Health New Zealand

Te Whatu Ora

Canterbury Waitaha

MATERNITY QUALITY AND SAFETY PROGRAMME

Annual Report

Pūrongo-a-tau

2022 - 23

Health New Zealand
Te Whatu Ora

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Maternity Whānau Voice Hui

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.

ACKNOWLEDGEMENT OF GENDER

Health NZ acknowledge that not all people who become pregnant identify as women or female. In line with HISO 10050:2023 Maternity Care Summary Standard, gender neutral terms are included alongside gendered terms where possible in this report in an effort to ensure greater inclusion and representation.

DISCLAIMER

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

Health NZ 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. Health NZ information will also include homebirths and private birthing facilities (such as St. Georges Maternity Centre). 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 Health NZ 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.

Health NZ Canterbury Waitaha information includes data for those women birthing, and babies born in Canterbury 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 Health NZ Canterbury Waitaha Service Improvement & Innovation 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

Whakataukī: *Nā tō rourou, nā taku rourou ka ora ai te iwi* – With your food basket and my food basket, the people will thrive.

This whakataukī embodies the collaborative approach essential to ensuring the wellbeing of hapū whānau, pēpi, and mothers. Midwives and multidisciplinary teams bring their skills, mātauranga, and expertise to support whānau as they navigate the hapūtanga continuum. By working together to ensure timely access to secondary and tertiary services, whānau receive care that enriches their journey. This whakataukī reflects the spirit of a collective and integrated approach to maternity care across Waitaha while recognising its strengths and, addressing areas for improvement.

The 2023 Maternity Quality and Safety Report reflects our growing understanding of *Pae Ora – Healthy Futures* and its application to whānau within community maternity services and Christchurch Women's Hospital. This year has focused on whakawhanaungatanga—strengthening collaboration and, kia takatū ki te rereke—preparing for change. We have embraced opportunities to grow, adapt, and reaffirm our commitment to whānau and communities accessing maternity services amidst significant national health system changes.

Central to these efforts is understanding the experiences of whānau and how services build meaningful relationships to support them. In 2022 and 2023, Nurturing Care hui were held across Te Waipounamu to strengthen cross-sector relationships using *Te Pā Harakeke* as a framework. These hui informed providers about work being done across services during the critical first 2000 days of a child's life. They also provided key recommendations for the Kahu Taurima section of the Te Waipounamu Regional Health and Wellbeing Plan.

As we anticipated the opening of the Central Birthing Unit in Ōtautahi, Kurawaka Waipapa—a name gifted by Te Maire Tau of Te Ngāi Tūāhuriri—was chosen for its profound significance in Te Ao Māori. It represents the sacred place where the first human, Hine-ahu-one, was created by Tāne. To prepare for this milestone, the Canterbury Clinical Network facilitated a series of hui with diverse communities across Waitaha. These gatherings captured the stories, aspirations, and values of the community, shaping the tikanga of Kurawaka Waipapa as envisioned by its people. The mātauranga gathered will guide the development of birthing units throughout Waitaha.

The establishment of Kaiawhina roles at Christchurch Women's Hospital introduced a fresh approach to meeting whānau needs in a busy tertiary environment. This initiative aimed to improve whānau experiences within the maternity system by increasing Māori and Pacific representation in the health workforce. It has inspired cultural responsiveness and innovation within our practices, particularly as we prepared for the opening of Kurawaka Waipapa.

Acknowledging the vital importance of mental health during and after pregnancy, the Birth Afterthoughts Clinic was established in early 2023. This compassionate service provides a safe space for whānau to discuss and process their birthing experiences—an essential step in understanding their maternity journey. Led by midwives pursuing counselling qualifications, and accessible via

LMC, hospital, community, or self-referral, this service has proven invaluable in guiding whānau toward understanding their maternity experience, mental health pathways and quality improvement in service delivery.

Since October 2020, we have been recording birthing outcome data through a maternity dashboard. Developed with our data analyst team, this up-to-date infographic, accessible via "Power BI - Seeing Our System" on Health Connect South, showcases outcomes for birthing mothers in Waitaha. This tool highlights areas of success and areas needing attention to improve care. Notably, the dashboard incorporates the Robson Ten Group Classification system, allowing us to analyse outcomes based on features such as parity, previous birth history, and whether labour onset was spontaneous or induced. This facilitates trend analysis over time and helps assess the impact of new treatments or policies on whānau care.

Showcasing the vibrant city of Ōtautahi, we were privileged to host the bi-annual Midwifery Conference in October and the Perinatal Society of Australia and New Zealand (PSANZ) conference in early 2024. These events underscore our commitment to innovation, excellence, and opportunities for connection with colleagues across Aotearoa and Australasia.

To everyone involved in this journey, our LMCs, community units, staff, stakeholders and especially the whānau we are privileged to serve—we extend our deepest gratitude. This report reflects our ongoing commitment to providing safe, equitable, and culturally attuned maternity care, weaving together the strength of many for the benefit of all.

Nau mai, haere mai—welcome to the 2023 Maternity Quality and Safety Report for Waitaha.

Kathleen Maki
Associate Director of Midwifery,
Health New Zealand Canterbury

Emma Jackson
Clinical Director, Obstetrics and Gynaecology,
Health New Zealand Canterbury

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OVERVIEW

BACKGROUND

This is the ninth 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

Health NZ Canterbury Waitaha is committed to improving the quality and safety of maternity services for consumers.

Canterbury 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 Health NZ 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 14.

PURPOSE

The purpose of this report is to provide information about Maternity services in Health NZ 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 Health NZ New Zealand Maternity Clinical Indicator Trends 2009 and 2022 (2024)
- Response to consumer feedback and ongoing consumer involvement
- Quality initiative goals for 2024/25

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
CBU	Community Birthing Unit
CS	Caesarean section
CWH	Christchurch Women's Hospital
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
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
RMO	Resident Medical Officer
SMO	Senior Medical Officer
SP	Standard Primiparae
SUDI	Sudden Unexpected Death in Infancy
W&CH	Women's and Children's Health

CANTERBURY WAITAHA MATERNITY STRATEGY

OUR VISION

Canterbury 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).

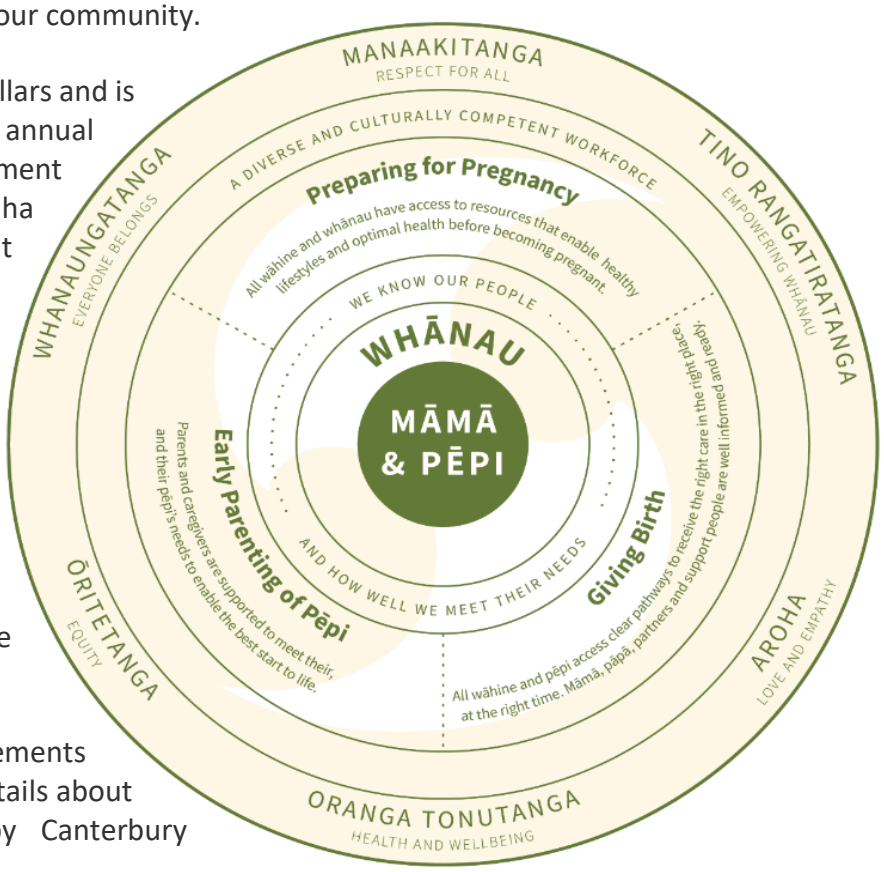
AROHA LOVE AND EMPATHY

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 Canterbury Waitaha Maternity Strategy also known as the Canterbury Maternity System Strategic Framework (2019-2024) (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 Health NZ Canterbury 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 Canterbury 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. Work still in progress has been rolled over to the 2024/2025 MQSP priorities and action plan.

OUR REGION

Health New Zealand Canterbury Waitaha is the second largest district in the country by both geographical area and population size - serving an estimated 651,000 people (13.0% of the New Zealand population) Stats NZ Tatauranga Aotearoa (NZ, 2024) in 2023, and covering 26,881 square kilometres.

There are three separate divisions within Health NZ Canterbury Waitaha responsible for providing maternity services; Women's and Children's Health (W&CH), Ashburton and Rural Health services, which includes the Chatham Islands. Health NZ Canterbury Waitaha also had a contract with St. George's Hospital, Maternity Centre to provide inpatient maternity care which ceased in June 2023.

CANTERBURY WAITAHA AND WEST COAST TE TAI O POUTINI 'TRANSALPINE' RELATIONSHIP

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

Health NZ Canterbury 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.

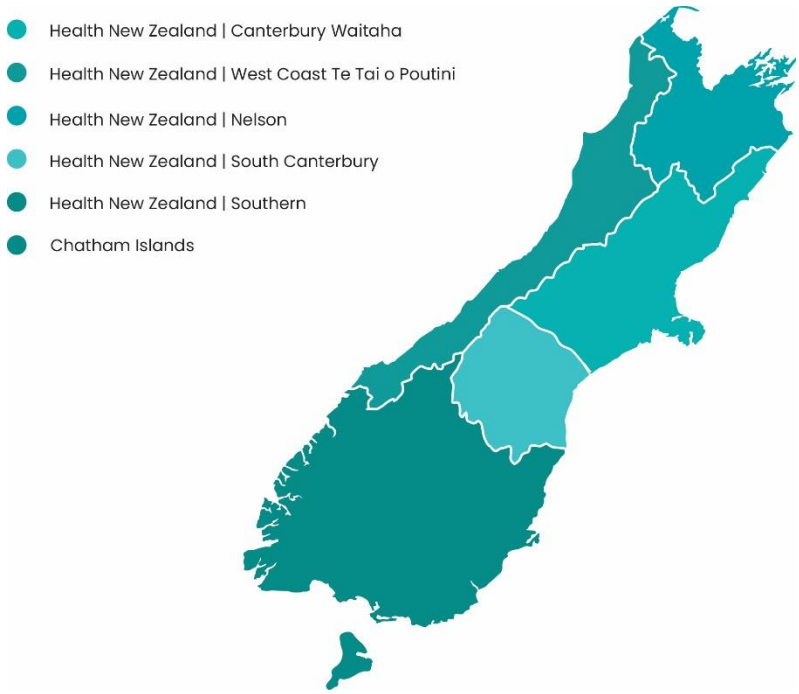


Figure 1. South Island Te Waipounamu District Boundaries

OUR COMMUNITY

Our community demographics are taken from the New Zealand Maternity Clinical Indicator Trends 2009 and 2022 (2024), Report on Maternity web tool (2024) These are the latest published reports and have been used to provide a visual picture of health statistics for women giving birth in Canterbury Waitaha in 2022/2023 which pair with the data presented in the New Zealand Maternity Clinical Indicators and illustrated in this report.

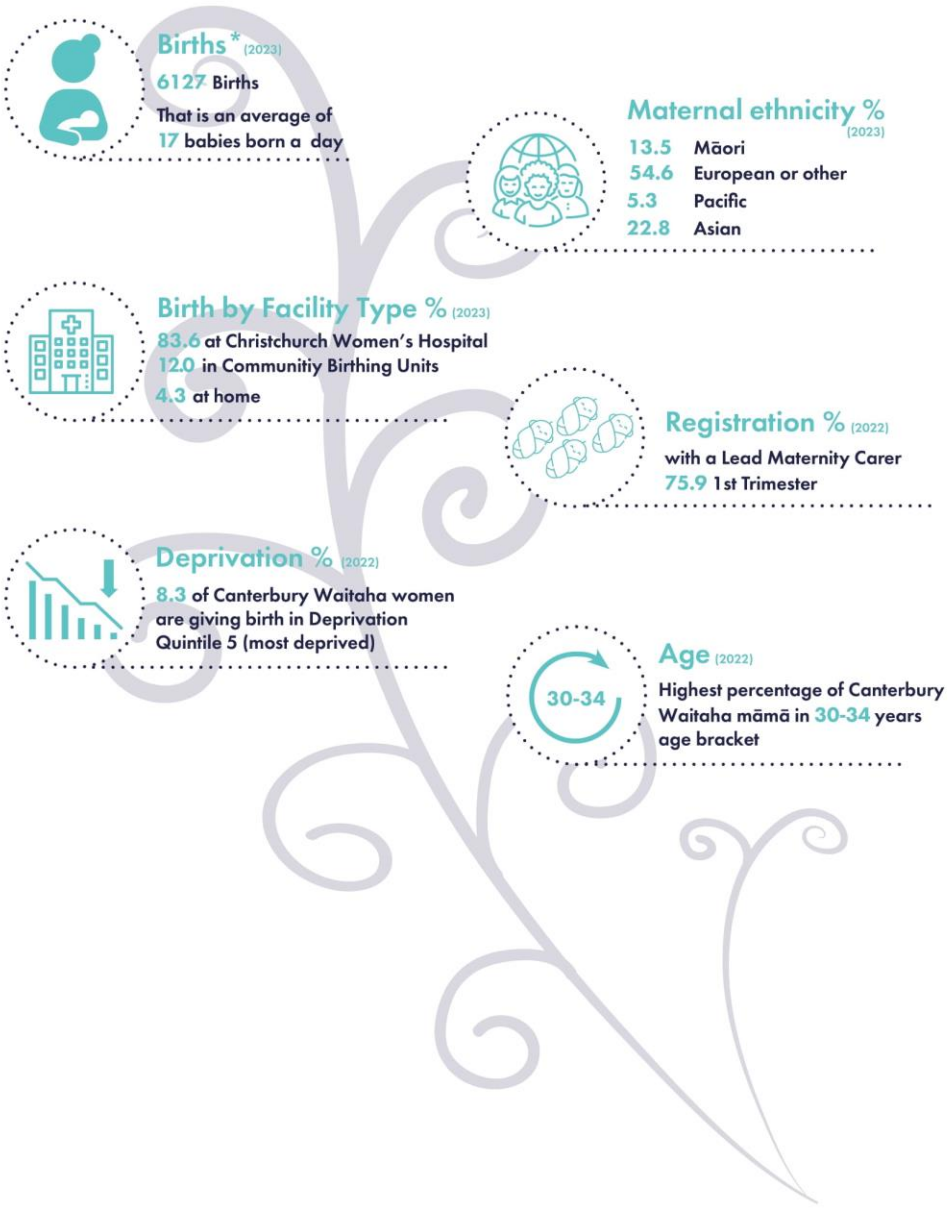


Figure 2. Health NZ Te Whatu Ora Waitaha Canterbury snapshot for women giving birth in 2022 and 2023

OUR MATERNITY SERVICES

There are a range of Maternity facilities available to women in Canterbury Waitaha (Table 1). Christchurch Women's Hospital (CWH) is the only tertiary facility and accepts referrals from Canterbury Waitaha and the West Coast 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 Health NZ West Coast Te Pai o Poutini primary and secondary units and Canterbury Waitaha community birthing units and homebirths are transferred to Christchurch Women's Hospital.

Figure 3 gives a visual representation of place of residence for rural and remote rural women birthing in Canterbury Waitaha in 2023. It also provides an indication of the number 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 Health NZ Canterbury 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. Canterbury Waitaha Maternity Facilities

Primary	**Women's and Children's Health Division**	**Ashburton**	**Rural Health Services**
	○ Rangiora Community Birthing Unit ○ St George's Maternity Centre (closed June 2023) ○ Oromairaki Community Birthing Unit (opened May 2022) ○ Kurawaka:Waipapa Community Birthing Unit (opened April 2024)	○ Ashburton Community Birthing Unit	○ Chatham Islands (since 2015) ○ Kaikoura Community Birthing Unit
Tertiary	Christchurch Women's Hospital		

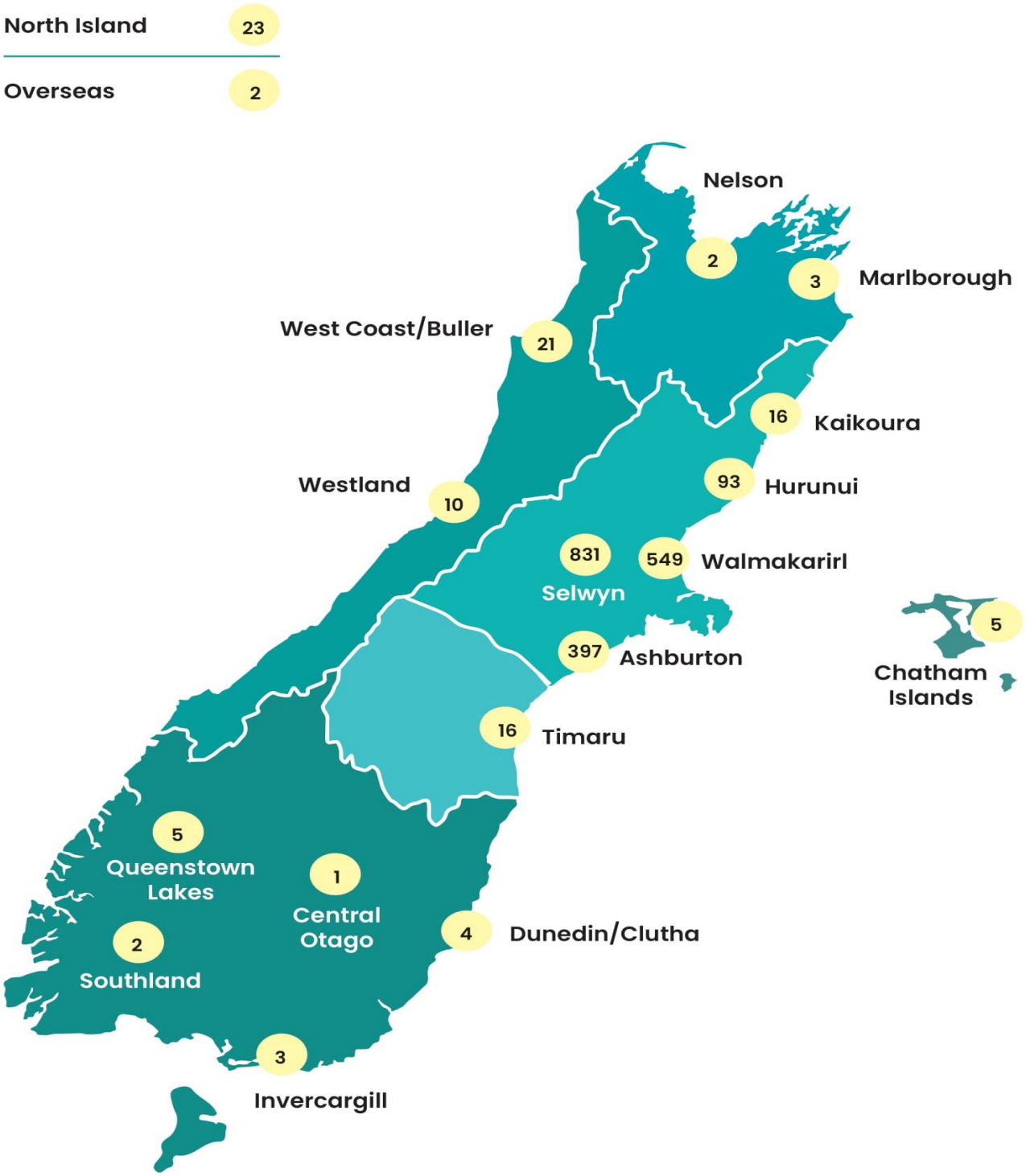


Figure 3. Place of residence for rural and remote rural women birthing in Canterbury Waitaha 2023

A high proportion of our birthing women choose Christchurch Women's Hospital as their place of birth, 83.6% gave birth at the secondary/tertiary maternity facility in 2023. Work to increase birth numbers in our community birthing units has been active and ongoing since 2010, and it remains a priority within our maternity strategy and quality planning.

Health NZ Canterbury 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 community birthing units and home birthing since 2009.

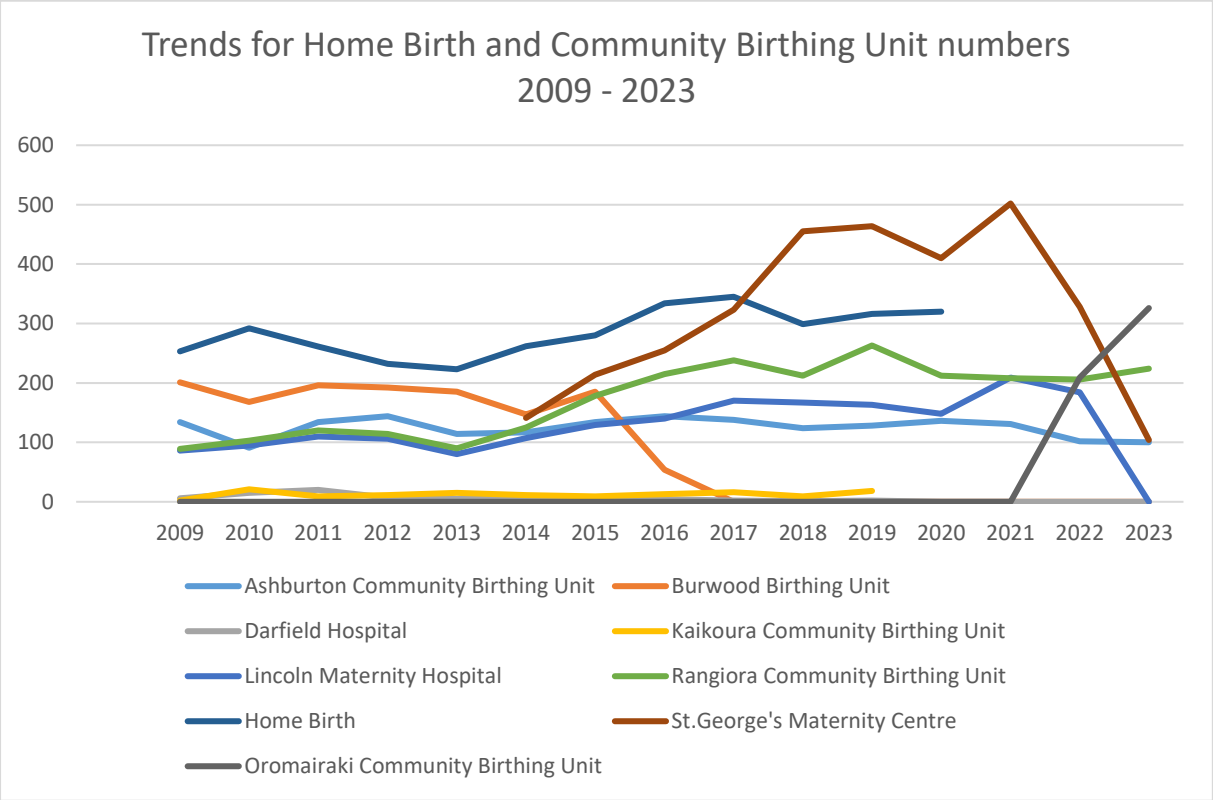


Figure 4. Canterbury Waitaha Trends for Home Birth and Community Birthing Unit Numbers 2009 – 2023

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

Oromairaki Community Birthing Unit

CANTERBURY WAITAHA MATERNITY HOSPITALS AND COMMUNITY BIRTHING UNITS

Our Maternity facilities extend across Canterbury 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 community birthing units. The following information provides an overview of these facilities and their activity during 2023 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' for whānau experiencing fetal loss
- **13** Rooms for labour and birth
- **2** Pools for water birth
- **4** Admission beds
- **5** Assessment rooms
- **2** Operating theatres
- **45** Antenatal / postnatal unit beds
- **16** Clinic rooms
- **11** Intensive care cots
- **30** Special care cots

RANGIORA COMMUNITY BIRTHING UNIT

JEN CUNNINGHAM,

MIDWIFE MANAGER

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

COMMUNITY BIRTHING UNIT

3 Rooms for labour and birth

2 Pools for water birth

4 Assessment rooms

10 Postnatal rooms

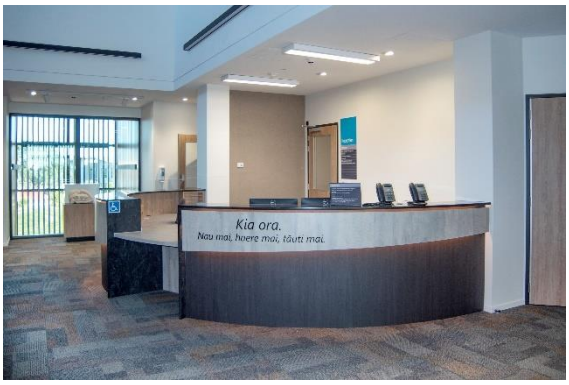
OROMAIRAKI COMMUNITY BIRTHING UNIT

BRONWYN TORRANCE,

MIDWIFE MANAGER

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

COMMUNITY BIRTHING UNIT



Opened May 2022

3 Room for labour and birth

2 Pools for water birth

2 Assessment room

10 Postnatal rooms

ASHBURTON COMMUNITY BIRTHING UNIT

JULIE DOCKRILL,

MIDWIFE MANAGER

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

COMMUNITY BIRTHING UNIT

2 Rooms for labour and birth

1 Pools for water birth

5 Postnatal rooms

KAIKOURA COMMUNITY BIRTHING UNIT

JANAYA COXSON - SMITH, LMC FOR KAIKOURA DISTRICTS

EMMA HERBERT, CHARGE NURSE MANAGER

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

COMMUNITY BIRTHING UNIT

1 Room for labour and birth

2 Postnatal rooms

Kaikoura birthing room

ST. GEORGE'S MATERNITY CENTRE (CLOSED JUNE 2023)

ANDREA ROBINSON,

MIDWIFE MANAGER

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

KURAWAKA:WAIPAPA COMMUNITY BIRTHING UNIT (OPENED APRIL 2024)

KELLY KARA,

MIDWIFE MANAGER

Distance **550m, 2mins from Christchurch Women's Hospital**
COMMUNITY BIRTHJING UNIT

20 Postnatal beds
4 Birthing rooms
6 Assessment rooms

OUR WORKFORCE

Canterbury Waitaha maternity service is provided by our multidisciplinary team of midwives (Lead Maternity Carers (LMC's) and Health NZ Canterbury Waitaha employed midwives, obstetric doctors, General Practitioner's (GP's), physicians, nurses, lactation consultants, allied health, Kaiawhina 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 Health NZ Canterbury Waitaha 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 provides a dedicated and appropriate assessment space for hapu women.

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
- 21.5 FTE Obstetricians and Gynaecologists
- 1.4 FTE Obstetric Physician
- 1 FTE Medical Officers
- 1 FTE Fellows
- 17 FTE Registrars (RMO)
- 9.5 FTE House Officers
- Anaesthetic cover 24/7

In 2023, 394 midwives identified Health NZ Canterbury Waitaha 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 190 (this is across the community birthing units and CWH), with a majority working at Christchurch Women's Hospital. The FTE for CWH is 70.0.
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
- 13 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. 65 ward clerks and hospital aids across the maternity service and 6 Kaiawhina who are all invaluable members of the team.
Six new graduate midwives were employed into the new graduate programme in 2022 and 4 in 2023.

OUR MATERNITY OPERATIONAL GOVERNANCE AND LEADERSHIP

GOVERNANCE STRUCTURE

Health NZ Canterbury 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 every six weeks via videoconferencing and bring together staff from Women's and Children's Health, Ashburton, Rural Health services and St. George's (before the service closed in June 2023).

QUALITY PLANNING AND REPORTING

Figure 5 below gives a graphic representation of the internal and external inputs that inform and drive the Canterbury Waitaha Maternity Quality Governance Group in developing an annual quality plan and MQSP annual report. It also outlines the governance structure and reporting lines within Health NZ Canterbury Waitaha which extend across the health system.

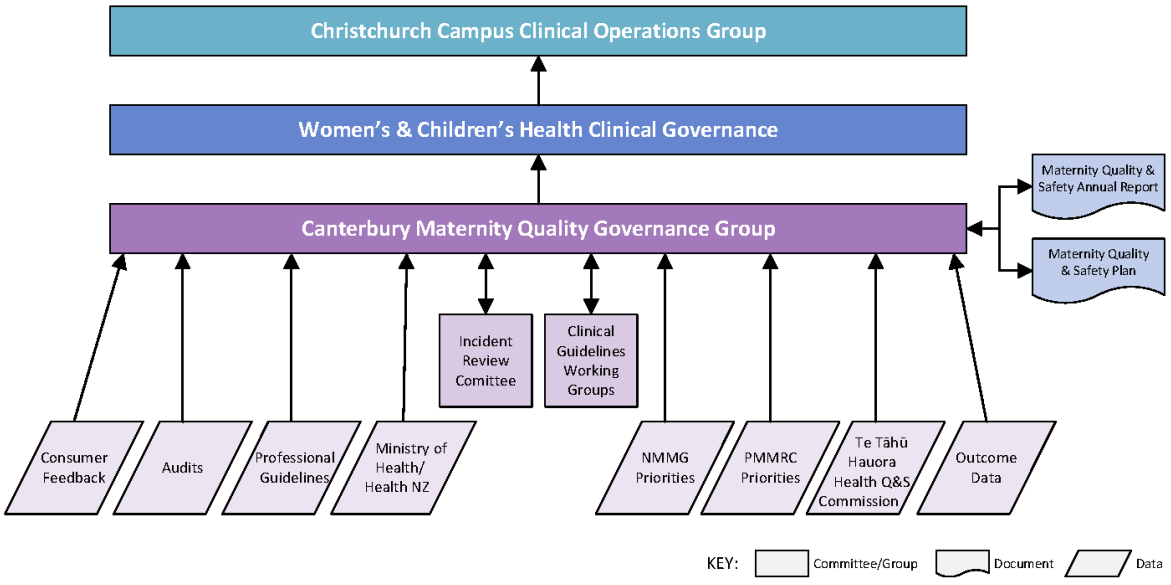


Figure 5. Governance Committee Structure and Reporting Lines

CONSUMER ENGAGEMENT

Engaging with our community through consumers of our maternity service continues to be one of the priorities of the Canterbury Waitaha Maternity Quality and Safety Programme (MQSP). The Maternity Whānau voice hui 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 Maternity Whānau Voice at different hui, for example, the Women's and Children's Clinical Governance, Maternity Quality Governance and the Baby Friendly Hospital Initiative (BFHI) steering group. Members do so as nominated by the group 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.

"As we move toward the maternity annual report I am reflective of last year and the consumer component that I wrote all those months ago to accompany this report. It was clear that there was not only hope but an absolute directive from the top that we had a responsibility to ensure the consumer voice is the loudest voice we listen to in all levels of the health system. Te Whatu Ora and Te Aka Whai Ora were moving at a pace never seen before within the huge engine that is our health system to address and effect change for all who use it.

The kōrero from then to now is a very different one, the conversations with Kaimahi & consumers speak to a massive shift from the acknowledgement and requirement of all parts of the system to actively seek out and engage the whānau voice to disestablishment of some consumer groups around Aotearoa.

Our maternity Whānau Voice roopu has been challenged by the moves within the new world of Houora. We made a clear statement in the initial days of change, that we have not seen a formal letter or received any korero to tell us to stop operating as a consumer group, so until we are told to stop we stay committed to this mahi. The commitment to carry on is built on the wāhine and whanau we serve, they deserve not only quality and safe care that meets their needs in a powerful way but also an ability to communicate those experiences through consumer engagement.

Alongside the MQSP coordinator and others we have put together some kōrero that clearly defines our position in the consumer space, our commitment and drive to continue to meet and hold space for what might come next, the incredible mahi that has been achieved out of this committed roopu is incredible, their heart for others has me in awe. If sitting around a table (can be virtual) is something you can see yourself, a friend or whānau member please nau mai haere mai, come along in our waka!

Our next 12 months are looking exciting, ensuring we are acknowledging the Mana & Tapu of all whānau who have touchpoints in our houora space".

Nga mihi mahana,

Lisa Kahu, Kaiawhina, Te Tai O Marokura
Health & Social Services, Kaikoura
Chairperson Maternity Whānau voice hui

STRENGTHENING AND SUPPORTING OUR MATERNITY TEAM

LMC LIAISON ROLE

SONYA GRAY
LMC LIAISON MIDWIFE

"Hello, my name is Sonya Gray and I am the LMC Liaison. I am a case loading midwife based in North Canterbury. I was selected to the role of LMC Liaison by the Canterbury West Coast Region of the New Zealand College of Midwives.
I attend many meetings within my role of LMC Liaison. The regular meetings are the Maternity Quality Governance Group and the Incident Review Group. I was involved in the working group for the new Community Birthing Unit, Kurawaka: Waipapa, and the working group for the establishment of the Birth Afterthoughts Clinic. I have also attended a variety of other meetings to give the LMC voice and perspective.
I encourage LMC's to attend the LMC forums that are held quarterly to voice any concerns, or to hear new polices that may be coming to CWH.
I meet regularly with the Associate Director of Midwifery and the Chair of the Canterbury West Coast Region for a community catch up, when we had a Director of Midwifery they were involved in this too.
I regularly attend Regional College meetings where I can feedback to the LMC community.
I am available for any LMC's to contact at any time via email if they have anything they want support with".

CARE CAPACITY DEMAND MANAGEMENT [CCDM] PROGRAMME

MARG BURNS
CCDM COORDINATOR HEALTH NZ CANTERBURY WAITAHA

In 2023 the Maternity Ward at Christchurch Women's Hospital participated in national timing studies for Transitional Baby [TCB] patient types, to identify if the Trendcare patient acuity system provides reasonable average category times for babies requiring transitional care [BAB].

The willingness of our maternity staff [both locally and nationally] to participate in the Transitional Babies timing study is testimony to their engagement and diligence in ensuring the collection of high-quality data that resulted in refinement of the patient acuity system.

As a result of the study [Trendcare, 2024], Patient Type HPPD benchmark ranges were modified, indicators will be added to the BAB, MVB and MCB patient type and additional weightings will be added to specific indicators with the next Trendcare upgrade scheduled for February 2025.

Trendcare CEO/Director Cherrie Lowe said "*We deeply appreciate the considerable time and effort your staff dedicated to this study. Their meticulous approach and professional commitment have been exemplary and are greatly valued by the Trendcare team*"

Keen to be agents of change, Waitaha Maternity had indicated a willingness to participate in national Induction of Labour [IOL] timing studies but this is on hold as currently we are the only site that is able to participate at present.

However, this month Waitaha Maternity made a formal request to Trendcare via the Safe Staffing Health Workplaces [SSHW] unit, who oversees the CCDM programme, to request timing studies of the Trendcare (TC) maternal postnatal patient types, Maternal Vaginal Birth (MVB) and Maternal Caesarean Birth (MCB). The purpose is to ensure the New Zealand maternity ward care context is reflected. The current time weighted indicators are not perceived to be accurately reflecting the care required across the 24hr continuum of care. Our request has the support of the national CCDM Maternity Advisory group.

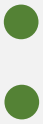
Kurawaka:Waipapa community birthing unit whānau room

OVERVIEW OF MQSP PRIORITIES 2023/24

This table summarises the quality improvement work undertaken by our Maternity Services as planned and approved by the Maternity Clinical Governance Group for 2023/24. 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.	MEWS audit and case review Morbidity review identified through trigger tool *HQSC Patient Deterioration Programme. 2019*	Monthly audits of MEWS charts continue in all Canterbury 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. - *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. All non-maternity areas across the Canterbury Waitaha hospitals implemented the maternity MEWS module in Patientrak (Patientrack is a web application used to replace parts of the traditional 'end of bed' observation charts) in June 2024. Clinical areas not using Patientrak have moved to the paper based MEWS observation charts.	

	Priority area	Progress Report	Status
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*	Increasing birthing numbers and occupancy of our primary maternity units has and continues to be a principle focus for our service. In April 2024 Health NZ Canterbury Waitaha' s new central city primary birthing unit (Kurawaka: Waipapa) opened. Ngāi Tūāhuriri gifted the special name – Kurawaka: Waipapa. The gifted name was chosen by Reriti Tau and given by Te Maire Tau, Te Ngāi Tūāhuriri hapū Ūpoko. Kurawaka has great significance in Te Ao Māori, the Māori world, as the birthplace of Hine. The interior design of Kurawaka is inspired by natural birthing practices, cultural awareness, whānau/family experience, and inclusiveness. The themes also include New Zealand flora and fauna, regional landmarks, and sustainability. The service is underpinned by the Canterbury Maternity Strategy and the Pae Ora legislation which is committed to supporting māmā and their whānau to create an environment that will enable their pēpi to have the best start to life, by providing community pregnancy support and birthing options that meet the needs of māmā, whānau and pēpi to receive care in the right place and at the right time. After extensive engagement with Tangata Whenua and others within our community, the facility is informed by and will deliver services based on a Te Ao Māori (the Māori world view) framework. The unit is 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 20. Continued quality work in this area has been rolled over to the MQSP 2024/25 priorities and action plan,	 
3.	Equitable access to postpartum contraception, including regular audit *NMMG Workplan, 2019*	An update on work in this area is given on page 46.	
4.	Reduce preterm birth and neonatal mortality *NMMG Workplan, 2019* *PMMRC recommendations, 2021 and 2022*	In 2022 and 2023 our pre-term birth rates were 8.16% and 7.95% respectively. As a service we continue to monitor these rates locally and report and reflect on the NZ Maternity Clinical Indicators.	

	Priority area	Progress Report	Status
		The Timing of Birth Assessment (TOBA) group formed in mid-2021 continues as a multidisciplinary group with representation from midwifery, obstetrics, fetal maternal medicine and neonatal to review referrals for planned inductions of labour and elective caesarean sections.	
5.	To continue to improve the screening and referral rates of women for family violence *MQSP 6 of 2020/21 priorities and action plan* *Canterbury Maternity System Strategic Framework, 2019*	Work in this area continues to improve family screening results for pregnant women. Family violence champions for the clinical areas meet monthly with the Tiaki Whanau team - Child and Family Safety. Monthly and quarterly reporting continues to audit FV screening across the Christchurch campus.	
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*	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 maternity whānau voice hui 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.	
7.	To reduce local postpartum haemorrhage (PPH) rate and sequelae, i.e., blood transfusion rates	National data Clinical Indicator 11 and 12: People requiring a blood transfusion with caesarean section and vaginal birth showed a noticeable rise in 2021 from 2.8% to 4.2% and 3.3% to 5.7% respectively and we were noted as an outlier nationally. A retrospective audit of PPH rates in 2022 confirmed an increase and identified areas for improvement in practice and data collection. 1. Implementation of the national consensus Guideline for the treatment of postpartum haemorrhage (2022) 2. Improve data collection and local reporting 3. Development of risk matrix and guidance when assessment is made for active vs physiological third stage and uterotonic Work is in progress on all three workstreams and regular meetings are set up with the project team to progress work.	

	Priority area	Progress Report	Status
8.	Continue to review local clinical outcomes and monitor district variation	Multidisciplinary meetings reintroduced with Service Improvement & Innovation analysts to review data priorities for 23/24 given quality plans and projects underway. Work progressed on an improved interactive report for maternity developed from the IOL dashboard, which was created alongside the implementation of Misoprostol in 2020. The maternity overview dashboard is based on Robson Classification and went live in November 2023. Meetings continue every four weeks to continue to continue to improve report.	   
9.	Workforce development *PMMRC Recommendations, 2021 and 2022* *Canterbury Maternity System Strategic Framework, 2019* *NMMG Workplan, 2019*	We 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 A summary of initiatives to support and grow the maternity workforce are as follows: • The Kaiāwhina role was successfully implemented in the maternity ward at CWH as a way to increase Māori and Pacific into the workforce, with an aim to encourage them into health. • Promotion of working as a new graduate at CWH and doing presentations with the local school of midwifery, and nationally. • Participation in online hui with Internationally Qualified Midwives (IQM) enquiring about working at CWH. • Strengthening the role of the clinical coaches to meet the needs of New Graduates, Return to Work midwives and IQM. Reviewing the New Graduate programme. Work completed on career progression. • Supporting Māori and Pasifika student midwives, midwives and meeting with the School of Midwifery, external monitor, Te Puawaitanga, Purapura Whetu, Etu Pasifika, Māori Midwives ki Tahu, Te Pā Harakeke Nurturing Care workshops. • Significant mahi around debriefing as a multi-disciplinary team. Hot debriefs, and facilitated cold debriefs were held throughout 2023, including supporting the team to facilitate these, and go to debrief workshops. People and Capability have also attended a couple of these hui and offered access to psychological support.	 

	Priority area	Progress Report	Status
		• As a leadership midwifery team, we foster an open door approach so our Kaimahi feel supported when they have concerns. • We encourage and support Māori midwives to attend Ngā Manukura : Clinical Leadership Programme. Two attended in 2023. • Cultural competency education/ workshops are weaved into our practice skills days, we also had pito korero (micro teaching) sessions available to all kaimahi on the ward and one on one sessions with our Mana Taurite Coordinators who also worked to embed mātaūranga into maternity. • Many of our Obstetrics and Gynaecology Consultants and all of our medical trainees attend the MIHI course run by the University of Otago Indigenous health unit. (Mihi) . It runs 1-2 times per year with pre reading and a face to face component. It teaches the Meihana model and Te Whare tapu Wha and communication training as well as historic education about the impacts of colonisation and its longitudinal intergenerational impacts .	

OUR QUALITY INITIATIVES

Continued evaluation and improvement of our maternity services is vitally important to Health NZ Canterbury 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 2023 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 TONUTANGA

SMOKING CESSATION

ELLA NEWEY
SMOKEFREE TEAM LEADER
WAITAHA| NATIONAL PUBLIC HEALTH SERVICE

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.

From January 2023 to December 2023 the service received 137 referrals of Hapū māmā. Over this time 65 Hapū māmā enrolled onto the programme, of which 39 made quit attempts. A total of 22 reached successful Smokefree status.

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, as well as whānau incentives if they are on our hapū whānau program.
- Pēpi pods encourage safer sleep and are available free to all pregnant women through the programme.

We now have our upscale project up and running. This project focuses on hapū māmā and their whānau to provide, intensive and long-lasting support to create a smokefree environment. This program provides

more incentives that encourages whakawhanaungatanga between the Quit Coach, the hapū māmā and their whānau to provide long term quit attempts. This project has really taken off from the start of 2024 and we will be excited to see the results of this in the community once it finishes in June 2025.
https://www.tehawaitaha.nz/

SUDI PREVENTION

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

Promoting safe sleep messaging and engaging with whānau continues to be a key focus for SUDI prevention for Te Puawaitanga ki Ōtautahi Trust.

In June 2023 Te Puawaitanga ki Ōtautahi Trust welcomed a new SUDI Health Promoter, Nichaela Gulbransen. Nichaela comes from a Nursing background and throughout 2023 has familiarised herself within the role, established relationships with colleagues, attended SUDI prevention hui, delivered SUDI education internally and externally, and shared SUDI prevention messaging with whānau in their whare.

For the period 1 January – 31 December 2023 Te Puawaitanga ki Ōtautahi Trust distributed 337 wahakura to whānau and held 8 wahakura wānanga with 80 participants in attendance. We continued to support Pregnancy Infancy Parenting Support (PIPs) with the recycling of pēpi pods and continued to facilitate the supply of pēpi pods into birthing units from Kaikoura to Ashburton.

Our highest referral reasons continue to be 'no sleep space for pēpi' and 'intention to bedshare'. This is likely a reflection of the challenges whānau face with the cost of living crisis. There has been a slight increase in the number of referrals for whānau who smoke in 2023, but this rate continues to be low. We continue to be experiencing a large number of requests for wahakura postnatally, despite socialisation of the referral process and encouragement of early referral.

Our Kairaranga, Kaiwhakapuawai and SUDI Health Promotor at Te Puawaitanga ki Ōtautahi Trust continue to work in many different group spaces, including Whānau Mai – Hapūtanga Wānanga, Wahakura Wānanga, Raranga Ora and Ūkaipō. These moments of connection all provide opportunities for SUDI prevention messaging across the spectrum of topics (infant feeding, safe sleep, smoking cessation etc) to be discussed in a way that is honouring of whānau knowledge and experience.

For Te Rā Mokopuna 2023, Te Puawaitanga ki Ōtautahi Trust had a stall at Aranui Affirm with a primary focus on SUDI prevention. This community event enabled the Trust to share SUDI prevention/safe sleep messaging to as many whānau as possible. As part of this event, we conducted a survey gathering information from whānau around their experiences and knowledge of SUDI and safe sleep. Each participant went in the draw to win a wahakura prize pack which included a wahakura full of gifts for their whānau. We also had doll size wahakura we gifted to six whānau to share the safe sleep korero with tamariki. This event was a great success, and we had the opportunity to engage with many whānau throughout the day, sharing kai, korero and connection with the community alongside safe sleep education.

PROMOTING AND PROTECTING BREASTFEEDING

SARITA GARGIULO-WELCH
MIDWIFE, BFHI COORDINATOR, HEALTH NZ CANTERBURY WAITAHA

Baby Friendly Hospital Initiative (BFHI) at Christchurch Women's Hospital

The Ten Steps to Successful Breastfeeding are the foundation of BFHI for maternity/perinatal services in both Aotearoa NZ and internationally.

Aotearoa NZ is unique in that the continuity of care model sees 94% of whānau (Health NZ), cared for by one midwife or midwifery practice from booking and throughout the duration of their pregnancy until 4-6 weeks after the birth of their pēpi. The New Zealand College of Midwives Consensus statement: Breastfeeding[1] identifies that midwives support the principles of BFHI, and have a primary role for provision of information, care and support so that whānau can meet their infant feeding goals and (NZCOM, 2016). Maternity/Perinatal services that have integrated BFHI into practice, such as Christchurch Women's Hospital, support LMC with this endeavour.

Step 3 of the 'Ten Steps to Successful Breastfeeding' reads: "Discuss the importance and management of breastfeeding with pregnant women and their families". Maternity/Perinatal facilities in Aotearoa alongside LMCs have a dual responsibility to ensure that whānau understand the importance and management of breastfeeding. With this in mind, and supported by 'Whānau Voice', during 2024 we developed small information postcards 'Let's talk about feeding your pēpi'. These are now being provided

[1] New Zealand College of Midwives. (2016). Consensus Statement: Breastfeeding. https://www.midwife.org.nz/wp-content/uploads/2019/05/Breastfeeding.pdf

for every whānau who comes through the antenatal/pregnancy outpatient's clinic or who have an inpatient stay on the Maternity Ward at Christchurch Women's Hospital.
The postcard suggests that whānau speak with their LMC about feeding their baby, encourages whānau to plan for feeding their pēpi as much as they plan for their birth, and provides some excellent basic breastfeeding/chestfeeding information easily accessible through QR codes.

2023 EXCLUSIVE BREASTFEEDING ON DISCHARGE FOR MATERNITY SERVICES CANTERBURY| WAITAHA

Exclusive breastfeeding means that to the parent's knowledge pēpi has had nothing but human milk or prescribed medication (as per the Medicines Act 1981). *(This includes milk directly from the breast, or expressed milk including: parents own expressed milk, pasteurised donor milk, screened unpasteurised donor milk, or unscreened unpasteurised donor milk.)*

Breastfeeding data at discharge is based on a well, term pēpi.
In this context, this means a pēpi must be:

- >37 weeks gestation
- Birth weight >10th centile and <95th centile
- Has not had an admission to NICU

Maternal/Parental factors that may impact the initiation of lactation are not taken into consideration.

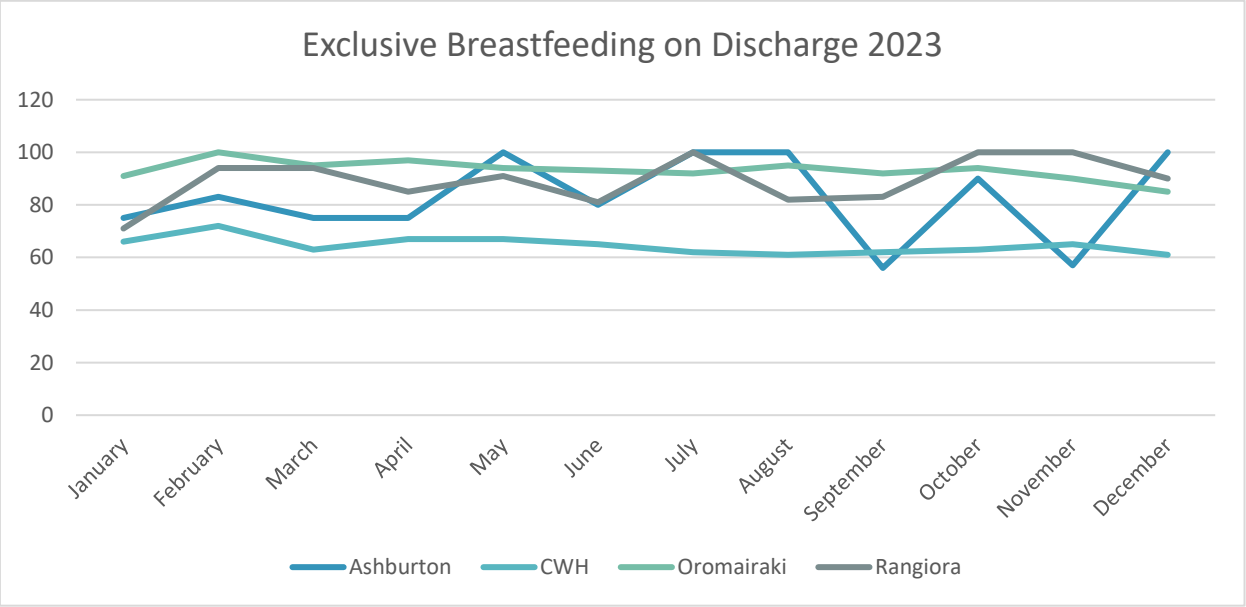


Figure 6. Exclusive Breastfeeding rates on discharge Health NZ Canterbury Waitaha 2023

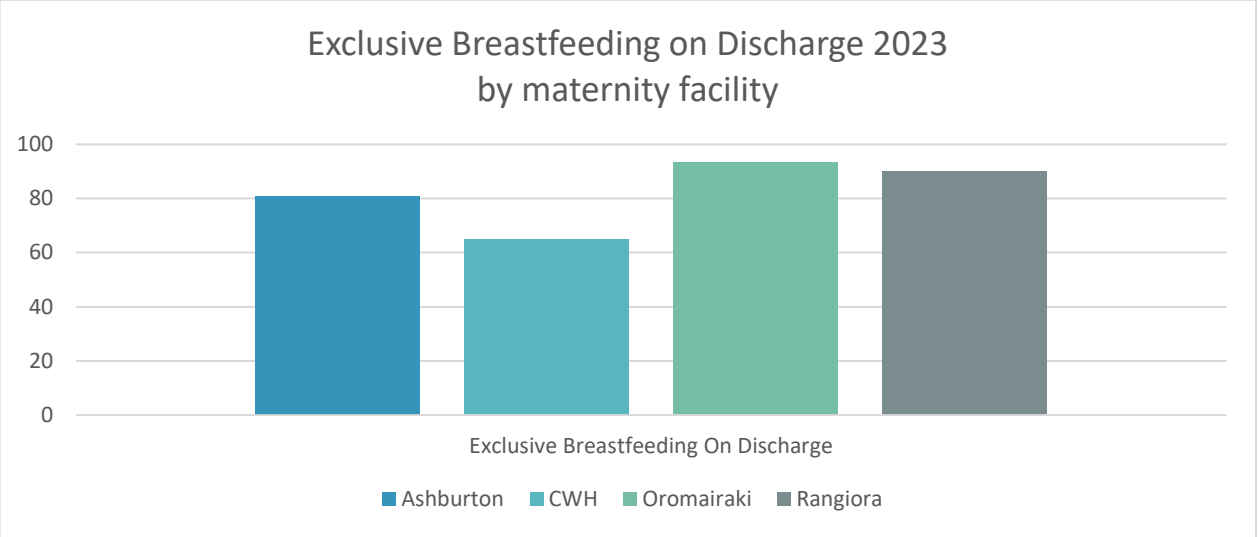


Figure 7. Exclusive Breastfeeding rates on discharge by maternity facility Health NZ Canterbury Waitaha 2023

BIRTH AFTERTHOUGHTS CLINIC

LOUISE MCKINNEY
MIDWIFE MANAGER, WOMEN'S OUTPATIENT DEPARTMENT, CWH

The Birth After Thoughts Clinic (BATC) was set up at the beginning of 2023 to offer a listening and debriefing service available to anyone who had given birth to their pēpi in a Health NZ Te Whatu Ora Waitaha Canterbury Facility from July 2022. It was acknowledged that there was a need for this service to be offered from community groups/consumers and the wider maternity team.

The Birth After Thoughts Clinic has now been providing a service for the women/whānau/persons of Waitaha Canterbury for over a year.

The total number of women/whānau/persons seen in BATC for January 2023 to January 2024 were 148.

127 (86%) women/whānau/person had a face-to-face appointment with three (2%) by phone and 13 (9%) by Zoom/telehealth appointment.

Five cancelled and rebooked and five (3%) did not attend their appointment.

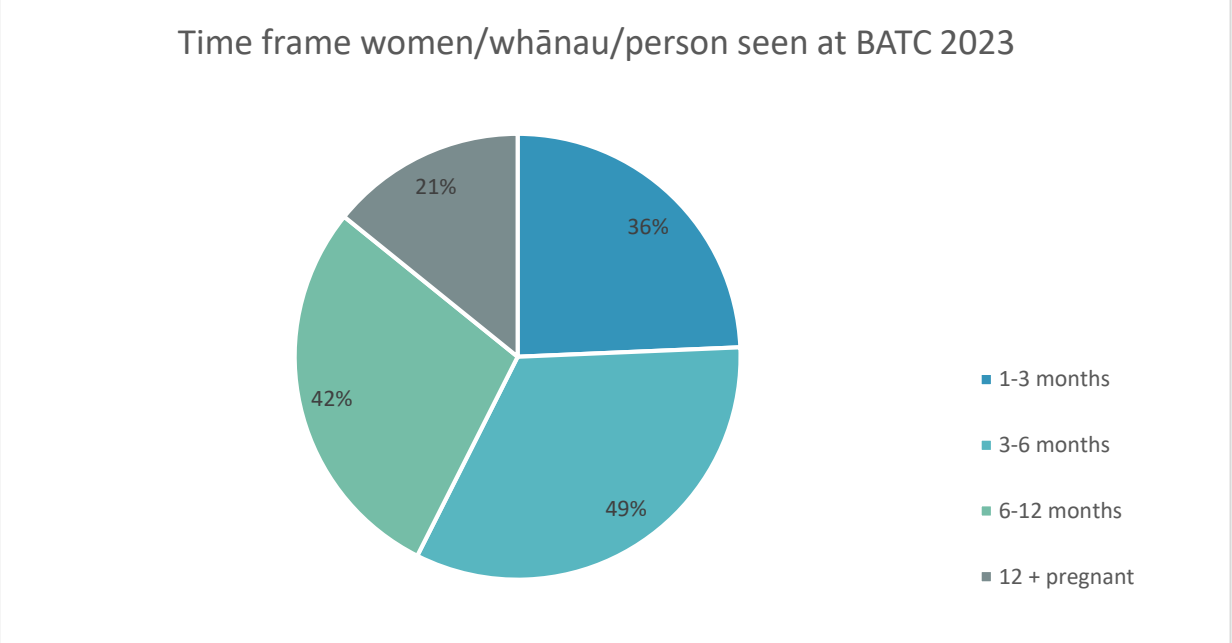
GRAVIDA

There were 113 (76%) women/whānau/person who were primigravida and 35 (24%) multiparous.

ETHNICITY

Ethnicity	Number of women	Percentage of women
Māori	14	9%
Pasifika	5	3%
New Zealand European	106	72%
Indian	7	5%
Other	16	11%

TIMEFRAME WOMEN/WHĀNAU/PERSON SEEN AFTER BIRTH



24 of the women/whānau/person that were seen in the clinic had babies in NICU.

REFERRED BY

- 115 (78%) were self-referrals
- 28 (19%) were referred by their LMC
- 2 (1%) were referred by their physiotherapist
- 1 (1%) was referred by Plunket and 1 (1%) by the Perinatal Well-being Group
- 1 (1%) was referred by a lactation consultant

From the data and whānau feedback that was collected over the year it was clear that the service was highly valued and essential.

Following the release of the BATC annual report further recommendations have been developed to further enhance the service.

NEWBORN HEARING SCREENING

ANGELA DEKEN

UNIVERSAL NEWBORN HEARING SCREENING (UNHSEIP) COORDINATOR, HEALTH NEW ZEALAND CANTERBURY WAITAHA

Approximately 1 baby per thousand (0.1%) is born each year in New Zealand with a moderate to profound hearing loss. Canterbury Waitaha District rate over this period is **0.35% 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, educational and career achievements. The early detection of hearing loss and the initiation of early medical and educational interventions does significantly improve long-term outcomes for children with hearing loss and their parents/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).

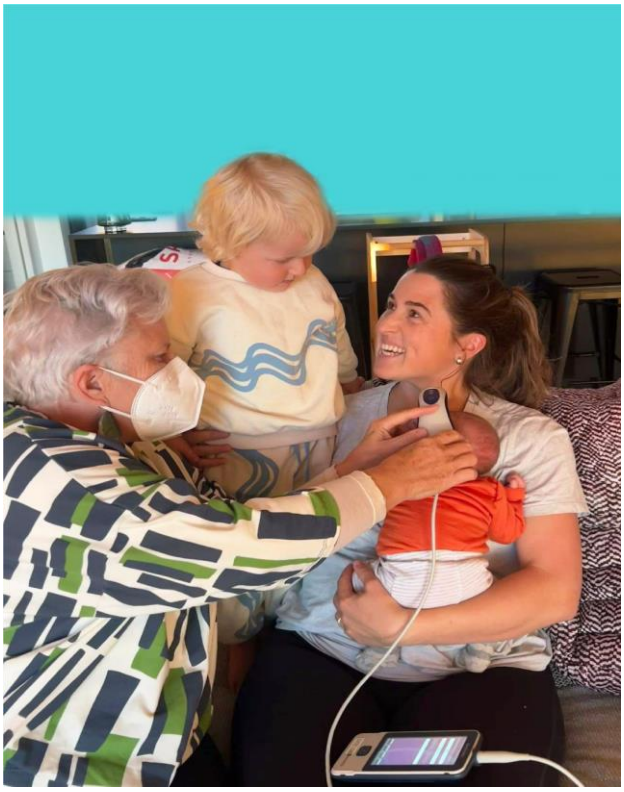
New born hearing screening is offered to all new parents/whānau for babies born in the Canterbury District regardless of place of birth. The goal is to **complete screening by 1 month of age** and refer to audiology, so a **diagnosis can be by 3 months of age** if a baby fails screening. For those diagnosed with a hearing loss the aim of the programme is to ensure **habilitation can be put in place by 6 months of age.** This is the goal of 1,3,6 from the Antenatal and Childhood Screening Unit (ACS) so that each baby has the best chance of normal development. Babies who fail screening are referred to and seen at Christchurch Hospital Audiology department. Those who have been diagnosed with hearing loss are referred to the University of Canterbury who are contracted to provide the children's hearing aid service. Babies who have severe to profound hearing loss are also referred to the Southern Cochlear Implant Plant Program at St Georges Hospital. If parents choose to have this surgery, implantation occurs between 6-12 months of age approximately.

Achievements' attained in 2023:

» Canterbury District UNSEIP completed their NSU program audit which was undertaken by DAA group and received 2 commendations out of the 5 standards that were being audited. There were no corrective actions to be undertaken.

» 5 new screeners from across New Zealand were trained as Canterbury is 1 of 4 Districts able to train new screeners.

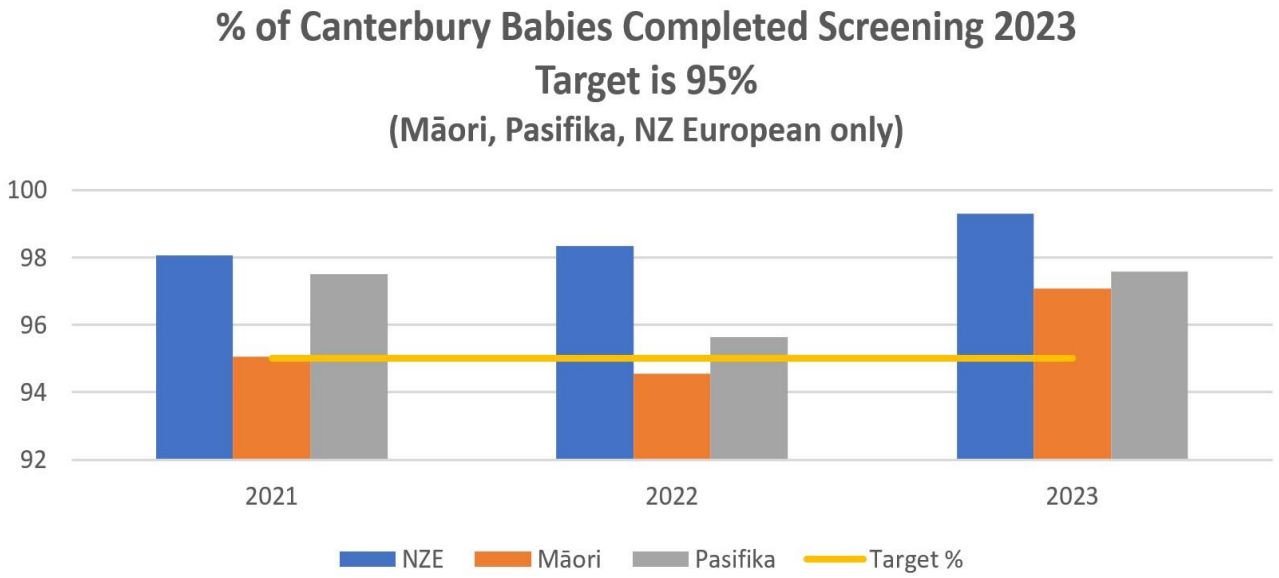
» Implementation of the new screening device EasyScreen completed.



Baby Drew having her hearing screened watched by big brother

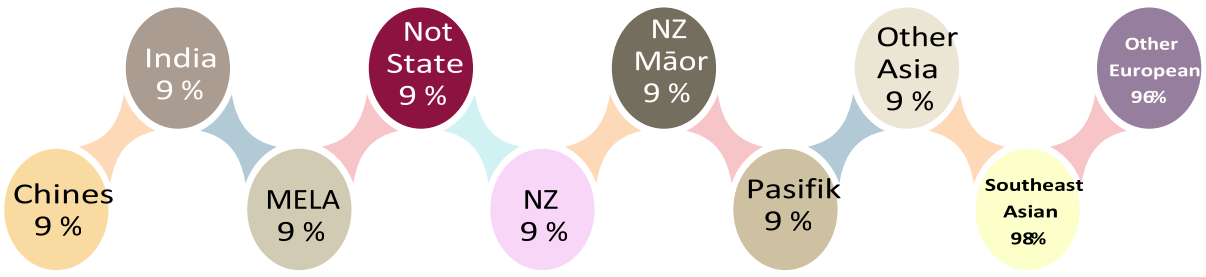
6,306 eligible babies were born in 2023

Outcome	Number	Percentage
Offered screening	6296	99.8%
Declined screening	41	0.6%
Completed screening	6208	98.4%
Referred to audiology	90	1.4%
Referred for surveillance	44	0.7%
Disengaged	43	0.6%
Lost/missed	7	0.1%



Monthly % of eligible babies screened by 1 month of age per ethnicity 2023 Target is

95% of babies will be screened by 1 month of age:

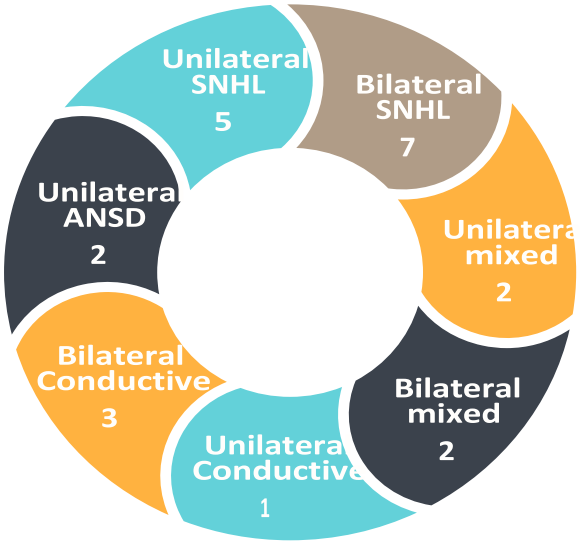


Only 1 ethnic group **NZ Māori** didn't achieve the **screen by 1 month of age** but overall this group did complete screening and met the target of 95%. This was due to some Whānau not attending outpatient appointments and requiring a second appointment or assistance with transport.
Ease of access to hearing screening services is key to programme success. Health New Zealand | Te Whatu Ora Canterbury Waitaha District UNHSEIP service has a regular visiting frequency to all birthing units each week and an extensive network of community clinics and home visiting across the District area. For remote rural clinics these are held as required.

Screening at Maternity Units and outpatient schedule:

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1	Christchurch Women's	Yes	Yes/OPD	Yes	Yes	Yes	Yes/OPD	Yes
2	Kurawaka Birthing unit	Yes	Yes	Yes	Yes	Yes	Yes	
3	Oromairaki Birthing unit	Yes		Yes		Yes/OPD	Yes	
4	Rangiora Birthing unit	Yes/OPD		Yes		Yes	Yes	
5	Ashburton Maternity		Yes/OPD					
6	Burwood OPD			Yes pm		Yes pm		
7	Hornby OPD			Yes pm	Yes am			
8	Hoon Hay Plunket OPD	Alt wks						
9	Woolston				Yes pm			
10	Aranui				Yes alt am			
11	Bishopdale/Montreal house				Yes alt wks			
12	Centaurus Plunket OPD	Alt wks						

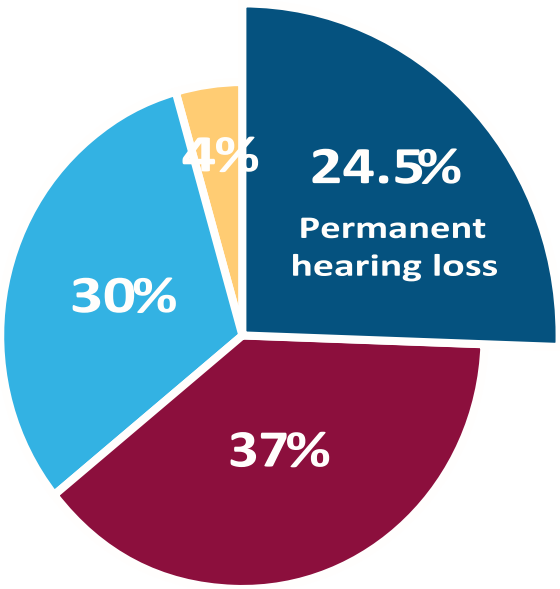
Audiology outcomes:



90 babies referred to audiology
22 were confirmed with permanent childhood hearing loss which equates to **24.5% predictive value**

Referred to other services:	Number
Advisors on Deaf Children	10
Ear, Nose and Throat specialist	18
Paediatric specialist	15
Children's hearing aid service	12
Southern Cochlear Implant Program	3
Babies who have had a cochlear implant	3

Only 18% of those diagnosed with a hearing loss had a known risk factor for hearing loss at time of screening. 4 babies who had a risk factor was due to Down syndrome, family history of loss, microtia/atresia and a NICU risk factors.



24.5% of babies referred to audiology had a permanent hearing loss

37% of babies had normal underlying hearing but had a temporary conductive loss and will be followed up by audiology and ear nose and throat clinic if conductive loss persists.

30% of babies seen in audiology passed their assessment

4% of babies weren't brought to audiology so were discharged although some had been seen once but didn't complete the audiology assessment

62% of babies who failed screening and were referred to audiology had either permanent loss or a temporary conductive loss.

Audiology goals:

» Baby to be seen in audiology 1-month post screening: 91% of babies seen by 1-month post screening.

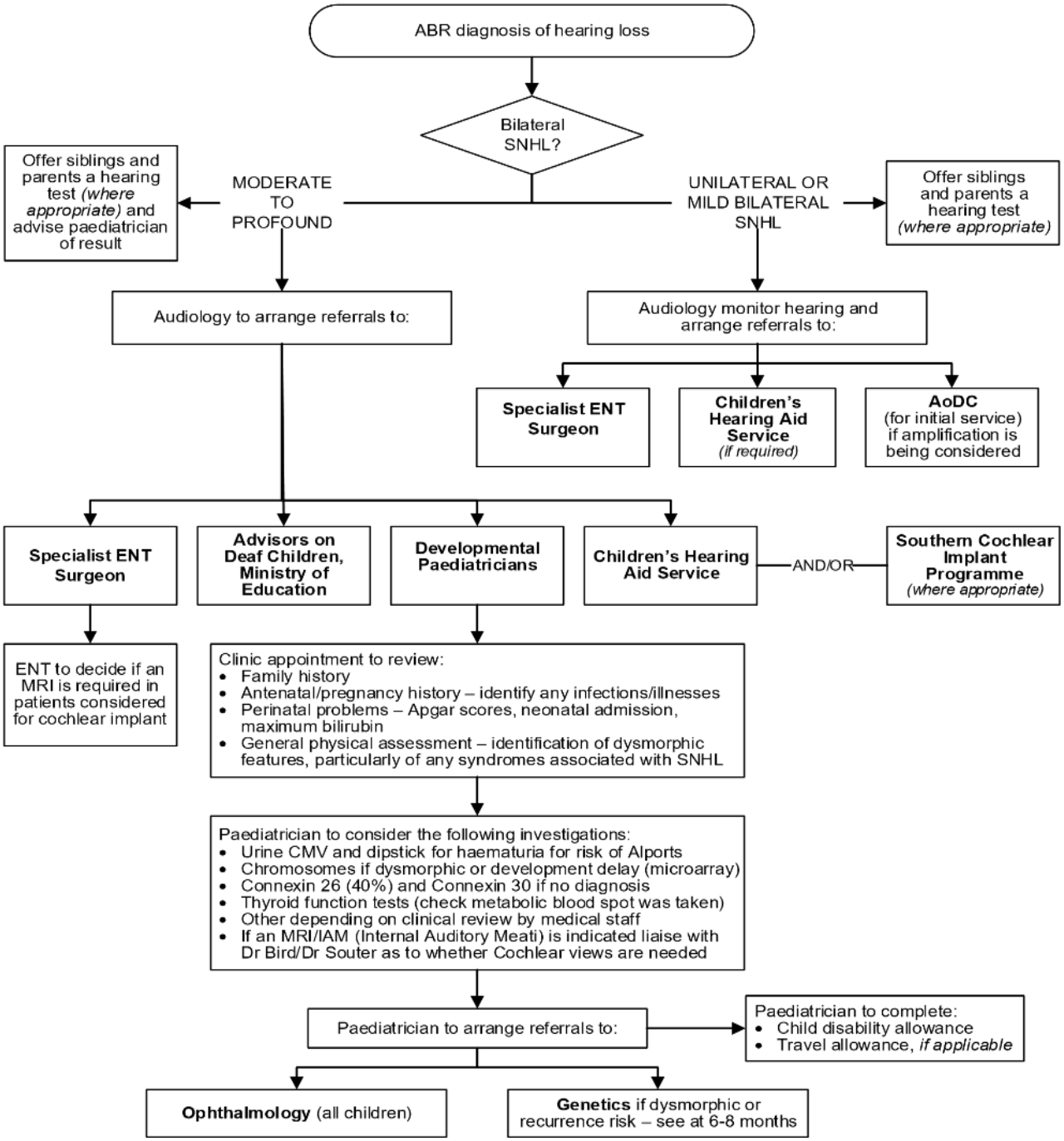
The remainder was due to DNAs but an appointment had been arranged by 1-month post screening

» Complete diagnosis by 3 months of age: 95.5% of babies completed audiology assessment by 3-months. The remainder were again due to DNAs – some of these babies had been since once but didn't return for final assessment.

» Start habilitation by 6 months of age: 100%.

Follow-up Programme for Infants with SNHL

CANTERBURY, WAITAHA REFERRAL PATHWAY



THE GROWTH ASSESSMENT PROTOCOL (GAP)

RENEE HAWES
REGISTERED MIDWIFE /GAP EDUCATION MIDWIFE, HEALTH NZ CANTERBURY WAITAHA

The Growth Assessment Protocol (GAP) is an international, award-winning program which aims to improve safety in maternity care and outcome of pregnancy, including perinatal mortality and morbidity, with the predominant focus on improving antenatal recognition of pregnancies at risk due to fetal growth restriction. GAP 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.

In Aotearoa New Zealand, GAP is commissioned nationally by Te Whatu Ora. Thanks to a concerted effort by districts and clinicians including midwives, obstetricians and sonographers, all expectant mothers can now be cared for with evidence based maternity guidelines, including New Zealand antenatal growth charts which are customised according to each individual pregnancy's characteristics.

The Jan-July 2023 National report showed that all districts were participating in the GAP program and over 94% of pregnancies were submitted. The national SGA detection rate was 43.3%, with SGA babies <3rd centile having improved detection rates of 63.2%.

The past 12 months has been an exciting and challenging time, with the introduction of the 2023 Small for Gestational Age/ Fetal Growth Restriction Guidelines, and the rollout of GROW 2.0. This transition has been difficult at times and we thank all clinicians for their patience and dedication as women / pregnant people have been moved onto the new program. We are delighted that customised GROW charts are now linked to NHI and can be updated and shared in real time with all maternity care providers. The Perinatal Institute continues to receive feedback about how GROW 2.0 can be improved, and further updates are planned.

Due to changes in the way data has been collected, the current statistics for Canterbury are unfortunately inaccurate and no conclusions can be drawn about submission or detection rates for 2024. We look forward to sharing this information when it is next available and continue to encourage all maternity providers to commence a GROW chart for the people in their care.

Canterbury is fortunate to have two GAP champions who work together to promote GAP education, support colleagues with using GROW 2.0, and audit missed cases of small for gestational age babies. Our LMC champion works predominantly in the community and North Canterbury, while I work as a Clinical Midwife Manager at CWH. We thank Kate Clayton for her previous excellent work in this space, and the knowledge and support she has provided.

"The continuity of care was awesome. The staff were all on the same level and offered as much advise as they each could when needed"

Rangiora Community Birthing Unit

MQSP Annual Presentation day speakers 2023. Photo: Left to right back: Sam Burke, Emma Jackson, Roisin McGarr, Norma Campbell, Jen Cunningham, Violet Clapham, Bronwyn Dixon, Kathleen Maki, Lisa Kahu, Erin Manning Left to right front: Julie Dockrill, Matthew Gould, Esther Calje, Bronwyn Torrance, Claire MacDonald. Not pictured: Heidi Goebbels Thanyamai Bulakul Marg Burns, Elizabeth Browne.

EDUCATORS UPDATE

SHARRON BOLITHO - CONSULTANT, OBSTETRICS AND GYNAECOLOGY
TINA HEWITT - MIDWIFERY EDUCATOR AND
RHONDA ROBERTSON - MIDWIFERY EDUCATOR, HEALTH NZ CANTERBURY WAITAHA

PROMPT- Practical Obstetric Multi Professional Training
'Making Childbirth Safer, Together.'

PROMPT
Mahi ngātahi kia haumaru ai te whānautanga o te pēpi
AOTEAROA

Why is PROMPT a key Te Whatu Ora Maternity Quality and Safety Initiative?

NZ Perinatal and Maternal Mortality Review Committee (PMMRC) has identified that 40% of poor outcomes are preventable. In depth analysis of de-identified cases has revealed that poor teamwork and communication leading to delay in receiving care was a factor in most cases.

PROMPT is the multi-professional obstetric emergency course used in all regions of Health NZ Te Whatu Ora to fulfil the PMMRC recommendation for all health professionals involved in maternity care. PROMPT is not just an 'education' tick box, it is a key quality and safety strategy with evidence that it has the power to reduce maternal and perinatal mortality and serious morbidity when attended annually by >90% of the health team.

The PROMPT course is endorsed by Te Kahui o Nuku (NZ RANZCOG Committee) and the Te Tatau o te Whare Kahu/ NZ Midwifery council.

PROMPT is now more than 20 years old and has matured from a local hospital course in Bristol into the international PROMPT Maternity Foundation, providing sustainable locally adapted courses around the world to low and middle income countries, in addition to the majority of obstetric emergency team training in the UK, Australia and Aotearoa-New Zealand.

See this PROMPT Maternity Foundation video for further information
https://www.youtube.com/watch?v=w1Pu6WOu7Mc

Does PROMPT actually improve clinical outcomes?
Unlike many other education packages that just show improvement in knowledge, attitudes or behaviour, PROMPT has robust published evidence base for the effectiveness of this kind of 'in-situ' simulation training to actually improve clinical outcomes.
Key findings in Units where >90% of the health team attend annually are;

- 50% reduction in Neonatal Encephalopathy (hypoxic brain injury)
- 100% reduction in permanent brachial plexus injuries (associated with shoulder dystocia)
- 40% quicker birth by emergency caesarean section
- 34% reduction in maternal deaths at Mpilo Hospital Zimbabwe, and 26% in Philippines

Please refer to the PROMPT Aotearoa NZ website www.promptnz.org under 'the evidence' tab.

Why does PROMPT work?
PROMPT works by making it easier for teams to 'do the right thing' in an emergency situation. Things are more likely to go wrong in an emergency for multiple human factor reasons such as tunnel vision, cutting corners, not following usual safety checks etc. PROMPT training reverses of these effects by specific training in;

- declaring the emergency,
- closed loop and structured communication,
- clearly defined team roles,
- use of protocols/ checklists
- situational awareness.

PROMPT then gives teams an opportunity to practice these skills in a realistic obstetric emergency setting. We don't expect our sports teams to perform well without regular practice together and our health teams are no different. Attending a presentation on teamwork does not improve teamwork but giving our busy maternity team time out to practice together does!

In addition to improving team performance PROMPT contributes to MSQP in 3 other ways;

1. PROMPT instructors and participants regularly identify potential systems errors (a kind of 'safety first') that have the potential to cause an incident. These are fed back to the quality department for correction before any real world harm occurs.
2. PROMPT is an effective vehicle to implement staff training recommendations from serious event reports and new guidelines.
3. PROMPT can be used for staff orientation, to 'test drive' new units and systems.

A recent example of this type of quality improvement work is that PROMPT ran training on the new national Massive Haemorrhage Pathway (MHP). Feedback from participants was that it was confusing and difficult to use. PROMPT Leaders worked with the Women's Quality Team and Blood Transfusion Committee to simplify the MHP by removing info not relevant to Obstetrics and also developed a lanyard simplifying the steps for initiation and activation. Feedback from our recent PROMPT was that these improvements have made it 'easier to do the right thing'.

Finally, PROMPT works because it has a positive impact on that elusive goal of all quality programmes 'to improve workplace safety culture'. Working together better makes childbirth safer for all our māmā and pēpi.

PROMPT Aotearoa Train the Trainers day 2021 . Held at Manawa Campus, Ōtautahi, Te Wai Pounamu.

OBSTETRIC RESEARCH UPDATE

DI LEISHMAN
RESEARCH MIDWIFE – UNIVERSITY OF OTAGO

C*STEROID

Ongoing recruitment for this trial.

International recruitment is over 1000 babies to date with the aim of 2500.
Recruitment is in Australia and NZ.
At CWH we have recruited 140 women.

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, 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.

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.

ROUTINE ANTENATAL ANTI -D PROPHYLAXIS (RAADP) PROGRAMME

AMANDA DANIELL
MATERNITY QUALITY COORDINATOR, HEALTH NZ CANTERBURY WAITAHA

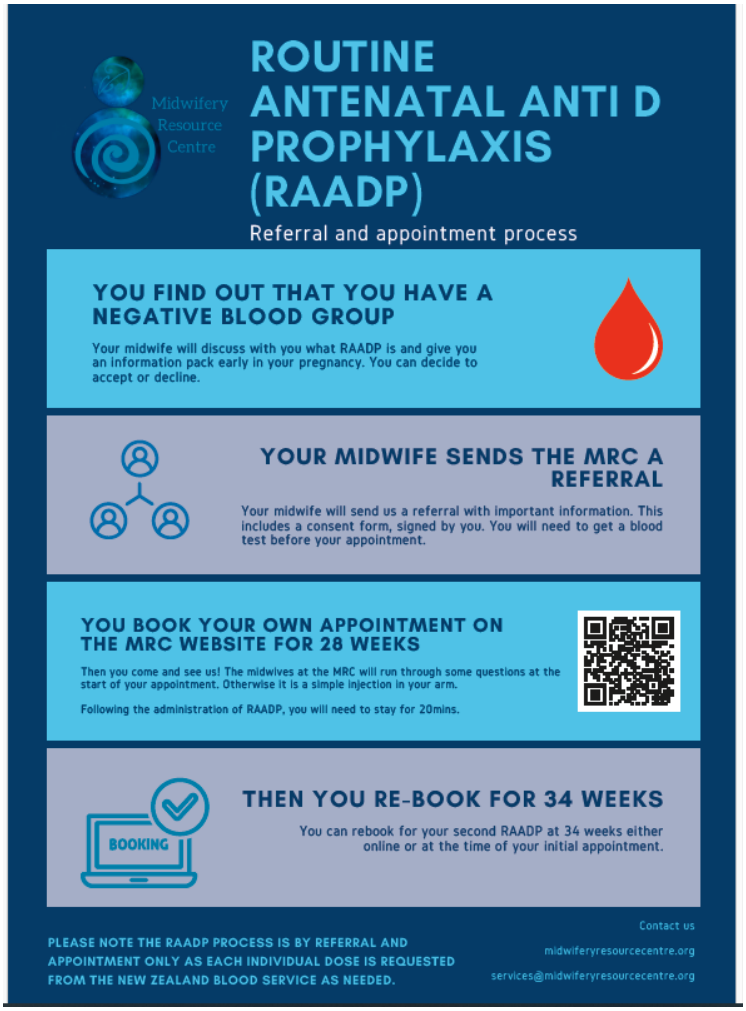
RAADP is offered to pregnant people with a Rhesus negative blood group to reduce the risk of sensitisation when a baby has a Rhesus positive blood group. As we are currently unable to test for baby's blood group until after delivery, we offer RAADP to all Rhesus Negative pregnant people.

Canterbury commenced this programme on 29th April 2024 as a community based service administered by the Midwifery Resource Centre in central Christchurch. It is a referral service initiated by the LMC and pregnant people are able to book their own appointments.

Pregnant people receiving core pregnancy care can receive RAADP through the hospital service.

RAADP is offered at around 28 and 34 weeks of pregnancy to pregnant people who are RhD negative.

At the outset of the project It was predicted that up to 650 pregnant people per year could access the service, which is potentially 1300 interactions for Anti-D administration.



We do not currently have data available to present in regard to uptake of this service but will be evaluating the service after 12 months.

> "10/10 Amazing! Very grateful for all the support. everyone was so kind and supportive. I was given a lot of help with breastfeeding, being a first time mum. I couldn't be more grateful. Thank you all!!"
> *Whānau feedback on Kaiāwhina*

EQUITY - MANA TAURITE

IMPROVING EQUITY FOR LONG TERM CONTRACEPTION

RACHEL THOMAS, SYSTEM DESIGN, LIVING WELL, COMMISSIONING, TE WAIPOUNAMU
AND
JESSICA CRAMPTON, REGISTRAR, CWH, HEALTH NZ CANTERBURY WAITAHA

Long acting reversible contraception (LARC) are available via all general practices either at the clinic or via practice to practice referrals. Figure 8 shows the Canterbury Waitaha LARC Insertions and removals for Primary care.

ELIGIBILITY

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

- are a resident in the Canterbury DHB area and enrolled in a Canterbury general practice, and
- live in quintile 5 deprivation areas, or
- hold a community services card, or
- are high risk. To be eligible for high risk, the patient must fulfil at least one of the following criteria:
    - Aged under 18 years
    - Māori or Pacific.
    - Currently alcohol or illicit drug dependent.
    - High user of maternity services or history of TOP, unplanned pregnancy, or miscarriage in the last 5 years.
    - Has a currently active long term severe mental health disorder, including any psychotic disorder, bipolar affective disorder, severe depression. Patients on antidepressants or psychotropic medication with little current impact on life are not eligible.
    - If the same type of device is removed and replaced on the same day, only one claim can be made.

The subsidy is not available for insertion or removal of LARCs at Family Planning clinics.

There is no minimum age for subsidy eligibility.

- low-cost consultation for patients aged 18 years or older for all contraception, including Depo Provera and emergency contraception. For patients aged 14 to 17 years use Youth Sexual Health funding.

- insertion and removal of IUDs, levonorgestrel intrauterine systems (e.g. Mirena or Jaydess), and implants regardless of age.

Hospital specialist services provide contraceptive needs for women prior to discharge from hospital. The Gynaecology Procedure Unit (GPU) have commenced a new process for women to come from the maternity ward to GPU or vice versa for Jadelle insertion. This service is currently provided by four medical staff and one nurse. Plans are underway to increase and formalise training of senior house officers/registrars and non-training registrars be accredited for Mirena and Jadelle insertion.

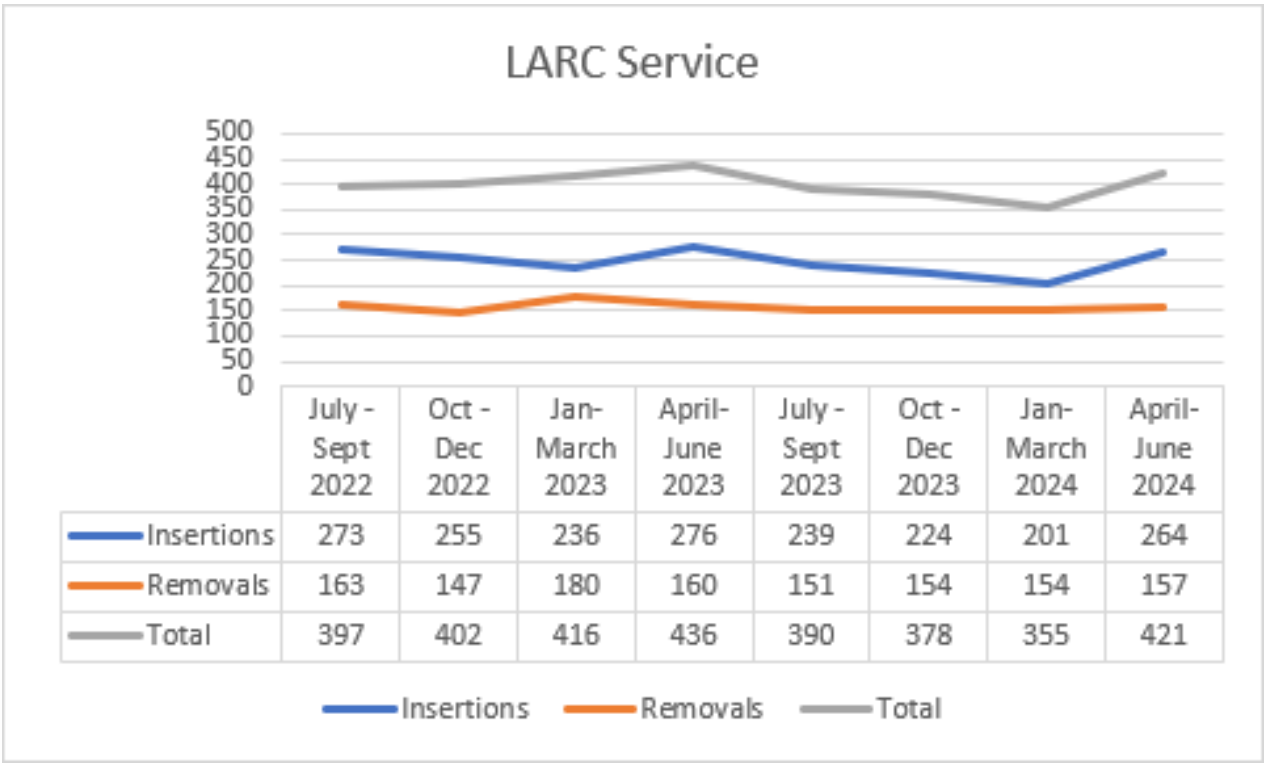


Figure 8. Canterbury Waitaha LARC Insertions and removals for Primary care

RURAL AND REMOTE RURAL NETWORKING

SAM BURKE

MATERNITY QUALITY SAFETY PROGRAMME (MQSP) COORDINATOR, HEALTH NZ CANTERBURY WAITAHA

In 2023 the Women's and Children's leadership team travelled to Kaikoura to meet with our rural community to hear what we could do better and what was working well in regard to the services we offer both in Kaikoura, and when there is the need to come to Christchurch Ōtautahi for care. The community hui was held on Takahanga Marae.

The hui was facilitated by Lisa Kahu, Kaiawhina, Te Tai O Marokura Health & Social Services, Kaikoura, Lisa is also the Chair of the Maternity Whānau Voice hui and sits at governance level within the Women's and Children's service.

During the day māmā and whānau came to speak to us about maternity, neonatal, paediatric and women's health services. The effect was profound and humbling as whānau spoke of what they would like to be different, but also acknowledging the work being done to improve care.

Kahu Taurima (maternity and early years) is one of the six priority areas of Te Pae Tata Interim New Zealand Health Plan 2022 (Te Whatu Ora and Te Aka Whai Ora, 2022) and the opportunity to have open discussions meant as a clinical team we were able to better understand our community. It also gave an opportunity for whānau to speak openly to the clinical leaders from the service they access.

TE PAE TATA (KAHU TAURIMA(MATERNITY AND EARLY YEARS))

ANNA HUNTER
SYSTEM DESIGN MANAGER, KAHU TAURIMA (MATERNITY & EARLY YEARS)
COMMISSIONING, REGIONAL SYSTEM INTEGRATION, TE WAIPOUNAMU

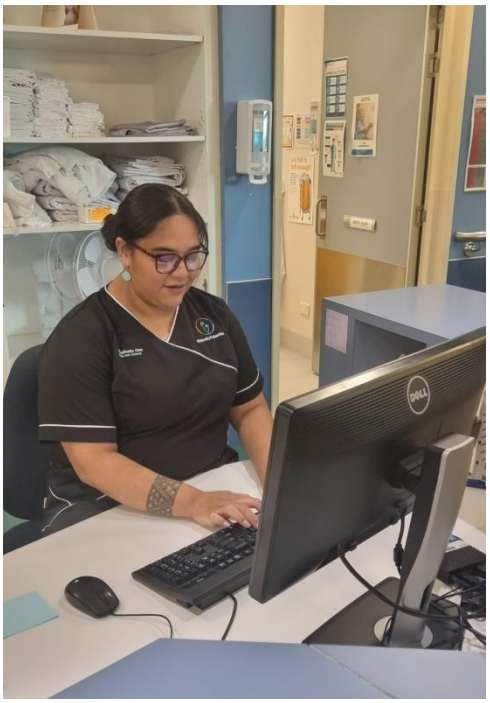
Over the past 12 months, Health NZ have prioritised the establishment of Kahu Taurima roles to support the rollout of initiatives that will move us closer to the vision of seamless, connected and integrated care throughout pregnancy and early years.

In the Commissioning space, we have introduced dedicated national and regional Kahu Taurima roles. Over recent months, we have contributed to the new Support for All Whānau prototype under the revised Well Child Tamariki Ora clinical schedule and fed into the national review of the Maternity components of care.

Our work in the regional space continues to progress as we get to know our role and how we can better align the needs of our communities with our health system offerings.

MATERNITY KAIĀWHINA

KELLY KARA
MIDWIFE MANAGER, KURAWAKA WAIPAPA, HEALTH NZ CANTERBURY WAITAHA



The Maternity Kaiāwhina programme was a workforce development project in Health NZ Canterbury Waitaha, Christchurch Women's Hospital, Maternity Ward. This was developed within the context of an ongoing national midwifery shortage and the need to develop strategies to support whānau and health care kaimahi in specialist services where this staffing shortage is pronounced and ongoing. There was a significant opportunity to alleviate some workforce stressors within health by upskilling and investing in the kaiāwhina workforce. Aotearoa has increasing cultural diversity and complex health, and social inequities exist. The Kaiāwhina workforce, through their work with whānau and communities can assist to increase equitable health outcomes.

The goals and outcomes identified for this programme were:

- Increase in number of Māori and Pacific people in the maternity workforce
- Satisfaction and retention of Kaiāwhina with ongoing cultural and pastoral care
- Kaiāwhina have a staircasing pathway of qualifications within Maternity sector
- Supporting a sustainable maternity workforce

The Maternity Kaiāwhina programme worked to serve a number of groups within the community. We recognised that whānau within the Maternity Ward, which is a high-risk antenatal and postnatal. This location was specifically selected for the pilot in recognition that whānau experiencing complexity for māmā or pēpi needed additional support while navigating their experiences in this setting. The kaimahi/staff on the Maternity Ward had been working with pronounced and prolonged workforce shortages and it was proposed that the Maternity Kaiāwhina role would alleviate some of the pressure and stress that the kaimahi/staff were experiencing. By creating a pathway into health careers, we also saw that the Maternity Kaiāwhina programme could benefit the kaiāwhina themselves, who may not have previously considered careers in health and this role could be a pathway into these careers.

With the goal of supporting Maternity Kaiāwhina into health careers there was a commitment, within this programme, to support the kaiāwhina to complete the Careerforce Level 3 Health and Wellbeing qualification. By the conclusion of this 12 month pilot programme a third of the kaiāwhina had completed this qualification, with the other kaiāwhina over half way to finishing this. A key aspect of supporting this was to have release time from working on the ward to come together, with support from clinical and cultural specialists to complete this aspect.

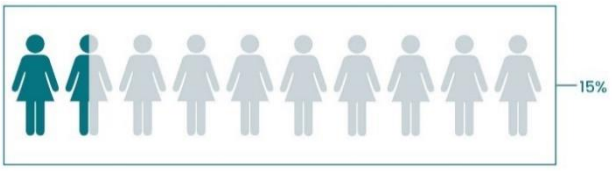
The task redistribution aspect of this role used the Calderdale Framework to provide structure to these delegation and escalation processes with the aim of optimising workforce capacity. The use of an established framework was key for ensuring that while there were changes in practice, the safety of whānau, kaimahi and kaiāwhina was paramount by ensuring clear delegation and escalation pathways were established.

OUR OUTCOMES

NZ MATERNITY CLINICAL INDICATORS ANALYSIS

The Health New Zealand Te Whatu Ora data New Zealand Maternity Clinical Indicator Trends 2009 and 2022 (2024), specifically, the years 2021 and 2022 are reviewed in this report. The online application shows key maternity outcomes for each district and is the most recent published 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 54.

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 2024/25.

Table 2. Te Whatu Ora Waitaha Clinical Indicator Analysis 2021 and 2022

Indicator	Title	2021 Waitaha Canterbury Rate	2022 Waitaha Canterbury Rate	Higher or lower national rate	2022 National Rate
INDICATOR 1 - REGISTRATION WITH AN LMC IN THE FIRST TRIMESTER OF PREGNANCY (ALL POPULATION GROUPS)		87.6%	87.7%	↑	76.4%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 2 - SPONTANEOUS VAGINAL BIRTH (ALL POPULATION GROUPS)		SP 59.7%	SP 57.6%	↓	SP 59.3%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 3 - INSTRUMENTAL VAGINAL BIRTH (ALL POPULATION GROUPS)		SP 22.6%	SP 23.2%	↑	SP 20.7%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 4 - CAESAREAN SECTION (ALL POPULATION GROUPS)		SP 17.6%	SP 19.2%	↓	SP 20.0%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 5 - INDUCTION OF LABOUR (ALL POPULATION GROUPS)		9.1%	9.3%	=	9.3%

Indicator	Title	2021 Waitaha Canterbury Rate	2022 Waitaha Canterbury Rate	Higher or lower than national rate	2022 National Rate
INDICATOR 6 - INTACT LOWER GENITAL TRACT (ALL POPULATION GROUPS)		SP 22.8%	SP 24.5%	=	SP 24.2%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 7 - EPISIOTOMY WITHOUT THIRD AND FOURTH DEGREE TEAR (ALL POPULATION GROUPS)		SP 28.0%	SP 29.2%	↑	SP 27.6%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 8 - THIRD OR FOURTH DEGREE TEAR WITHOUT EPISIOTOMY (ALL POPULATION GROUPS)		SP 6.0%	SP 5.9%	↑	SP 4.5%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 9 - EPISIOTOMY WITH THIRD OR FOURTH DEGREE TEAR (ALL POPULATION GROUPS)		SP 2.9%	SP 1.7%	↓	SP 2.1%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 10 - GENERAL ANAESTHETIC FOR CAESAREAN SECTION (ALL POPULATION GROUPS)		5.1%	5.1%	↓	7.5%

Indicator	Title	2021 Waitaha Canterbury Rate	2022 Waitaha Canterbury Rate	Higher or lower than national rate	2022 National Rate
INDICATORS 11 AND 12 - BLOOD TRANSFUSION AFTER CAESAREAN SECTION AND VAGINAL BIRTH (ALL POPULATION GROUPS)		5.7% Caesarean 4.2% Vaginal	3.7% Caesarean 3.0% Vaginal		3.8% Caesarean 2.7% Vaginal

Indicator	Title	2021 Waitaha Canterbury (n)	2022 Waitaha Canterbury (n)	2022 National (n)
INDICATOR 13 - DIAGNOSIS OF ECLAMPSIA (ALL POPULATION GROUPS)		(n = 3)	(n = 5)	(n=24)

Indicator	Title	2021 Waitaha Canterbury (n)	2022 Waitaha Canterbury (n)	2022 National (n)
INDICATOR 14 - PERIPARTUM HYSTERECTOMY (ALL POPULATION GROUPS)		(n=0)	(n = 2)	(n=44)

Indicator	Title	2021 Waitaha Canterbury (n)	2022 Waitaha Canterbury (n)	2022 National (n)
INDICATOR 15 - MECHANICAL VENTILATION (ALL POPULATION GROUPS)		(n=2)	(n = 1)	(n=13)

Indicator	Title	2021 Waitaha Canterbury Rate	Higher or lower than national rate	2021 National Rate
INDICATOR 16 - TOBACCO USE DURING THE POSTNATAL PERIOD (ALL POPULATION GROUPS)		6.5%		7.3%

Indicator	Title	2021 Waitaha Canterbury Rate	2022 Waitaha Canterbury Rate	Higher or lower than national rate	2022 National Rate
INDICATOR 17 - PRE-TERM BIRTHS (UNDER 37 WEEK'S GESTATION) (ALL POPULATION GROUPS)		7.2%	6.8%		7.7%

Indicator	Title	2021 Waitaha Canterbury Rate	2022 Waitaha Canterbury Rate	Higher or lower than national rate	2022 National Rate
INDICATOR 18 - SMALL BABIES AT TERM (37 – 42 WEEKS GESTATION) (ALL POPULATION GROUPS)		2.5%	3.0%	↓	3.1%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 19 - SMALL BABIES AT TERM (BORN AT 40 – 42 WEEKS GESTATION) (ALL POPULATION GROUPS)		25.2%	24.6%	↓	25.6%
Indicator	**Title**	**2021 Waitaha Canterbury Rate**	**2022 Waitaha Canterbury Rate**	**Higher or lower than national rate**	**2022 National Rate**
INDICATOR 20 - BABIES REQUIRING RESPIRATORY SUPPORT BORN AT 37+ WEEKS GESTATION (ALL POPULATION GROUPS)		3.1%	4.2%	↑	3.4%

Conclusion

A review of the maternity clinical indicators (both SP and total Waitaha Canterbury population) and local data by the multidisciplinary team have identified areas for further review, and these are included in the 2024/25 priorities and action plan.

There is a need to carry on our work to reduce the number of caesarean sections, instrumental births, third and fourth degree tears 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 Health NZ Te Whatu Ora Canterbury Waitaha maternity data sources and shows 2023 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 Health NZ Te Whatu Ora Canterbury Waitaha facilities and so excludes data for homebirths or St. George's Hospital (which closed in June 2023), which is included as part of the overview of hospitals and community birthing units in Canterbury Waitaha (page 18).

QUALITY AND ANALYSIS OF ROBSON CLASSIFICATION REPORT DATA

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 61.

For this report we have also be used the nine of categories from the Robsons Classification (WHO, 2017), which has been adopted by Canterbury 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 of clinical outcomes.

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 3.

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

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%), 2023 data shows the CS rate for this group at 45.6%**
- **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 8.5% (2023) 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 was found to inaccurate in 6 cases and follow up was required.** A review of each case was made, they were all noted to be a transverse presentation but cephalic births (without intervention) and **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.

2023 ANALYSIS USING ROBSON CLASSIFICATION

Table 3. Te Whatu Ora Waitaha Robson Classification report for 2023

Health NZ Te Whatu Ora Canterbury Waitaha	Period: January 2023 to December 2023			
	Number of CS in group/ number of women in group 2065/5764 = 35.8%	**Group size[1] (%)**	**Group CS Rate[2] (%)**	**Absolute group contribution to overall CS rate[3] (%) Total 36.6%**
1 Nullip single cephalic>=37 weeks spontaneous labour	281/1257	21.6	22.3	4.87%
2A and **2B** Nullip single cephalic >=37weeks induced or CS before labour	489/1071	18.4	45.6	8.48%
3 Multip (excluding previous caesarean sections) single cephalic >=37 weeks spontaneous labour	119/1409	24.2	8.4	2.0%
4 Multip (excluding previous caesarean sections) single cephalic >=37weeks induced or CS before labour	273/745	12.8	36.6	4.7%
5 Previous caesarean section single cephalic >= 37 weeks	491/621	10.7	79.0	8.5%
6 All nulliparous breeches	127/133	2.3	95.7	2.2%
7 All multiparous breeches (including previous caesarean sections)	72/77	1.3	93.5	2.2%
8 All multiple pregnancies (including previous caesarean sections)	41/67	2.2	61.0	0.7%
9 All abnormal lies (including previous caesarean sections)	42/42	0.7	100.0	0.7%
10 All single cephalic <= 36 weeks (including previous caesarean sections)	136/324	5.6	42.0	2.3%

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 10

The groups of the Robson Classification

Health New Zealand
Te Whatu Ora

GROUP 1

Nulliparous women/persons and whānau with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

GROUP 2A

Nulliparous women/persons and whānau with a single cephalic pregnancy, ≥37 weeks gestation who had labour induced.

GROUP 2B

Nulliparous women/persons and whānau with a single cephalic pregnancy, ≥37 weeks gestation who delivered by caesarean section before labour

GROUP 3

Multiparous women/persons and whānau without a previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

GROUP 4

Multiparous women/persons and whānau without a previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

GROUP 5

All multiparous women/persons and whānau with at least one previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation

GROUP 6

All nulliparous women/persons and whānau with a single breech pregnancy

GROUP 7

All multiparous women/persons and whānau with a single breech pregnancy, including women/persons and whānau with previous uterine scars

GROUP 8

All women/persons and whānau with multiple pregnancies, including women/persons and whānau with previous uterine scars

GROUP 9

All women/persons and whānau with a single pregnancy with a transverse or oblique lie, including women/persons and whānau with previous uterine scars

GROUP 10

All women/persons and whānau with a single cephalic pregnancy <37weeks gestation, including women/persons and whānau with previous scars

- **Nulliparous** - never birthed a baby before (over 20 weeks gestation)
- **Multiparous** - has previously birthed
- **Cephalic** - head first
- **Breech**- bottom first
- **Transverse** - baby is lying sideways
- **Oblique** - baby's body and hip are lying diagonal
- An induced labour (induction) is one that is started artificially, rather than starting naturally on its own

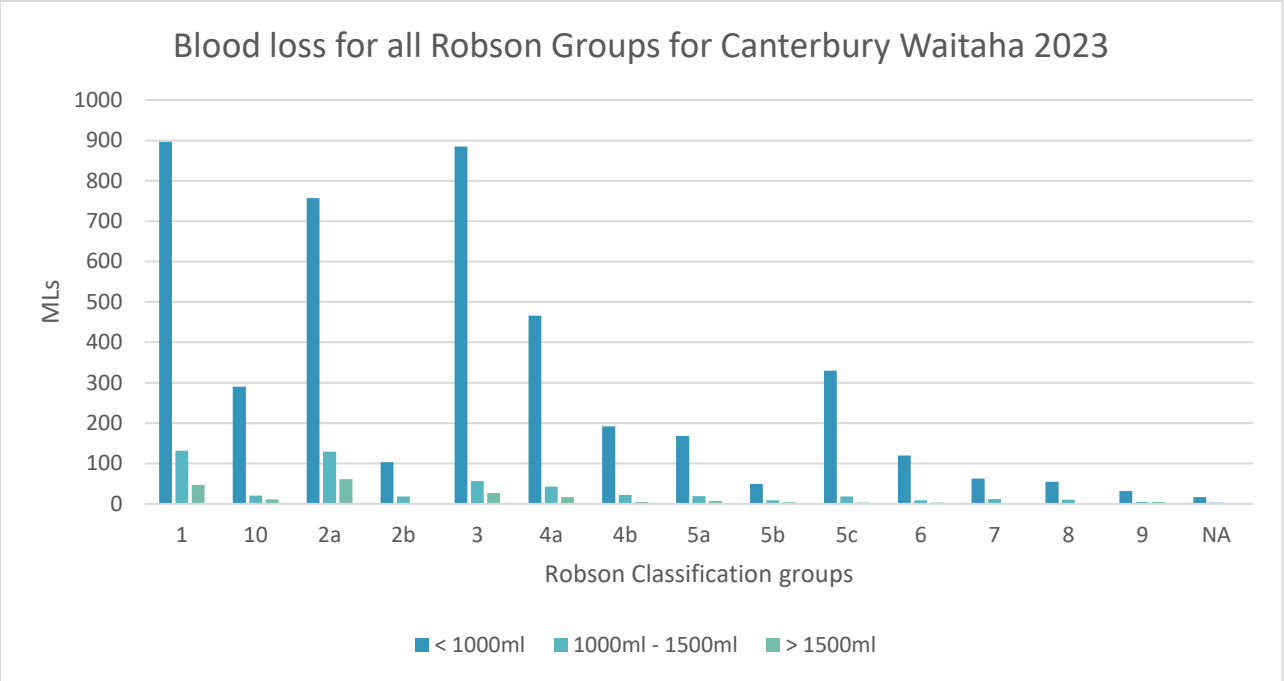
Ref 241098

Authorised by: Clinical Director Obstetrics & Gynaecology, Christchurch Hospital Canterbury Waitaha

August 2024

Robson Classification Poster (Health NZ Canterbury Waitaha, 2024)

Figure 9. Blood loss for all Robson groups for Canterbury Waitaha 2023



The following tables give an overview of Robson groups 1, 2A, 3 and 5 and key clinical outcomes.

Figure 10 shows the birthing outcomes for a nulliparous women (never birthed a baby before and over 20 weeks gestation) who labours spontaneously with a term baby in a cephalic (head first) presentation. The group accounts for 21.6% of the total birthing population for Canterbury Waitaha.

Figure 10. Robson Group 1 birthing outcomes for Canterbury Waitaha 2023

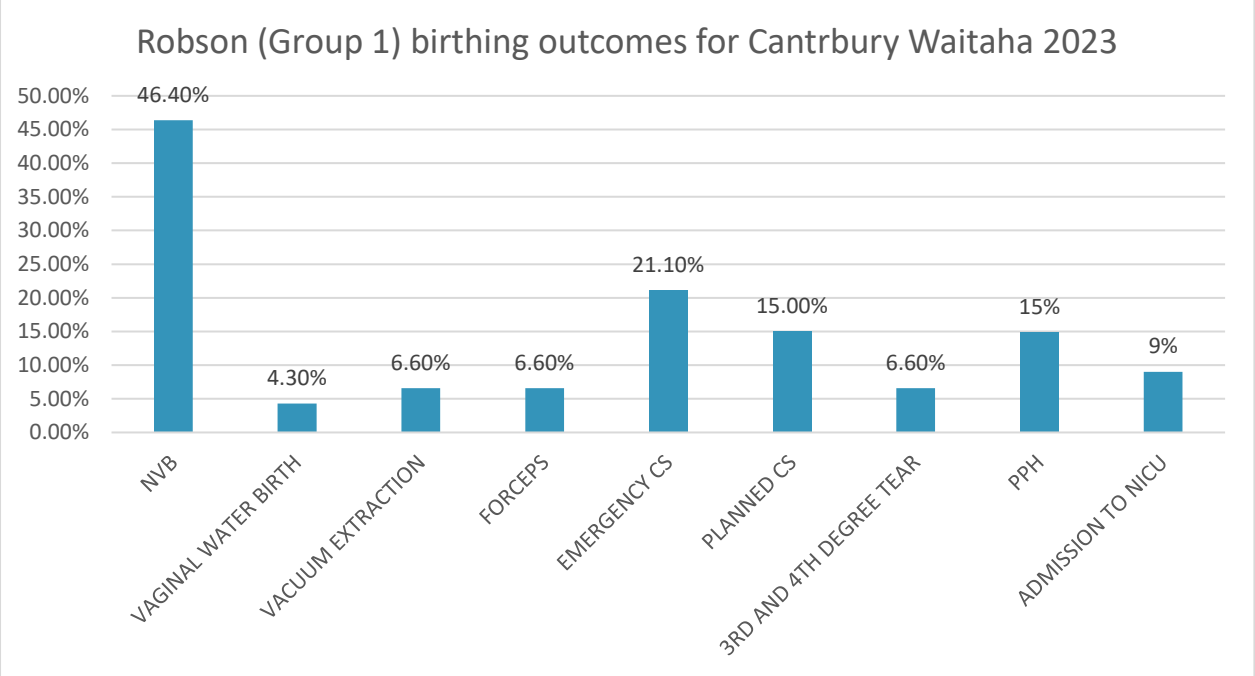


Figure 11. Robson Group 2A birthing outcomes for Canterbury Waitaha 2023

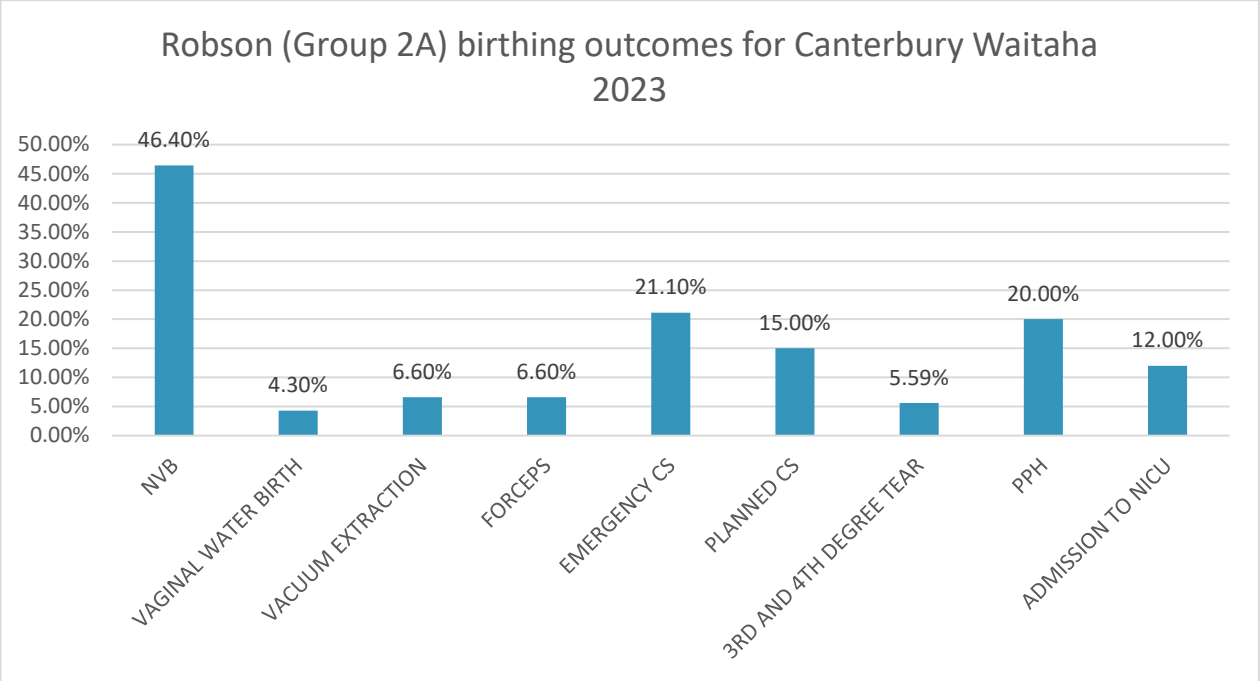


Figure 11 shows the birthing outcomes for a nulliparous women (never birthed a baby before and over 20 weeks gestation) who has labour induced with a term baby in a cephalic (head first) presentation. The group accounts for 16.3% of the total birthing population for Canterbury Waitaha.

Figure 12. Robson Group 3 birthing outcomes for Canterbury Waitaha 2023

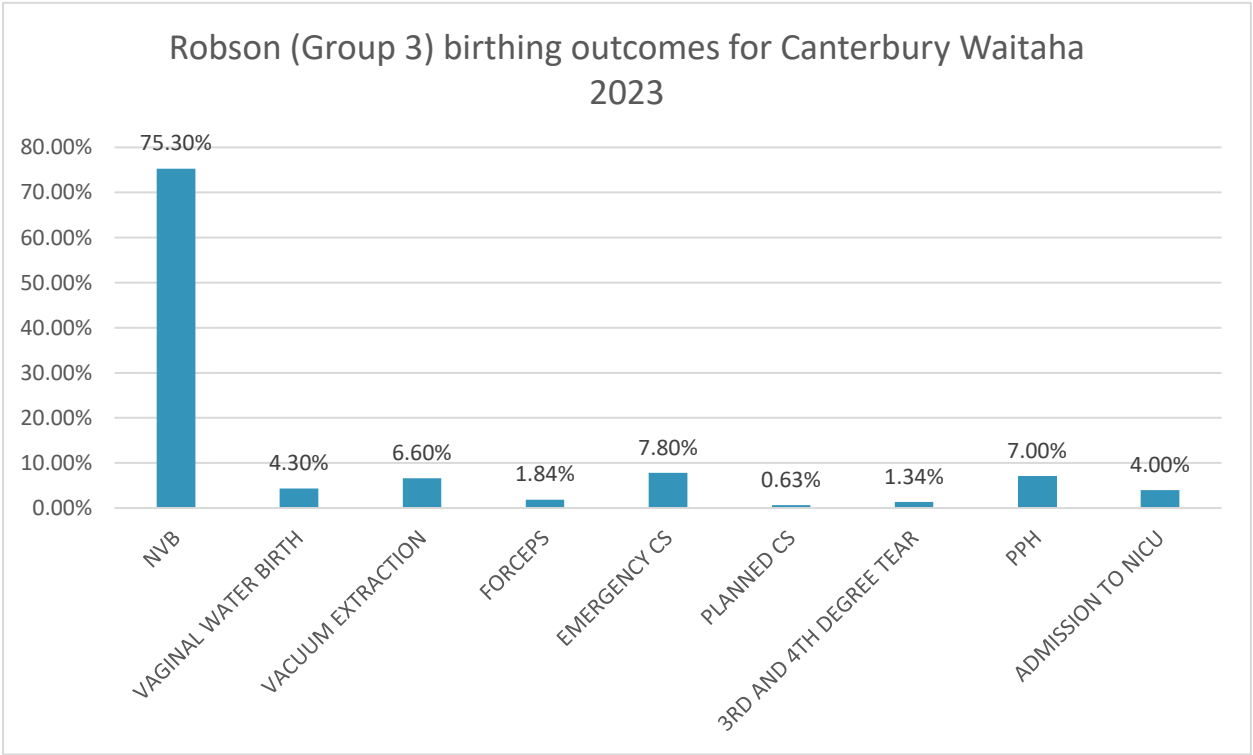


Figure 12 shows the birthing outcomes for a multiparous women (previously birthed a baby before and over 20 weeks gestation) who labour spontaneously with a term baby in a cephalic (head first) presentation. The group accounts for 24.2% of the total birthing population for Canterbury Waitaha.

Figure 13. Robson Group 4A birthing outcomes for Canterbury Waitaha 2023

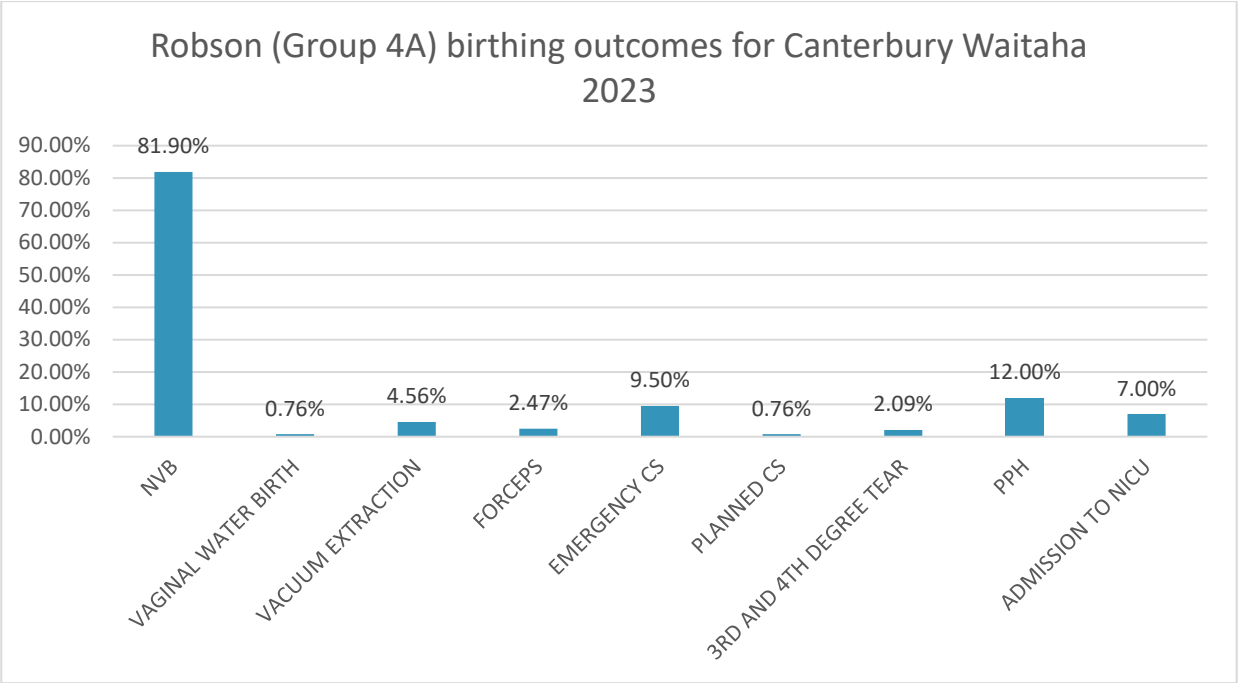


Figure 13 shows the birthing outcomes for a multiparous women (previously birthed a baby before and over 20 weeks gestation) who have labour induced with a term baby in a cephalic (head first) presentation. The group accounts for 9% of the total birthing population for Canterbury Waitaha.

Figure 14. Robson Group 5 birthing outcomes for Canterbury Waitaha 2023

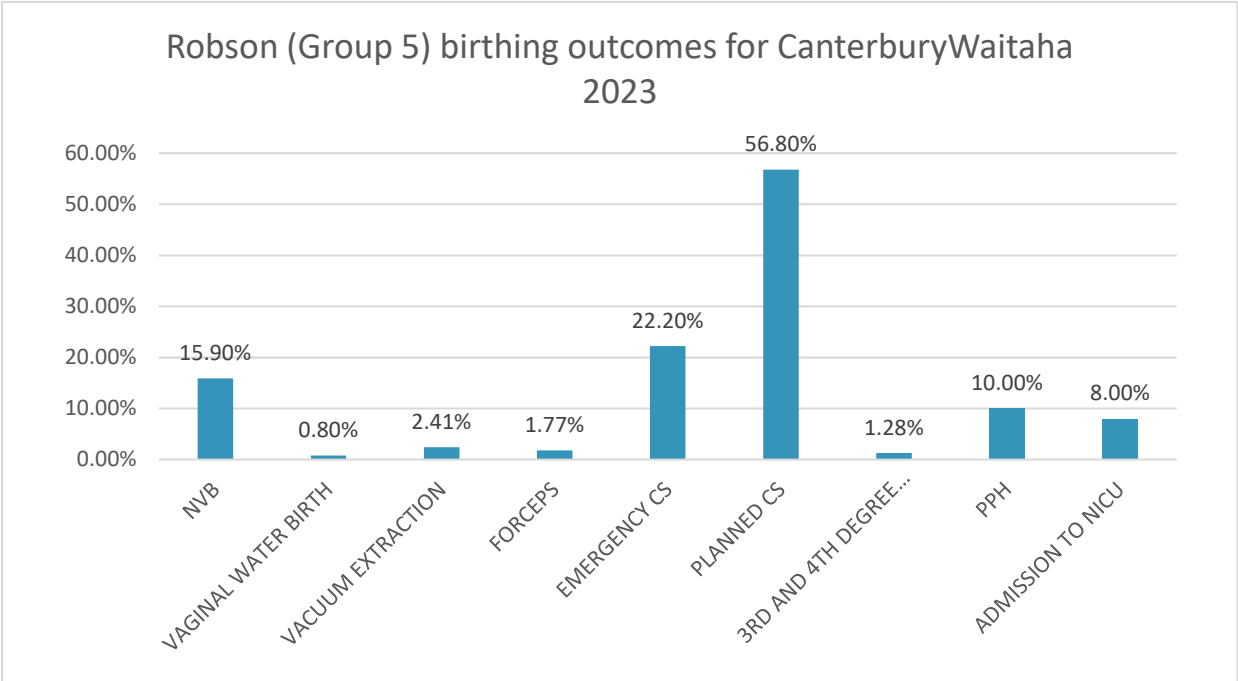


Figure 14 shows the birthing outcomes for a multiparous women (previously birthed a baby before and over 20 weeks gestation) who have had a previous caesarean section with a term baby in a cephalic (head first) presentation. The group accounts for 10.7% of the total birthing population for Canterbury Waitaha.

Table 4. Gestation at birth for total population 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Gestation at Birth	Number of Births 2022		Number of Births 2023	
Extremely preterm (<28 weeks)	27	0.50%	48	0.83%
Very preterm (28-31 weeks)	25	0.47%	62	1.07%
Moderate preterm (32-34 weeks)	120	2.24%	90	1.56%
Late preterm (35-36 weeks)	269	5.03%	238	4.12%
Term (37-41 weeks)	4867	90.99%	5323	92.3%
Prolonged (>42 weeks)	66	0.77%	43	0.74%
Total	**5349**	**100%**	**5804**	**100%**

Data in 2023 showed an increase of births <28weeks and 28-31 weeks gestation. Other categories remain similar over the years with the exception of a continued drop in in prolonged gestation (>42 weeks) since 2018.

Table 5. Type of labour for total population 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Type of labour	Number of deliveries 2022		Number of deliveries 2023	
Spontaneous	2549	48.34%	3169	54.8%
Induced	1709	32.41%	1625	28.1%
Did not labour	1015	19.24%	970	17.1%
Total	**5273**	**100%**	**5764**	**100%**

Table 6. Method of Birth 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Method of Birth	Number of Births 2022		Number of Births 2023	
Vaginal	2376	45.06%	2679	46.4%
Vaginal Water Birth	84	1.59%	250	4.3%
Vacuum Extraction	441	8.36%	387	6.6%
Forceps	382	7.24%	383	6.6%
Caesarean Section	1990	37.74%	2065	36.1%
Total	**5273**	**100%**	**5804**	**100%**

Data shows little change for years 2022 and 2023.

Table 7. Breech birth for total population 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Breech Birth	Number of Births 2022		Number of Births 2023	
No	5115	95.63%	5556	95.73%
Yes	234	4.37%	248	4.27%
Total	**5349**	**100%**	**5804**	**100%**

There was very little change in the percentage of breech births between 2022 and 2023.

Table 8. Anaesthetic for total population 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Anaesthetic	Number of deliveries 2022		Number of deliveries 2023	
None	1736	31.86%	1566	27.1%
Local	527	9.67%	475	8.24%
Pudendal Block	105	1.93%	111	1.92%
Epidural	1187	21.78%	1191	20.6&
Spinal/Epidural	273	5.01%	264	4.58%
Spinal	1510	27.71%	1583	27.4%

General	97	1.78%	74	1.28%
Mixed general/Epidural	9	0.17%	5	0.08%
Other	6	0.11%	14	0.24%
Total	**5273**	**100%**	**5764**	**100%**

A review of our 2022 and 2023 data shows similar rates since 2018. Our anaesthetic rates are also captured by our senior anaesthetist and reviewed regularly.

Table 9. Perineal Tears for total population 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Perineal Tears	Number of deliveries 2022		Number of deliveries 2023	
Intact	2749	52.13%	2919	50.6%
First Degree Tear	505	9.58%	635	11.0%
Second Degree Tear	990	18.77%	1169	20.2%
3rd Degree Tear	167	1.67%	246	3.17%
4th Degree Tear	8	0.15%	6	0.10%
Episiotomy	854	16.20%	789	13.7%
Total	**5273**	**100%**	**5764**	**100%**

The 2022 and 2023 data shows an increase in the 3rd degree tear rates since the last report. These rates are also reflected in the New Zealand Maternity Clinical Indicators 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 2024/25.

Table 10. Blood transfusion required 2022-2023 Health NZ Te Whatu Ora Canterbury Waitaha

Blood Transfusion Required	Number of deliveries 2022		Number of deliveries 2023	
No	5085	96.43%	5558	96.4%
Yes	188	3.56%	206	3.57%
Total	**5273**	**100%**	**5764**	**100%**

There has been an increase in blood transfusions required. Quality work is ongoing to work on improving our PPH rates and has been included in our quality plan for 2024/25.

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 National Maternity Clinical Indicators.

Table 11. Health NZ Te Whatu Ora Canterbury Waitaha Babies requiring respiratory support and admission to NICU by gestation 2022 – 2023

	Number of Babies 2022		Number of Babies 2023	
<26 weeks gestation	9	2.02%	9	1.93%
26 – 27 weeks gestation	14	3.14%	14	3.01%
28 – 31 weeks gestation	32	7.17%	34	7.31%
32 – 36 weeks gestation	134	30.04%	138	29.67%
≥ 37 weeks gestation	257	57.62%	270	58.0%
Total	**446**	**100%**	**465**	100%

Figure 15 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 Health New Zealand Te Whatu Ora data New Zealand Maternity Clinical Indicator Trends 2009 and 2022 (2024)and shows a steady increase in the rates of babies requiring neonatal admission and respiratory support at ≥ 37 weeks gestation.

Figure 15. Health NZ Te Whatu Ora Canterbury Waitaha Babies requiring support and admission to NICU by gestation 2013 – 2023

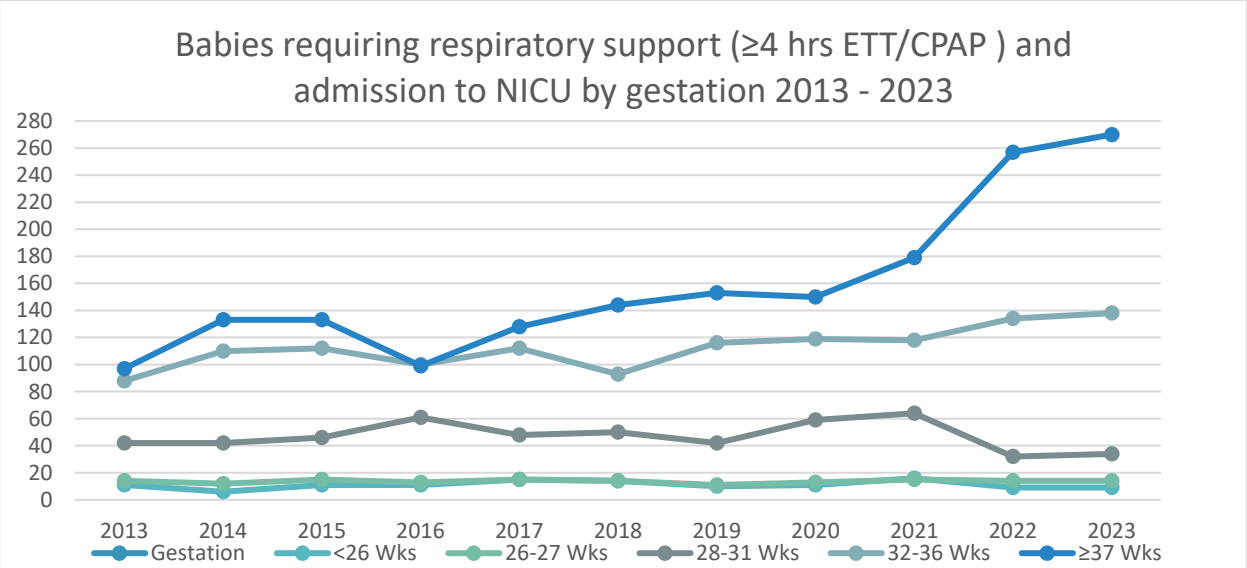


Figure 16 shows the percentage of steroid administration for babies <32 weeks gestation. The data is taken from the clinical record and verified on MedChart.

Figure 16. Health NZ Te Whatu ora Canterbury Waitaha steroids administered for babies <32 weeks gestation 2017 - 2023 as % of total numbers born

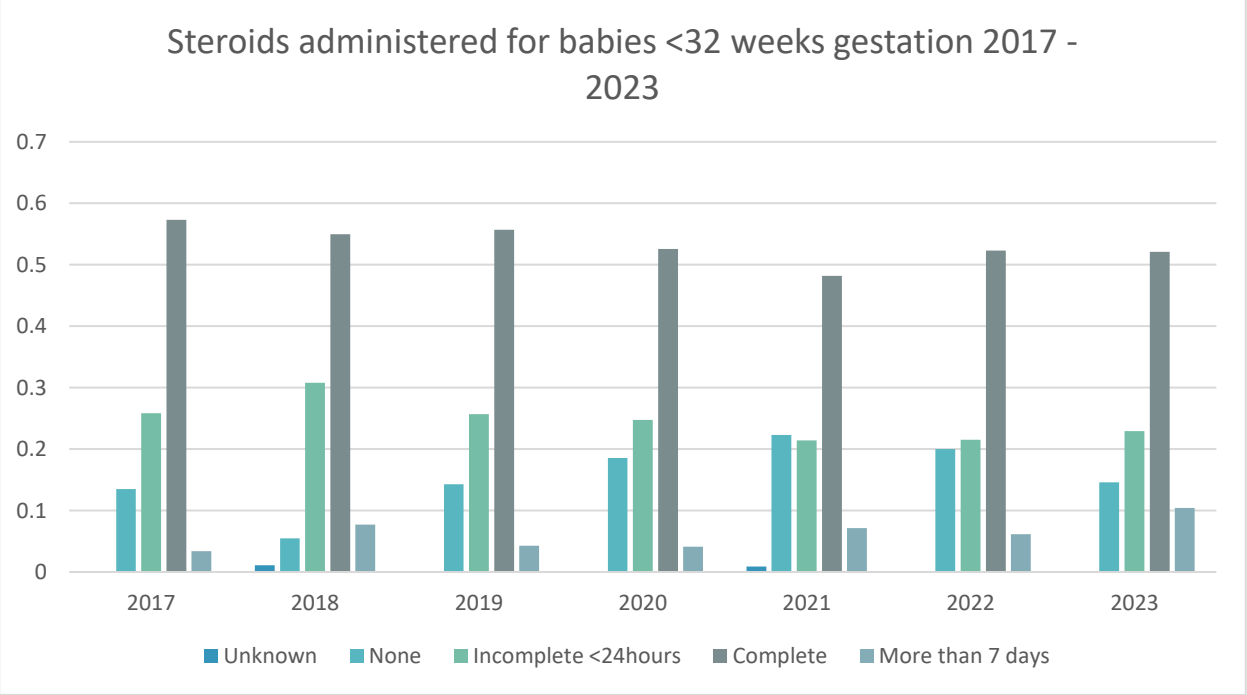
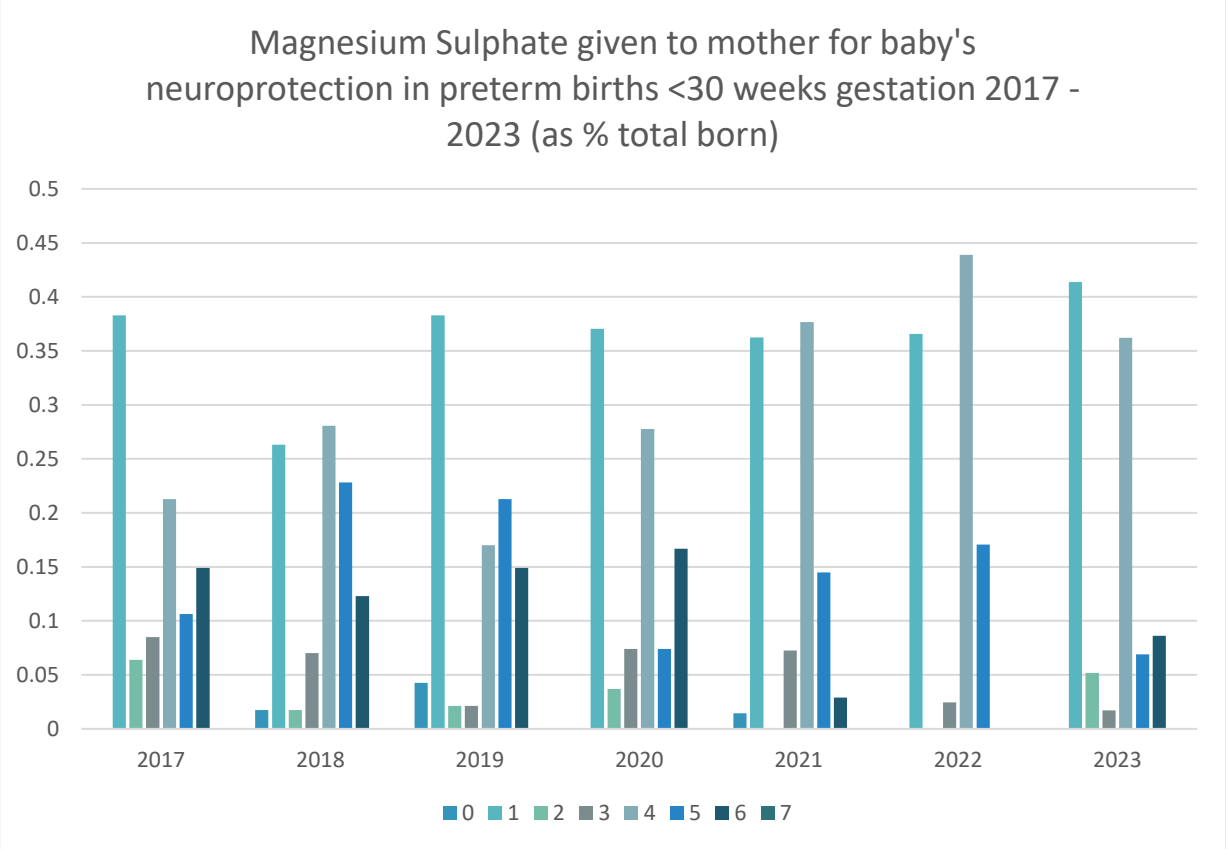


Figure 17 shows the percentage of Magnesium Sulphate given for baby's neuroprotection in preterm births <30 weeks from 2017 to 2023. As with the previous data set this is collected form the clinical record and verified on MedChart. The coding for this data set is:

- 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 17. Health NZ Te Whatu Ora Canterbury Waitaha Magnesium Sulphate given to mothers for baby's neuroprotection in preterm births <30 weeks gestation 2017 - 2023



> 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 2024/25

As a district we have identified MQSP priorities for 2024/2025 (see Appendix 4). 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 Sixteenth Annual Report of the Perinatal and Maternal Morbidity Review Committee (PMMRC, 2024), New Zealand Health Strategy (MoH, 2023) and Women's Health Strategy (MoH, 2023) and identified quality work to address our clinical outcomes following review of our local data.

As a district we also align any quality work to the Canterbury Maternity System Strategic Framework. We also acknowledge that Kahu Taurima is the joint Te Aka Whai Ora and Health New Zealand and Te Whatu Ora approach to maternity and early years (pre-conception to 5 years old, or the First 2,000 Days of life) for all whānau in Aotearoa New Zealand and is 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.

Bibliography

CDHB. (2019). *Canterbury Maternity System Strategic Framework 2019 - 2024.* CDHB.

HQ&SC. (2018). *Maternal Morbidity Working Group Annual Report.* Wellington: Health Quality and Safety Commision New Zealand.

HQSC. (2019). *Maternal Morbidity Working Group Annual Report.* Wellington: HQSC.

MCNZ. (n.d.). *Workforce Survey 2023.* Wellington: MCNZ.

MOH. (2011). *New Zealand Maternity Standards.* Wellington: MoH.

MoH. (2023). *New Zeland Health Strategy.* Wellington: MoH.

MoH. (2023). *Women's Health Strategy.* Wellington: MoH.

NMMG. (2020). *National Maternity Monitoring Group Annual Report.* Wellington: NMMG.

NZ, S. (2024). *Stats NZ*.

Ora, H. N. (2024). *New Zealand Maternity Clinical Indicator trends 2009 - 2022*.

organisation, H. i. (2022). *Maternity care summary standard HISO 10050:2022.* Wellington: Manatu Hauora.

PMMRC. (2024). *Sixteenth Annual Report of the Perinatal and Maternal Morbidity Review Committee.* Wellington: PMMRC.

Te Whatu Ora and Te Aka Whai Ora. (2022). *Te Pae Tata: interim New Zealand Health Plan.* Wellington: Te Kāwanatanga o Aotearoa.

WHO. (2017). *Robson Classification: Implementation Manual.* Geneva.

Zealand, H. N. (2024). *Report on Maternity web tool*.

APPENDIX 1

BIRTH STATISTICS AND CLINICAL OUTCOMES FOR CANTERBURY WAITAHA COMMUNITY BIRTHING UNITS 2023

The following graphs show the data from Waitaha Community Birthing Units: Oromairaki, Rangiora, Ashburton & Kaikoura. The collective data:

- Informs and supports midwifery practice, illustrating what we can celebrate and where we can do better
- Determines if outcomes align to research confirming safety of birth in community units
- Most importantly, it provides data to inform decision-making for wāhine and their whānau around planned place of birth

BIRTHS: PARITY (1ST OR SUBSEQUENT PĒPI), USE OF WATER, WATERBIRTH, 3RD STAGE (WHENUA) & PERINEAL OUTCOMES

Figure 18. Proportion of births in the community birthing unit and transfer in labour 2023

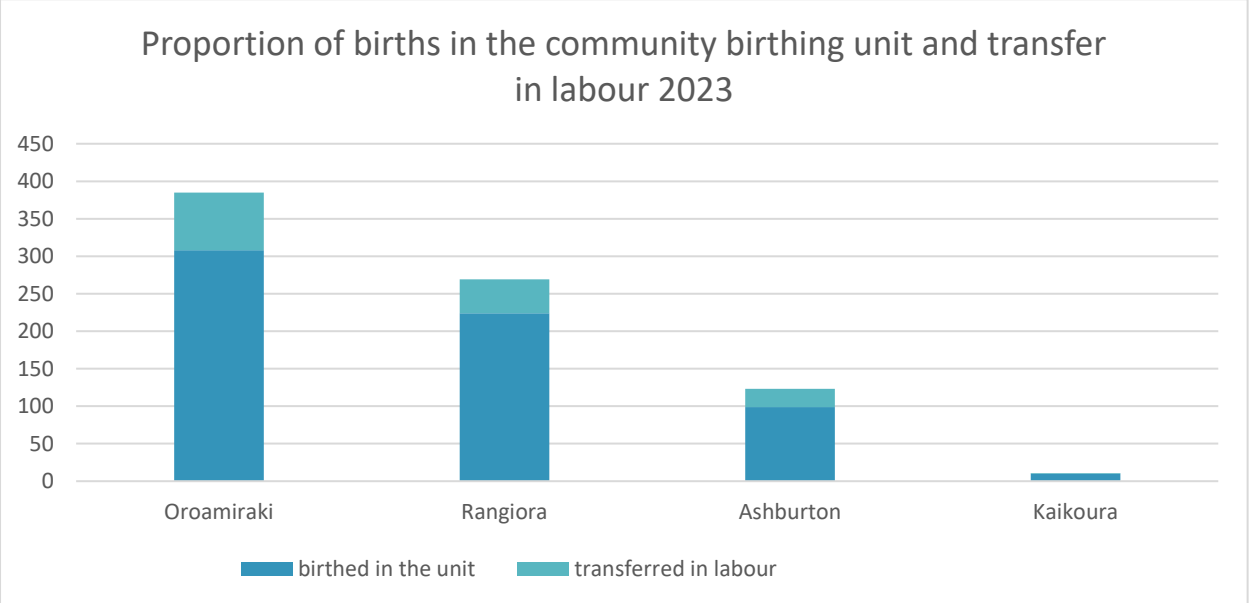


Figure 19. Parity of women birthing in a community birthing unit 2023

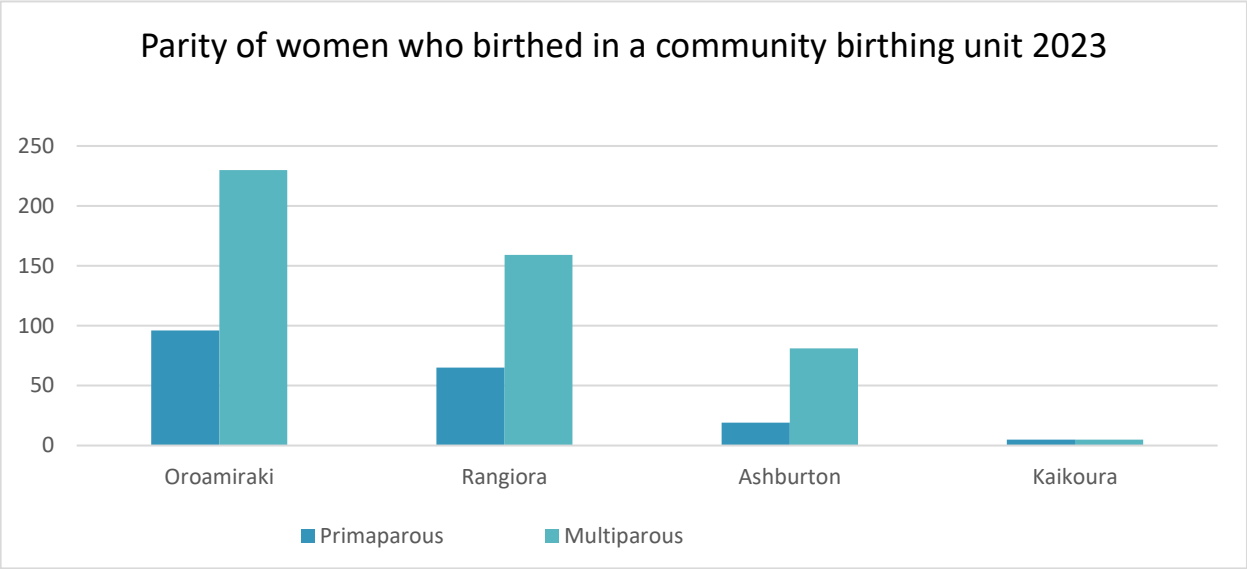


Figure 20. Water birth and water immersion for pain relief in a community birthing unit 2023

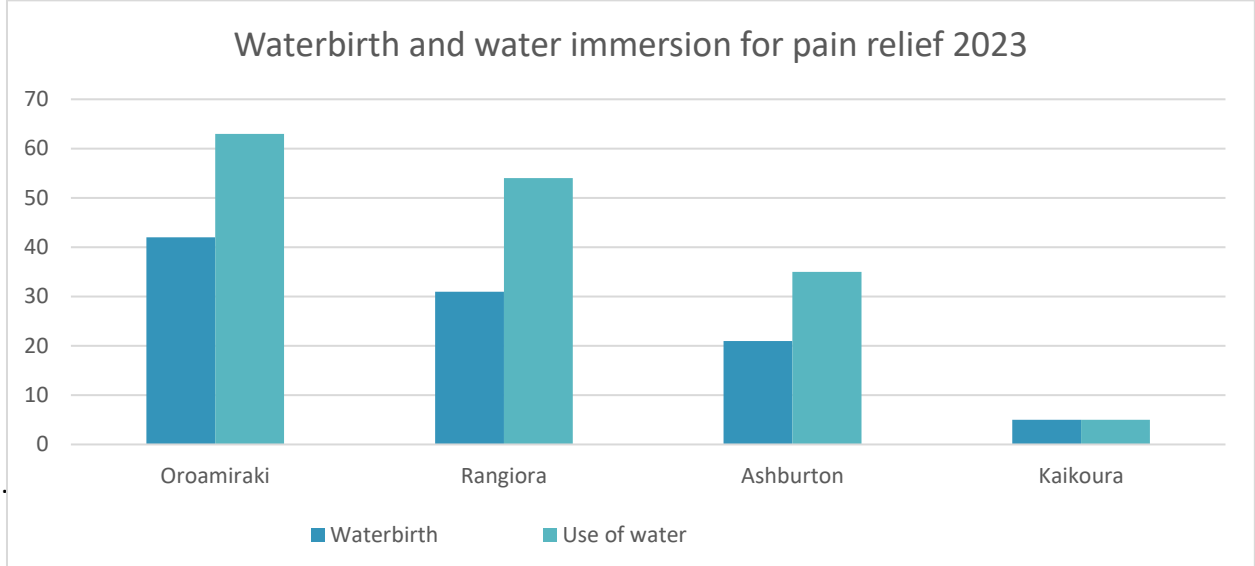


Figure 21. Parity of women who transferred to CWH from a community birthing unit 2023

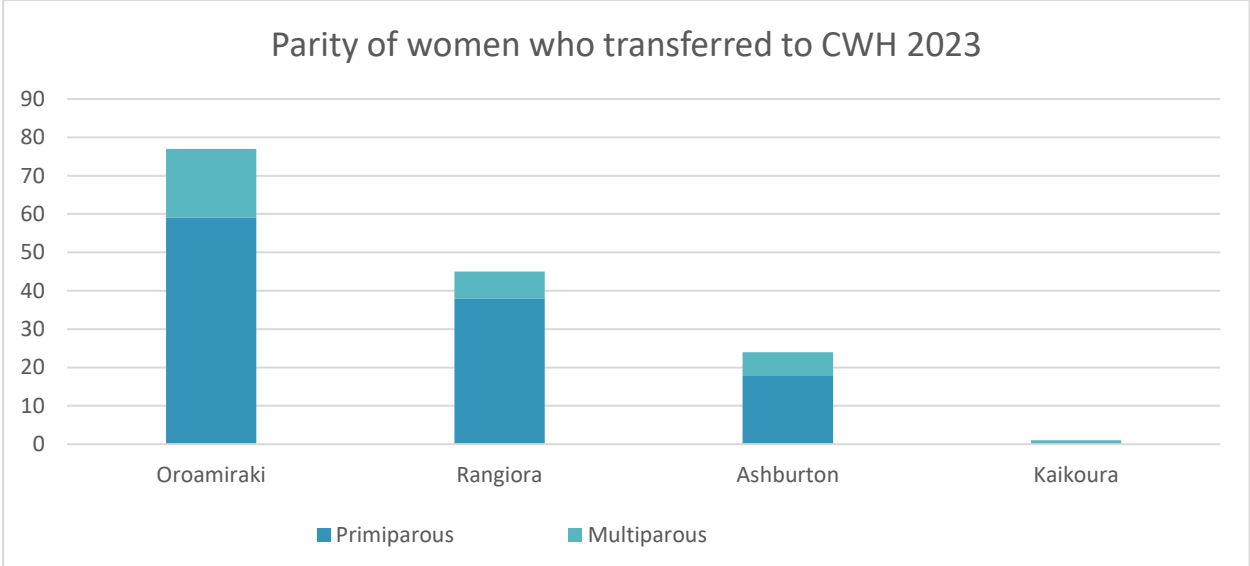


Figure 22. Percentage of physiological vs active management in a community birthing unit 2023

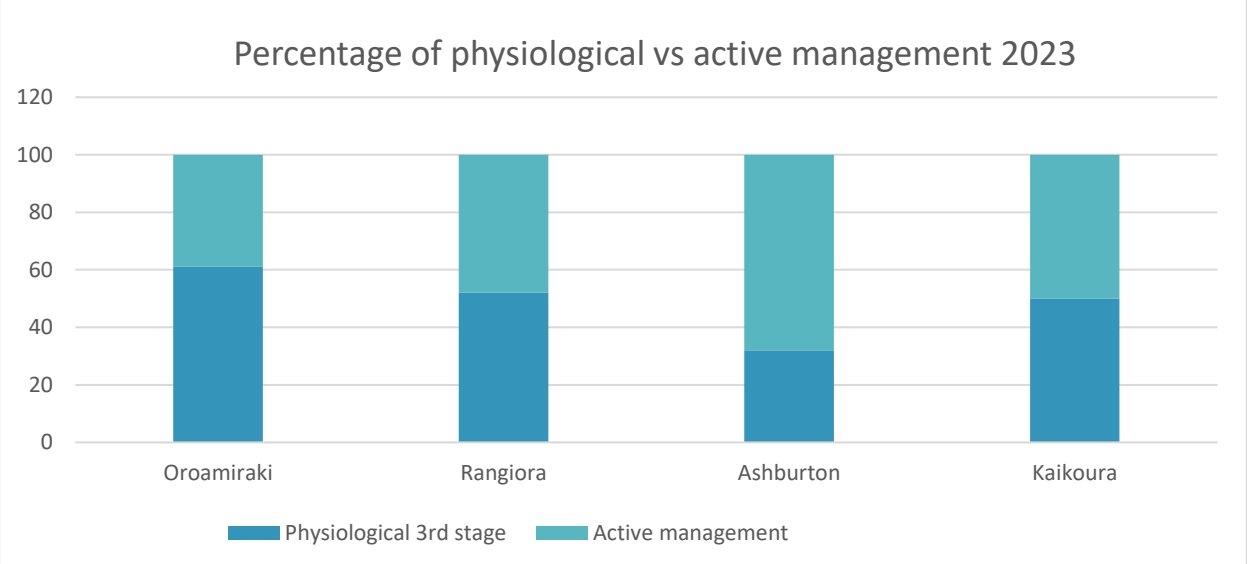


Figure 23. Number of births and postpartum haemorrhage in a community birthing unit 2023

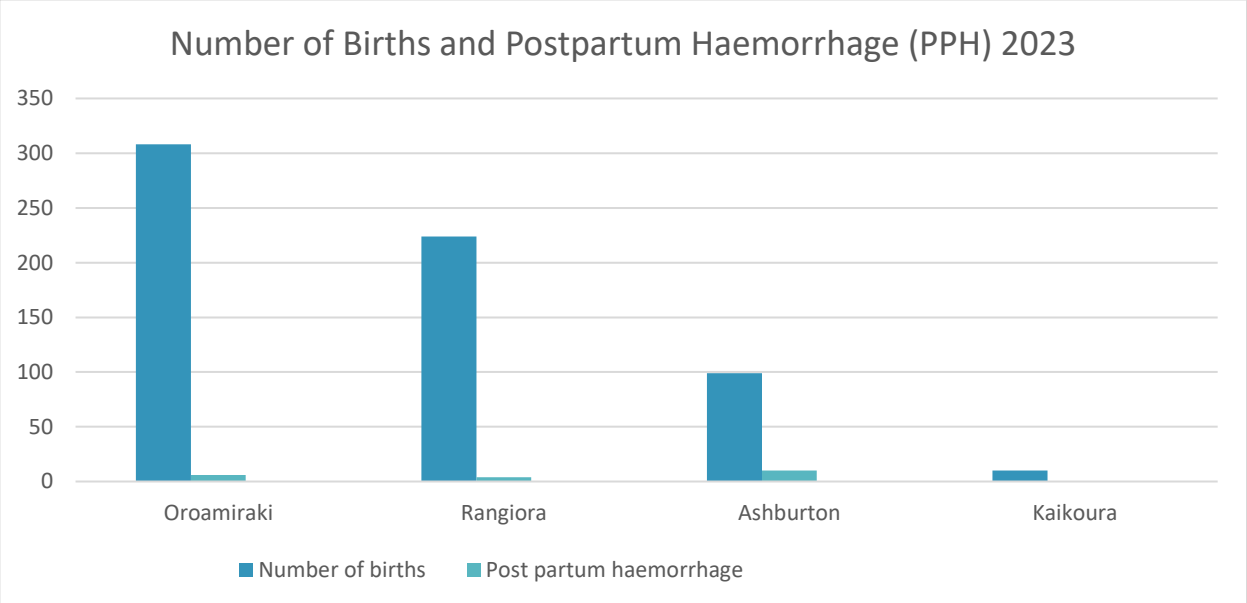
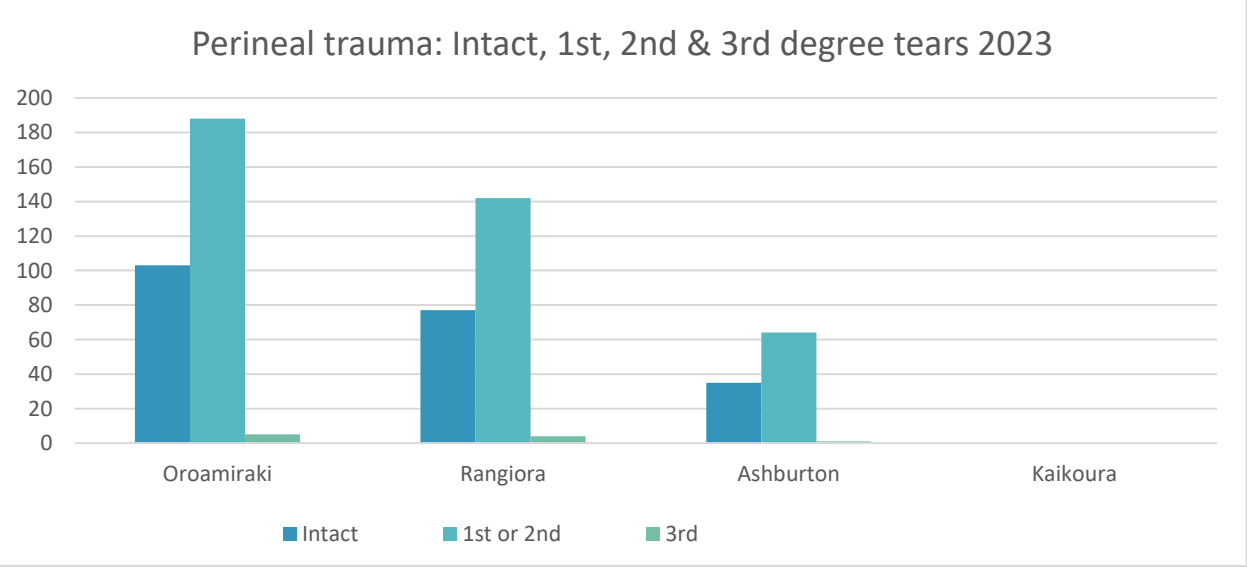


Figure 24. Perineal trauma in a community birthing unit 2023

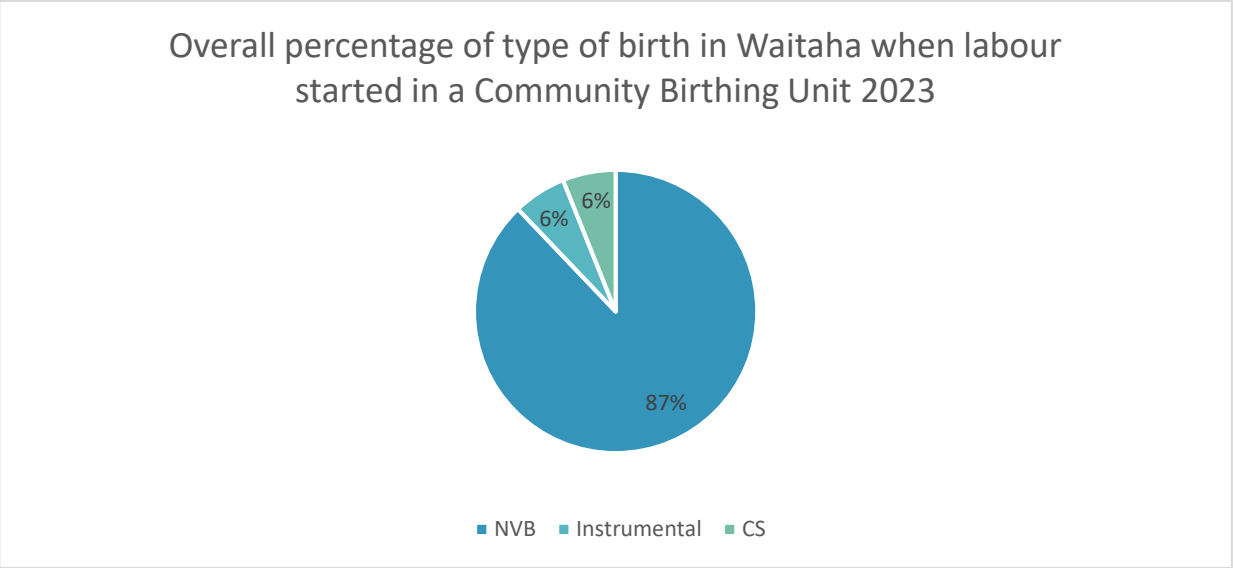


No Episiotomies were recorded at Ashburton or Kaikoura, 1 at Rangiora and 11 were performed at Oromairaki

Reasons for transfer in labour

- Range between 3.8 to 4.4% for fetal distress
- >86 % are for delay in 1st or 2nd stage or meconium liquor
- Between 4 and 10% are for one of the remaining reasons: breech, APH, raised BP & other
- No transfers from Rangiora, Ashburton or Kaikoura occurred with epidural indicated as reason. Six women transferred for this reason from Oromairaki

Figure 25. Overall percentage of type of birth in Waitaha when labour started in a community birthing unit 2023



NEONATAL RETRIEVAL

- The rate of neonatal retrieval from Oromairaki was higher than usual at 6.1%. Of the 19 babies retrieved, not all were admitted to NICU, Longest length of stay: 4 babies spent > 1 week and < 3 weeks in NICU
- 4% retrieval rate from Rangiora (n=9)
- Ashburton had 8% of babies born in the unit retrieved, but notably 6 of these were in the postnatal period (not at birth). RDS and jaundice the most common reasons
- No neonatal retrievals from Kaikoura
- Other retrievals occurring from community units include those born at CWH, who had transferred to community unit for postnatal care

NEONATAL OUTCOMES FOR THOSE BORN WITHIN 1 HOUR OF EMERGENCY TRANSFER IN LABOUR FROM OROMAIRAKI

- International measure of 1 hour after transfer (BPE)
- Of the 77 emergency transfers in labour, 9 babies were born within 1 hour of arrival
- 1 baby had a 1 minute Apgar of < 7 (5,9,9), was not admitted to NICU
- 2 were admitted to NICU, with 1 discharged 3 days later. The other was transferred to Timaru hospital but was notably preterm (emergency stop at Oromairaki on way to CWH & ambulance from there)

APPENDIX 2

HEALTH NZ TE WHATU ORA CANTERBURY WAITAHA DATA ANALYSIS BY POPULATION 2023

HEALTH NZ TE WHATU ORA CANTERBURY WAITAHA GESTATION AT BIRTH BY POPULATION GROUP 2023

Figure 26. Ethnicity of birthing population for Canterbury Waitaha 2023

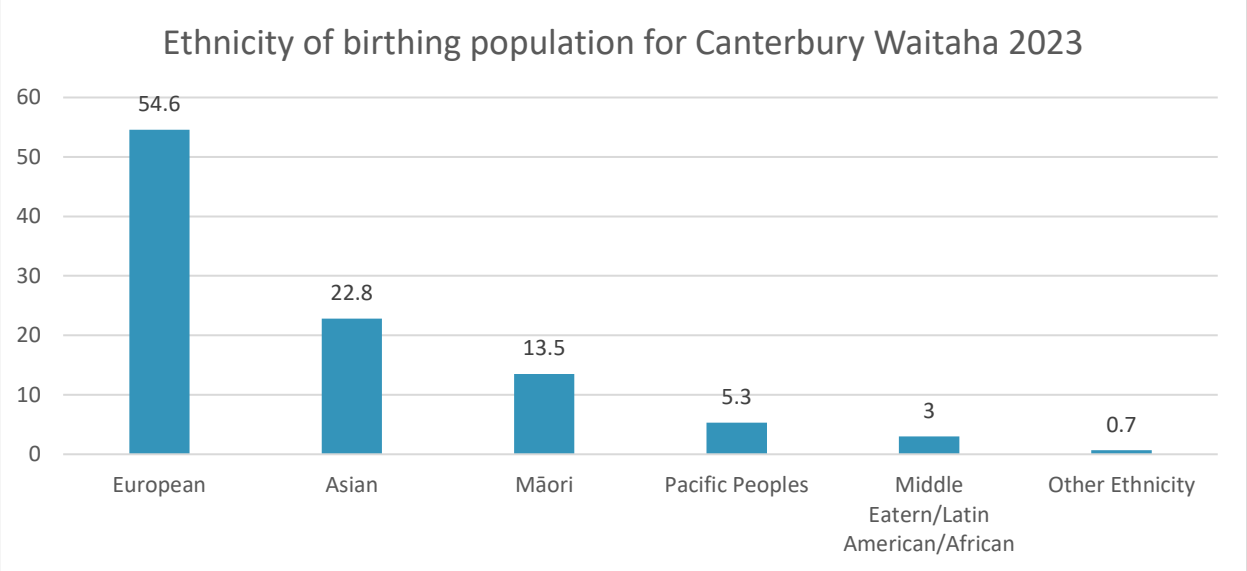


Figure 27. NICU admissions by population group for Canterbury Waitaha 2023

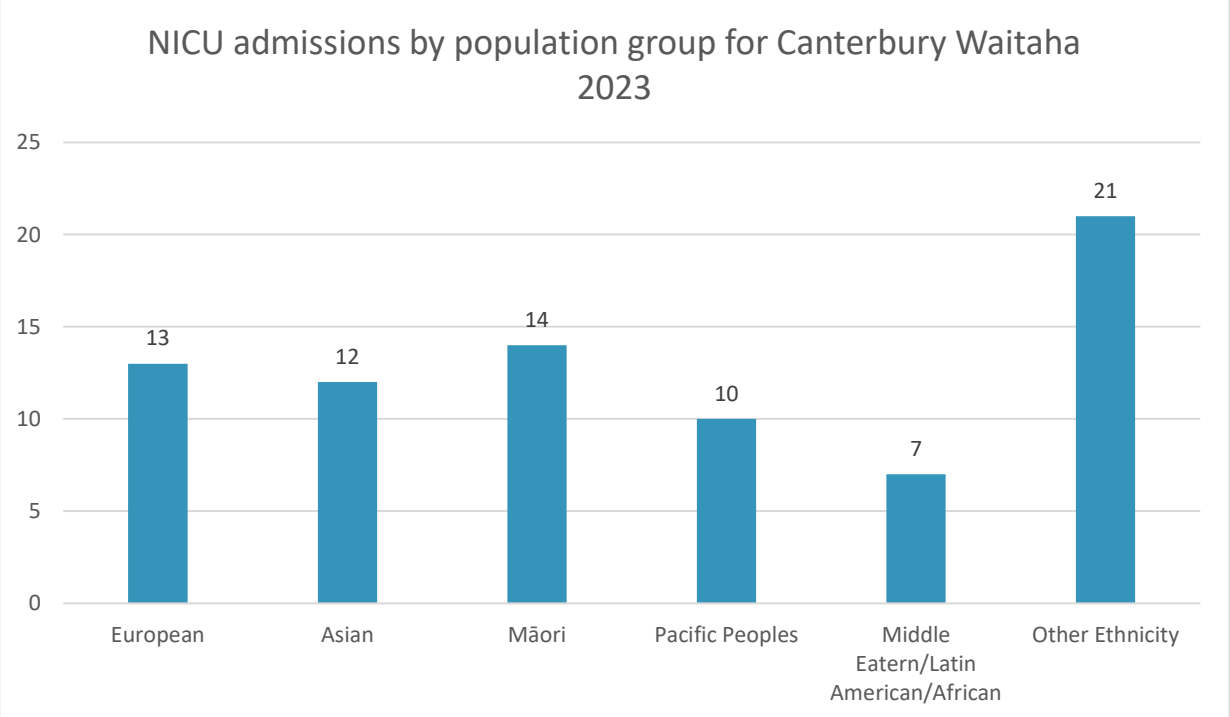


Figure 28. Gestation at birth by population group for Canterbury Waitaha 2023

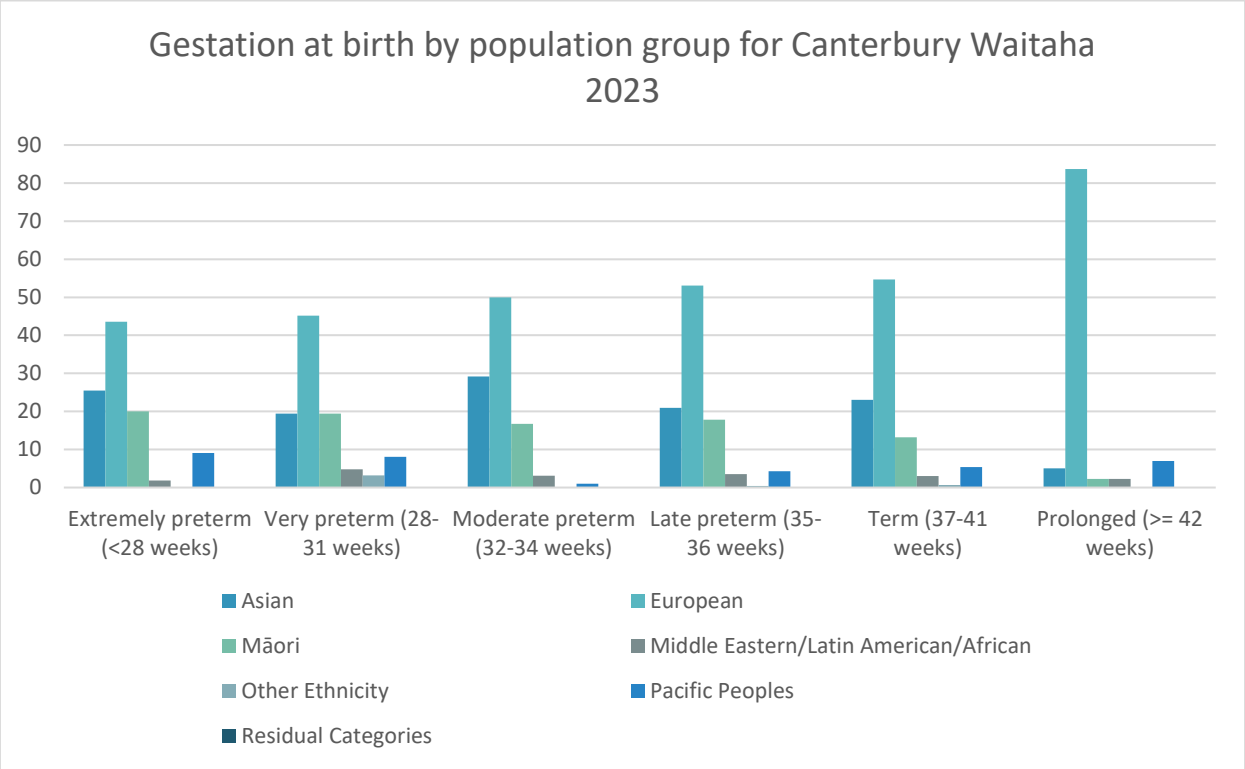
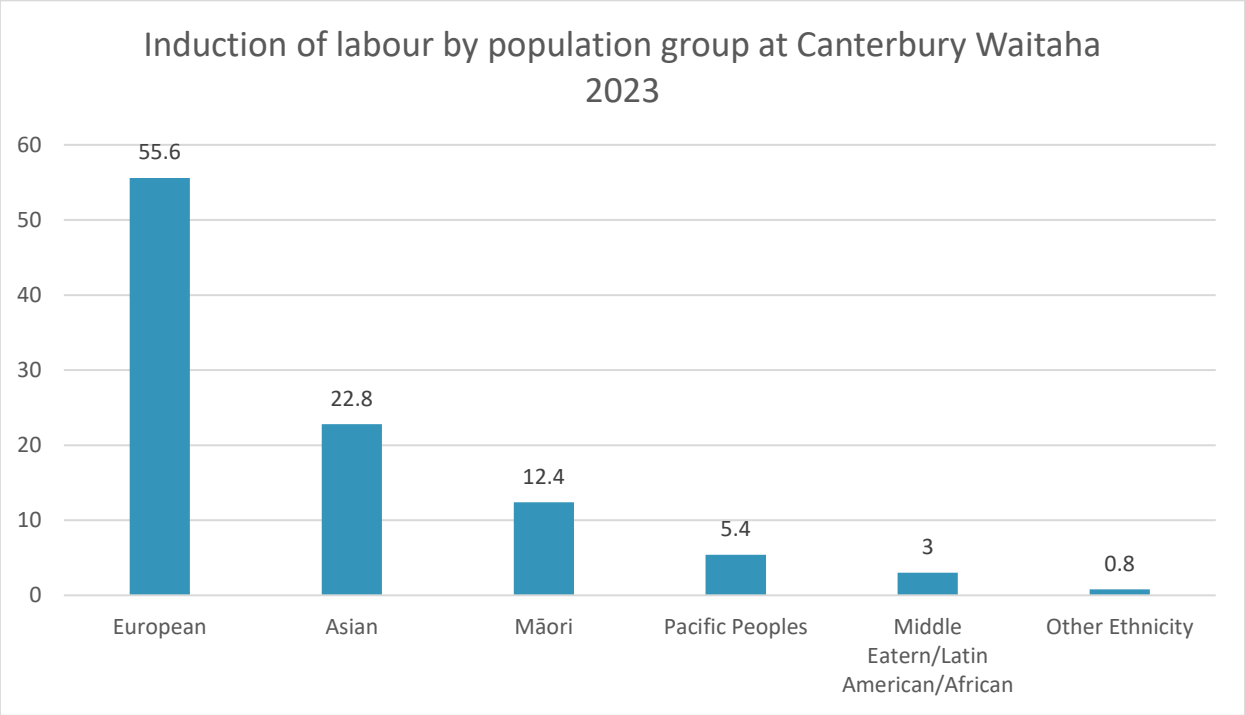


Figure 29. Induction of labour by population group for Canterbury Waitaha 2023



APPENDIX 3

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 4

MQSP PRIORITIES AND ACTION PLAN 2024/25

	Initiative/Priority	Action	Expected Outcome	Measure
1.	Supporting wāhine/women/people and whānau with low risk of developing complications, to plan birth in their local Community Birthing Unit (CBU) MQSP 2 of 2021/22 priorities and action plan NMMG Work plan, 2019 Canterbury Maternity System Strategic Framework, 2019	Promote on social media platform: • Share research and local statistics • Address the "what if"; reframe safety and risk • Share consumer feedback Engage and facilitate resources for midwives Engage and facilitate resources for Childbirth Educators CBU's are accessible for wāhine/women/people and whānau when hapū	• Increase in the number of wāhine/women/people and whānau planning/booking to birth in their local CBU • Midwives are confident to promote CBU's to low risk wāhine/women/people and whānau as the place of birth recommended to improve outcomes	• The ratio of wāhine/women/people and whānau birthing in their local CBU increases, corresponding to a decrease in need for postnatal transfer from CWH • Wāhine/women/people and whānau who have complex pregnancy and/or labour and birth transfer to their local CBU for postnatal care
2.	MEWS audit and case review Morbidity review identified through trigger tool MQSP 1 of 2021/22 priorities and action plan HQSC Patient Deterioration Programme. 2019	• Continued audit of MEWS charts used in all Canterbury Waitaha Maternity areas • Continued review of all ICU admissions and escalations for review • Continued work to rollout MEWS module of Patientrak across all maternity areas	• MEWS is completed for all maternity inpatients • MEWS is completed for all women from positive pregnancy test to six weeks postpartum entering any part of the health system	• 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

	Initiative/Priority	Action	Expected Outcome	Measure
				score are followed as per hospital pathway
3.	To continue to improve the screening and referral rates of women for family violence MQSP 5 of 2021/22 priorities and action plan Canterbury Maternity System Strategic Framework, 2019	• A plan for regular, mandatory training is made annually and all employed staff working in maternity services are attending these sessions once per year • Survey staff to ascertain the barriers to staff carrying out this screening	• Health professionals working in the maternity setting have all received training and are confident to screen for family violence • 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	• Evidence of regular audits shows improved family violence screening results for pregnant women accessing maternity services
4.	To reduce local postpartum haemorrhage (PPH) rate and sequelae, i.e., blood transfusion rates MQSP 7 of 2021/22 priorities and action plan	• 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 multiprofessional team training on management of postpartum haemorrhage	• 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
5.	Continue to review local clinical outcomes and monitor district variation MQSP 8 of 2021/22 priorities and action plan	• 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
6.	Implementation of national Pulse oximetry screening guidelines for newborn babies (Health NZ 2024)	• Review published national maternity clinical guidelines and implement these • Review accessibility of documents to staff	• Guidelines are implemented	• Documents are up to date and easily accessible to staff
7.	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 kaupapa Māori	• Regular feedback from māmā and whanāu demonstrate a high level of consumer safety

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