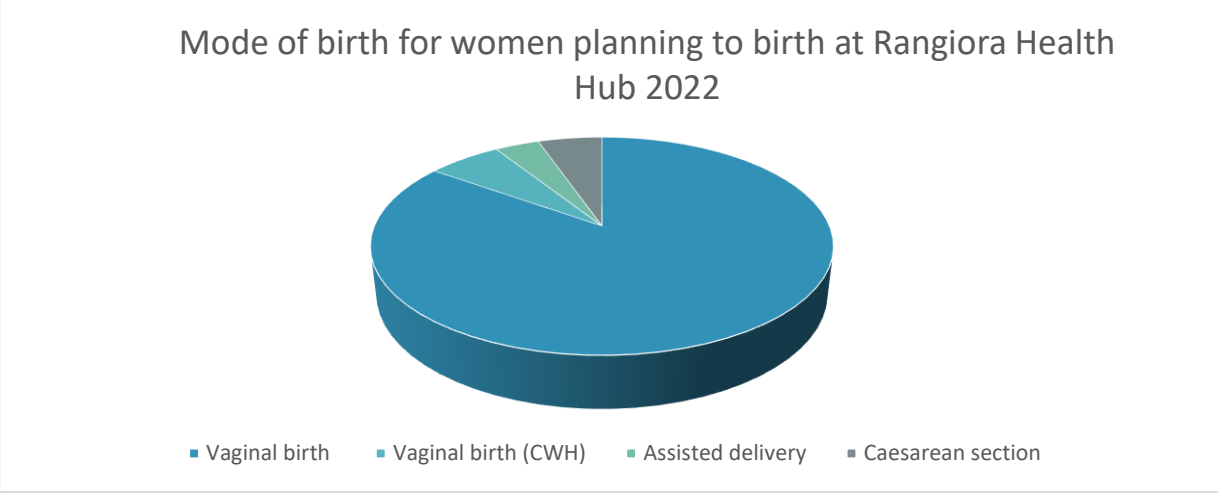


Figure 11. Perineal outcomes for women birthing at Rangiora Health Hub 2021

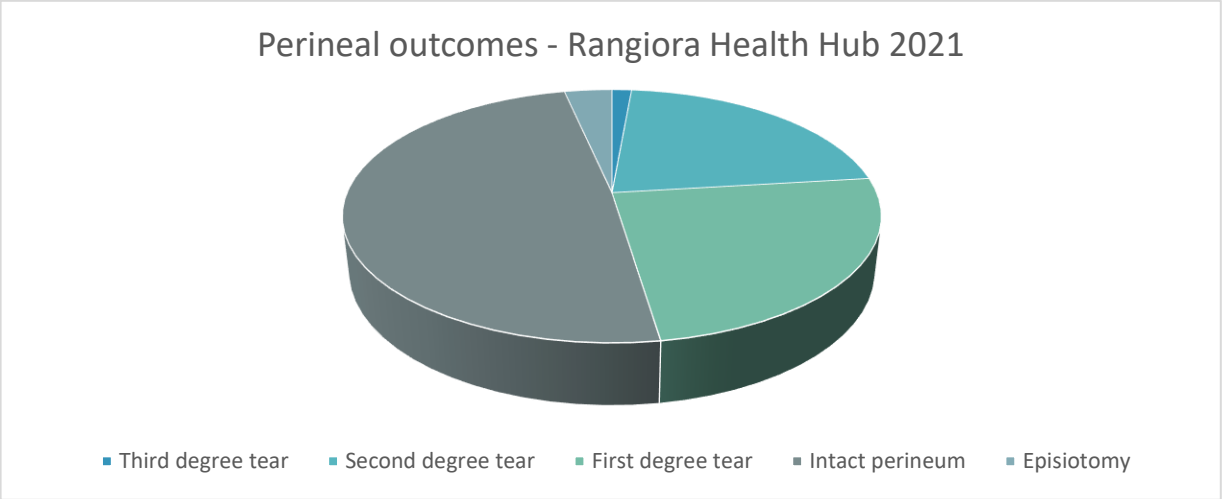
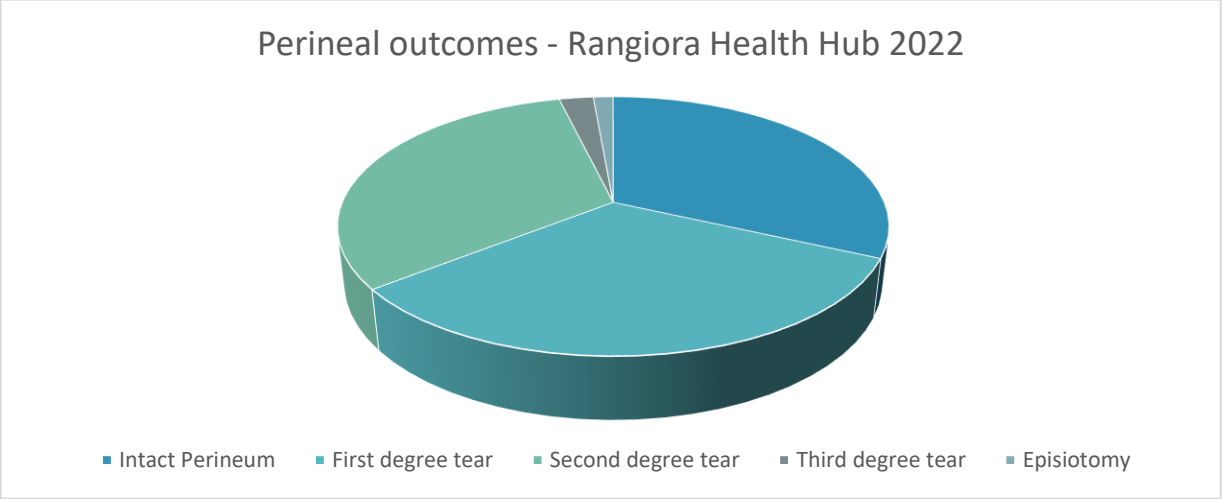


Figure 12. Perineal outcomes for women birthing at Rangiora Health Hub 2022



TRANSFERS FROM RANGIORA HEALTH HUB TO CHRISTCHURCH WOMENS HOSPITAL – MATERNAL OUTCOMES

2021

- **15.4%** women transferred in labour (n = 38) Please note some women transferring had multiple categories (i.e. meconium liquor and delay in first stage).
- That is a **2.0%** chance of transfer in labour for multiparous women, and a **13.4%** chance for a primigravida
- **14** women transferred after birth for maternal reasons
- Total transfer rate before and after birth **21.5%**
- The reasons for maternal transfer after birth include retained placenta, suturing, post-partum haemorrhage
- Of the women who planned to birth and commenced labour at Rangiora Health Hub in 2021 (n=246), **96.3%** gave birth vaginally regardless of actual place of birth

2022

- **15.2%** women transferred in labour (n = 37) Please note some women transferring had multiple categories (i.e. meconium liquor and delay in first stage).
- That is a **4.1%** chance of transfer in labour for multiparous women, and a **11.1%** chance for a primigravida
- **11** women transferred after birth for maternal reasons

- Total transfer rate before and after birth **20.5%**
- The reasons for maternal transfer after birth include retained placenta, suturing, post-partum haemorrhage
- Of the women who planned to birth and commenced labour at Rangiora Health Hub in 2022 (n=243), **94.6%** gave birth vaginally regardless of actual place of birth

Figure 13. Reasons for transfer in labour - Rangiora Health Hub 2021

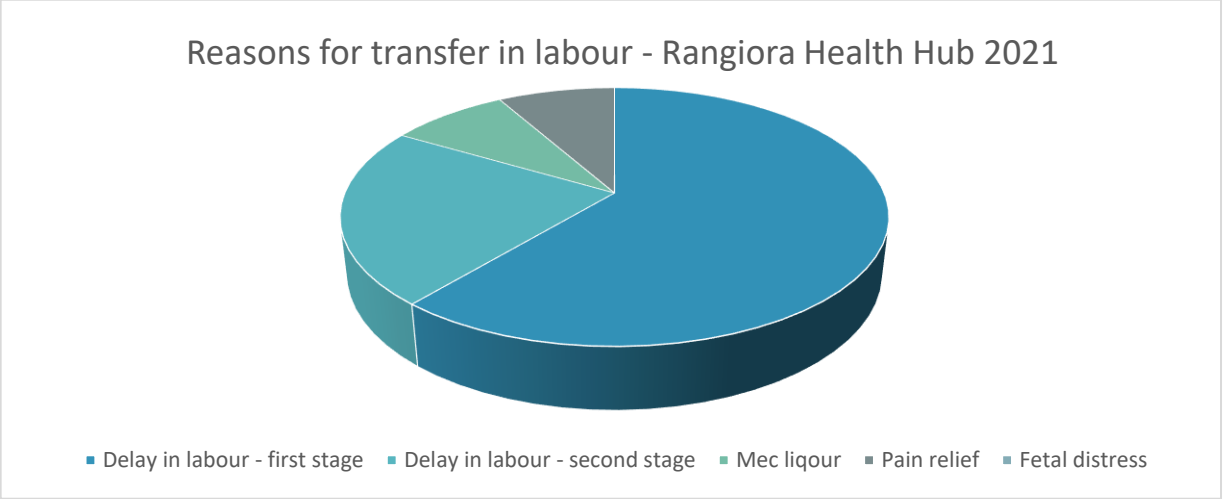
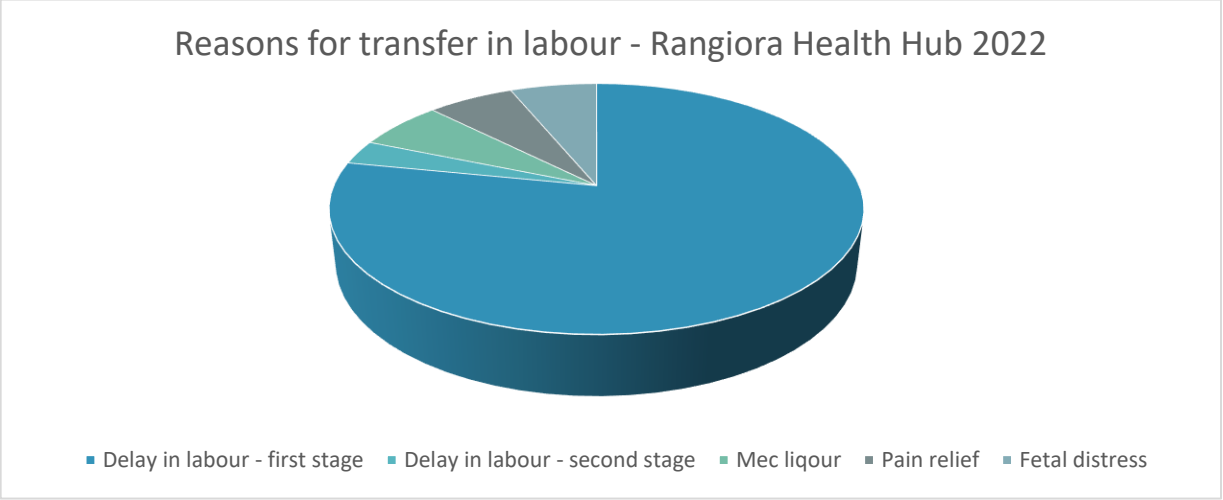


Figure 14. Reasons for transfer in labour - Rangiora Health Hub 2022



NEONATAL OUTCOMES

2021

- **5** babies born at Rangiora were retrieved and admitted to NICU for closer observation
- The rate of neonatal retrieval for babies born in Rangiora is **2.4%**

2022

- **2** babies born at Rangiora were retrieved and admitted to NICU for closer observation
- The rate of neonatal retrieval for babies born in Rangiora is **0.97%**

WOMEN ACCESSING RANGIORA HEALTH HUB FOR POSTNATAL CARE

2021

- **787** women and their babies received postnatal care
- **15** women birthed before arrival (BBA) but were admitted for postnatal care
- **559** women transferred to Rangiora Health Hub after birth at Christchurch Women's Hospital
- **4** woman returned to Christchurch Women's Hospital for complex care
- **2** babies were retrieved for ongoing care

2022

- **819** women and their babies received postnatal care
- **13** women birthed before arrival (BBA) but were admitted for postnatal care
- **599** women transferred to Rangiora Health Hub after birth at Christchurch Women's Hospital
- **1** woman returned to Christchurch Women's Hospital for complex care

Figure 13. Mode of birth of postnatal transfers to Rangiora Health Hub from Christchurch Women's Hospital 2021

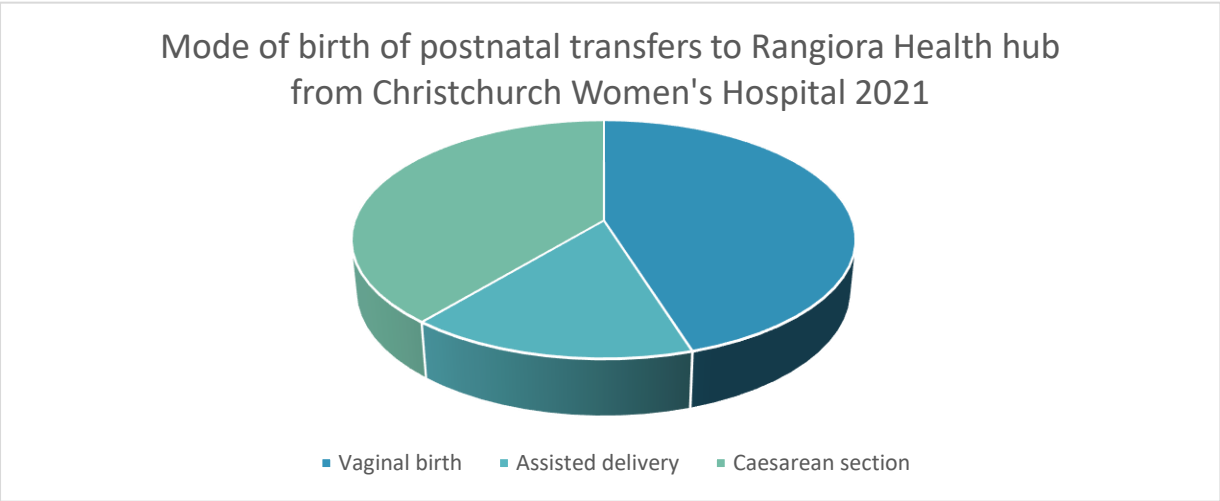


Figure 14. Mode of birth of postnatal transfers to Rangiora Health Hub from Christchurch Women's Hospital 2022

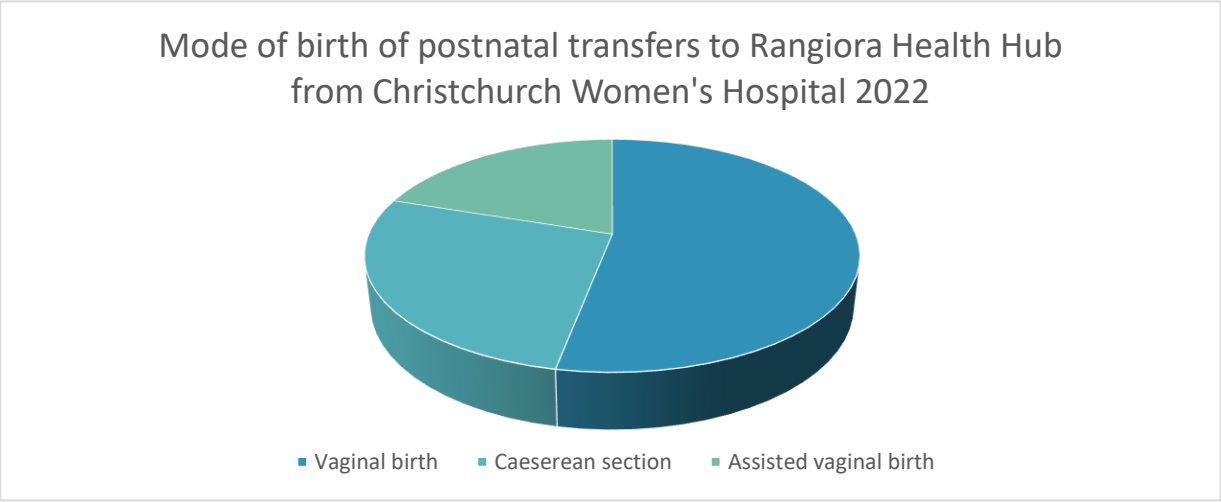


Figure 15. Ethnicity of Rangiora Health Hub births 2021

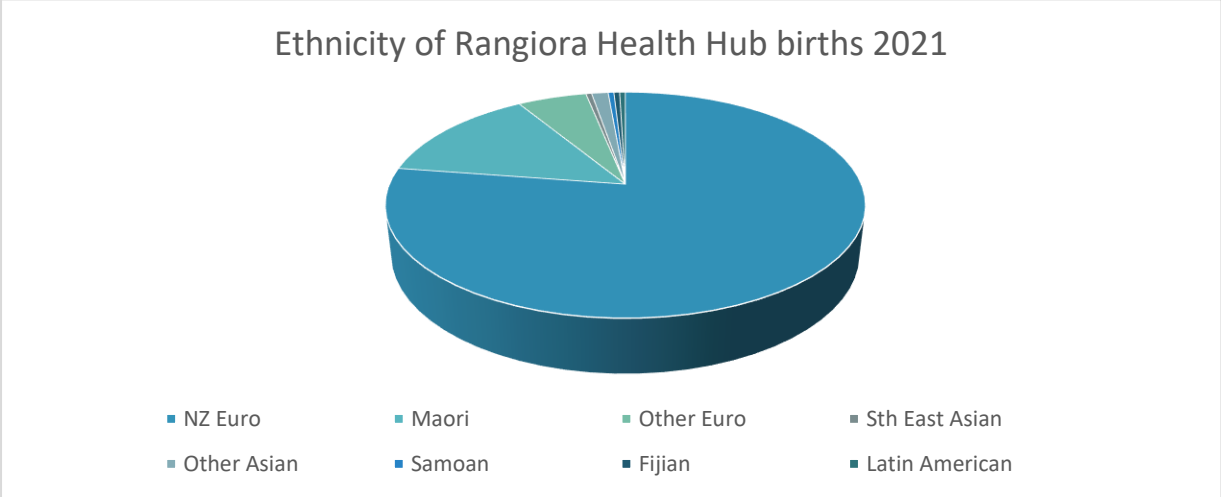
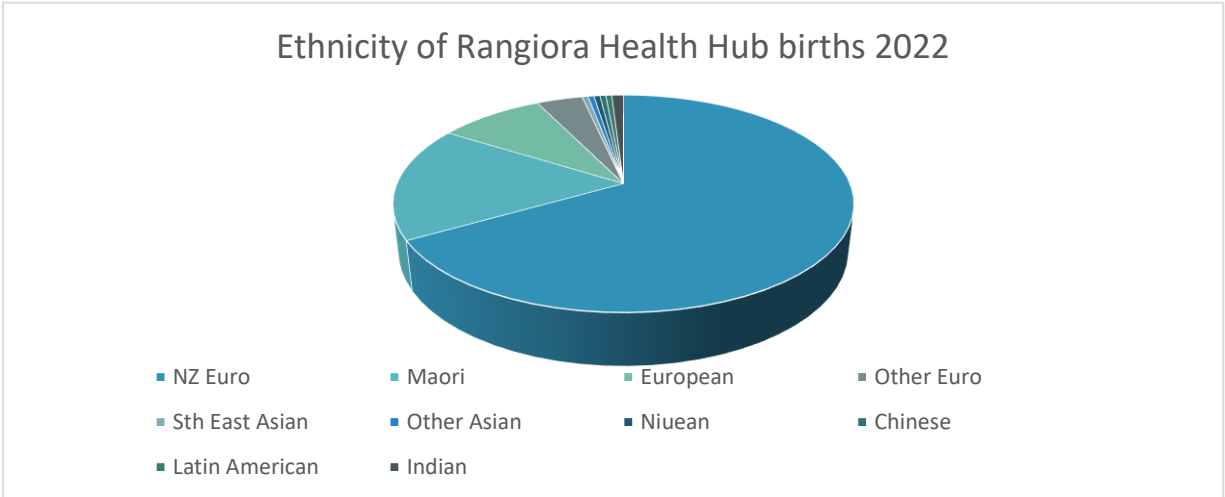


Figure 16. Ethnicity of Rangiora Health Hub births 2022



2021 - 210 BIRTHS

- **48.0%** used water emersion for birth and / or pain relief
- **56.7%** of women were multiparous
- **37.1%** were primiparous
- **31.9%** did not require suturing

2022 - 83 BIRTHS (JANUARY – MAY)

- **61.4%** used water emersion for birth and / or pain relief
- **54.2%** of women were multiparous
- **27.7%** were primiparous
- **28.9%** did not require suturing

Figure 17. Mode of birth for women planning to birth at Lincoln Maternity Hospital 2021

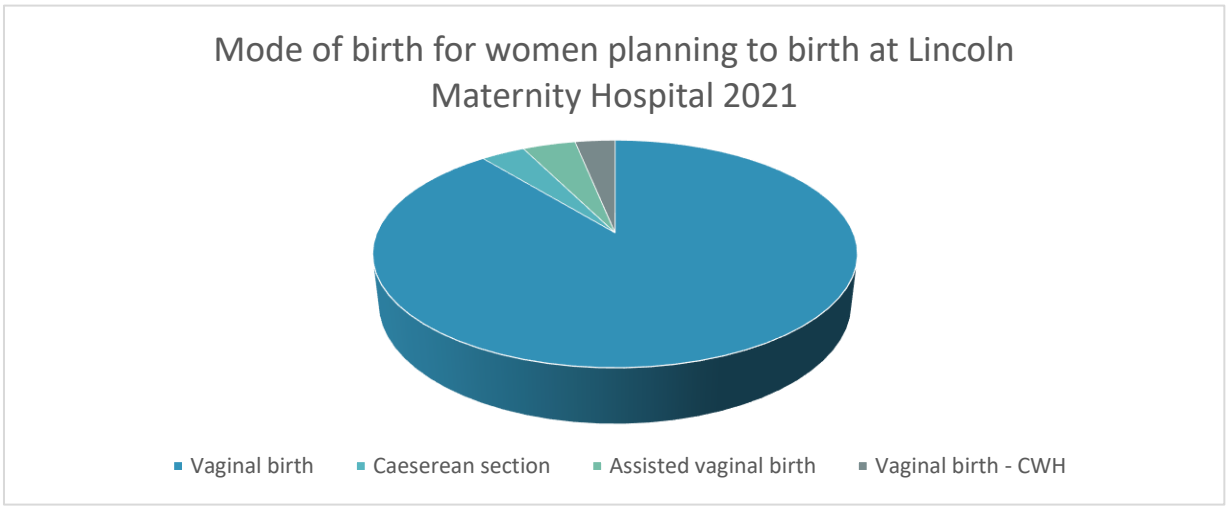


Figure 18. Mode of birth for women planning to birth at Lincoln Maternity Hospital 2022

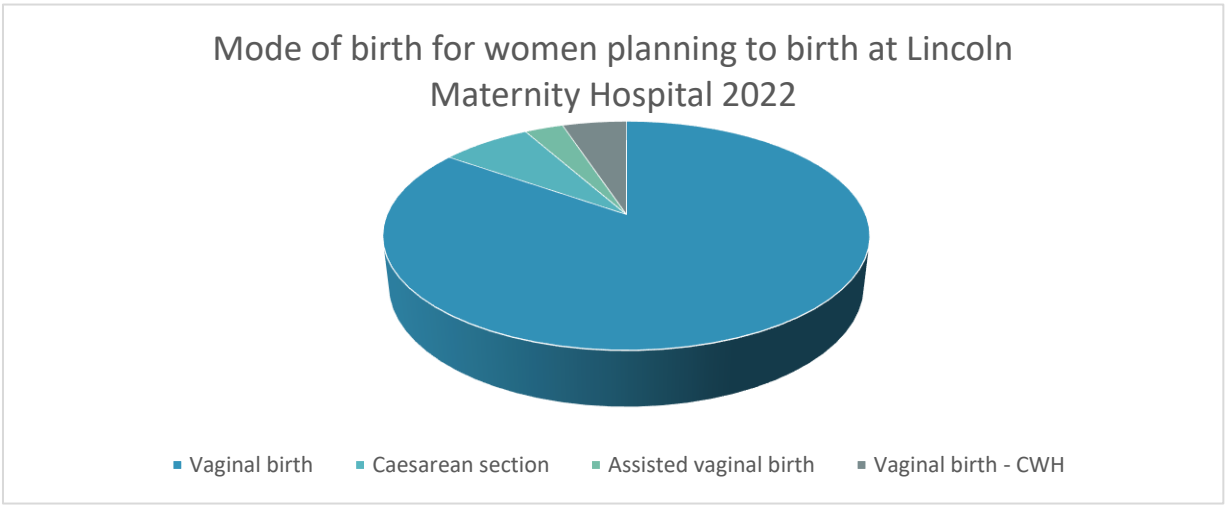


Figure 19. Perineal outcomes for women birthing at Lincoln Maternity Hospital 2021

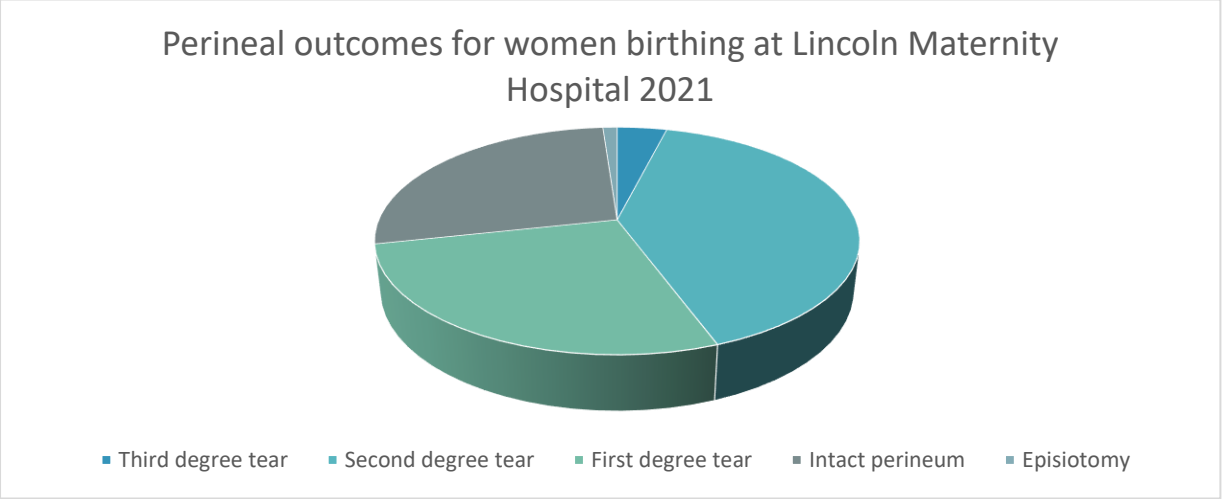
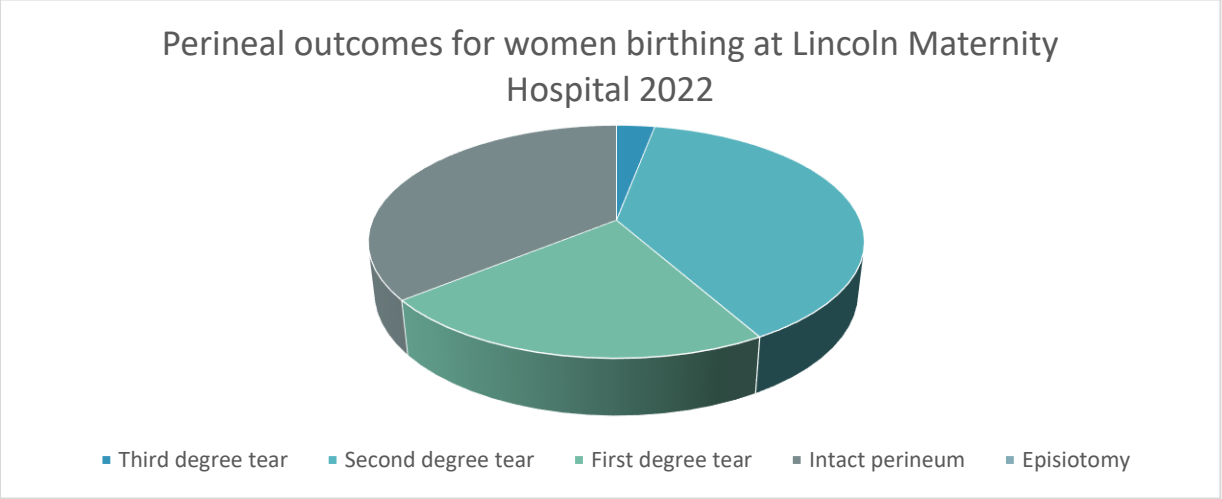


Figure 20. Perineal outcomes for women birthing at Lincoln Maternity Hospital 2022



NEONATAL OUTCOMES

2021

- 8 babies born at Lincoln were retrieved
- 0 babies of women who transferred from Lincoln then birthed at CWH, were admitted to NICU
- The rate of neonatal retrieval for babies born to at Lincoln is 3.8%

2022

- 2 babies born at Lincoln were retrieved
- 0 babies of women who transferred from Lincoln then birthed at CWH, were admitted to NICU
- The rate of neonatal retrieval for babies born to at Lincoln is 2.4%

2021

- **752** women and their babies received postnatal care
- **14** women birthed before arrival (BBA) but were admitted for postnatal care
- **542** women transferred to Lincoln Maternity Hospital after birth at Christchurch Women's Hospital
- **1** women returned to Christchurch Women's Hospital for complex care, and **8** babies were retrieved for ongoing care

2022

- **294** women and their babies received postnatal care
- **5** women birthed before arrival (BBA) but were admitted for postnatal care
- **211** women transferred to Lincoln Maternity Hospital after birth at Christchurch Women's Hospital
- **5** women returned to Christchurch Women's Hospital for complex care, and **2** babies were retrieved for ongoing care

Figure 21. Mode of birth of postnatal transfers to Lincoln Maternity Hospital from Christchurch Women's Hospital 2021

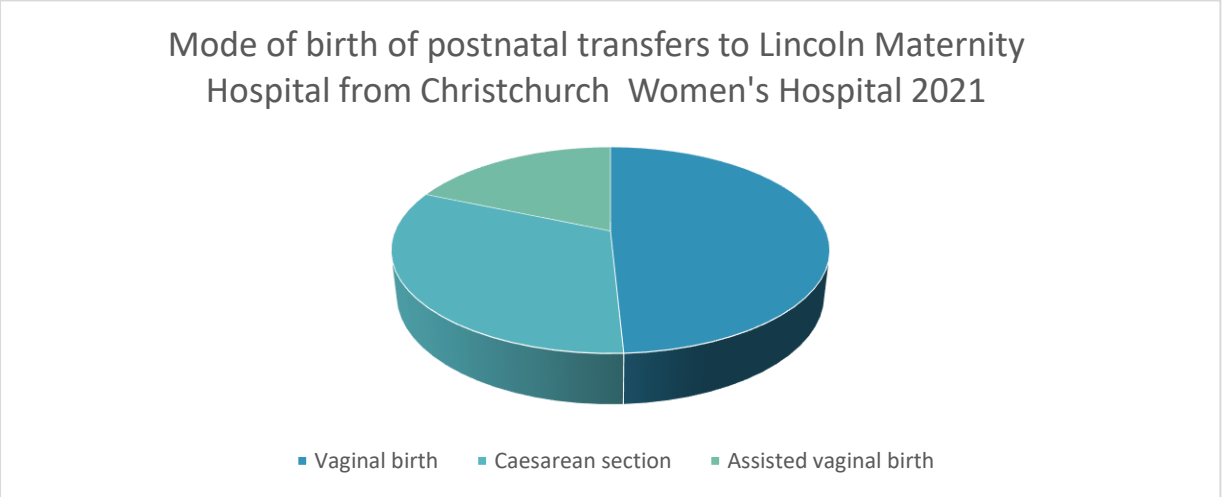


Figure 22. Mode of birth of postnatal transfers from Christchurch Women's Hospital 2022

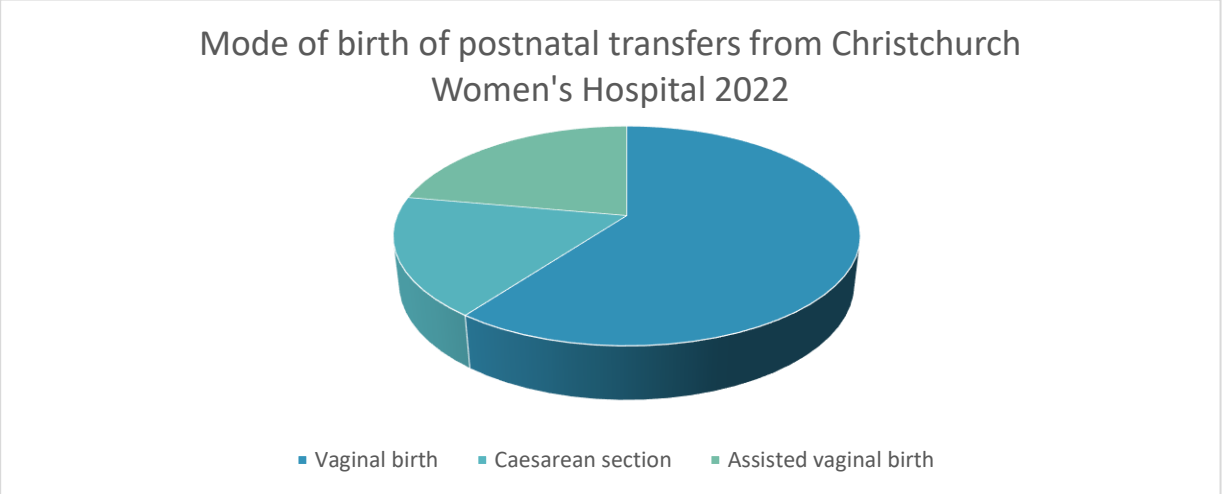


Figure 23. Ethnicity of Lincoln Maternity Hospital births 2021

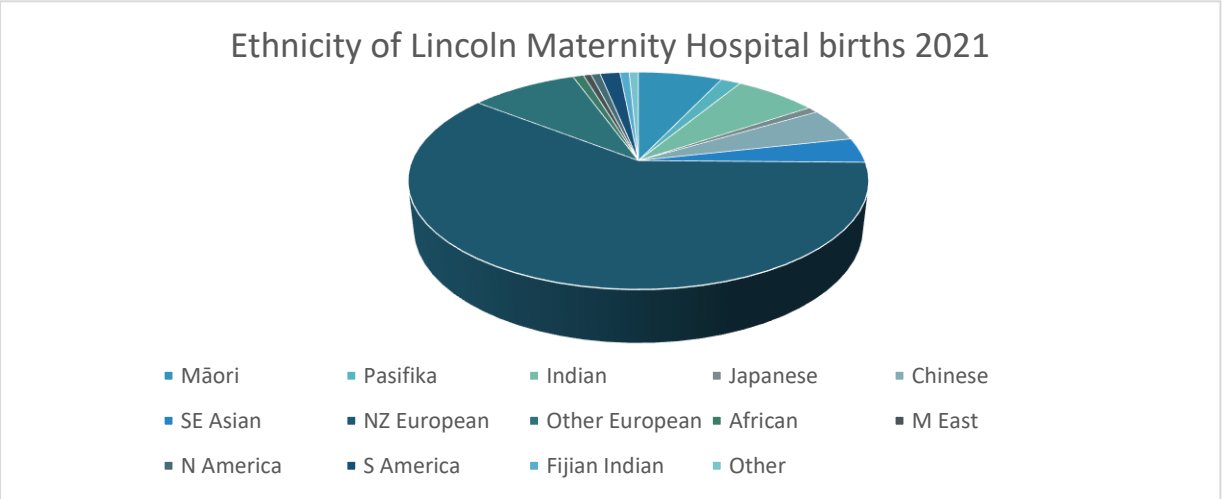
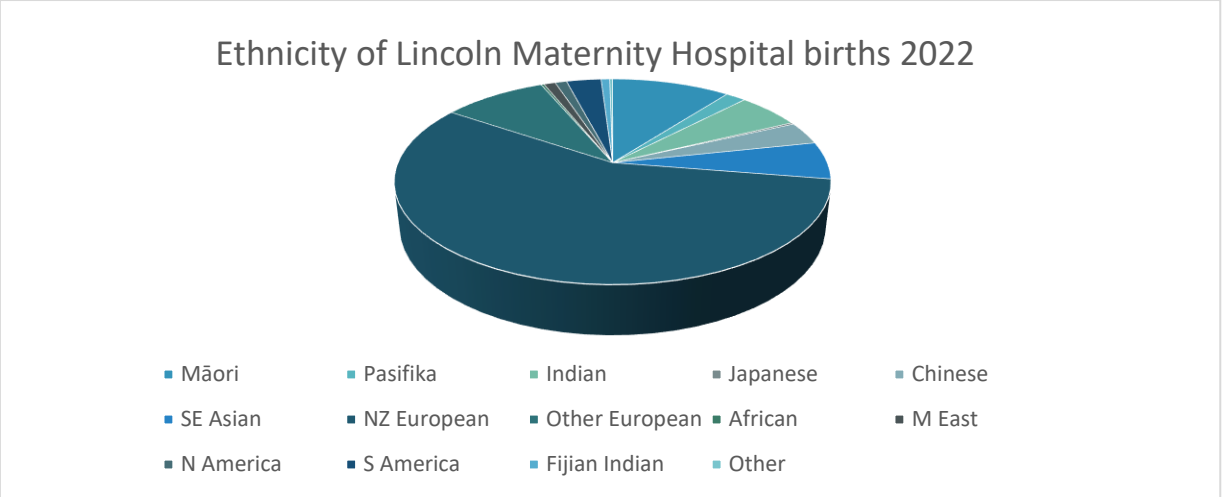


Figure 24. Ethnicity of Lincoln Maternity Hospital births 2022



WOMEN BIRTHING AT OROMAIRAKI MATERNITY UNIT 2022

2022 - 182 BIRTHS (MAY – DECEMBER)

- 66.4% used water emersion for birth and / or pain relief
- 57.8% of women were multiparous
- 42.9% were primiparous

Figure 25. Mode of birth for women planning to birth at Oromairaki Maternity Unit 2022

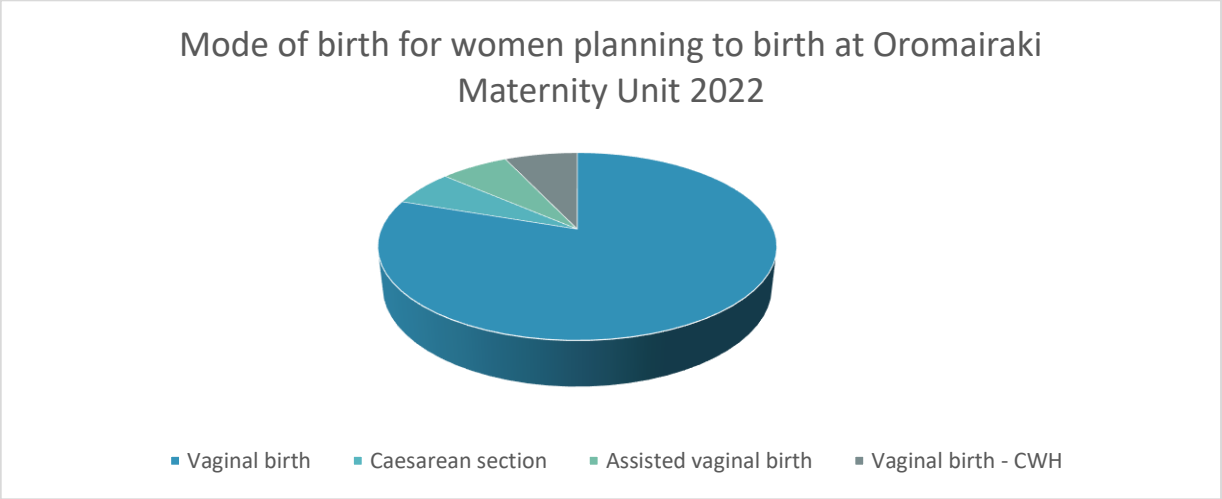


Figure 26. Perineal outcomes for women birthing at Oromairaki Maternity Unit 2022

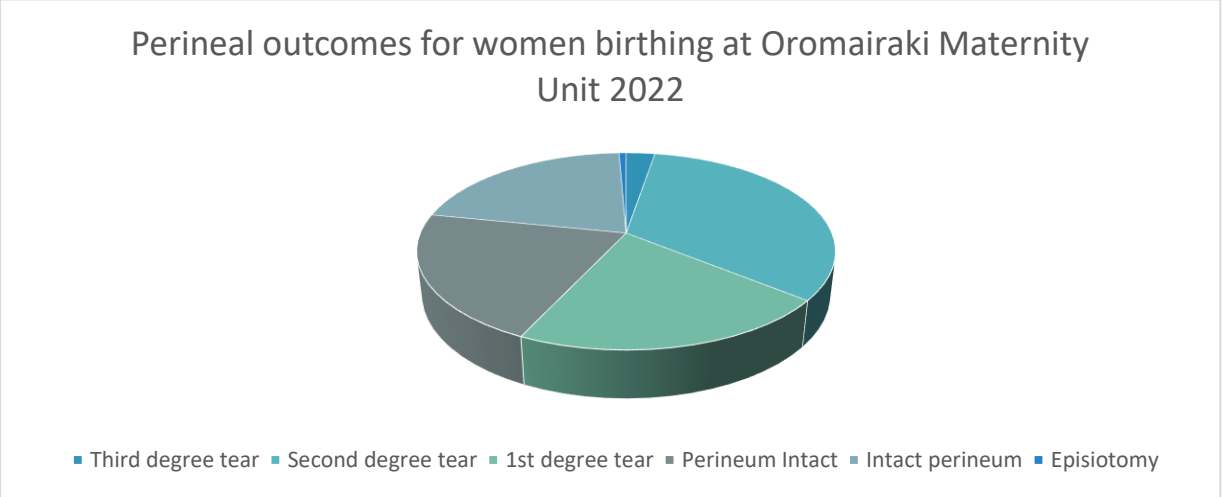
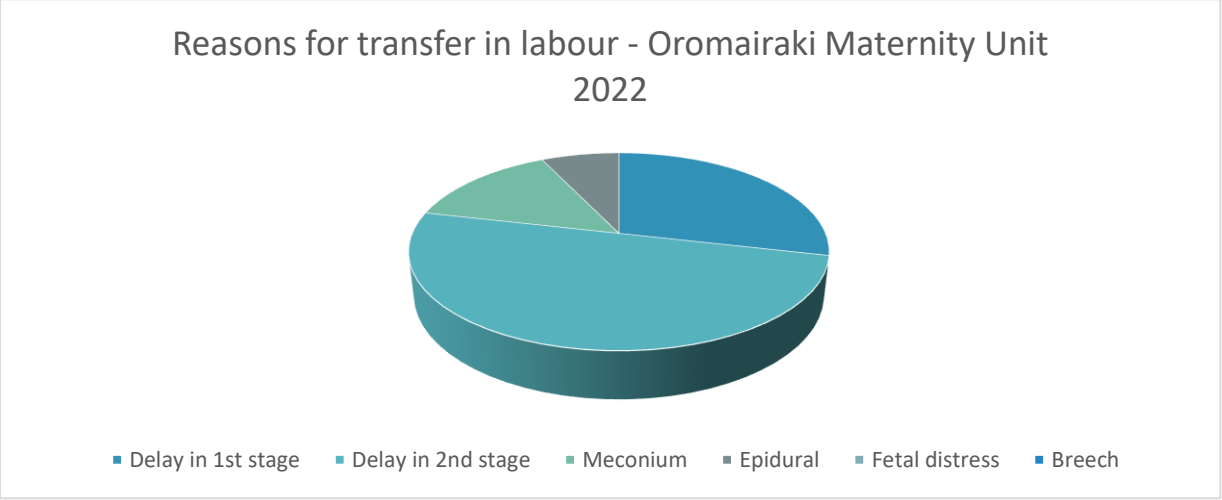


Figure 27. Reasons for transfer in labour - Oromairaki Maternity Unit 2022



NEONATAL OUTCOMES

2022

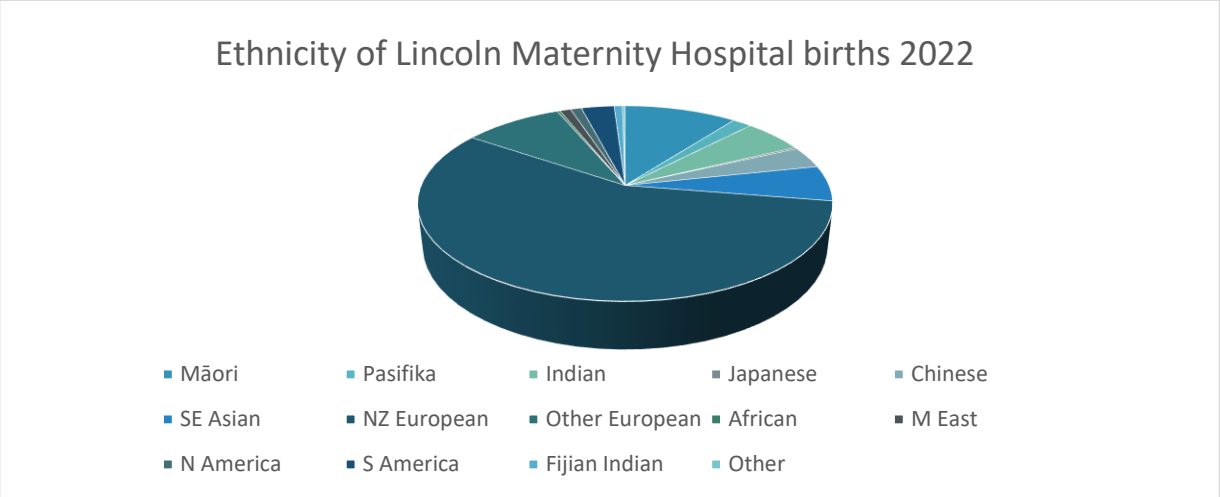
- 5 babies born at Oromairaki were retrieved
- 5 babies of women who transferred from Oromairaki then birthed at CWH, were admitted to NICU
- The rate of neonatal retrieval for babies born to at Oromairaki is 2.7%
- Length of stay in NICU total 5 days

WOMEN ACCESSING OROMAIRAKI MATERNITY UNIT FOR POSTNATAL CARE

2022

- 521 women and their babies received postnatal care
- 9 women birthed before arrival (BBA) but were admitted for postnatal care
- 339 women transferred to Oromairaki Maternity Hospital after birth at Christchurch Women's Hospital
- 0 women returned to Christchurch Women's Hospital for complex care, and 5 babies were retrieved for ongoing care

Figure 28. Ethnicity of Oromairaki births 2022



WOMEN BIRTHING AT ASHBURTON MATERNITY 2021 AND 2022

2021 - 131 BIRTHS

- 44% used water emersion for birth and / or pain relief
- 81% of women were multiparous
- 45% had physiological 3rd stage

2022 – 98 BIRTHS

- 44% used water emersion for birth and / or pain relief
- 76.5% of women were multiparous
- 48% had physiological 3rd stage

Figure 29. Perineal outcomes - Ashburton Maternity 2021

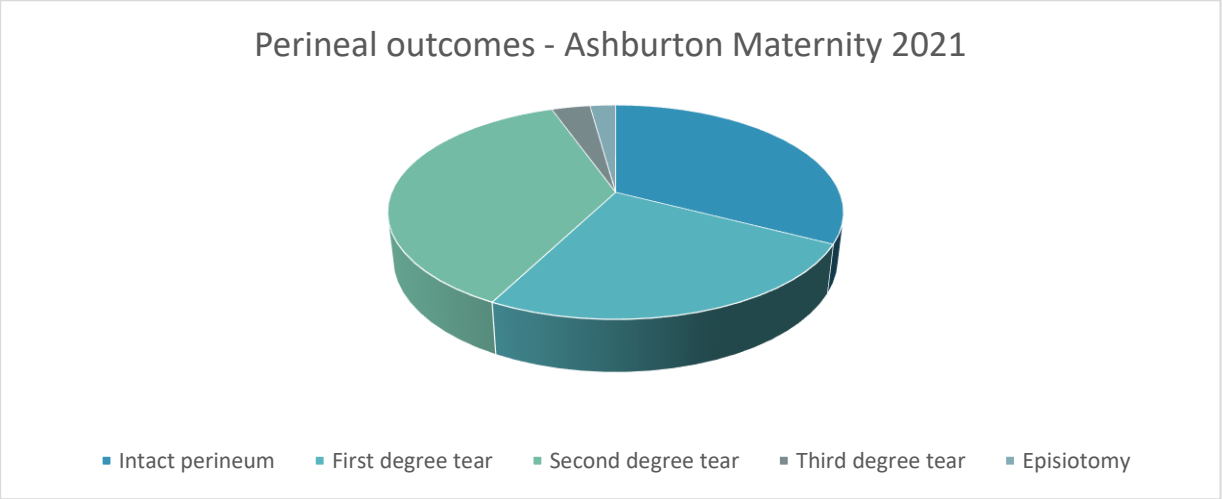
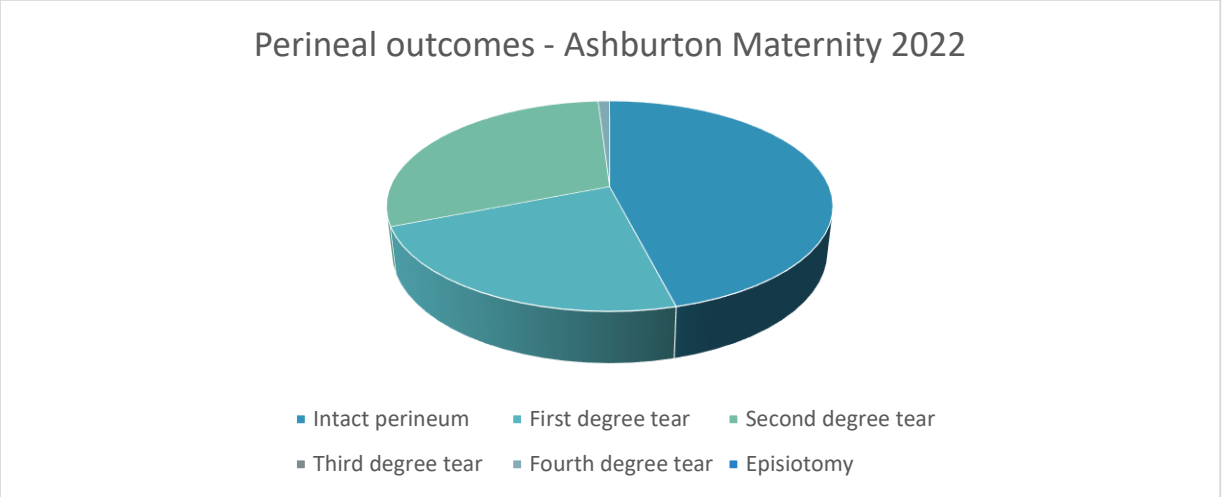


Figure 30. Perineal outcomes - Ashburton Maternity 2022



TRANSFERS FROM ASHBURTON MATERNITY TO CHRISTCHURCH WOMEN'S HOSPITAL – MATERNAL OUTCOMES

2021

- **18%** women transferred in labour (n = 29)
- **12** women transferred after birth for maternal reasons
- Total transfer rate before and after birth **12.9%**
- The postpartum haemorrhage rate for women who birth at Ashburton is **12.5%**
- The reasons for maternal transfer after birth were retained placenta, post-partum haemorrhage and suturing

2022

- **12%** women transferred in labour (n = 13)
- **13** women transferred after birth for maternal reasons
- The postpartum haemorrhage rate for women who birth at Ashburton is **12 %**
- The reasons for maternal transfer after birth were retained placenta, post-partum haemorrhage and suturing

NEONATAL OUTCOMES

2021

- **6** babies born at Ashburton were retrieved
- The rate of neonatal retrieval for babies born to at Ashburton is **4.5%**

2022

- **12** babies born at Ashburton were retrieved
- The rate of neonatal retrieval for babies born to at Ashburton is **12.2%**

WOMEN ACCESSING ASHBURTON MATERNITY FOR POSTNATAL CARE

2021

- **257** women and their babies received postnatal care
- **4** women birthed before arrival (BBA) but were admitted for postnatal care
- **126** women transferred to Ashburton Maternity after birth at Christchurch Women's Hospital

2022

- **222** women and their babies received postnatal care
- **4** women birthed before arrival (BBA) but were admitted for postnatal care
- **96** women transferred to Ashburton Maternity after birth at Christchurch Women's Hospital

Figure 31. Mode of birth of postnatal transfers to Ashburton Maternity from Christchurch Women's Hospital 2021

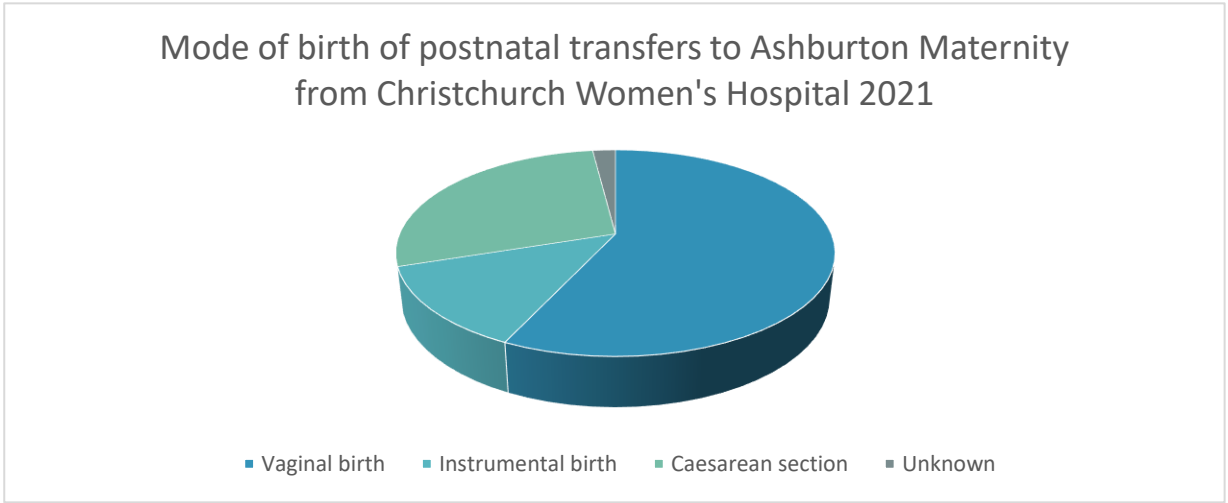


Figure 32. Mode of birth of postnatal transfers to Ashburton Maternity from Christchurch Women's Hospital 2022

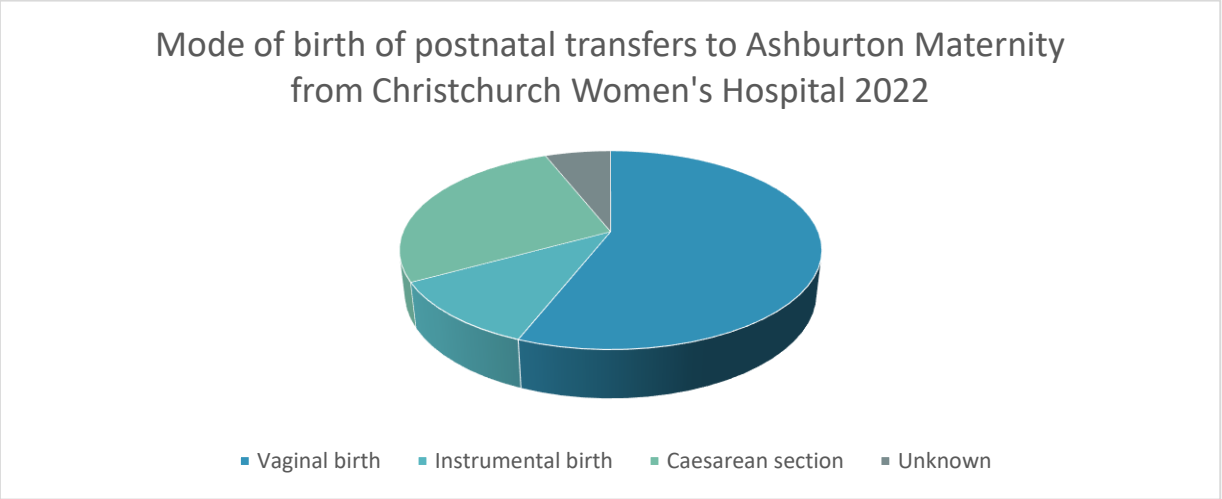


Figure 33. Ethnicity of births Ashburton Maternity 2021

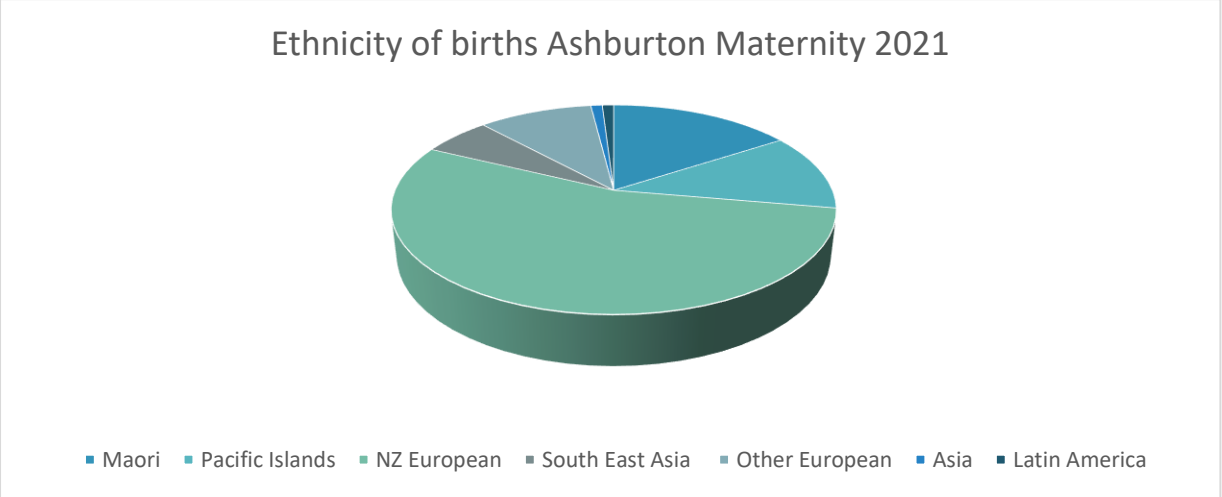
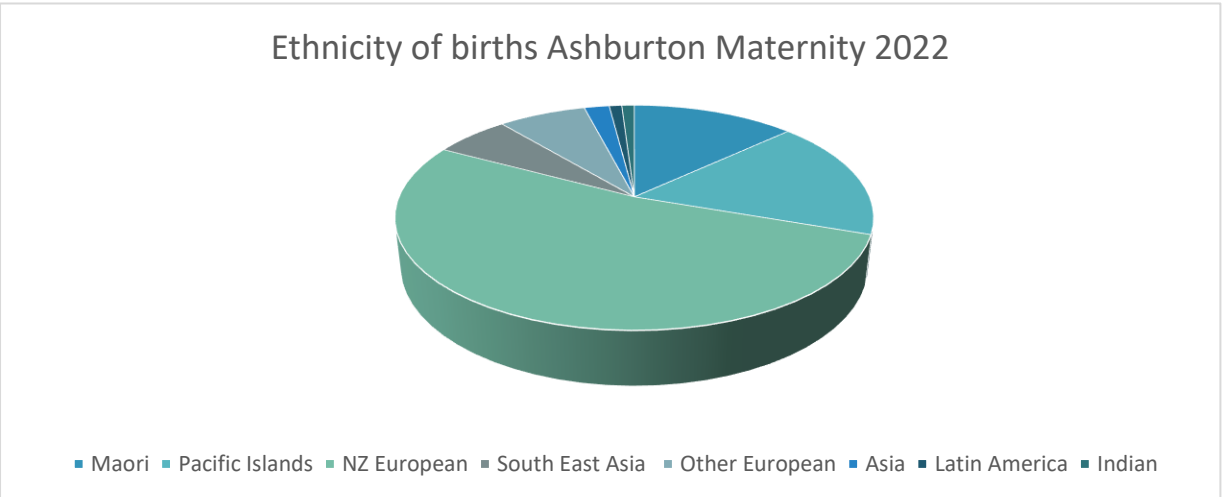


Figure 34. Ethnicity of births Ashburton Maternity 2022



2021 - 502 BIRTHS

- **34%** used water emersion for birth
- **64%** of women were multiparous
- **36%** of women were primiparous

2022 – 328 BIRTHS

- **27%** used water emersion for birth
- **68%** of women were multiparous
- **32%** of women were primiparous

Figure 35. Perineal outcomes - St. George's Maternity Centre 2021

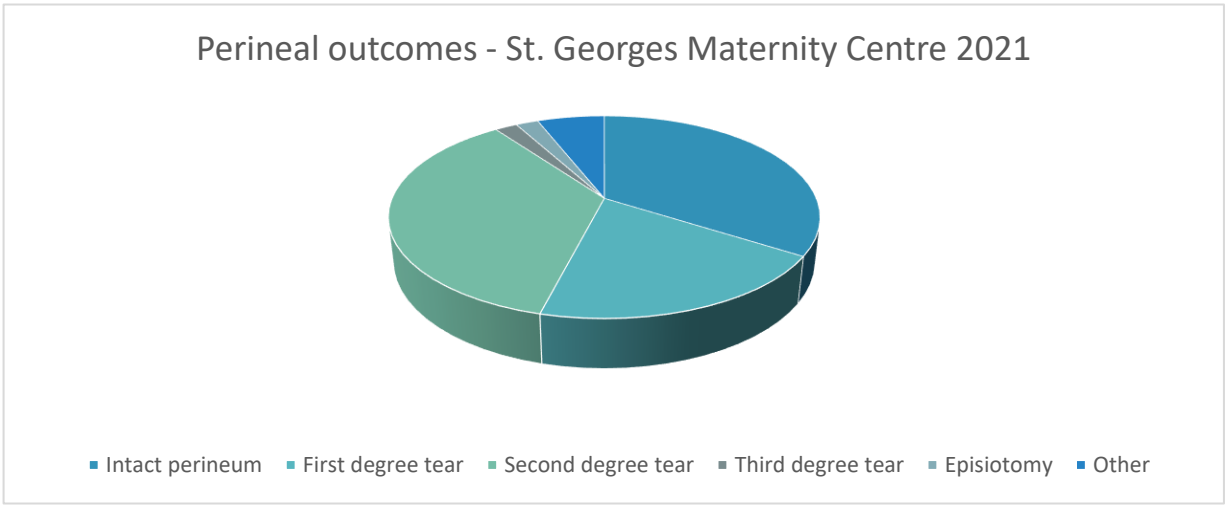
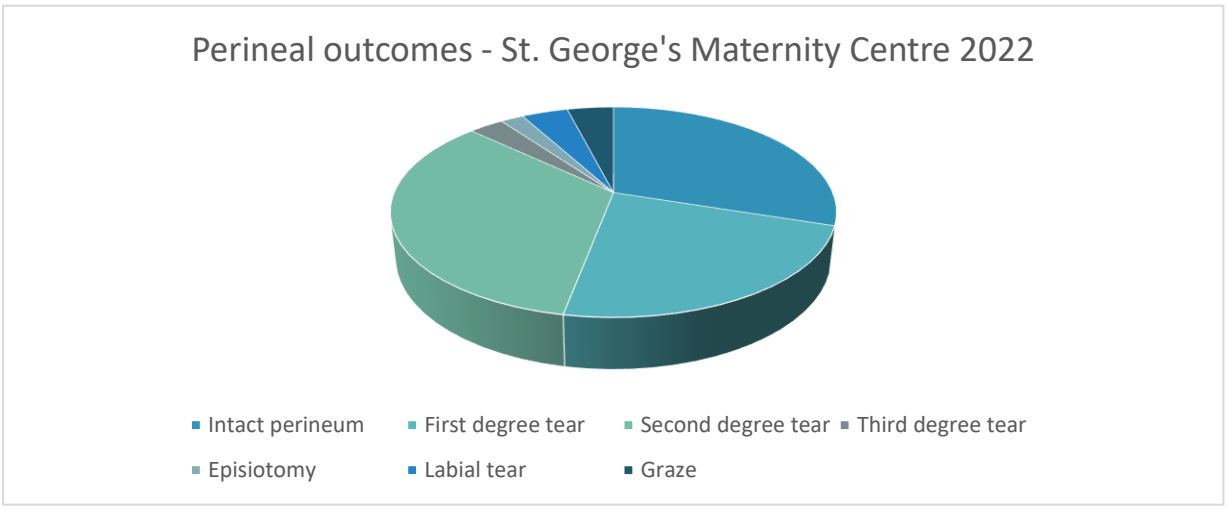


Figure 36. Perineal outcomes - St. George's Maternity Centre 2022



TRANSFER FROM ST GEORGE'S MATERNITY CENTRE TO CHRISTCHURCH WOMENS HOSPITAL – MATERNAL OUTCOMES

2021

- **22%** women transferred in labour (n = 77)
- **43** women transferred after birth for maternal reasons
- Total transfer rate before and after birth is **29.6%**

- The postpartum haemorrhage rate for women who birth at St George's Maternity Centre is **3%**
- The reasons for maternal transfer after birth include; retained placenta, suturing, maternal pyrexia, hypertension and post-partum haemorrhage

2022

- **18%** women transferred in labour (n = 144)
- **46** women transferred after birth for maternal reasons
- Total transfer rate before and after birth is **32%**
- The postpartum haemorrhage rate for women who birth at St George's Maternity Centre is **4.9%**
- The reasons for maternal transfer after birth include; retained placenta, suturing, unwell māmā and post-partum haemorrhage

Figure 37. Reasons for transfer St. George's Maternity Centre 202

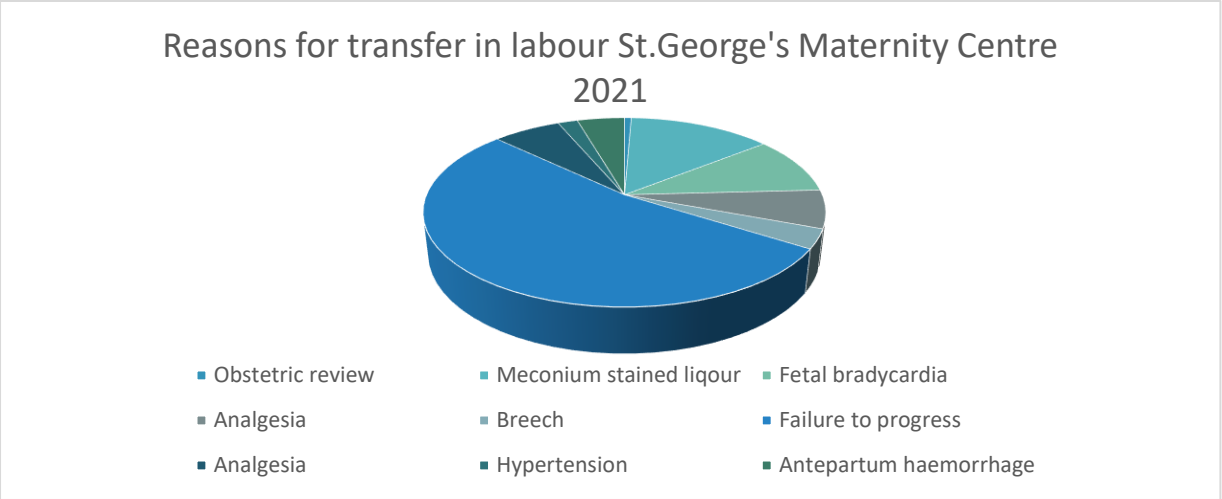
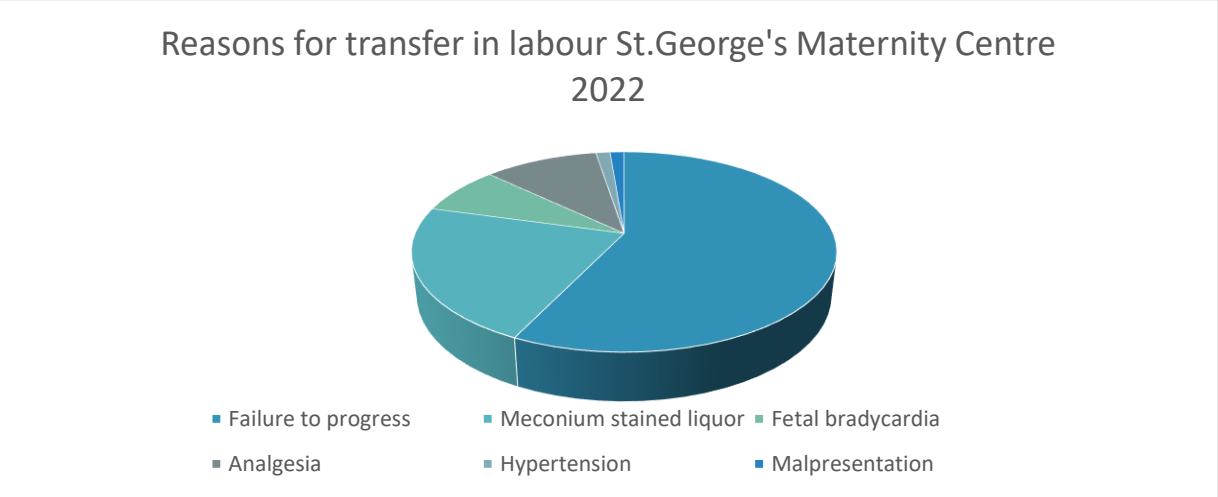


Figure 38. Reasons for transfer in labour St. George's Maternity Centre 2022



NEONATAL OUTCOMES

- **34** babies were retrieved
- The rate of neonatal retrieval for babies born at St George's Maternity is **7%**

- Data unavailable to report length of stay in NICU for babies retrieved from St George's Maternity Centre, as this is not shared from Te Whatu Ora Waitaha

Figure 39. Ethnicity of births for St. George's Maternity Centre 2021

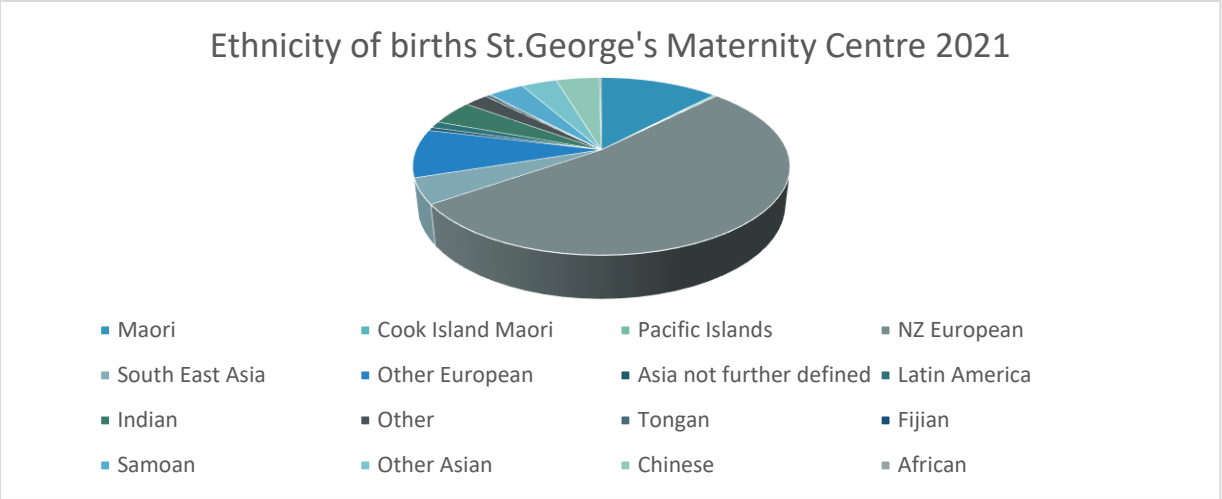
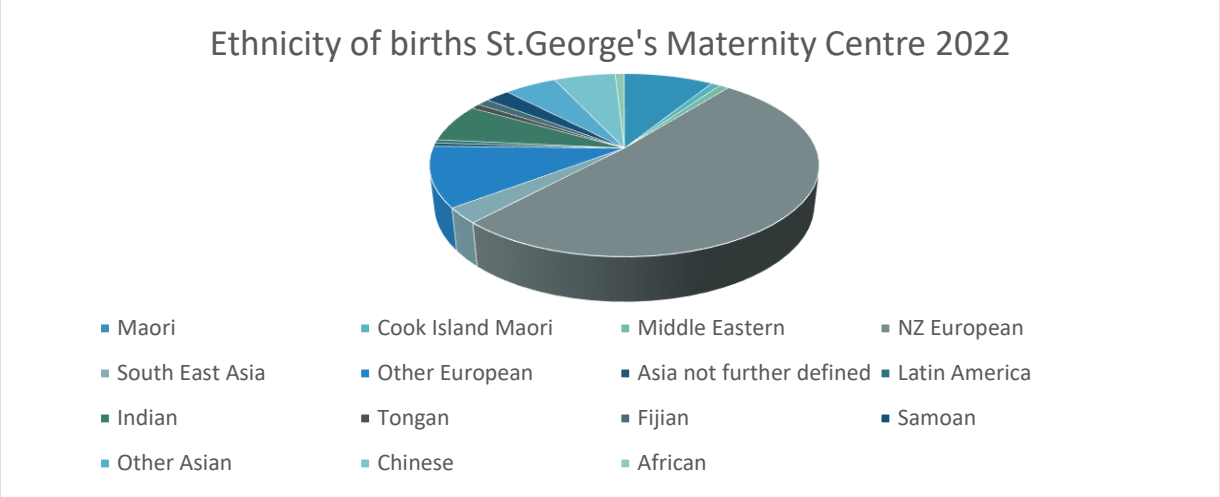


Figure 40. Ethnicity of births St. George's Maternity Centre 2022



WOMEN BIRTHING AT KAIKOURA HEALTH HUB 2021 - 2022

(Limited data available)

2021 – 10 BIRTHS

(October – December 2021)

- Of the 5 woman planning to birth in Kaikoura 40% did so (n=2)

2022 – 9 BIRTHS

APPENDIX 2

NEW ZEALAND MATERNITY CLINICAL INDICATORS

INDICATOR 1 - REGISTRATION WITH A LEAD MATERNITY CARER IN THE FIRST TRIMESTER OF PREGNANCY

Figure 41. Te Whatu Ora Waitaha rates for registration with an LMC in the first trimester of pregnancy 2009 - 2020 (All population groups)

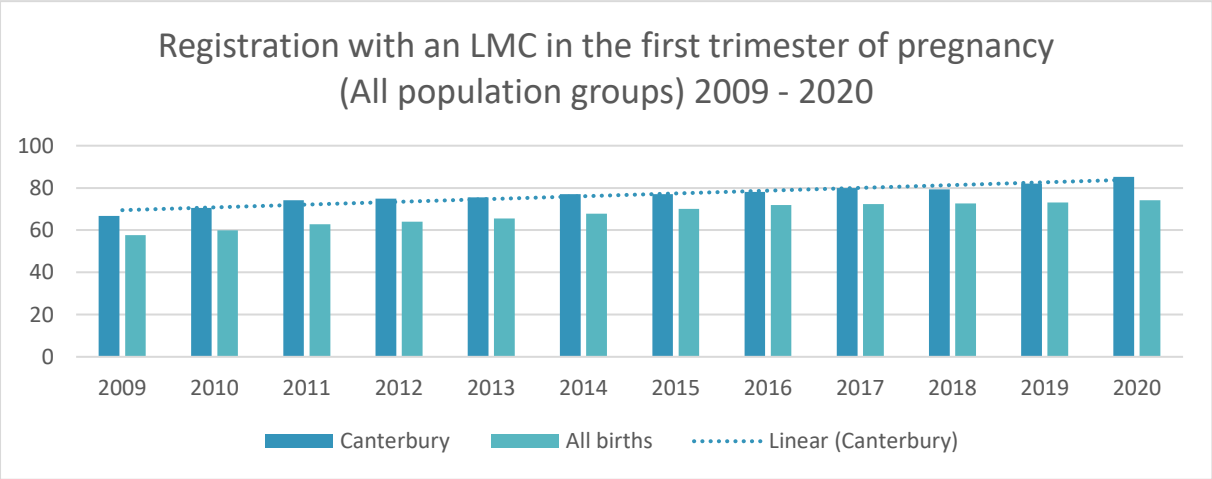


Figure 42. Te Whatu Ora Waitaha registration with an LMC in the first trimester of pregnancy (Māori) 2009 - 2020

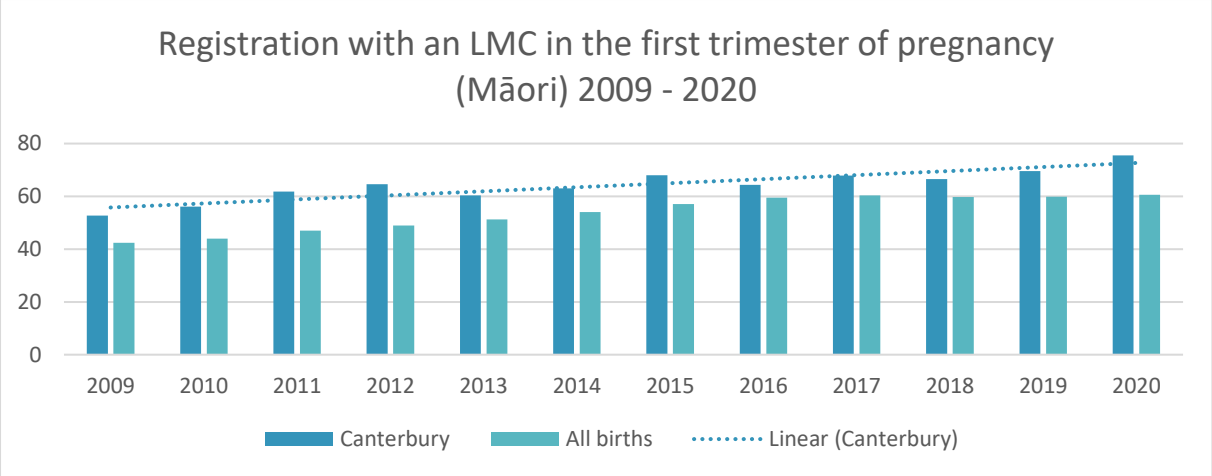


Figure 43. Te Whatu Ora Waitaha registration with an LMC in the first trimester in pregnancy (Pacific Peoples) 2009 - 2020

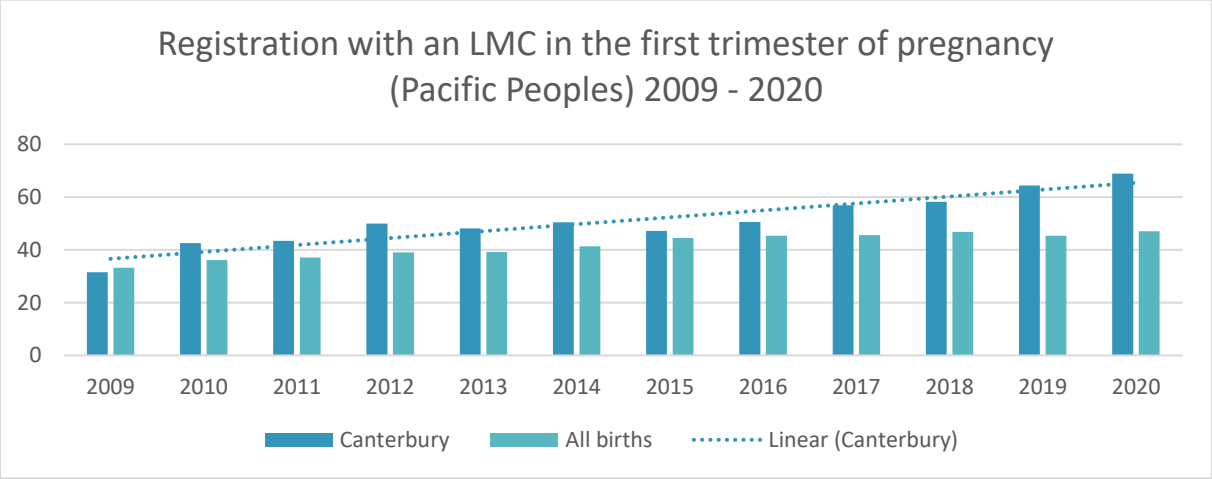
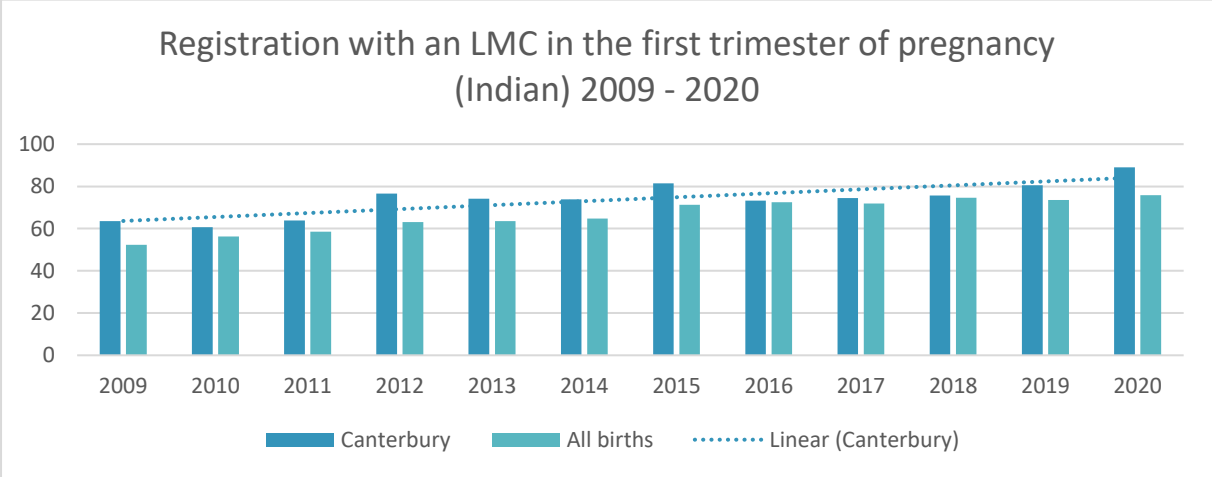
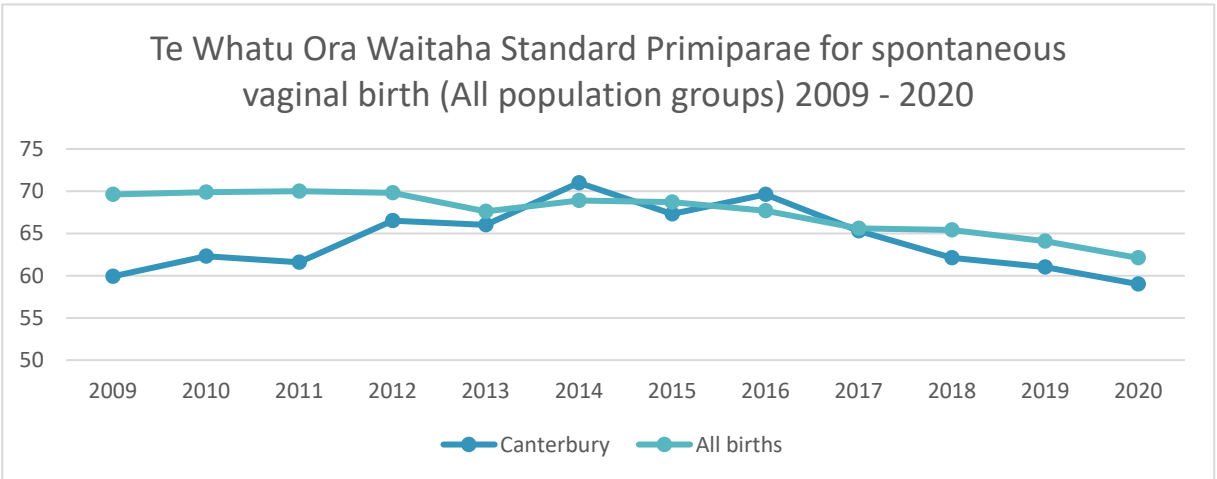


Figure 44. Te Whatu Ora Waitaha registration with an LMC in the first trimester of pregnancy (Indian) 2009 - 2020



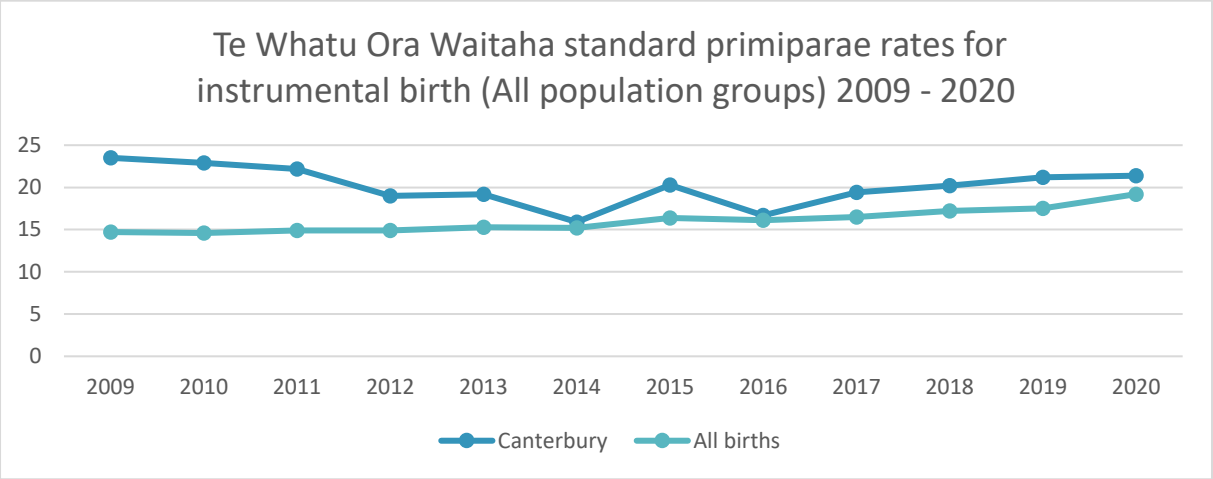
INDICATOR 2 - SPONTANEOUS VAGINAL BIRTH

Figure 45. Te Whatu Ora Waitaha Standard Primiparae rates for spontaneous vaginal births (all population groups) 2009 - 2020



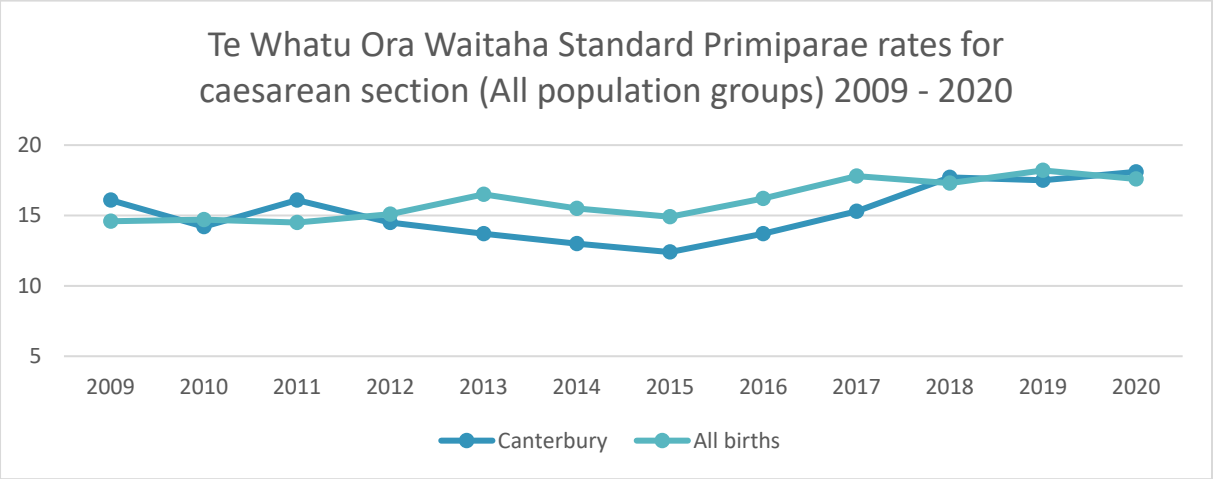
INDICATOR 3 - INSTRUMENTAL VAGINAL BIRTH

Figure 46. Te Whatu Ora Waitaha Standard Primiparae rates for instrumental birth (All population groups) 2009 - 2020



INDICATOR 4 – CAESAREN SECTION

Figure 47. Te Whatu Ora Waitaha Standard Primiparae Rates for Caesarean Section (All population groups) 2009 - 2020



INDICATOR 5 - INDUCTION OF LABOUR

Figure 48. Te Whatu Ora Waitaha Standard Primiparae Rates for Induction of Labour (All population groups) 2009 - 2020

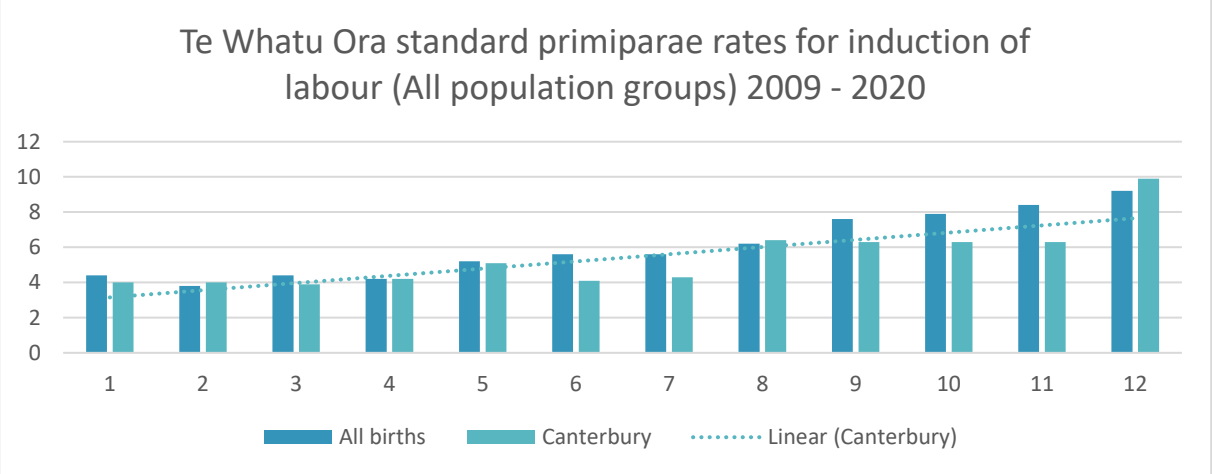
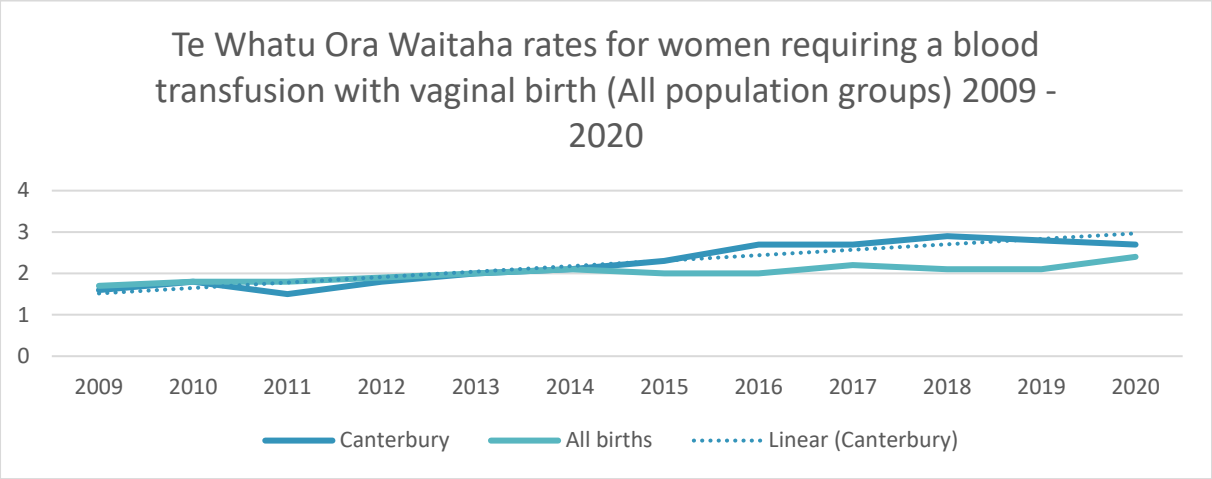


Figure 49. Te Whatu Ora Waitaha rates for women requiring a blood transfusion with vaginal birth (All population groups) 2009 - 2020



APPENDIX 3

TE WHATU ORA WAITAHA DATA ANALYSIS

TE WHATU ORA WAITAHA GESTATION AT BIRTH BY POPULATION GROUP 2021 AND 2022

Figure 50. Te Whatu Ora Waitaha Gestation at birth by population group 2021

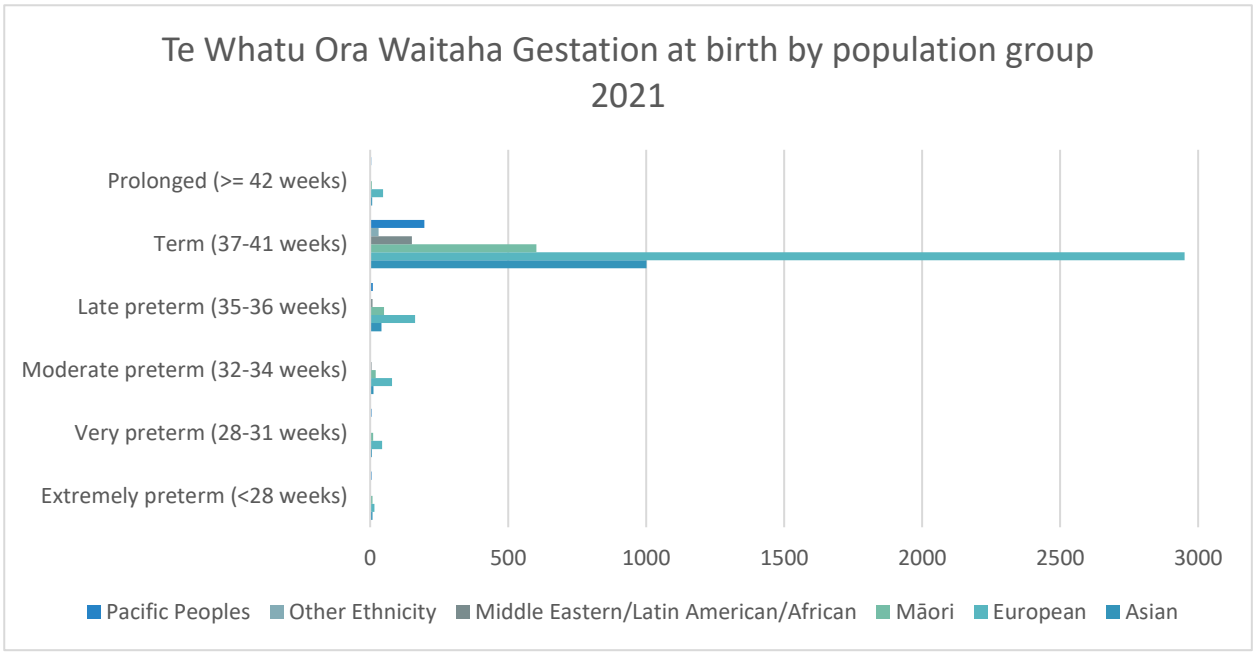


Figure 51. Te Whatu Ora Waitaha Gestation of birth by population group 2022

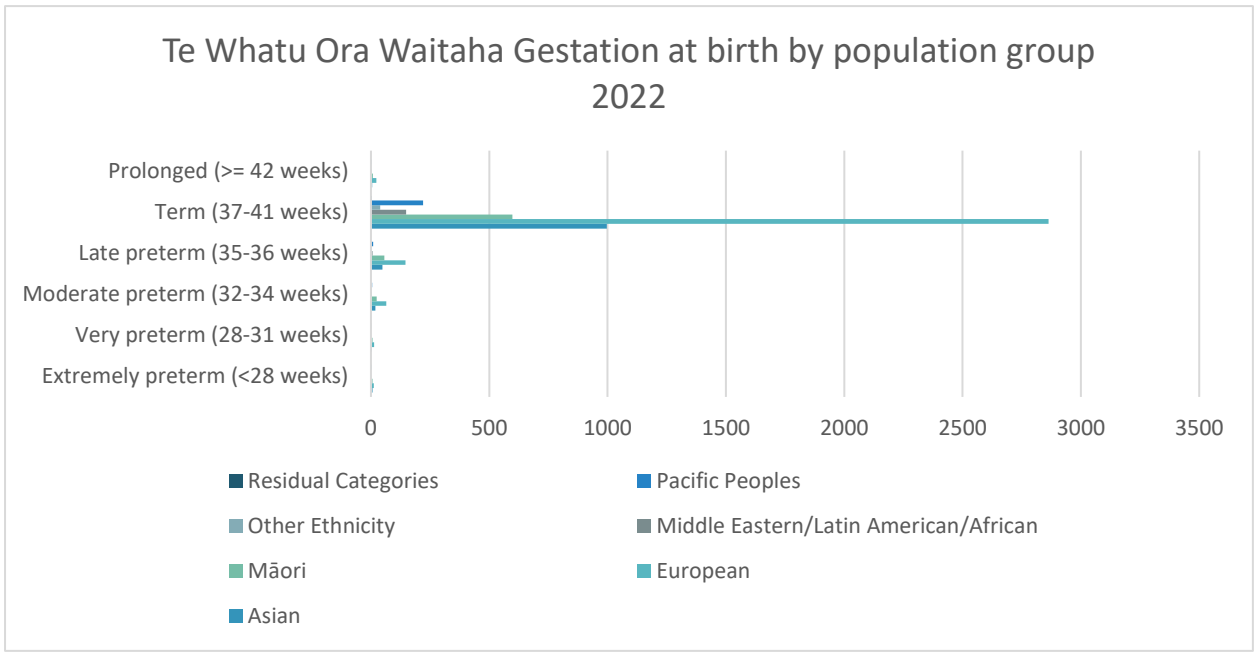


Figure 52. Te Whatu Ora Waitaha Induction of labour by population group 2021

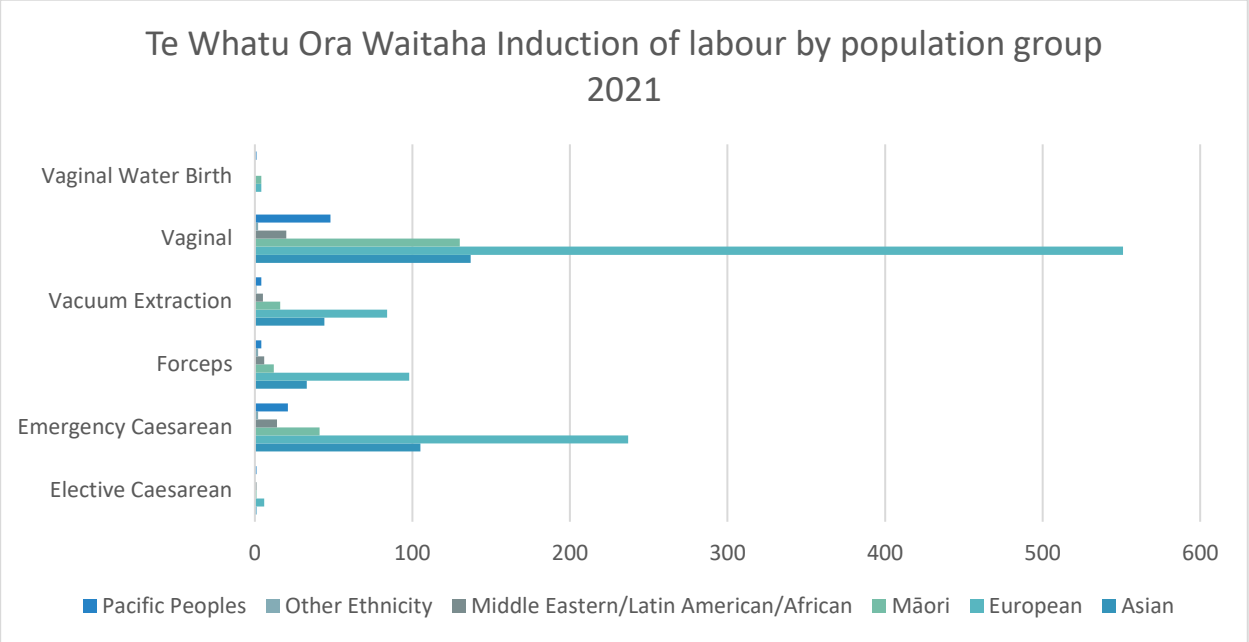


Figure 53. Te Whatu Ora Waitaha Induction of labour by population group 2022

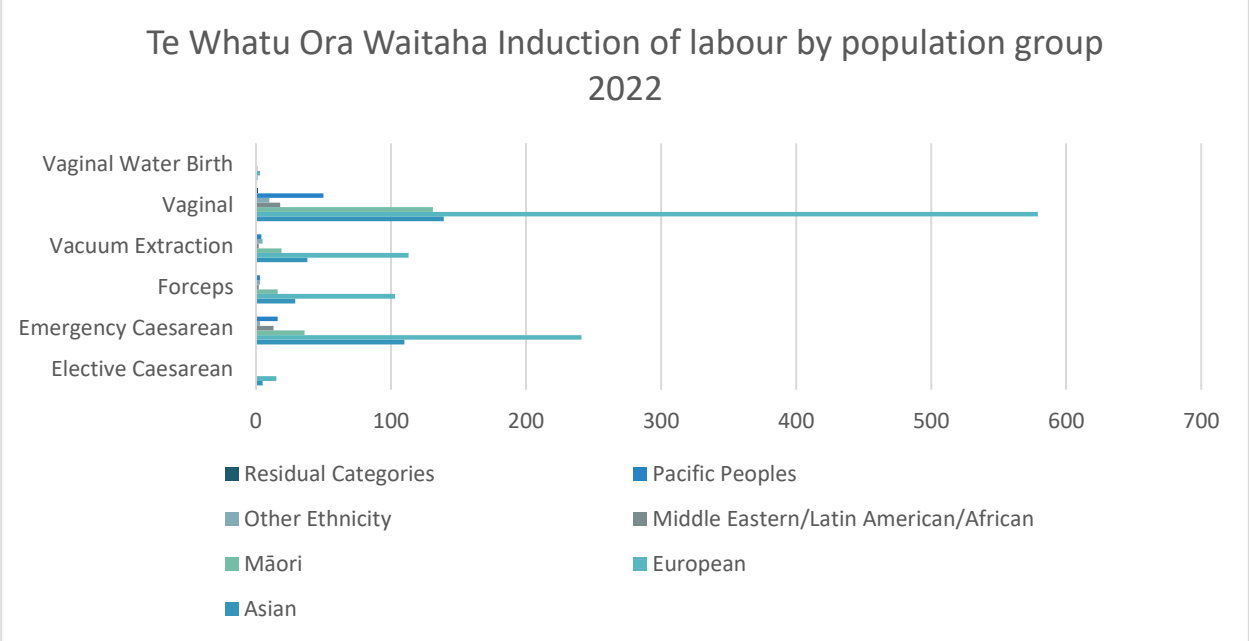


Figure 54. Te Whatu Ora Waitaha Method of birth by population group 2021

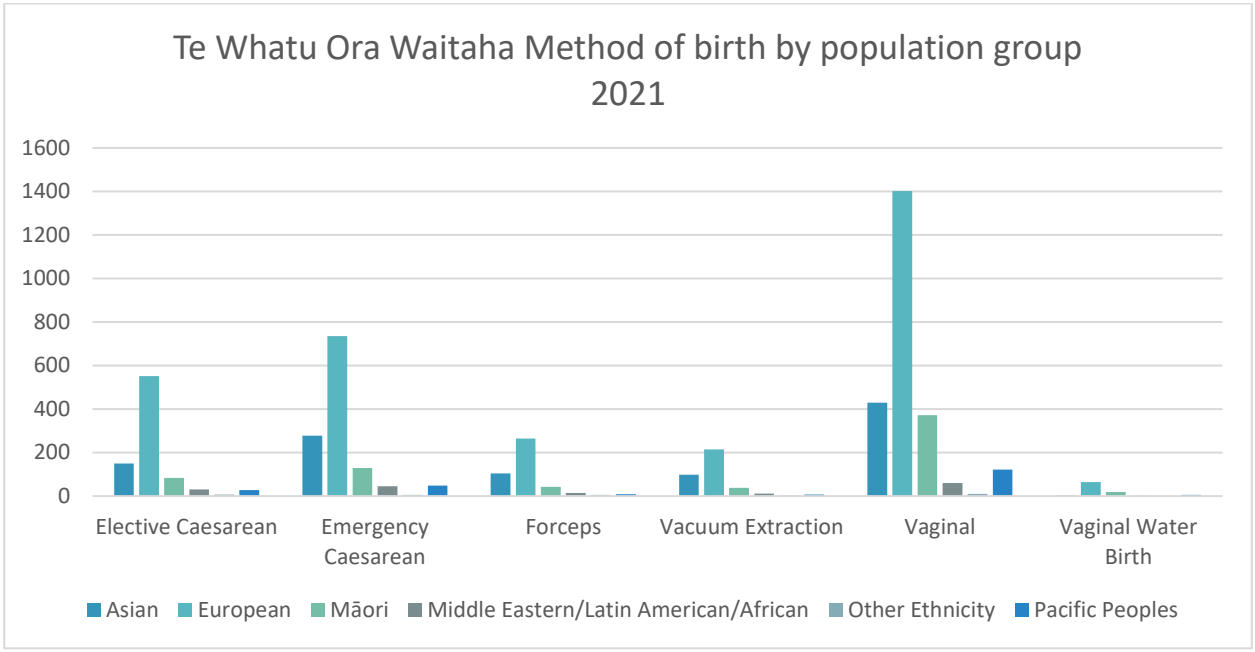
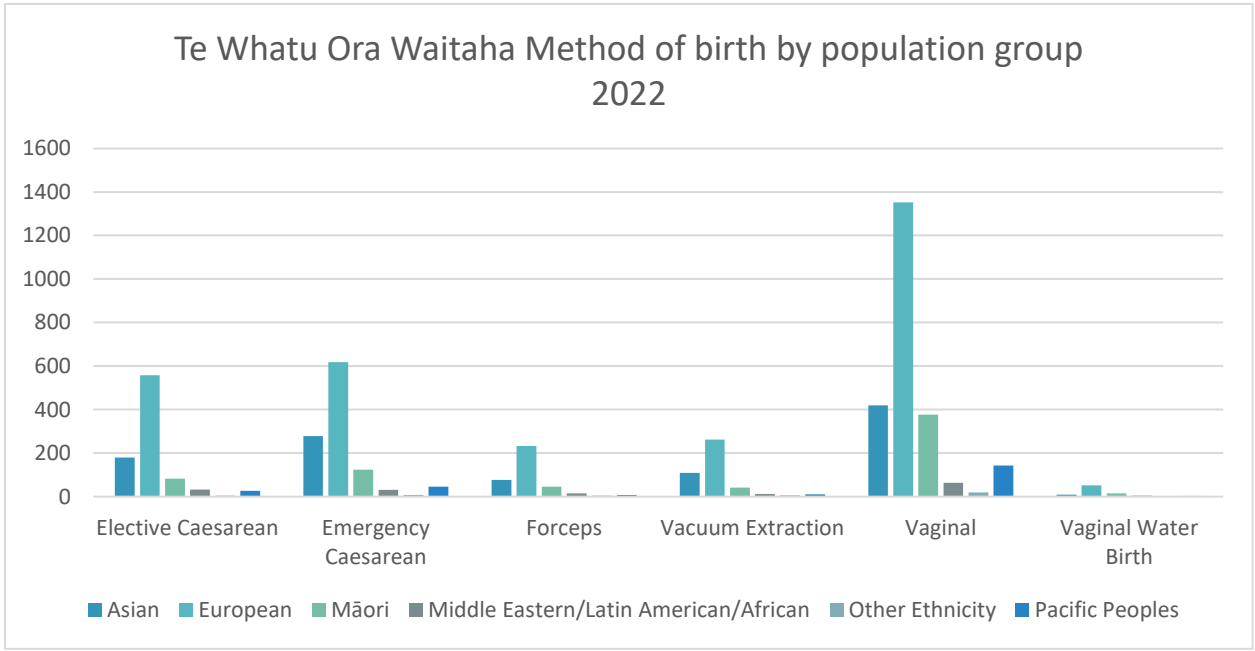


Figure 55. Te Wahtu Ora Waitaha Method of birth by population group 2022



APPENDIX 4

ROBSONS CLASSIFICATION (WITH SUBDIVISIONS)

GROUP	CLINICAL CHARACTERISTICS
1	Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour
2	Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced or were delivered by caesarean section before labour
2a	Labour induced
2b	Pre-labour caesarean section
3	Multiparous women without a previous caesarean section, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour
4	Multiparous women without a previous caesarean section, with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced or were delivered by caesarean section before labour
4a	Labour induced
4b	Pre-labour caesarean section
5	All multiparous women with at least one previous CS, with a single cephalic pregnancy, ≥37 weeks gestation
5.1	With one previous caesarean section
5.2	With two or more previous caesarean sections
6	All nulliparous women with a single breech pregnancy
7	All multiparous women with a single breech pregnancy including women with previous caesarean section(s)
8	All women with multiple pregnancies including women with previous caesarean section(s)
9	All women with a single pregnancy with a transverse or oblique lie, including women with previous caesarean sections(s)
10	All women with a single cephalic pregnancy < 37 weeks gestation, including women with previous caesarean section(s)

APPENDIX 5

MQSP PRIORITIES AND ACTION PLAN 2023/24

	Initiative/Priority	Action	Expected Outcome	Measure
1.	MEWS audit and case review Morbidity review identified through trigger tool HQSC Patient Deterioration Programme. 2019	• Continued audit of MEWS charts used in all CDHB Maternity areas • Continued review of all ICU admissions and escalations for review • Continued work to rollout MEWS across the rest of the district as national work on the maternity module for Patientrak progresses	• MEWS is completed for all maternity inpatients • When MEWS is rolled out across the district that a MEWS is completed for all women from positive pregnancy test to six weeks postpartum	• Auditing of MEWS demonstrates: - Frequency of observations are appropriate - All vital signs are completed correctly - MEWS scores are correctly calculated - Escalations made due to an increased MEWS score are followed as per hospital pathway
2.	Encouraging low-risk women to birth at home or in a primary facility Promotion of primary birthing facilities MQSP 5 of 2020/21 priorities and action plan NMMG Work plan, 2019 Canterbury Maternity System Strategic Framework, 2019	• Further investigation of what determines women's preferences regarding place of birth • Build on quality initiatives already developed to promote primary birthing units • Develop strategies to further support LMCs to utilise primary birthing units and support homebirth	• Increase in number of women choosing to birth or have postnatal care in primary birthing units • More women commence their labours at midwifery led units, or at home.	• Bed occupation and birth location indicates increasing usage of primary birthing units

	Initiative/Priority	Action	Expected Outcome	Measure
3.	Equitable access to postpartum contraception, including regular audit NMMG Workplan, 2019	• Audit local LARC services over a twelve-month period to determine trends and areas for improvement • Progress training with NZ Family Planning to provide training for midwives to widen access for women.	• Increase in the number of women accessing LARC	• Evidence of audit shows access and uptake of LARC in all community groups
4.	Reduce preterm birth and neonatal mortality NMMG Workplan, 2019 PMMRC recommendations, 2021 and 2022	• Using local data determine the priority areas to focus on for 2020/21 • Following community engagement formulate action plans to address areas for improvement, particularly Induction of labour/ Instrumental birth and caesarean section • Consider quality initiatives around timing of birth/gestation • Consider further support for early engagement and processes to ensure follow up for women with previous preterm birth	• Data is used to evaluate the effectiveness of previous actions and plan future actions • Capture quality improvement activity resulting from community engagement	• Evidence of improvement in preterm birth rates as identified through our local data
5.	To continue to improve the screening and referral rates of women for family violence MQSP 6 of 2020/21 priorities and action plan	• A plan for regular, mandatory training is made annually and all employed staff working in maternity services are attending these sessions once per year	• Health professionals working in the maternity setting have all received training and are confident to screen for family violence	• Evidence of regular audits shows improved family violence screening results for pregnant women accessing maternity services

	Initiative/Priority	Action	Expected Outcome	Measure
	Canterbury Maternity System Strategic Framework, 2019	• Survey staff to ascertain the barriers to staff carrying out this screening	• Women in violent and/or psychologically harmful relationships increasingly feel able to disclose this and work towards safety • The training sessions address the barriers that staff have identified • Health professionals are familiar with the screening tool and referrals process	
6.	Monitor key maternity indicators by ethnicity to identify variations in outcomes & improve areas where there are differences in outcome Co-design models of care to meet the needs of Indian women PMMRC Recommendation, 2021 and 2022 Canterbury Maternity System Strategic Framework, 2019	• Continue to review local data • Continue to work with community groups to develop a programme of work tailored and targeted at their population group to improve maternity care and clinical outcomes for example, BMI, gestational diabetes and access to services, for example ultrasound	• To have an engaged community that is working with the maternity service on a programme of work to provide health literacy, navigation and supports for their population groups	• Improved early engagement with maternity services across the population groups • Increased referral for services to improve clinical outcomes and health e.g., smoking cessation referrals
7.	To reduce local postpartum haemorrhage (PPH) rate and sequelae, i.e., blood transfusion rates	• Continue to review local data to inform potential contributory factors for increased rates • Utilise audit results to formulate an action plan to address postpartum haemorrhage rates • Develop a multidisciplinary group to implement the agreed action plan	• An agreed pathway/risk matrix is developed for the management of the third stage of labour, based on best practice evidence • Staff are aware of the content of the revised pathway/risk matrix and women receive treatment in line with it • All clinical staff to attend regular practical	• A re audit of all postpartum haemorrhages shows: a. the agreed pathway is being b. there is a reduction in the rate of blood transfusion c. there is a decreased rate of PPH

	Initiative/Priority	Action	Expected Outcome	Measure
			multiprofessional team training on management of postpartum haemorrhage	•
8.	Continue to review local clinical outcomes and monitor district variation	• Multidisciplinary review of maternity clinical indicators using local data including perineal trauma, induction of labour, caesarean section and instrumental birth rates • Evaluation whether previous actions have impacted on data • Formulate action plan to address areas for improvement	• Data is used to evaluate the effectiveness of previous actions and plan future actions • Capture quality improvement activity resulting from comparing local outcomes to national trends	• There is evidence of a direct correlation between clinical indicator data and relevant quality improvement initiatives and/or changes in practice
9.	Workforce development PMMRC Recommendations, 2021 and 2022 Canterbury Maternity System Strategic Framework, 2019 NMMG Workplan, 2019	• Continue to build a culturally and linguistically diverse maternity workforce to meet the needs of our community with a priority on the development of our Māori workforce • Successful implementation of Kaiāwhina role at Christchurch Women's Hospital	• Health professionals working in the maternity setting have received cultural safety education • Kaiāwhina workforce is implemented in the maternity setting • Models of maternity care centre around Te Ao Māori	• Regular feedback from māmā and whanāu demonstrate a high level of consumer safety

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