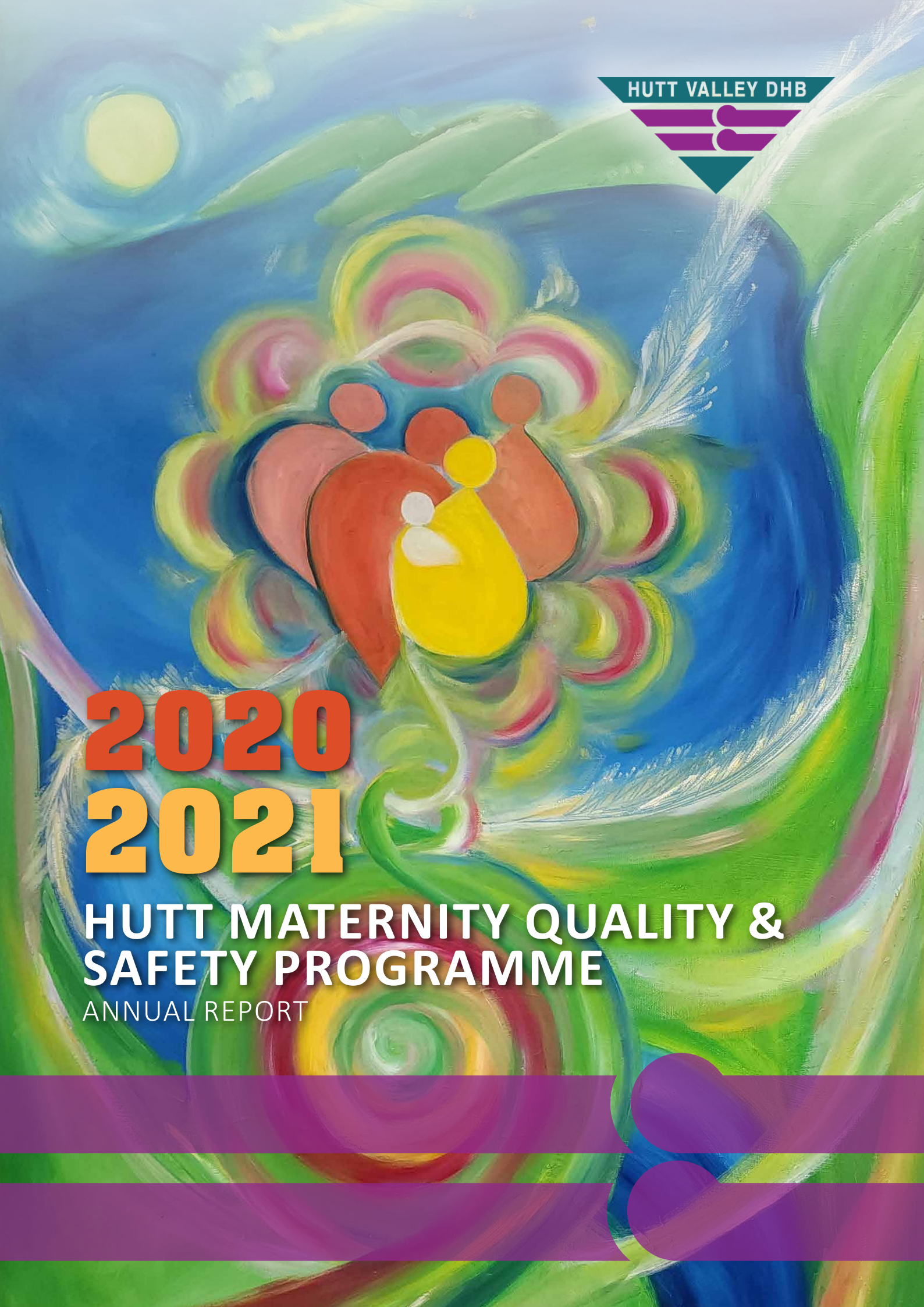

2020 2021

HUTT MATERNITY QUALITY & SAFETY PROGRAMME

ANNUAL REPORT

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COVER PAGE EXPLANATION:
(OIL PAINTING)

POST 'THE REVIEW' (2019).

The Koru on the left hand side has taken centre stage. We have experienced doctors, ACMMs 24 hours, our surroundings, equipment are improving. We have more staff, we have two CMMs instead of one. There is clearly a stronger foundation, more hope, better alignments with the Marae and our community. Here, the Hutt maternity logo sits centre stage, proud of what we are doing and striving for better ways of doing things. Making numerous stronger connections within and around our service.

The three feathers represent on one hand the foundation of Midwifery practice and a critical element is to develop a trusting relationship, built on using the guiding principles protection, partnership and participation from the Tiriti O Waitangi. By using these principles from the Treaty illustrates a Mothers, baby/child and whānau centred care:

Protection – health services to recognise and respond to mothers, babies and whānau cultural beliefs, values and practices. Spending time directed towards protecting 'at risk' individuals and assessing the risk factors of poor health, for example immunisation, ensuring good child and maternal health outcomes are achieved.

Partnership – working together. To make partnership work communication is key, ensuring both hearing (listening to concerns) and being heard is required. Both partners are equal. In time, trust is essential in any relationship and underpins the information sharing, decision making, from here individual growth and development will occur and as Maslow explains empowerment and self-actualisation (1943).

Participation – providing an environment to enable Mothers, babies and whānau to participate across the different health providers to ensure continuity of care. An integrated service that is guided and supported/ tailored for Mothers, babies and whānau then they can be active in taking a greater responsibility in their care.

Also, I see the feathers symbolising our Unit aligning with Culture (as above), Council (all of the standards of practice as Midwives we strive for each and every day and our Country (the diversity of our people, their health and best outcomes).

Amanda Ashcroft
(Artist)

ACKNOWLEDGEMENTS

Thank you to the many administration, midwifery and medical staff who have contributed to the content of this report.

Special thanks to the Maternity Quality & Safety Governance Group (MQSGG) including Karen Ferraccioli, Nikita Hunter, Nicole Anderson, Elaine Newman, Heather LaDell, Victoria Parsons, Davina Smith, Jeya Wilkes, Krystal Williams, Margaret Hope, Marleen Greenwood, Meera Sood, Sarah Mills, Wendy Castle, Hineuru Tutua-Nathan, Kelly Jackson-Sagmyr and Shelley James who put in an extraordinary effort throughout an incredibly challenging year.

It is with genuine appreciation that we thank our workforce, consumers, lead maternity carers (LMCs) and wider health care partners and communities.

Thank you also to all the whānau and staff who kindly let us use their images to illustrate our report.

REPRODUCTION OF MATERIAL

FOREWORD

It gives us great pleasure to present the Maternity Quality and Safety Programme (MQSP) report for Hutt Valley District Health Board 2020_2021.

This report covers the period from July 2020 to December 2021.

As with many health service providers across the motu, the Covid 19 pandemic has had a significant impact on the workload of both the clinical and non-clinical workforce in the maternity service with increased levels of staff sickness, and restricted visiting within inpatient areas. Midwifery workforce vacancies meant that maternity services were severely stretched over this time.

In recognition of this Manatū Hauora the Ministry of Health have allowed an extended period for the Maternity Annual reports to be completed.

Special thanks goes to Nicole Anderson (MQSP Coordinator) for pulling this report together.

We hope you enjoy reading this year's report.

Carolyn Coles
Director of Midwifery

Meera Sood
Clinical Head of Department
Clinical Leader of Obstetrics

Shelley James
Service Manager
Women's and Children's Health

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HUTT VALLEY DISTRICT HEALTH BOARD

VISION AND VALUES

Hutt Valley DHB is committed to meeting the Ministry of Health's expectation and delivering our vision of keeping our community healthy and well

OUR VALUES AT HUTT VALLEY DHB

ALWAYS CARING

CAN DO

IN PARTNERSHIP

BEING OUR BEST

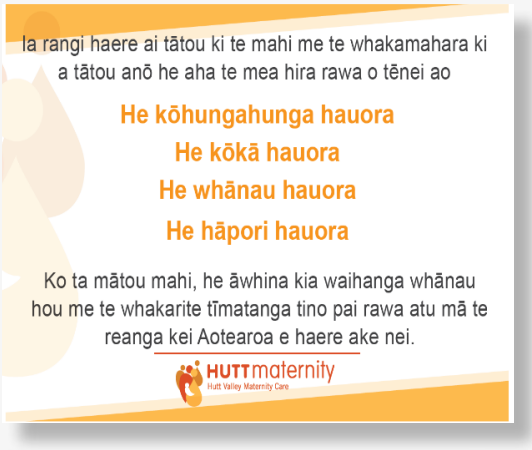
Our aim is to make Hutt Valley DHB a place where our people love to work and where our patients recieve the best possibel care 'every person, every time'.

Together we have:

- Created a vision for people's experience working and being cared for here
- Shaped refreshed values and behaviours we do and don't want to see from eachother
- Started to embed our values into how we work together to deliver a great service to our community

OUR VISION WHĀNAU ORA KI TE AWAKAIRANGI

OUR VISION FOR HUTT MATERNITY



STRATEGIC ALIGNMENTS

During the 2020-2021 time period this report covers, Hutt Maternity and the Maternity Quality & Safety Programme at Hutt Valley DHB has strengthened its relationship with our Māori Health Unit implementing an equity focus on any future initiatives and service provision.

The Maternity Quality & Safety Governance Group (MQSGG) Terms of Reference have been redeveloped with a particular emphasis "To align the MQSP programmes with Te Pae Amorangi (HVDHB Māori Health Strategy 2018-2027). The strategy recognises the established principles of Partnership, Participation and Protection and recognises steps towards the reviewed interpretation of Te Tiriti principles to date (from the Wai275 claim into health). These are tino rangitiratanga, equity, active protection, partnership and options."

Taurite Ora: Māori Health Strategy 2019- 2030
Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025
New Zealand Health Strategy: Future direction
Living Life Well – A Strategy for mental health and addiction 2019-2025
Health System Plan 2030
New Zealand Maternity Standards
National Maternity Monitoring Group recommendations
Perinatal and Maternal Mortality Review Committee recommendations
Maternal Morbidity Working Group recommendations
Pae ora – healthy futures
Whakamaua: Māori Health Action Plan 2020-2025

The Maternity Quality & Safety Programme has also renewed focus on strengthening ties with our Pacific community through representation of Consumers on the Maternity Quality & Safety Governance Group. The 3DHB Pacific Directorate has developed the Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025.

This plan identifies six strategic priorities with Priority One being Pacific child health & wellbeing.

"Efforts should be focused on the provision of culturally responsive maternal health services that support healthy pregnancies and delivered close to and in people's homes and in the communities. We want to see easy access and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers".

"In addition, we need to progress health services support and care that focus on good nutrition and physical activity, smoking cessation, positive parenting, immunisation, warm homes, mental health and wellbeing of parents are crucial for healthy physical and social development".

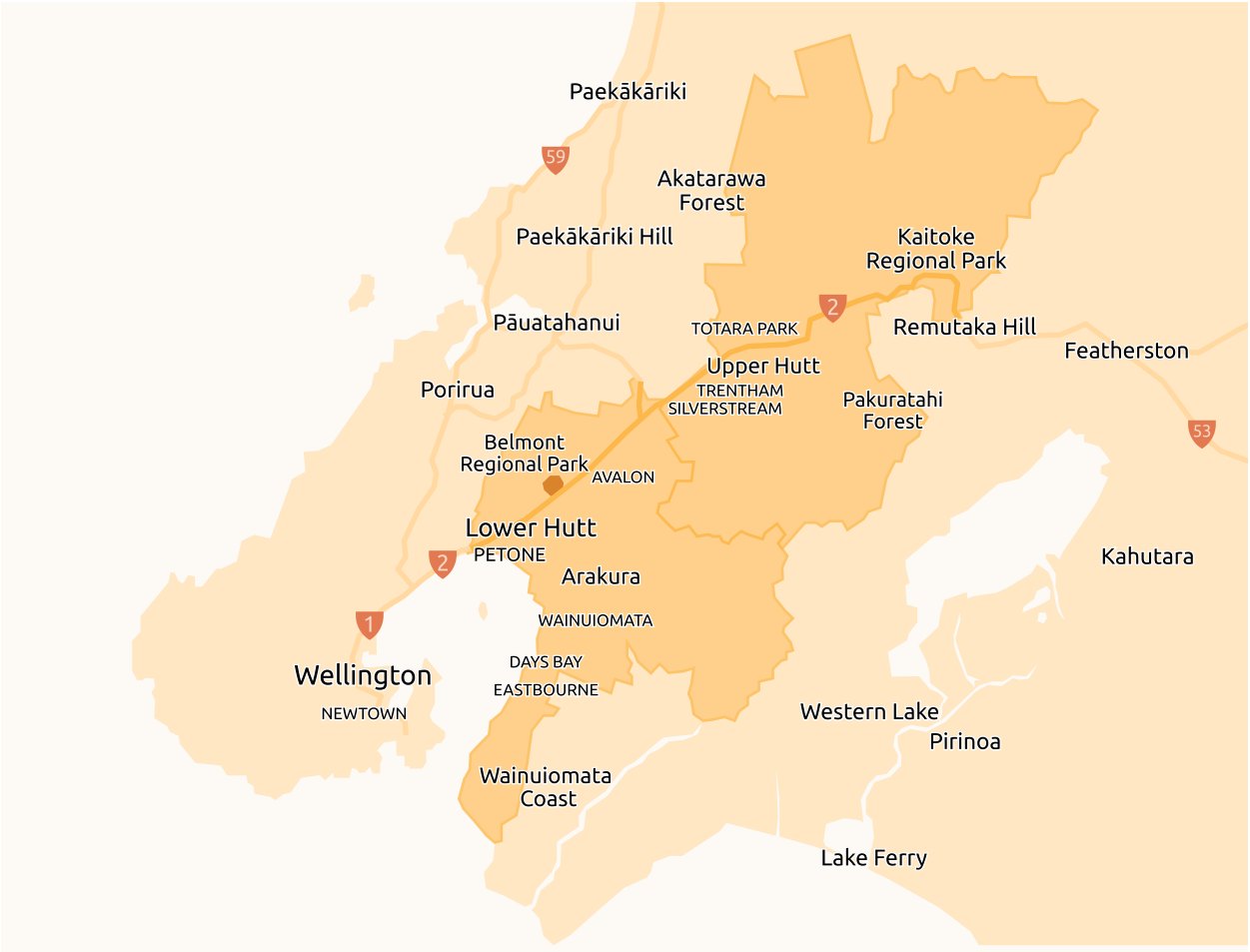
http://www.huttvalleydhb.org.nz/about-us/reports-and-publications/pacific-health-wellbeing-strategic-plan/pacific-health-wellbeing-strategic-plan-for-gwr-final.pdf

Ia ifo le fuiniu i le lapalapa
As to each coconut leaf belongs to a cluster of young nuts, so each individual belongs to his family

Samoan proverb

Ō mātou hunga
Our People

THE HUTT VALLEY REGION



TE AWAKAIRANGI

The name Te Awakairangi, originally given to the Hutt River, means esteemed or precious and is attributed to the first Polynesian explorer Kupe.

OUR POPULATION

The Hutt Valley region is situated in the Lower North Island close to the capital city Wellington.

The region extends from Wainuiomata to Upper Hutt, on the southern side of the Remutaka range.

In 2020/21 our population was around 156,000 with 18% of our population identifying as Māori, 8% as Pacific and 11% as Asian. This was a slightly higher proportion of Māori and Pacific people compared to the national average and fewer people in the 20-29 age group. (MOH 2021). Hutt has a relatively equal proportion of people in each section of the population, with a slightly higher proportion of people in the least deprived section.

Greater numbers of Māori and Pacific families reside in the most deprived areas. Health disparities linked to deprivation are evidenced in poorer health outcomes and we acknowledge our responsibility to design and deliver maternity services that are accessible and responsive to our population's needs.

THE MATERNITY POPULATION

There were 58,995 people recorded as giving birth in New Zealand in 2020, according to the Ministry of Health (MOH) Report on Maternity web tool, released in 2021. In 2020, Hutt Valley recorded 1624 people and 1657 in 2021 who either birthed at Hutt Maternity, had an unplanned birth at home, or birthed in transit, en route to hospital. Hutt Valley births equate to 2.8% for both 2020 and 2021 of the birthing population of New Zealand .

Figure 1: Births 2020

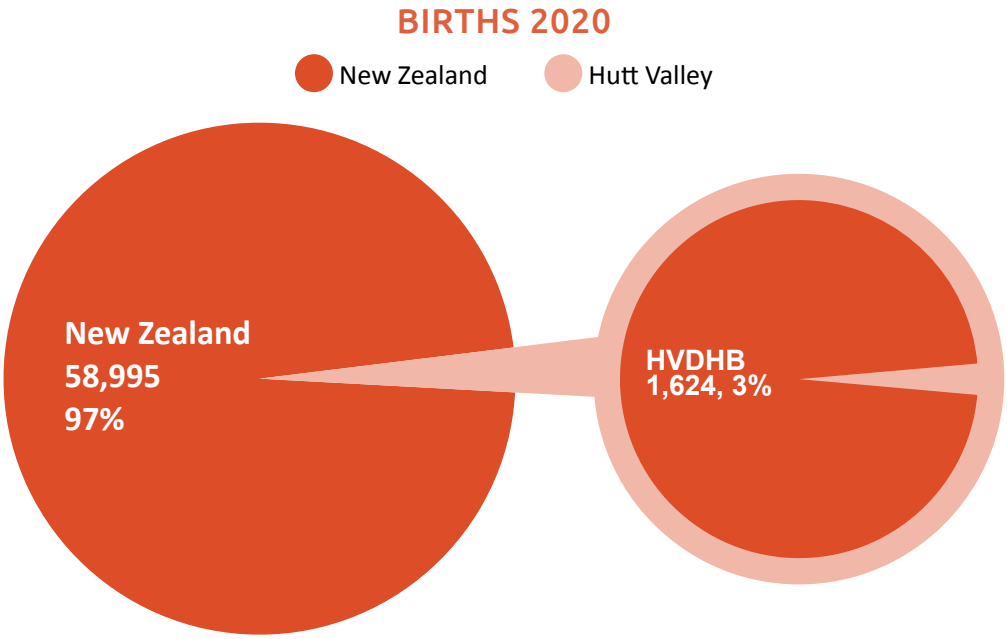
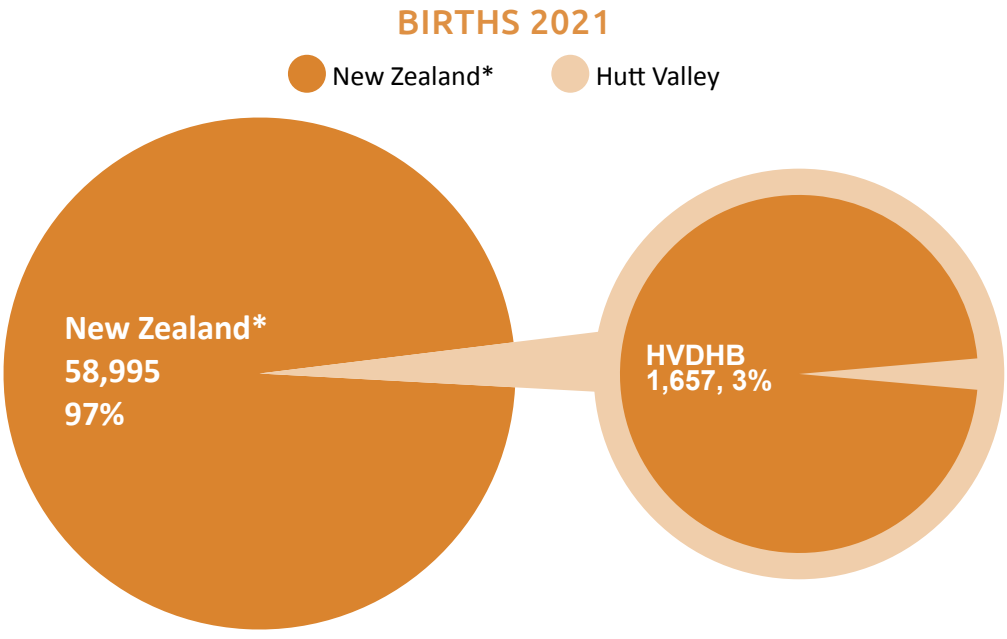


Figure 2: Births 2021

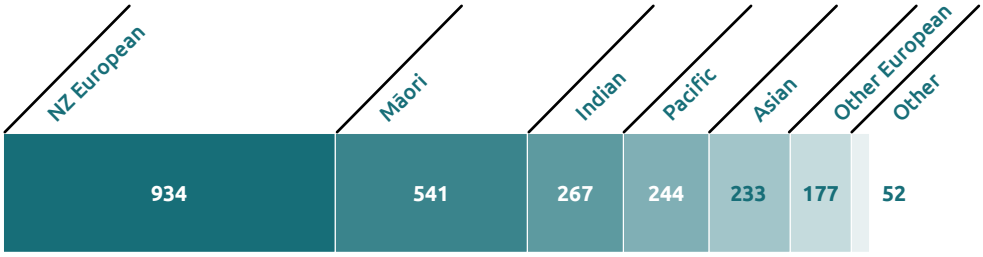


* Births New Zealand 2020

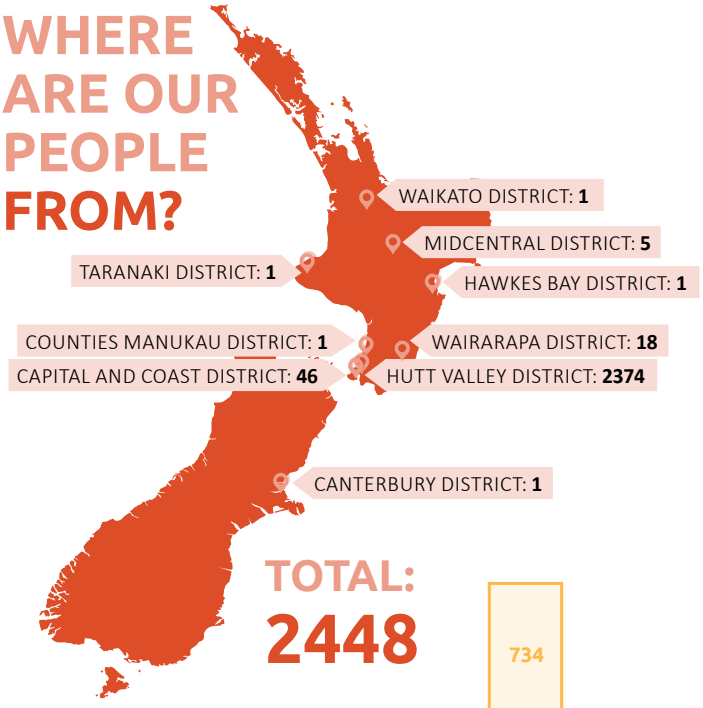
ALL WOMEN BIRTHING AT HUTT VALLEY DHB

2020/2021: 2465

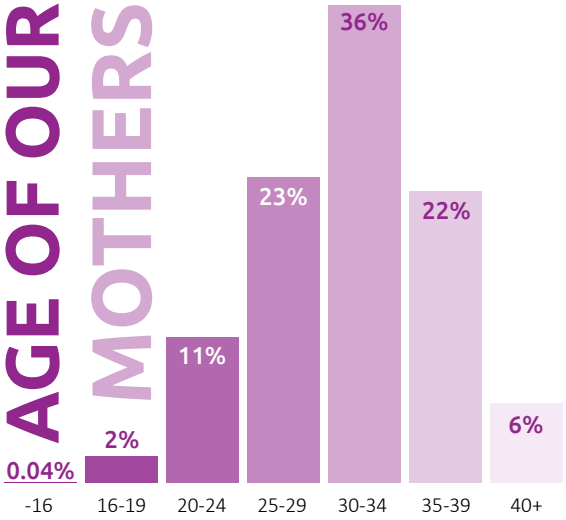
ETHNICITY LIVE BIRTHS 2448



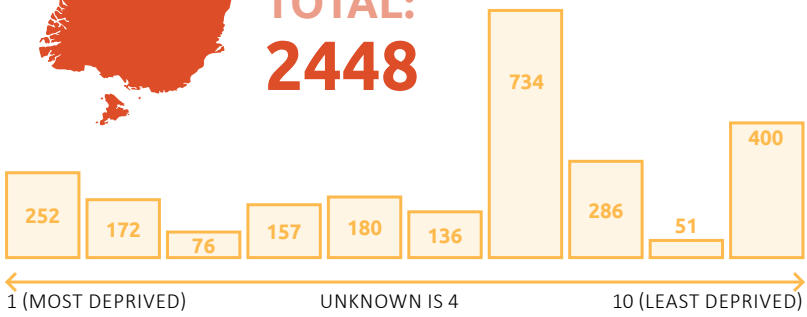
WHERE ARE OUR PEOPLE FROM?



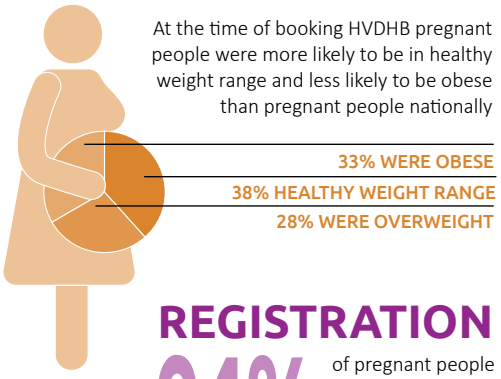
AGE OF OUR MOTHERS



TOTAL: 2448



LIVE BIRTHS BY DEPRIVATION BY DOMICILE



At the time of booking HVDHB pregnant people were more likely to be in healthy weight range and less likely to be obese than pregnant people nationally

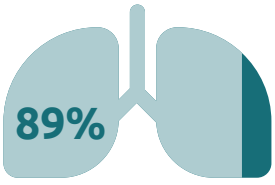
33% WERE OBESE
38% HEALTHY WEIGHT RANGE
28% WERE OVERWEIGHT

REGISTRATION

94% of pregnant people registered with either an LMC midwife or DHB Community Midwife

registered with the DHB Community Midwifery Team **55%**

45% registered with a Lead Maternity Carer midwife



SMOKING

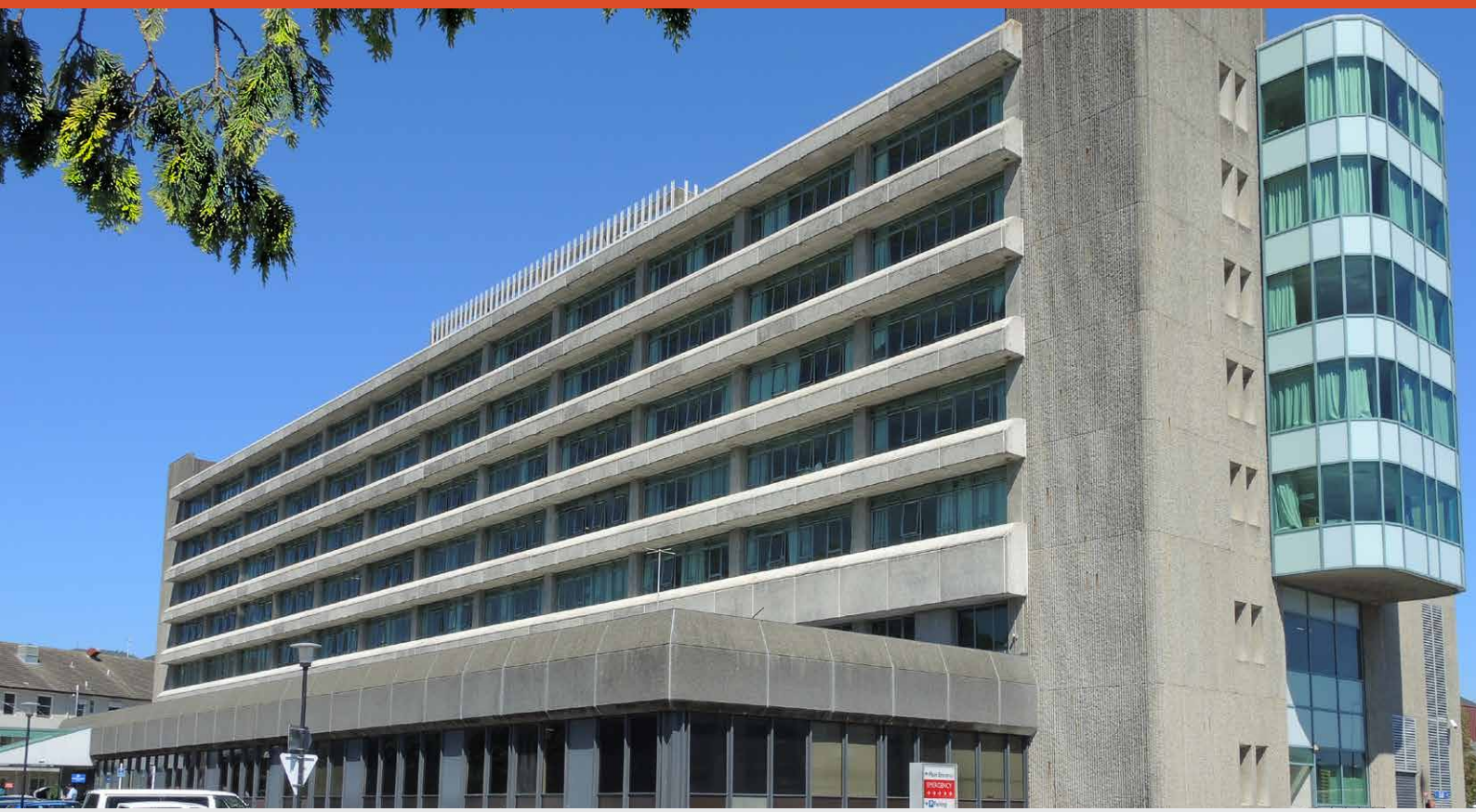
OF PEOPLE SMOKING AT HUTT WERE NOT SMOKING AT THE TIME OF THEIR BIRTH

NUMBER OF HOMEBIRTHS

2020
53 – 3.1% percentage of total number of births

2021
77 – 5.3% percentage of total number of births

MATERNITY FACILITIES



At Hutt Valley DHB we provide both primary & secondary level maternity care. As a teaching hospital we support training for doctors, midwives and nurses. We regularly provide clinical placement opportunities for student midwives both from Otago Polytechnic and Victoria University.

Our facilities are located at Hutt Hospital and currently include

- Birthing Suite 8 rooms
- Antenatal & Postnatal Unit 17 beds
- Maternity Assessment Unit (MAU)
- Early Pregnancy Clinics
- Community Midwifery Clinics
- Secondary care and Gestational Diabetes Clinic

Improvements to our facility and equipment continued in 2021 with the completion of a dedicated waiting area and clinic rooms for the DHB Community Midwifery Team.

Preparatory work was also undertaken in 2021 for the expansion and improvement to the Maternity Assessment Unit space and initial planning commenced for the Maternity Ward redevelopment.

MATERNITY SERVICES

Clinical Midwifery Manager - Elaine Newman and ACMM Verity O'Conner with Birthing Suite midwives

BIRTHING SUITE AND MATERNITY WARD

Providing a Maternity service during the Level 4 Covid-19 'lockdown' period presented a lot of new challenges and a new way of working. There was a lot of planning around how we screen and care for people with Covid-19, teaching on how to correctly 'don and doff' PPE to keep staff well protected, we needed to close our whānau room to enable a change space and storage of large amounts of PPE that were needed. Staff rose to the challenge of the evolving situation, taking everything covid in their stride and continued to provide excellent care in very challenging situations, including covering staff who became unwell with Covid-19. The visitor policy evolved daily as new information was implemented, this was a challenge for whānau and staff alike. The restriction of visitors was upsetting for many whānau and we acknowledge this. Unfortunately these were exceptional circumstances that we had no prior experience of. Central to all decision making was the safety of those accessing the service and those providing the care to ensure effective operations continued.

Message from our MQSP Consumer Representative who has provided feedback about the Maternity Ward

"Over the past few years I have been involved in volunteer work within maternity, providing women / birthing people and their whanau with non-medical support. This has given me with a good understanding of our maternity system, cultural diversity, maternal mental health, breastfeeding and the unique support needs of whanau including premature birth, caesarean, loss, multiples and more.

I have met many diverse families in varying situations including agency involvement, single parents, LGBTQIA+, disability, teen pregnancies and

more. This face to face time gives invaluable insight into areas for improvement, what we are doing well and where we can make change.

Hutt maternity is a unique environment in which we can learn, discover and embrace the significance of Te Tiriti o Waitangi, along with many opportunities to implement. One thing I often notice is the outstanding whānau support crew when Pēpē is born. The option for Māori whānau to participate in ways that are appropriate for their needs is something that I encourage and value. Providing a service that promotes this type of support achieves better outcomes for māmas, especially around breastfeeding, maternal mental health and resilience. I feel very privileged to be able to contribute to this support.

It has been an extremely positive experience being able to give time and encouragement to new parents, especially during the Covid 19 pandemic where many were separated from their family. I am often in SCBU with new parents who have spent long days in the hospital facing big emotional challenges. It is incredibly rewarding to be able to brighten their day with a cup of tea and a listening ear."

THEATRE

During the 2020-2021 the Hutt Maternity service continued to provide a Theatre Midwifery Team as a core service for women undergoing Caesarean section operations. The team maintain their close links with the operating theatre and staff and ensure seamless handover post operatively to the Nurses and Midwives on the postnatal ward.

SCBU

Hutt Hospital has a Special Care Baby Unit (SCBU), which has 12-14 cots. This unit provides care for babies greater than 32 weeks' gestation. Babies born under this gestation are transferred to the Neonatal Intensive Care Unit (NICU) at Capital and Coast DHB. Staff in SCBU and maternity work closely together to provide seamless care to māmā, pēpi and whānau. In 2020-2021 there was a decrease in the rate of preterm births (< 37 weeks gestation) at Hutt Hospital. Overall there were 108 babies born at Hutt Hospital between 32 and 36+6 weeks gestation during 2021 .

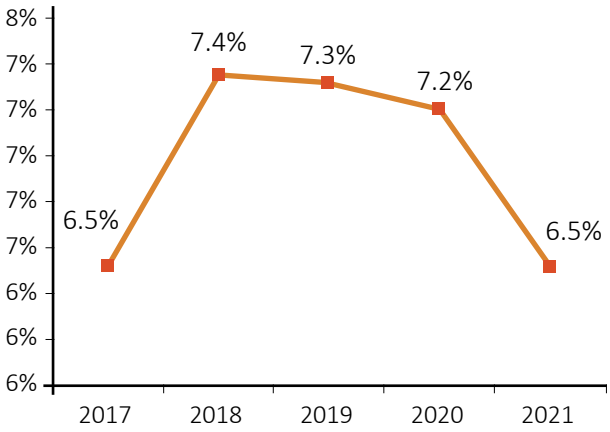


Figure 3: Percentage of Babies Born between 32 and 36 Weeks Gestation

MATERNITY ASSESSMENT UNIT (MAU)

Women and pregnant people who require ongoing assessments for pregnancy or postnatal complications are referred to the MAU. LMC midwives can also bring their own clients into MAU for assessments.

People are referred for a variety of reasons including pre-eclampsia, day case assessments, blood pressure monitoring, fetal growth monitoring and Anti-D prophylaxis administration for clients booked with the DHB Community Midwife Team.

The Maternity Assessment Unit is open between 0800 and 1630 Monday to Friday with a Midwife who coordinates assessments and ongoing care planning with the on call Obstetrician.

People needing assessments outside of the MAU opening hours are seen on Birthing Suite .

MAU Midwives and student midwife

EARLY PREGANCY ASSESSMENT CLINIC (EPAC)

For those women and pregnant people experiencing pain and/or bleeding at less than 20 weeks gestation, they may be referred to the EPAC for assessment and management. People can be referred from their GP, LMC and the Emergency Department.

EPAC is staffed by both Registered Nurses and Registered Midwives who co-ordinate scans, blood tests and liaise with the Obstetrician regarding ongoing management.

Numbers of assessments provided by EPAC have also demonstrated a significant increase with over 300 more people seen 2020/21 than in 2019/20.

Table 1: Admissions to early pregnancy clinic

2017/18	2018/19	2019/20	2020/21
1432	1611	1639	1947

COMMUNITY MIDWIFERY TEAM

A change in title was created for the Community Midwifery Team (CMT) Leader role to become Associate Clinical Midwife Manager (ACMM), this was endorsed by our union partner MERAS.

The ACMM who was appointed into the role has been a great asset to the team, having had previous LMC midwifery experience, has been a bonus. The ACMM manages the daily requirements of the team, overseeing workflow with midwifery resources caring for pregnant people that are often have very complex needs.

In addition to providing care on the Maternity ward, the Community midwives had to be very creative to manage the evolving situation and continue to see people who were self-isolating. One of the ways that we changed our model of care was to introduce phone or virtual consultation appointments. The plan to facilitate this involved many hours of planning, with the multi-disciplinary team to ensure all aspects were addressed. We soon realised that we needed to have a system for

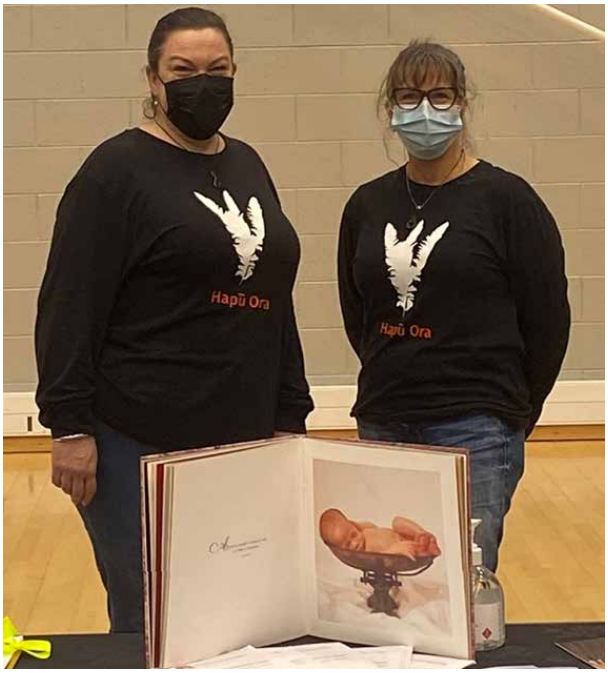
physical checks that did not involve coming into hospital, and set up a drive through clinic where the midwife would be wearing full PPE and carry out a physical check in the backseat of the car, a blood pressure check, palpation and fetal heart. This was incredibly challenging, hot, and different from our normal practice and worked really well.

The number of pregnant people who were being cared for by the CMT increased dramatically over this time, which unfortunately coincided with decreasing midwifery staff availability. This placed additional pressure on the current team.

The community midwives gained a new midwifery hub that expanded their single office to include 3 consultation rooms, a great sized waiting room, a kitchenette and a bigger office. The facilities are warm, inviting and work really well for the community with a location that is easy to access.

Associate Clinical Midwife Manager (CMT).Julie Mannering.

HAPŪ ORA CLINIC



Clinical Midwifery Manager Krystal Williams with Community Midwife Catherine Charles promoting the Hapū Ora service

Hapū Ora, is a drop-in clinic based at Lower Hutt's Waiwhetu Marae, it is a collaborative Māori maternity service for whānau expecting a new baby. The drop-in service provides a continuum of care covering everything from midwifery to breastfeeding for new parents and their whānau.

The free services are run by mana whenua Te Runanganui O Te Atiawa with support from Hutt Maternity and Hutt Valley DHB.

Demand for Hapū Ora's services has grown steadily since opening in 2017, with many Māori whānau finding the marae environment an ongoing source of comfort.

The breadth of the Māori cultural knowledge available helps connect whānau with traditional practises such as ipu whenua, or the importance of tūpuna, and the natural benefits of generations of wahine breastfeeding.

OBSTETRIC SECONDARY CARE CLINICS

Referrals are received from the Hutt Valley and Wairarapa districts for those pregnant people requiring secondary care services.

Hutt Valley DHB runs a multi-disciplinary gestational diabetes clinic where people may be seen by an Endocrinologist, Diabetes Nurse Specialist, Obstetrician, Midwife and Dietician during the same clinic visit. This initiative was set up to avoid multiple appointments for those pregnant people requiring multi-disciplinary care.

The number of secondary care referrals and consultations has shown a steady increase.

Table 2: Obstetric Secondary Care Referrals and Consultations

	2017/2018	2018/2019	2019/2020	2020/2021
Referrals	1467	1965	2139	2567
Consultations	2951	3163	3160	3210

COMMUNITY OBSTETRIC CLINIC

A community obstetric clinic was trialled in 2020/2021, located at Pacific Health Services in Naenae, a community hub with close links to public transport, and plenty of free parking close by. This clinic ran once each month and was led by a Consultant Obstetrician. An average of six pregnant people were seen at each clinic and it was initially well attended.

This initiative was developed to reduce barriers of access to appointments due to financial, transport or childcare constraints.

The community obstetric clinic was discontinued in June 2021 due to staff and space constraints, along with pregnant people finding the proximity to hospital a barrier to attend.

Registered midwife Natalie Albertyn.

PREGNANCY AND PARENTING EDUCATION

Free childbirth and parenting education classes are provided. These classes were established to provide greater access for Māori, Pacific, migrant people, and people who may not be able to afford to attend a paid class. The DHB funded childbirth education through community based external providers. The objective was to increase the number of first-time pregnant people accessing antenatal education.

HAPŪ WĀNANGA – TAILORED ANTENATAL EDUCATION

Hapū Wānanga on the marae provides a safe and nurturing environment for Hapū Māmā and Support Partners that will inform, empower and give them the confidence to navigate their birthing journey.

Hapū Wānanga weave the strands of Indigenous Māori narratives and birthing practices in childbirth today. These are woven together with current evidence-based antenatal education in preparation for normal labour and birth including key messages around breastfeeding and baby safety.

Whānau engage in workshop components utilising natural resources to create ipu whenua, Muka pito and Kono.

ANOFALE

Supports parents from pregnancy up until their childs second birthday. Anofale also encourages parents to find out more about childbirth programmes and resources in their local community.

“Our mums really love our Hub and are comfortable with the space. We are very pleased with the diversity of Mums attending the programme. Anofale is working alongside Pacific Parents Innovation centre, and some of our mums are now participating in the programme and love it.”

PARENTS CENTRE’S ANTENATAL AND POSTNATAL PROGRAMMES

Designed to provide accurate, evidence-based information within programmes that are fun, interactive and engaging. To network with other parents at the same stage as you, experiencing similar challenges and joys is confidence boosting and very rewarding.

WORKFORCE

The Hutt Valley DHB Maternity service in June 2021 included the following staff:

- Service Manager, Women's and Children's Health – 1.0 FTE
- Clinical Head of Department- 0.20 FTE
- Obstetric Leader – 0.10 FTE
- Director of Midwifery – 1.0 FTE
- Clinical Midwifery Manager/s- 1.6 FTE
- Associate Clinical Midwifery Managers- 4.8 FTE
- Associate Clinical Midwifery Manager Community Team- 0.8 FTE
- Midwifery Educator- 1.0 FTE
- Lactation Specialists- 1.1 FTE
- Obstetrics and Gynaecology Consultants – 6.9 FTE
- Registered Medical Officers- 11.0 FTE
- Midwives and Nurses – 24.7 FTE
- Healthcare Assistants- 5.7 FTE
- Administration – 1.4 FTE

This represents an overall loss of 12 DHB employed midwifery staff and an increase of 6 registered nurses since the previous report. The Midwifery workforce FTE at Hutt Maternity continues to be lower than similar sized maternity services in other North Island locations (average 41 FTE). There is a formal framework, regular monitoring and leadership in place to ensure that high standards of care are delivered for pregnant people, pēpi, and whānau across our region.

Midwifery workforce vacancies are, however, a significant issue and during 2021 work continued to stabilise the employed midwifery workforce including:

- Relocation packages were made available for midwives relocating nationally and internationally
- On-call payments were paid to senior midwives after-hours
- A business case was developed in collaboration with the Capital and Coast DHB that would subsequently see:
    - Retention payments made to all midwives that had been employed for over six months.
    - Payments that would continue to be made until 85% of the required midwifery FTE was recruited to, or for a period of five years, whichever came first.
    - Additional shift payments were agreed for any midwife who increased their contracted FTE for a period of three, six, nine, or 12 months.
    - The equivalent of one week pro-rated leave was gifted for all employed midwives.
    - New graduates were given a sign-on fee that was paid after one month's employment and then the same amount of money was given at the end of 12 month's employment.

One initiative implemented was to instigate a DHB employed case-loading midwifery continuity of care team, where full antenatal, labour and birth and postnatal care would be provided by the team, reducing the workload for labour and birth care from the birthing suite core midwives. This was put in place in April 2020 and four midwives at 0.80 FTE were employed on this team. In June 2020 a review of case numbers showed that the team had 82 women booked to birth between May 2020 and January 2021. Of these approximately 70% were classified as high risk. Resignations of two of the team from July 2020 led to the continuity of care model no longer being sustainable and the remaining two midwives transferred to the DHB Community Midwifery Team.

In July 2021 the Ministry of Health announced the funding of Midwife Clinical Coach roles to provide in-person clinical support for maternity and nursing staff on the floor. Hutt Valley DHB has employed two Clinical Coaches into these positions and have found them a valuable asset to our workforce.

Director of Midwifery (2021) Karen Ferraccioli with New Beginnings Midwifery Group.

During this period there were 25 LMC midwives. The Director of Midwifery and Midwifery Managers continually interface with the LMC midwives of the region. Our regular bi-monthly internal newsletter for core staff and LMCs keeps everyone connected and includes news items, education and training, staff news, upcoming meetings, recommendations, policy updates and meeting minutes.

KIA ORA HAUORA

Kia ora Hauora is a National Māori health workforce programme operating out of regional DHB's from 2010. The Central Region originally led by Capital & Coast DHB, is now (since 2018), led by Wairarapa DHB.

Many Māori workforce initiatives were delivered out of CCDHB, however since 2020 Hutt Valley DHB has also participated in the CCDHB Work Observation Week (WOW) programme renamed for HVDHB as Rangatahi ki te Ao (RKTA) and CCDHB Work Exposure Day (WED) renamed for HVDHB as Mahi Exposure Day (MED).

Mahi Exposure Day, targeted at junior high school students (Years 9 – 11) is an annual one day exposure to multiple disciplines. Each work station (delivered by DHB staff) is designed to have fun hands on activities, which not only showcases the variety of careers in health but also inspires the rangatahi start thinking about a future career in health. DHB staff are encouraged to talk about subject choices and in particular the science subjects they'll need.

Rangatahi ki te Ao programme is a weeklong hospital internship for Year 13s during their school holidays. The outcome is to give the students a snapshot of 'a day in the life of…' As Year 13s they should have already formulated ideas about what career pathway they would be interested in, the RKTA programme gives them the opportunity to see themselves working in that profession and to decide whether that career pathway is for them or not before heading to university.

Since 2020 until now, HVDHB has had 3 RKTA programmes with the attendance of local high school kids doubling each time. The first cohort had two high school girls from Naenae College and Te Ara Whanui (Te kura kauapapa Māori) from Alicetown and ending this year with 6 rangatahi, 3 from Sacred Heart Girls college, 2 from St Bernards Boys College and 1 from St Patricks Boys College, Silverstream.

The Director of Midwifery, Midwifery team and Maternity unit have all participated in both initiatives MED and RKTA. Feedback from all events have proven midwifery to be a highlight for the rangatahi, even with the boys. In the final evaluation form, the students were asked 'What was the event or the presentation that you will remember the most?' with one student responding 'Midwifery because we were really involved in it instead of just sitting down and listening'.

Director of Midwifery Karen Ferraccioli with 2 students.

Message from our MQSP Consumer Representative: Kia ora Hauora and HVDHB Collaboration- Mahi Exposure Day

In May 2021, I was part of the group that put together the Midwifery Expo as part of the Mahi

Exposure day. It was a fantastic day with all students engaged in the interactive activities we had set up to give them an idea of what midwifery is all about.

Firstly, we covered pregnancy; the students each had a turn at wearing a life sized baby belly and using a Doppler to check heart rates. Next was birth, our community midwife gave a brilliant visual example of birth using a ping pong ball (the baby) making its way out of an inflated balloon (the uterus) and birthing through the pelvic bones. We also had a hospital and homebirth space with birthing pool set up for students to see different birthing environments. Lastly, we showed them pregnancy after care including breastfeeding, how to care for the birthing person/mother and they were able to hold life sized (mannequin) babies.

The students took in a lot of information followed by plenty of insightful questions, including several gender diverse questions which we were well prepared for due to our diversity project. Of the many different areas of health, our interactive midwifery experience was voted #1 of the day by students.

Thank you to Lower Hutt Parents Centre for the use of the pregnancy belly.

Te whakapiki ngā pukenga hauora

Improving Quality of Care

IMPROVING QUALITY OF CARE

MATERNITY REDESIGN

In November 2018, the DHB undertook an external review of the Women's Health Service, prompted by a number of factors including staff shortages, a high rate of complaints and adverse outcomes. Since this time, significant changes have been made across the service. Milestones have been reached in recruitment, resourcing, environment, clinical improvements, quality, safety and culture.

The Single Stage Business Case (SSBC) to the National Capital Investment Committee to refurbish Hutt Valley DHB's Maternity Unit was submitted and approved. The funding for the refurbishment will see four areas upgraded. Dedicated clinic rooms in the Community Midwifery Team space, these were completed by June 2021. Planning for ongoing works include the expansion of the Maternity Assessment Unit and obstetric clinic area, re-development of the Maternity ward including a dedicated space for primary birthing and re-development of the Special Care Baby Unit.

The upgrading of these services will improve the physical space to enable delivery of optimal maternity outpatient services, birthing and postnatal care, and special care for babies. Key themes of the redesign include designated functional spaces, an environment that reflects a person's journey, culturally responsive design and whānau inclusive spaces.

While significant milestones have been reached, the journey does not end here. Our focus extends beyond maternity services, to the broader maternal health system. The hospital setting is only one part of the equation. We are also focused on improving equity and outcomes for Māori, Pacific and other families whose needs are not always met by traditional models of care.

We continue our mahi to have robust systems in place to ensure ongoing monitoring and review against Maternity Health & Disability Commission recommendations and outcomes nationally, HVDHB and national policy and guidelines reviews, morbidity and mortality review along with regular clinical audit to enhance our care for birthing people and their whānau in the Hutt Valley community.

BABY FRIENDLY HOSPITAL INTIATIVE (BFHI)

As a BFHI accredited Hospital our lactation consultants and staff work with mothers to support them with breast feeding in all clinical areas of the hospital campus. Our breast feeding support clinic is available to any mother and baby with breast feeding difficulties.

Our Service was audited by New Zealand Breastfeeding Alliance (NZBA) in March 2021 and we achieved re – accreditation for a further 4 years.

To protect and honour Te Tiriti o Waitangi as an important part of breastfeeding education and to support parents and whānau, Māmā Aroha breastfeeding information cards were introduced as a valuable visual resource when discussing breast/chest feeding. These cards were available for parents and whānau to take home.

GROWTH ASSESSMENT PROGRAMME (GAP)

GAP is a programme designed by the Perinatal Institute to improve detection of small for gestational age (SGA) babies. It has been linked to increased SGA detection, and a decrease in stillbirth in the UK (Hugh et al, 2021). https://www.perinatal.org.uk/GAP/NZ

ACC has funded the national implementation of GAP across all DHBs in New Zealand. There has been steady improvement in detection of SGA at Hutt Valley DHB over 2021, compared to during

2020, when the program was officially started, with two champions appointed. Prior to this there was some use of the GAP software but not full implementation of the program which involves education of all clinicians, quarterly reporting of outcomes, auditing of records where SGA has not been detected in pregnancy, following of national SGA guideline and use of algorithms for risk assessment and management.

For each pregnancy a customised growth chart (GROW) is generated which takes into account ethnicity, age, BMI, number of previous births, birth weights of previous babies and calculates a "term optimal weight" (TOW) for this current pregnancy. The chart calculates and plots 5th, 10th, 90th and 95th centiles allowing for detection of small for gestational age, large for gestational age and slowing of growth based on estimated fetal weights from ultrasound scanning.

Table 3: GAP Data 31 January to 31 December 2021

DESCRIPTION	NUMBER	PERCENTAGE	NATIONAL GAP USER AVERAGE
Number of completed records: (The pregnancy had a GROW chart which was linked to a customised birth weight centile when the baby was born)	1751	100%	
Number of babies born SGA: (< 10th customised birthweight centile)	265	15.1%	
Number of babies born <3rd centile (severely SGA)	68	3.9%	
Antenatal detection of SGA for babies with weight < 10th centile		48.5%	41.3%
Antenatal detection of SGA babies with weight < 3rd centile		73.8%	59.1%

NEXT STEPS

- While engagement with GAP education has been good and the majority of clinicians have attended a full GAP workshop, many are yet to complete their annual e-learning refresher.
- Auditing of missed cases of SGA to identify areas for quality improvement is ongoing.

RMO Simon Schenk, Midwife Educator Alison Grant,, ACMM Abby McCarthy, Duty Nurse Manager Mike Johnson.

SMOKING CESSATION

We have continued to strengthen smoking cessation programmes with Hapū Māmā quit coaches in our community. Education sessions, monthly meetings, support for inpatient and outpatient services.

E –referrals were introduced to improve response times, number of referrals and improve smoking cessation rates.

The region had collective work and messaging for World Smokefree Day, including strength based messaging along with promotional information that was endorsed by the CEO.

Our plan going forward:

- Continue with monthly meetings with Maori Health Unit.
- Maanaki whānau have been updated on how to refer patients
- Education for midwives, students
- Auditing of advice given and looking at where we need to focus education.
- Regular updates in maternity newsletter
- Video loop for the antenatal education in waiting rooms.
- Potential for midwife workshops including SUDI and smoking cessation

PREGNANCY CARE, POLICY AND GUIDELINE GROUP (PPG)

In 2021 the Pregnancy Care, Policy and Guideline Group was established. This is a multi-disciplinary group consisting of representation from obstetrics, midwifery, nursing, consumers and Māori, Pacific and disability equity leads. The purpose of the group is to review all policies, guidelines and patient facing information in line with current evidence based practice and national guidance.

All of Hutt maternity's current policies are available on the website for consumers and their whānau.

Te kounga me te haumaru o te taurima wāhine hapū

Maternity Quality and Safety

MATERNITY QUALITY AND SAFETY PROGRAMME

The Hutt Valley maternity quality and safety programme continues to actively review and improve the quality and safety of maternity services for women, pregnant people, babies and their whānau in the Hutt Valley.

The maternity quality and safety programme is a national programme which establishes and builds upon national and local maternity quality improvement activities. It seeks to ensure the highest possible safety and best possible outcomes for all pregnant people and babies.

This report is underpinned by the New Zealand Maternity Standards (New Zealand Ministry of Health, 2011), which are overseen by NMMG.

STANDARD ONE: Maternity services provide safe, high quality services that are nationally consistent and achieve optimal health outcomes for all pregnant people and babies.

STANDARD TWO: Maternity services ensure a person centred approach that acknowledges pregnancy and childbirth as a normal life stage.

STANDARD THREE: All pregnant people 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 pregnant people.

The role of the Maternity Quality & Safety Programme is to:

- Assess and report on our performance over the previous year, including implementation of recommendations from the National Maternity Monitoring Group (NMMG) and the Perinatal and Maternal Mortality Review Committee (PMMRC).
- Provide information about the quality improvement work underway in the Hutt Valley area for pregnant people and their whānau living and birthing in our district as well as the maternity workforce.
- Provide the Ministry of Health with the contractually required information as set out in Section 2 of the Maternity Quality Safety Programme (MQSP) Crown Funding Agreement Variation.
- Demonstrate Hutt Maternity's self-audit against the New Zealand Maternity Standards.
- Provide feedback to the NMMG on their recommendations.
- Benchmark against New Zealand Maternity Clinical Indicators. Provide a monthly update of performance to the MQSGG and Hutt Valley Executive Leadership.
- Maintain Hutt Maternity's progress towards meeting the objectives of the MQSP 3 year roadmap developed in 2021.
- Describe the work planned to improve the quality and safety of maternity services delivered in the 2020-2021 period.

The MQSP Coordinator position was vacant at Hutt Valley DHB between June 2020 and March 2021.

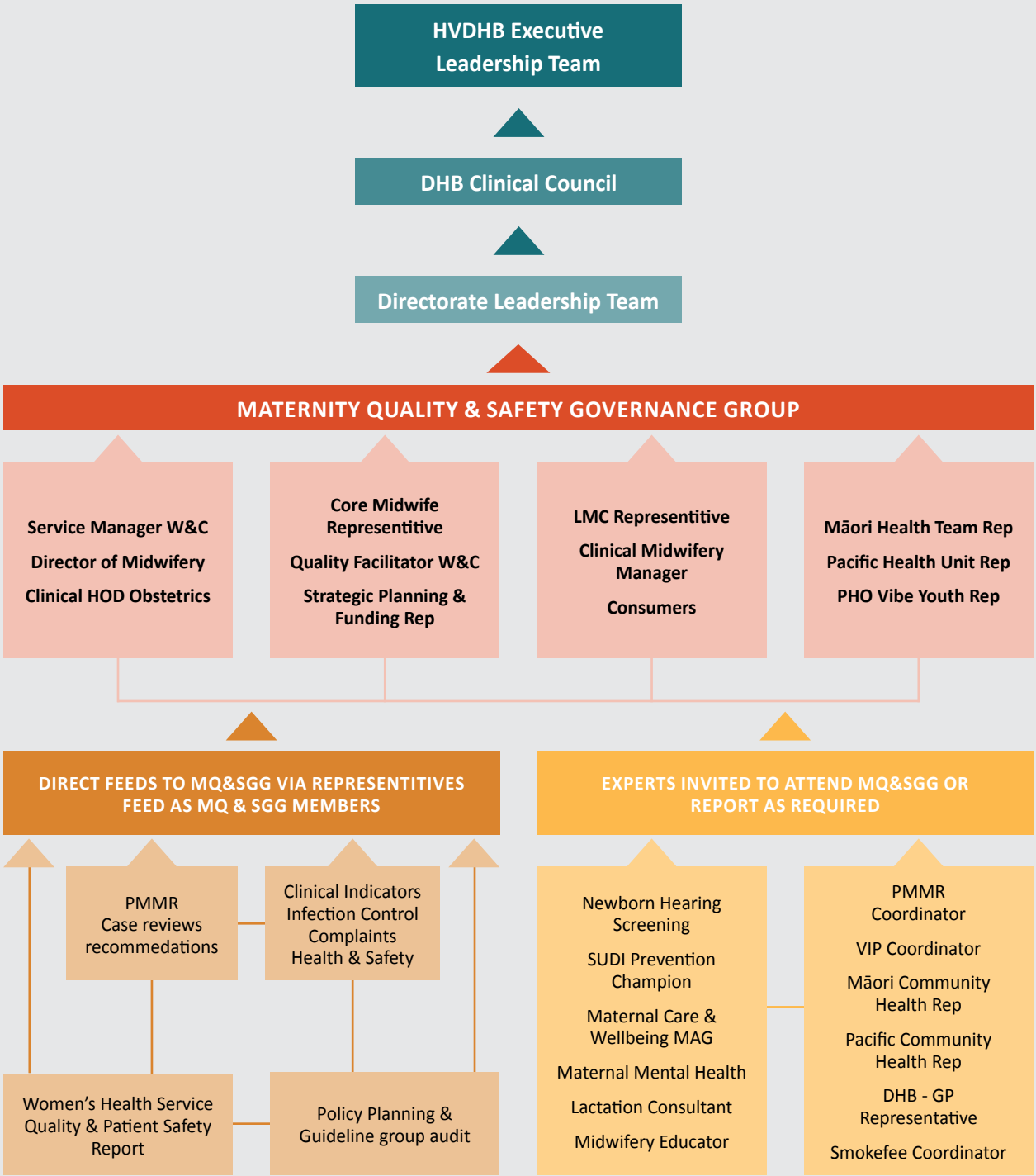
Since March 2021 there has been a renewed approach to strengthen the collaborative multidisciplinary team approach to service provision, including the voice of consumers and an equity based approach at all levels of service planning.

This has included re-establishment of the Maternity Quality & Safety Governance Group (MQSGG) whose membership includes representation across a wide cross-section of maternity and allied service providers and other key stakeholders. This governance group ensures that systems are in place to enable clinicians and managers to share responsibility and accountability for patient safety, to minimise risks to pregnant people and babies and to continuously monitor and improve the quality of clinical care provided.

Maternity Quality Safety Programme Coordinator – Nicole (Niki) Anderson.

HUTT VALLEY DHB MQSP GOVERNANCE STRUCTURE

MATERNITY QUALITY AND SAFETY PROGRAMME STRUCTURE 2021



VOICES OF PEOPLE AND WHĀNAU

MATERNITY QUALITY AND SAFETY
TE MANAAKITANGA Ō TE WHARE TANGATA

Hutt maternity service welcomes feedback from pregnant people and whānau and provides a variety of methods for this. One of the ways consumers can provide positive feedback either to individuals or staff in general is to complete a Tumeke card. Once received these cards are given to the staff member receiving the compliment.

I WANT YOU TO KNOW I APPRECIATED IT WHEN YOU ….
"were understanding and reassuring of my concerns. When you were all so patient with me and I love how I felt no judgment from any of you. What an amazing team. Thank you for caring for my family."
"encouraged my partner and I to embrace our first time as a family and assure us of your support."
"Encouraged, supported and explained everything so we understood what was happening clearly. Your passion and love is infectious and has helped us through the process to help keep our mind at ease. Thank you. "
"were just being yourself. Made labour and birth a fantastic experience for all of us."
"thank you for all your wonderful care. We think you are amazing; your knowledge and calming nature gave us confidence and was reassuring. Ka pai."
"your dedication, help and support has been truly amazing on this first hours and days of this journey. Thank you so much."
"took the time to talk and get to know us, and share your stories. Human connections create trust and comfort."
"showed good humour, discretion and candidness even though it was the middle of the night and everyone was evidently tired. Eagerly doing obs and delivering pills and answering silly questions."
"came and saved the morning when the contractions ramped up – and when you came back to visit."
"thank you for being the dedicated thoughtful and compassionate doctor you are. You went above and beyond. We feel blessed to have had you involved in our care."

MQSP ACHIEVEMENTS 2020-2021

ULTRA-VIOLET TOWEL WARMERS

'Ultra violet towel warmers were introduced into Birthing Suite to assist with support of the perineum and perineal protection during birth.

PREGANCY CARE POLICY, PRACTICE AND GUIDELINE GROUP

Establishment of a multidisciplinary group to have oversight over the updating of policies, guidelines and patient information. Terms of reference developed and procedures for review and consultation established.

PERINEAL CARE PATHWAY POST BIRTH

Development of Perineal Trauma prevention, Assessment and Repair Guidelines and introduction of Perineal Injury and Repair Form to be completed for all births. Introduction of orange wristbands to indicate when vaginal packing is in situ.

NEURO-DIVERSITY FORUM

The Neuro-Diversity forum and webinar was held on 5 October 2021. This was well attended with approximately 35 in person attendees and 40 zoom attendees from all over Aotearoa New Zealand.

Speakers and topics ranged from personal experience of neurodiverse people sharing their experiences of their maternity journeys both in New Zealand and overseas, to topics aimed specifically at health professionals such as pharmacology and antenatal/postnatal support.

EMBRACING DIVERSITY THROUGH THE CHILDBERAING JOURNEY 3DHB MQSP CAMPAIGN

2021-2023 with Capital, Coast, Hutt Valley and Wairarapa DHBs

The purpose of the campaign is articulated in three stages which are physiologically and emotionally connected to each other, acknowledging the importance to see the three phases of the woman, pregnant person as a whole. The campaign highlights the importance to give visibility to the continuum in maternity.

1. #EverybodyBirth 2021
2. #BornThisWay 2022
3. #AfterTheBirth 2023

BIRTH FOR EVERYBODY FORUM 2021

Message from our MQSP Consumer Representative: #BirthForEveryBody

In 2020 I was involved in co-designing for the #BirthForEveryBody campaign, with the purpose of bringing awareness to the growing diverse needs in our birthing unit, particularly cultural, disabled and LGBTQIA+.

The initial ideas and plans were discussed and agreed upon across 3DHB and we came up with a 3 part campaign

PREGNANCY ~ BIRTH ~ AFTER BIRTH

A working group was then formed by volunteers from across HVDHB & CCDHB. To pull this all together and highlight areas for improvement and focus, we needed to hear from our community. What could we do to make a difference? We held a one day, Community Open Forum which was an incredibly successful and moving event. The day consisted of three panels and relevant speakers followed by Q&A with opportunities to speak and feedback in a safe environment including online, open questions and post it notes.

We had a range of members from the community including Dr Elizabeth Kerekere, queer families, transgender parents, Births, Deaths & Marriages representatives, speaking on gender identity, Rainbow Tick and many more. There were laughs, tears, good stories and sad stories. We all came together to be heard, to bring awareness and to create change.

We presented our #BirthForEveryBody poster that was designed and rolled out by our working group. The posters acknowledged that as a DHB, we recognise the need for change, we see you, we hear you, and we are taking steps to create a more accepting environment. Stage one of the campaign included a plan to display visual representation of diversity throughout the ward. We are also working through all our policies to use gender inclusive language.

Photos from the Birth for Everybody Forum:

ACUPUNCTURE

Late in 2021 our consumers requested the re-establishment of acupuncture services at Hutt. Approval was sort through MQSP to request approval from the Ministry of Health to use MQSP funding provided under the CFA to recompense the Acupuncturist for her time and consumables during the course of this project under the NMMG recommendations to promote primary birth and reduce rates of IOL and caesarean section. We are waiting on a response and hoping to proceed our next steps 2022.

IMPLEMENTATION OF THE NOC/ NEWS CHARTS

The Newborn Observation Chart (NOC) is a vital signs chart which has been developed to standardise the initial assessment and care of all newborns in New Zealand. The NOC will also provide a single view of clinical information assist in recognising trends which may indicate a baby's condition has deviated from the norm. The Newborn Early Warning Score (NEWS) has been developed to assist with the early recognition of clinical deterioration of infants who are at risk, with the aim of improving outcomes for these infants and help to detect and reduce the severity of Neonatal Encephalopathy.

NOC/NEWS charts were implemented into the Postnatal Ward in August 2021. Education was provided in the lead up to implementation with both in person and eLearning packages in place.

MATERNITY VITAL SIGNS CHARTS (MVSC) AND MATERNITY EARLY WARNING SYSTEM (MEWS)

Introduction of the Maternity Vital Signs Charts (MVSC) with Maternity Early Warning System was (MEWS) embedded at HVDHB.

CULTURAL COMPETENCY

HAPŪTANGA WĀNANGA WORKSHOPS

CULTURAL COMPETENCE/KAUPAPA MĀORI BIRTH CHOICES

It is clear that a gap exists in education for staff around cultural competence in maternity care. Work was ongoing through 2020-21 between the Midwife Educator and Māori Health to develop a specific education framework for maternity staff. New 2DHB Māori Health leadership changed the anticipated scope and structure of this, and in November 2021, we were able to provide a full day Hāputanga Wānanga workshops facilitated by Hukatai Consultants (Tākuta Ferris and Iriaka Epiha-Ferris).

He Kunenga Mai I Tawhiti workshop session covering

He Āronga Māori – A Māori worldview

Kaupapa and tikanga that stem from a Māori worldview

A Māori worldview of wāhine and the impact of colonisation

A Māori worldview of hapūtanga, birth and children

Nearly 40 people from across Capital, Coast and Hutt Valley District Maternity Services attended the day with great feedback. Three further four hour standalone education sessions were being developed for 2022 by Hukatai at the end of 2021.

TE ARATIATIA – CULTURAL COMPETENCY INTERVENTION

Late 2021 a selection of 16 staff across the Hutt Maternity Unit embarked on a programme of learning that raised their awareness and understanding of culturally appropriate services to Māori. This included identifying systemic racism and bias that impacted on the culture of the unit currently and disaffects both Māori staff and the consumer of the services the unit provides.

This process provided a safe environment for reflective practice and problem solving through another cultural lens in order to achieve better outcomes. The team was able to develop a fuller understanding of Māori world view, define how they were going to give effect to its Tiriti commitments and values to improve outcomes for Māori. Understand people's barriers/reservations/ resistance to Māori and provide tools to enable full commitment.

NATIONAL MATERNITY MONITORING GROUP (NMMG) PRIORITES

The Hutt Valley DHB MQSP work programme includes a focus on the NMMG recommendations as directed by the Ministry of Health.

1. **Responding to Workforce Issues**
    - All senior positions identified in the external review recommendations of 2018 were appointed
2. **Primary Birthing**
    - In 2021 the Te Awakairangi Primary Birthing Unit closed. Work commenced on scoping the refurbishment of one of the existing birthing rooms in Delivery Suite to become a dedicated primary birthing space. Further investigative work is ongoing regarding promotion of home birth and removing barriers that may exist for pregnant people to birth at home.
3. **Investigation of standard primiparae's induction and caesarean rate.**
    - The Optimising Birth project was commenced in 2020 to interpret and respond to the rising rates of caesarean birth, and induction of labour at HVDHB. Similar to what was happening around the region at other DHBs, HVDHB adopted the Robson 10 reporting system to analyse birth outcomes according to a defined criteria.
    - It became apparent during the analysis of the first audit that the rates of caesarean birth were comparatively high in Group 1 (nulliparous people with a single cephalic pregnancy and ≥ 37 weeks gestation in spontaneous labour), Group 2 (nulliparous people with a single cephalic pregnancy and ≥ 37 weeks gestation who had their labour induced or were delivered by CS before labour) and group 5 (All multiparous women with at least one previous CS, with a single cephalic pregnancy, ≥37 weeks gestation) with caesarean section rates of 27.93%, 51.85% and 82.14 % respectively.
    - This prompted a the working group to do a further audit focusing specifically on these groups
4. **Access to postpartum contraception**
    - Jadelle and mirena insertion are available on the maternity ward prior to discharge.
5. **Access to primary Maternal Mental Health Services**
    - The Specialist Maternal Mental Health Team continue to support us with provision of non- acute mental health services. LMC's and Obstetricians can refer women into a local maternal mental health clinic run by a Specialist Maternal Mental Health Nurse and held twice a month in the Maternity Assessment Unit. Women can also self-refer to this clinic.

Our Community Support brochure highlights support available for women with mental health concerns. The Edinburgh Postnatal Depression Scale is accessible to midwives to use with their clients. Education on awareness of the Maternal Mental Health Pathway for our DHB was covered in the planned workshops on maternal mental health, dealing with trauma and a cultural view of mental health in February 2019.

MATERNITY AND NEONATAL SYSTEM STRATEGY PLAN

Pregnancy, and the first 1,000 days of life lay the foundations for life-long health and wellbeing. Against many metrics, mothers and babies living in CCDHBs catchment area experience good health access and outcomes. However, many people in our district experience inequitable outcomes, most commonly Māori, Pacific, and people with disabilities, and babies with impairments. To gain momentum on addressing the inequities in the current system, a 2DHB Maternity and Neonatal System Plan was created.

The Maternity and Neonatal System Plan design process involved undertaking workshops with stakeholders and community including an experienced advisory group of clinical, cultural, providers, and lived experience experts. This ensures that subsequent work is grounded in the views, experience and expertise of families, community providers, cultural and clinical leaders, and other important voices from within our maternity system.

During these workshops we discussed priority action areas, including: culturally responsive care, new community models of care, enabling maternal and neonatal care, improved access to primary birthing, and a connected system. The process offered rich insights and valuable suggestions to make the Maternal and Neonatal System Strategy stronger and more effective.

The final result is an implementation plan that articulates a whole-of-system approach to improving maternal and neonatal care for all families in the region, with a pro-equity focus on improving outcomes for Māori and Pacific whānau and families, disabled people, and babies with impairments.

SOURCES OF GUIDANCE FOR MQSP WORK PROGRAMME

PERINATAL EDUCATION

HVDHB Perinatal Morbidity and Mortality Meetings are scheduled quarterly. Multidisciplinary team education is in place and a focus on near misses, good catches in our care occurs at this forum. We continue to welcome Dr Kate Strachan Pathologist, at our quarterly meetings .

PERINATAL AND MATERNAL MORTALITY REVIEW COMMITTEE

The PMMRC provides a comprehensive reporting system on perinatal and maternal death, a network of nationally linked coordinators, and a framework for assessing cases with the aim of reducing perinatal deaths while continuously improving the quality of systems and policy.

The committee reviews the deaths of babies (from 20 weeks of pregnancy to 28 days after birth) and people who die as a result of pregnancy or child birth, and advises on how to prevent such deaths.

NATIONAL MATERNITY MONITORING GROUP

The NMMG plays a key role in the implementation of the maternity standards and oversees the quality and safety of New Zealand's maternity services at a local, regional, and national level. They provide strategic advice to the MOH on priorities for national improvement based on the national maternity report, nationally standardised benchmarked data, and the audited reports from DHB service specifications. Annually DHBs are provided a national overview of the quality and safety of the New Zealand maternity sector, and advised of priorities for local improvement.

MATERNAL MORBIDITY WORKING GROUP

The PMMRC established the Maternal Morbidity Working Group (MMWG) to investigate maternal morbidity. The vision created by the MMWG is 'better outcomes for mothers in New Zealand', with an aim to 'to improve the quality and experience of maternity care for people, babies, families and whānau, informed by robust, consistent, reportable and people-centred maternal morbidity review'.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

The HQSC patient deterioration programme aims to reduce harm from failures to recogniseor respond to acute physical deterioration for all adult inpatients by July 2021. The programme works with hospitals to establish recognition and response systems for managing the care of acutely deteriorating patients.

NATIONAL PRIORITIES

MATERNAL MENTAL HEALTH

The Specialist Maternal Mental Health Service (SMMHS) is a community-based, tertiary mental health service. The focus is on providing support for pregnant people and babies within the Hutt Valley, Kapiti and Wellington areas.

Referrals for pregnant people living in the Hutt Valley can be made through Te Haika (mental health intake centre). Referrals can be made by a midwife, GP or other health professional. Criteria for referral is anyone who is pregnant or postpartum with an infant up to twelve months, who are experiencing a moderate to severe mood disorder/mental illness; this may be new onset, or previous history re-triggered in the perinatal period. Women with an existing mental illness requiring consultation or advice related to conception or pregnancy can also be referred. Pregnant people who have miscarried or do not have the care of their child, or who are already being supporting by another mental health team do not come under this service.

The SMMHS also provides consultation and education support to all DHBs in the Central Region. This can include virtual multidisciplinary meetings, case consultations, service development support and workshops.

The SMMHS service works closely with other health and social service providers who support people, babies and families. Wherever possible they support and promote education and awareness about perinatal mental illness.

Hutt Valley DHB also runs Maternal Mental Health clinics twice a month. These clinics are led by a Maternal Mental Health Nurse and provide support and direction for both people and LMC midwives accessing the SMMHS.

In the last 6 months of 2020 there were 42 referrals made to SMMHS.

In 2021 there were 288 referrals made to the SMMHS. Hutt Valley resident people made up 30.2% (87) of the referrals. For people resident in Te Whatu Ora Hutt Valley, 83 referrals to SMMHS and four requests for maternal mental health consultation. The majority of these referrals and requests came from GPs (35.6%) followed by midwives (20.7%), and 'Other' (12.6%).

The SMMHS closed a total of 257 maternal mental health referrals in 2021 of which 75 (29.2%) were residents of Hutt Valley. This figure may have included referrals from previous years. The majority were closed due to treatment being completed (64.0%). A number were closed due to the service declining the referral (9.3%) and 6.7% of referrals were closed due to the patients declining treatment. 17.3% of the referrals were closed due to being lost to services for various reasons including being uncontactable, moving from the area, or not attending appointments.

MATERNITY CLINICAL INDICATORS

Clinical indicators give an opportunity for DHBs and local maternity stakeholders to identify areas for further investigation and potential service improvement.

The New Zealand Maternity Clinical Indicators show key outcomes for each DHB region, and secondary and tertiary maternity facilities.

Data is presented in the report in two ways.

- By DHB of residence: this data is intended to provide DHBs with information relevant to their usually resident population.
- By facility of birth: this data is intended to allow for the monitoring of trends over time at the facility level.

Data for these indicators were extracted for all pregnancies and live births recorded on the

National Maternity Collection (MAT) dataset. MAT integrates maternity-related data from the National Minimum Dataset (NMDS) and LMC claim forms submitted to and compiled by the MOH.

Clinical indicators are monitored by comparing data for a defined subgroup of women who are considered to be 'low risk'. This group is referred to as the 'standard primiparae' (SP) group.

A 'standard primiparae' is defined as 'a woman aged between 20 and 34 years at the time of birth, having her first baby at term (37 to 41^{+6} weeks gestation) where the outcome of the birth is a singleton baby, the presentation is cephalic and there have been no recorded obstetric complications that are indications for specific obstetric intervention'.

The 'standard primiparae' represents a woman expected to have an uncomplicated pregnancy. Intervention and complication rates for such women should be low and consistent across all hospitals nationally. Standard primiparae represent approximately 15% of all births but this proportion varies across DHBs.

The following page shows results for Hutt Valley as a whole and by each ethnic group, for the year 2020 (New Zealand Ministry of Health, 2022). The table and commentary is based on the clinical indicator results by DHB of residence. The data can also be seen here: **https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/new-zealand-maternity-clinical-indicators-series**

Hutt Hospital has developed an internal data report based on the above system that enables us to look at our data from the previous year in order to react more responsively, instigating audits and changes in clinical practice.

OVERVIEW OF HUTT VALLEY VS NEW ZEALAND RATES

In the table below, the Hutt Valley rate is compared against the New Zealand National rate and the clinical indicators are highlighted to show if the Hutt Valley rate is statistically significantly different to the New Zealand rate.

Please note that whilst this report covers 1 July 2020 to 31 December 2020 and 2021. We are presenting all our data for 2020. We do not currently have any data available to us for 2021.

The Hutt Valley data is further broken down by ethnicity to show how that ethnicity compares to the New Zealand National rate (whole of NZ, all ethnicities), and is again highlighted to show if the rate is significantly different from the New Zealand rate.

While some indicators have what appear to be significant differences in rates, small sample sizes can mean the differences fail to reach statistical significance. Indicators 13-15 are not included due to small numbers.

Table 4: New Zealand Maternity Clinical Indicators 2020, by DHB of residence, showing Hutt Valley ethnicities compared to the whole of New Zealand.

Clinical indicators: Hutt Valley rate compared to the New Zealand rate		New Zealand Rate (%)	Hutt Valley Rate (%)	Hutt Valley ethnicity groups compared to the New Zealand national rate (whole of NZ)				
				Māori Rate (%)	Pacific Rate (%)	Indian Rate (%)	Asian (excl Indian) Rate (%)	European /Other Rate (%)
1	Registration with an LMC in the first trimester	74.1	60.8	47.8	46.2	50.8	57.4	74.9
2	SP who have a spontaneous vaginal birth	62.1	53.5	63.5	73.9	44.7	42.9	51.2
3	SP who undergo an instrumental vaginal birth	19.2	24.2	19.2	13.0	28.9	20.0	28.1
4	SP who undergo caesarean section	17.6	19.0	9.6	8.7	26.3	34.3	18.2
5	SP who undergo induction of labour	9.2	8.6	11.5	8.7	15.8	8.6	5.0
6	SP with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy)	26.7	29.4	44.7	28.6	7.1	21.7	30.3
7	SP undergoing episiotomy and no 3rd- or 4th-degree perineal tear	26.1	36.2	23.4	28.6	53.6	34.8	39.4
8	SP sustaining a 3rd- or 4th-degree perineal tear and no episiotomy	4.3	5.5	4.3	9.5	7.1	8.7	4.0
9	SP undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear	2.1	0.9	0.0	0.0	3.6	0.0	1.0
10	Women having a general anaesthetic for caesarean section	7.8	7.4	7.8	5.9	7.5	6.0	7.8
11	Women requiring a blood transfusion with caesarean section	3.4	3.6	3.9	5.9	3.2	3.6	3.0
12	Women requiring a blood transfusion with vaginal birth	2.4	3.6	4.1	1.6	5.7	6.2	2.7
16	Maternal tobacco use during postnatal period	8.6	7.1	18.6	6.7	0.0	0.6	3.2
17	Preterm birth	7.9	9.3	11.8	6.8	7.5	10.3	8.1
18	Small babies at term (37–42 weeks' gestation)	3.0	3.0	3.0	0.6	10.8	4.0	1.3
19	Small babies at term born at 40–42 weeks' gestation	29.6	37.0	25.0	0	40.0	57.1	40.0
20	Babies born at 37+ weeks' gestation requiring respiratory support	2.7	3.2	3.4	2.8	4.9	2.3	3.0

EQUITY WITHIN HUTT VALLEY

While it is good to see how Hutt Valley compares nationally, to know whether we are equitable in our outcomes, we need to compare each ethnicity against the average for the district. Ideally we would like there to be no significant differences between any of the ethnicities.

In the following table, the ethnicity columns show the rate for each ethnicity compared to the Hutt Valley rate (all ethnicities). Once again, the clinical indicators are highlighted to show if the indicator is statistically significantly different from the Hutt Valley average. Again, while some indicators have what appear to be significant differences in rates, small sample sizes can mean the differences fail to reach statistical significance. Indicators 13-15 are not included due to small numbers.

Table 5: New Zealand Maternity Clinical Indicators 2020, by DHB of residence, showing Hutt Valley ethnicities compared to the Hutt Valley rate (%).

	Clinical indicators: Hutt Valley ethnicity groups compared to the Hutt Valley rate (%)	Hutt Valley Rate (%)	Māori Rate (%)	Pacific Rate (%)	Indian Rate (%)	Asian (excl Indian) Rate (%)	European /Other Rate (%)
1	Registration with an LMC in the first trimester	60.8	47.8	46.2	50.8	57.4	74.9
2	SP who have a spontaneous vaginal birth	53.5	63.5	73.9	44.7	42.9	51.2
3	SP who undergo an instrumental vaginal birth	24.2	19.2	13.0	28.9	20.0	28.1
4	SP who undergo caesarean section	18.0	9.6	8.7	26.3	34.3	18.2
5	SP who undergo induction of labour	8.6	11.5	8.7	15.8	8.6	5.0
6	SP with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy)	29.4	44.7	28.6	7.1	21.7	30.3
7	SP undergoing episiotomy and no 3rd- or 4th-degree perineal tear	36.2	23.4	28.6	53.6	34.8	39.4
8	SP sustaining a 3rd- or 4th-degree perineal tear and no episiotomy	5.5	4.3	9.5	7.1	8.7	4.0
9	SP undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear	0.9	0.0	0.0	3.6	0.0	1.0
10	Women having a general anaesthetic for caesarean section	7.4	7.8	5.9	7.5	6.0	7.8
11	Women requiring a blood transfusion with caesarean section	3.6	3.9	5.9	3.2	3.6	3.0
12	Women requiring a blood transfusion with vaginal birth	3.6	4.1	1.6	5.7	6.2	2.7
16	Maternal tobacco use during postnatal period	7.1	18.6	6.7	0.0	0.6	3.2
17	Preterm birth	9.3	11.8	6.8	7.5	10.3	8.1
18	Small babies at term (37–42 weeks' gestation)	3.0	3.0	0.6	10.8	4.0	1.3
19	Small babies at term born at 40–42 weeks' gestation	37.0	25.0	0.0	40.0	57.1	40.0
20	Babies born at 37+ weeks' gestation requiring respiratory support	3.2	3.4	2.8	4.9	2.3	3.0

WHAT WE ARE NEEDING TO FOCUS ON OVER THE NEXT 3 YEARS

(ESPECIALLY FOR MĀORI AND PACIFICA)

- Registration with an LMC in the first trimester
- Standard Primiparae who have a spontaneous vaginal birth.
- Standard Primiparae who undergo an instrumental vaginal birth
- Standard Primiparae undergoing episiotomy and no 3rd- or 4th-degree perineal tear
- Whilst our SP spontaneous vaginal birth rate is 53.5 % compared to the national average and our instrumental birth rates are higher than the nationally average our CS rate for the Standard Primiparae is within accepted parameters. We are doing further work looking into optimising birth for our population
- Women requiring a blood transfusion with vaginal birth
- Maternal tobacco use during postnatal period
- Preterm birth

ETHNICITY REPORTING

Reporting of ethnicity is complex and different systems are used in various reports.

The New Zealand MOH uses a prioritised ethnicity group classification system (New Zealand Ministry of Health, 2010). This system is used when an individual chooses multiple ethnicities based on their preferences or self-concept. The classification system then determines the ethnicity group value for multiple ethnicities using a hierarchical system of 21 ethnicity descriptions. This is based on the following priority: Māori, Pacific Peoples, Asian, other groups except Other European, New Zealand European. For the reporting period Hutt Valley DHB have separated out our ethnicity data as tabled below.

Table 6: Ethnicity Data 2020-2021

Ethnicity	Ethnicity Level 2	2020	2021	Grand Total
Asian	Asian not further defined	1	1	2
	Chinese	21	40	61
	Other Asian	29	58	87
	Southeast Asian	32	51	83
Asian Total		**83**	**150**	**233**
Indian	Indian	77	190	267
Indian Total		**77**	**190**	**267**
Maori	NZ Maori	187	354	541
Maori Total		**187**	**354**	**541**
NZ European	NZ European	305	629	934
NZ European Total		**305**	**629**	**934**
Other	African	5	6	11
	Latin American/Hispanic	8	10	18
	Middle Eastern	3	12	15
	Not Stated	2	1	3
	Other Ethnicity	2	3	5
Other Total		**20**	**32**	**52**
Other European	European not further definied	10	9	19
	Other European	46	112	158
Other European Total		**56**	**121**	**177**
Pacific	Cook Island Maori	8	16	24
	Fijian	11	21	32
	Niuean	1	5	6
	Other Pacific Island	3	5	8
	Samoan	36	96	132
	Tokelauan	4	14	18
	Tongan	10	14	24
Pacific Total		**73**	**171**	**244**
GRAND TOTAL		**801**	**1,647**	**2,448**

ADVERSE EVENTS

Adverse events are any 'event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned'. Adverse events or near misses are reported in an effort to increase patient safety by examining the situation in which the event took place.

A total of 156 reportable events were generated across maternity services during 2020_2021, with both categories for Maternal/Childbirth, and Staffing being the highest.

In addition event reporting system, Hutt Maternity also maintains a weekly Trigger Review Group. Trigger Forms are completed when an unexpected outcome occurs during an inpatient event. All completed trigger forms are reviewed by the Trigger Review Group who consist of senior clinicians and plans are formulated which could include nil further action required, systems review, case review or referral on to the Serious Events Review Committee (SERC).

Table 7: Reportable Events

BIRTHING SUITE	78
Clinical Care/Service/Coordination	1
Maternal/Childbirth	29
Medication	5
Patient Falls	1
Safety/Security/Privacy	3
Skin tissue	1
Staff and Others Health and Safety	9
Staffing	29
MAU	**12**
Clinical Care/Service/Coordination	5
Maternal/Childbirth	3
Staff and Others Health and Safety	2
Staffing	2
POST NATAL WARD	**66**
Clinical Care/Service/Coordination	17
Good Catch	2
Infection Control	2
Maternal/Childbirth	20
Medication	10
Nutrition	1
Patient Falls	1
Safety/Security/Privacy	2
Staff and Others Health and Safety	3
Staffing	8
GRAND TOTAL	**156**

Events referred on to SERC are events which come under the Severity Assessment Code (SAC) rating in the National Adverse Events reporting Policy 20171. SAC 1 and SAC 2 events are those where the patient has incurred permanent or severe but temporary loss of function, or where death has occurred as a result of the event.

A group of Senior Leaders (the Quality and Patient Safety Committee) endorse the review findings and monitor the outcomes of recommendations.

For the reporting period 2020_2021 there were five reportable events that were considered as severe (SAC 1) and two as major (SAC 2) events. Each event was fully investigated by review teams, with any learnings applied to reduce the risk of a similar event occurring, through internal communication, online staff folders and internal newsletters.

Some of the recommendations included: Pharmacy provided pre-made MgSO4 infusions, labouring women transferring to HVDHB for complications should be assessed by an ACMM and O&G SMO, a midwife to attend any unstable mother in Emergency Department along with O&G registrar, HVDHB ECV policy updated, along with consumer information resources, all emergencies need to go through the 777 process and all staff to be socialised to this process through PROMPT course training.

APPENDIX 1 - MQSP ACTION PLAN 2020_ 2021

This action plan has identified the priority areas for focus in Quality Improvement at Hutt Maternity. A progress report is presented each month to the Maternity Quality & Safety Governance Group and also the HVDHB Directorate Leadership Team .

Domain	Initiative		Rationale	Action: December 2021	Expected Outcome	Measure	Timeframe
Consumer engagement and models of care	P1	Embracing Diversity Campaign 3 DHB	Regional campaign to display photographs illustration 'Diversity' in the Hutt birthing population.	Recruitment commenced	Range of photographs on display	May have to reduce scope due to slow uptake	By end of 2023
	P2	Rainbow Co-design 2DHB	Establish a Group to develop project initiatives across both DHBs to improve the experience for the rainbow community	Not started	Group to identify and manage projects	Projects implemented with specific Rainbow community requirements	Group set up by end of 2021
	P3	Primary Birth – Acupuncture clinic	Re-establish free acupuncture provision for the Hutt birthing population	Exploration of MQSP funding commenced	Re-establish free acupuncture in pregnancy clinic at HVDHB	Audit clinic data to measure improvement of IOL & C/S rates	Clinic commencing start of 2022. Audit completed by Q4 2023
	P4	Increase early Registration for Māori & Pacific. Explore models of care for <20 year olds	Explore avenues to increase early registration specifically for Māori, Pacific and Youth. Improve community engagement	Bus campaign proposed but needs evaluating	Increase in rates of LMC registration in 1st trimester for Māori, Pacific and Youth.	Monitor gestation at registration data collected by HVDHB by ethnicity Improved community engagement with Youth	Improved outcomes by mid end of Q4 2023
	P5	Explore Models of care for Indian Women	PMMRC recommendation to co-design models of care to meet the needs of Indian women	Not started Indian consumers to be consulted	That Indian consumers are engaged with care provision	Monitor outcomes by ethnicity to address issues	Initiate by end of Q3 2022

Domain	Initiative		Rationale	Action: December 2021	Expected Outcome	Measure	Timeframe
Reporting/Data development	P6	Caesarean section Audit	HVDHB identified as outlier for caesarean section rates.	Auditor recruited	Audit information available by Dec 2021	Service to look at audit information in line with Robson 10 project	2022-2023
		MOH Quarterly reporting	Ongoing – trends reported to MQSGG	Q3 report submitted			ongoing
		MQSP Annual report	Ongoing	2019/20 report submitted May 2021			
Cultural Competency		Ongoing Education provision & implementation into practice	MMWG – use of HEAT tool to assess services for the impact of health equity. PMMRC – Cultural Competency Education provision.	MHT and PHU representation sought on MQSGG Source CC training providers	More input on MQSGG from Māori & Pacific perspective	Implement ongoing CC training opportunities. Service implements measures to address inequities.	Ongoing Regular CC training provision in 2022
Clinical Pathways / Forms / Audits & Reporting		Policy Procedure & Guideline Group: Document Control	Out of date policies identified as risk for serious adverse events. Establishment of PPG group for oversight of robust evidence based policies & guidelines	MQSP working with Document Control.	All policies & guidelines up to date	Regular monitoring of out of date guidelines & plan for updates	All policies & guidelines updated by end of 2022
		MEWS	NMMG Recommendation Implemented December 2020.	Monitoring Auditing			
		NOC/NEWS	HQSC/ ACC National Project	Implemented August 2021	Use of NEWS to be well established on ward	NEWS auditing to be submitted to ACC	April 2022
		Pathway for Placental Implantation abnormalities	No separate policy at HVDHB – to be discussed at PPG.	Not started			
		Cortico-steroid administration < 34 weeks gestation	PMMRC recommendation	Plan to appoint auditor	Analyse steroid administration to determine if equitable	Measure ethnicity / DHB / and age	End of Q3 2022

Domain	Initiative		Rationale	Action: December 2021	Expected Outcome	Measure	Timeframe
Improving Access		Long Acting reversible Contraception	NMMG – equitable access to postpartum contraception – including audit	No new initiatives commenced	Data collection for audit Training of staff to provide LARC	Implement data collection	End of Q3 2022
Safety		SUDI	Audit	Not started			
	P7	Sepsis Bundles	Establish pathway and bundles	Started	Implementation of sepsis bundles on ward	Monitor sepsis admissions and LOS to show improvement in severity & LOS	Implementation Q2 2021. Audit ongoing.
Fetal Monitoring		FSEP	Ongoing education & weekly CTG Meetings	Established and ongoing	Provision of extra training opportunities	All staff up to date with FSEP training	2022- 2023
		GAP/GROW	Audit GROW birth centiles	Not started			
		NE Taskforce	Awaiting final guideline				

APPENDIX 2 – Abbreviations and definitions

Abbreviations

2 DHB	Capital & Coast, and Hutt Valley DHBs
ACC	Accident Compensation Corporation
ACMM	Associate Clinical Midwifery Manager
BF	Breast Feeding
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
BUDSET	Birthing Unit Design Spatial Evaluation Tool
CCDHB	Capital and Coast District Health Board
CMM	Clinical Midwifery Manager
CMT	Community Midwifery Team
CTG	Cardiotocograph
CPAS	Child Protection Alert System
CS	Caesarean Section
DHB	District Health Board
DNA	Did not attend
ED	Emergency Department
FSEP	Fetal Surveillance Education Programme
FTE	Full Time Equivalent
GAP	Growth Assessment Protocol
GP	General Practitioner
GROW	Gestational related optimal weight
HEAT	Health Equity Assessment Tool
HDU / ICU	High Dependency Unit / Intensive Care Unit
HCG	Human Chorionic Gonadotropin
HDC	Health and Disability Commission
HIE	Hypoxic Ischaemic Encephalopathy
HELLP	Haemolysis, Elevated liver enzymes, Low platelet count
HQSC	Health Quality and Safety Commission
HVDHB	Hutt Valley District Health Board
IOL	Induction of labour
LARC	Long-acting reversible contraceptives
LMC	Lead Maternity Carer
MAU	Maternity Assessment Unit
MCGG	Maternity Clinical Governance Group
MDT	Multi-Disciplinary Team
MEWS	Maternity early warning score
MOH	Ministry of Health
MQSP	Maternity Quality and Safety Programme
NE	Neonatal Encephalopathy
NMMG	National Maternity Monitoring Group
NOC/NEWS	Newborn Observation Chart/Newborn Early Warning Score
NZ	New Zealand
PBU	Primary Birthing Unit
PCEA	Patient Controlled Epidural Anaesthesia
PMMRC	Perinatal and Maternity Mortality Review Committee
PMT	Primary Midwife Team
PPE	Personal Protective Equipment
PROMPT	Practical *Obstetric* Multi-Professional *Training*
RANZCOG	Royal Australian and New Zealand College of Obstetrics & Gynaecology
RMO	Registered Medical Officer
SCBU	Special Care Baby Unit
SGA	Small for gestation age
SMMHS	Specialist Maternal Mental Health Service
SMO	Senior Medical Officer
SP	Standard Primiparae
SSBC	Single Stage Business Case
SUDI	Sudden Unexplained Death in Infancy
VIP	Violence Intervention Programme

Definitions	
Body mass index	A measure of weight adjusted for height.
Dashboard	A modern analytics tool to monitor healthcare KPIs in a dynamic and interactive way
Deprivation	A lack of the types of diet, clothing, housing and environmental, educational, working and social conditions, activities and facilities which are customary in a society
Domicile	A person's usual residential address
Ethnicity	The ethnic group or groups that people identify with or feel they belong to
Jadelle	A hormone releasing sub-cutaneous implant
Jaydess	A hormone releasing intra-uterine device
Kairaranga	Traditional weaver
Kaupapa	Topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative.
Mirena	A hormone releasing intra-uterine device
Misoprostol	A synthetic prostaglandin medication used to induce labour
Morbidity	The consequences and complications (other than death) that result from a disease
Multidisciplinary team	A multidisciplinary team involves a range of health professionals working together to deliver comprehensive health care
Nulliparous	Has not given birth previously
Pākehā	New Zealander of European descent
Parity	The number of previous pregnancies that were carried to 20 weeks
Pēpi	A baby or infant
Robson 10	A classification system by which all perinatal events and outcomes can be compared
Tamariki	Children
Tertiary	Specialised consultative health care, usually for inpatients and on referral from a primary or secondary health professional
Wahakura	A woven flax bassinet for infants up to 5-6 months of age
Wānanga	Teaching and research that maintains, advances, and disseminates knowledge and develops intellectual independence
Whānau	Extended family, family group, a familiar term of address to a number of people

APPENDIX 3 – DATA SOURCES

The information in this report has been sourced from the following database systems:

- HVDHB Business Intelligence and Analytics Unit
- HVDHB patient management system
- HVDHB Maternity Clinical Indicators (MOH)
- MOH Report on Maternity web tool
- MOH Qlik Sense Hub

APPENDIX 4 – REFERENCES

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HUTT VALLEY DHB