Hauora Tairāwhiti

2018/19 Maternity Quality & Safety Annual Report

Improving Equity

Cover Photo

Thank you to Tania Hill for providing the beautiful cover photograph for our Maternity Quality and Safety Programme Annual Report.

Tania Hill of the iwi of Te Aitanga a Hauiti. was born at Hauora Tairāwhiti on the 7th of December 1990 and coincidentally gave birth to her son, Daniel exactly 28 years later on the 7th of December 2018.

Tania resides inland from Tolaga Bay and enjoys being outdoors. Since becoming a mum, she loves taking Daniel adventuring and cannot wait until he is big enough to go hunting and fishing.

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1.0 Acknowledgements

We would like to thank the many people who have contributed to the completion of this our seventh edition of the Tairāwhiti Maternity Services Annual Report. We also acknowledge that the report may not be totally inclusive of all our community partners - we value our relationships always.

"Ka mihi maioha atu ki te nui o te tangata nana I homai he korero kia tutuki ai tenei kaupapa ko te putanga tuawhitu o te ripoata a tau mo te Puawai Aroha o te Tairāwhiti . Ka mihi hoki ki etahi o o tatou roopu a hapori kaare i watea ai ki te tuku mai he korero I te wa e tika ana – ahakoa tena ka kaingakautia o tatou whānaungatanga I nga wa katoa."

2.0 Introduction

Local Leadership of MQSP – Introduction from Liz

It is a great pleasure as the Director of Midwifery for Hauora Tairāwhiti to present our seventh Maternity Quality and Safety Programme (MQSP) Annual Report for 2018/19. This report provides you with a comprehensive overview of our district-wide maternity services, our highlights and achievements, how we continue to work with our community colleagues and services and ongoing opportunities to improve our services.

The maternity team at Hauora Tairāwhiti work in partnership with the local Lead Maternity Carer (LMC) midwives, our community primary care and iwi providers and consumers to provide a service which reflects and meets the needs of our local population. Our overall aim is to maintain and improve the quality and safety of the care we provide to all women, babies and their whānau. However, we acknowledge there is inequity in the health of our population which we continuously strive to address.

We will achieve this through our commitment to continuously drive forward by reviewing what we do through the MQSP. With the new MQSP quarterly reporting requirement we have been able to keep a closer eye on the areas which we are working on. The MQSP broadens our vision on what we can do as a community 'together', when we can do it, and what we can achieve now and in the future. Our main focus is on ensuring that our services are women and baby focused, equitable, accessible and engaging, starting from increasing the number of pregnant women who engage early with their LMC through to the discharge of a happy and healthy māmā and pēpi.

Once again we have had a challenging year with increasing acuity within the unit, with higher numbers of women requiring more complex care due to co-morbidities. This has impacted on the number of women handed over during labour for secondary care. The challenge has been addressing capacity to meet demand, sometimes with little or no warning. The workforce is an area which is constantly being reviewed so that we can ensure we can meet this increased demand on our services whilst maintaining safe staffing and high quality safe services. We have been encouraging staff to improve the accuracy of Trendcare data so that we can monitor this growing acuity. We are also in the process of establishing the Care, Capacity and Demand Management (CCDM) programme in maternity and part of the hospital wide CCDM. This is still in its early stages but we aim to have this fully implemented by the required national deadline of June 2021.

We are also in the process of implementing the national hypertension guideline and the Maternity Early Warning System (MEWS), both are large projects which we are hoping to have completed by the end of this year.

We are proud of our achievements over the past year and look forward to the challenges ahead in making further improvements through our dedication and commitment to a 'one team/one community system' approach. I hope you enjoy reading our report.

Liz Lee Taylor
Director of Midwifery & Clinical Midwife Manager

Maternity Consumer Leader Jess Claffey

I am Jess Claffey, and I am a mum to 3 beautiful children including a set of twins. We live on a sheep and beef station an hour in land of Gisborne. I became a maternity consumer is August 2016 but I had a bit of time off while looking after my new-born twins. I'm a Consumer Leader for the Tairāwhiti Maternity Quality Safety Programme (MQSP) and I feel valued, included and respected as a consumer voice for mothers.

Jess Pomare and I are in communication with other consumers through our Facebook page (Puawai Aroha Maternity Unit, Hauora Tairāwhiti) as well as face to face interactions, we have monthly catch ups. We share information by speaking with family and friends and using social media. We have 2 Consumer Leaders at the moment, myself and Jess Pomare who is our Māori Maternity Consumer Leader, we are both active members of the Maternity Quality & Safety Programme Committee and contribute to the annual report (which is on the Hauora Tairāwhiti website).We support community events and lead as needed.

Pictured: Jess Claffey and family

We do a maternity survey once a year in April. I feel very privileged to be a part of the maternity survey; I really enjoyed chatting with all the mums in the postnatal ward about the care they received during and after baby. I also rang them back 2 months later to ask about a follow up on their surveys and to see if they had any further thoughts or suggestions. We had very positive feedback about our LMC and hospital midwives. We have made a poster of our local maternity consumers and have them in all postnatal wards and it helps to connect better with all the new mums and families. The results also help the service make improvements for women and babies.

I feel that making the Facebook page has been a massive success we can share lots of great advice, community events, photos of us maternity consumers, we are yet to make some more progress on the page. It helps us have a greater reach to our priority consumers.

Moving forward, I am looking forward to continuing my role in MQSP, being valued as a consumer and making a difference in the community.

Jess Claffey
Maternity Consumer Leader

Maternity Consumer Leader Jessee Pomare

Pictured: (Lincoln-Gray Bunce – Born March 12, 2019 at Puawai Aroha Maternity Unit)

The second year of being a Maternity Consumer Leader in our Tairāwhiti region has been nothing short of amazing. Being a part of the Maternity Quality Safety Programme has broadened my knowledge around the amount of work that our local health services/providers put into pregnant women and their whānau.

Our Facebook page, (Puawai Aroha Maternity Unit, Hauora Tairāwhiti) has given us the opportunity to engage with the community about upcoming events in our region, while also acting as a platform for anyone in the community who may want to reach out or contact us. It has created such an awesome way for us consumers to interact with the wider community. Social media for us as consumers has most definitely been the easiest way to communicate with our target audience.

April's annual consumer survey always keeps us busy. It is a privilege to be able to connect with new mums and their whānau, while learning about what is needed in our maternity services in our community. Our annual survey will always be a pathway to provide the information that is needed, in order for us, to cater to our pregnant women and their whānau.

Pictured: Jessee Pomare and partner

As a maternity consumer leader, meeting new people and helping them in any way possible will always be a highlight. The future is most definitely looking bright and positive as a maternity consumer leader in our Tairāwhiti region.

Jessee Pomare
Maternity Consumer Leader

3.0 Maternity Tairāwhiti Vision and Values

To provide evidence informed/based maternity services which are seamless, culturally appropriate, woman-centred, and integrated within Tairāwhiti.

Our Clinical Leadership and Partnership aim is: “Keeping the woman at the centre of care in the Tairāwhiti Maternity Services”.

Whakarangatira | Enrich:
We value and validate the role of mothers and parents. The woman is nurtured and respected. We form and follow guidelines to promote best practice such as breastfeeding. Screening to ensure good mental health is used regularly to help preserve and improve maternal emotional and mental wellbeing.

Awhi | Support:
The dignity of the woman and her whanau are recognized. The infants are recognised as the lines to the future. Haoura Tairawhiti continues to provide Pepi pods and support safe sleep for infants. The maternity department provides 24 hour a day advice and supervision for transitioning into parenthood. Mothercrafting is available for mothers with infants in the neonatal ICU.

Kotahitanga | Togetherness:
Midwives and consultants work in partnership with women in the community to pursue healthy pregnancies and safe births. Midwifery and consultant care is planned with the women we see to prioritise and implement actions that protect mothers and their infants from risk. Women are encouraged to involve their whanau in their health and care.

Aroha | Compassion:
We share in the joy and the sadness of our women along life’s paths. Words of praise and encouragement are used whenever possible during a woman’s care. During times of loss, for example miscarriages, we listen to and hold her sadness. With joy and sadness we facilitate the creation of memories for the woman and her whanau to carry with them in to the future.

Puawai Aroha | Blossoming of Love

Working in Harmony together for the women of Tairāwhiti:

- We always treat each other with courtesy and respect
- We value constructive feedback
- We will avoid being defensive and give feedback in a constructive manner
- We strive to recognise and celebrate individual and team accomplishments
- As Team members, we will pitch in to help where necessary to help solve problems and catch up on behind scheduled work
- We acknowledge differences in knowledge and skills between professions and areas of work and respect each contribution to team working and the women and baby’s care
- We will commit to attending clinical audit and reflection meetings whenever possible and value those as important learning tools.

4.0 Our Population

Tairāwhiti District Health Board Area

Te Tairāwhiti "the coast upon which the sun shines across the water."

Geographically Tairāwhiti is unique and very beautiful. Located on the East Coast of the North Island, Tairāwhiti starts in the East Cape areas beyond Hicks Bay (north of Gisborne) and traverses down to the Wharerata ranges (South of Gisborne). The western boundary runs along the Raukumara Range, which separates it from the Opotiki district. In the southwest, its boundary runs along the western edge of Te Urewera National Park.

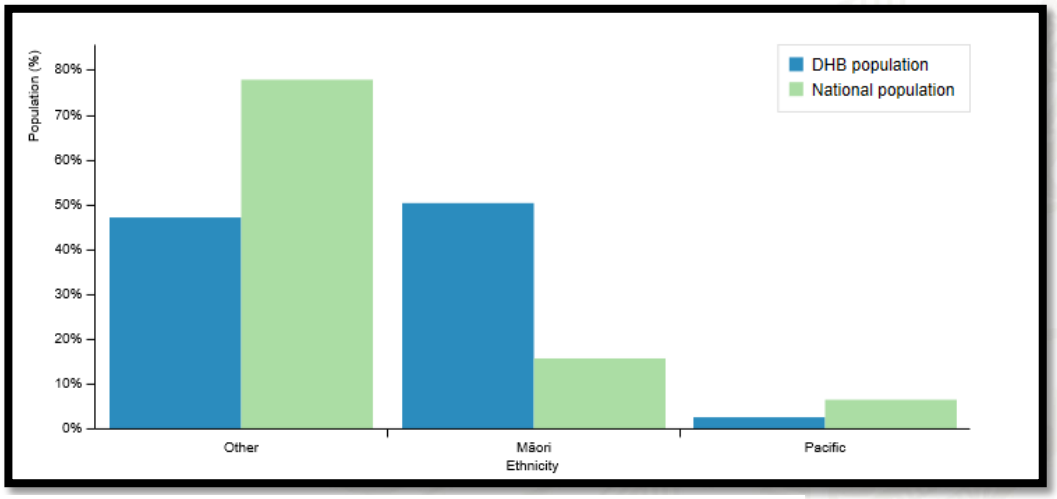
Hauora Tairāwhiti is located in Gisborne City the “first city in the world to see the sun”. We have long sandy beaches, sunny weather and mild winters. Although very tranquil, Tairāwhiti is very remote, rural and isolated from our other main centres in New Zealand. This can be advantageous at times and at other times it can be very challenging.

The population of Tairāwhiti sits around 48,680 (PHO enrolment data 2019 Q2). The ethnic diversity of Tairāwhiti is quite small, with around 24,524 or 50.4% of the population in Tairāwhiti identifying as Māori, which is proportionately higher than the national average.

Tairāwhiti is sparsely inhabited and isolated, with small settlements along the eastern shore including Tokomaru Bay and Tolaga Bay. Around 35,700 live in the city of Gisborne. The largest other settlements are the towns of Tolaga Bay and Ruatoria, each with populations of over 700.

Inland, the land is rough, predominantly forested, hill country. A spine of rough ridges dominates the centre of the region, culminating in the impressive bulk of the 1752 metre Mount Hikurangi in Waiapu Valley in the region's northeast. This mountain is the fifth highest mountain in the North Island, and the highest that is not a volcano. Regarded as sacred by the Māori, there is some justification to the claims that this is the first mountain to see the sun in summer.

The region's population has higher than the national average proportion of Māori - over 50% - and still maintains strong ties to both Māori tradition and the iwi and marae structure. The predominant iwi are Ngāti Porou, Rongowhakaata, Ngai Tamanuhiri, Te Aitanga a Mahaki.

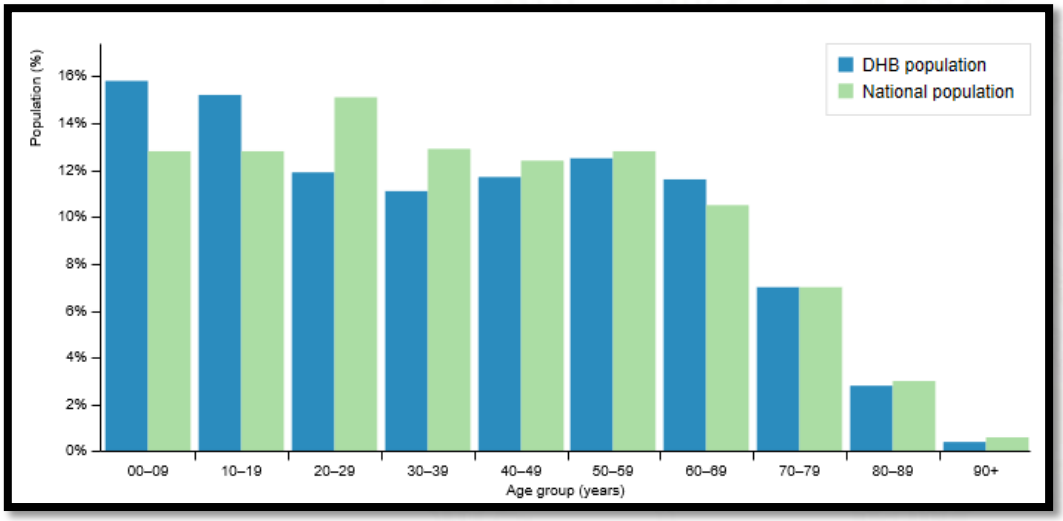


Source: Tairāwhiti Population 2018/19 - Ministry of Health website/My DHB

Tairāwhiti is economically supported by industries such as agriculture, forestry (including timber processing), fishing, viticulture, and horticulture.

Tairāwhiti has a large proportion of young people much higher than the national average in those aged between 0 and 19 years of age. This associates a much higher resource cost.

These factors: geography, industry, and age of the population attribute to the overall deprivation of Tairāwhiti.



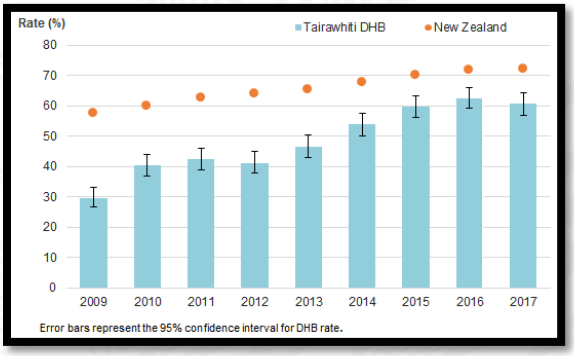
Source: Tairāwhiti Population 2018/19 - Ministry of Health website/My DHB

5.0 Maternity Clinical Indicators

Source of graphs: New Zealand Maternity Clinical Indicators 2017 Publication

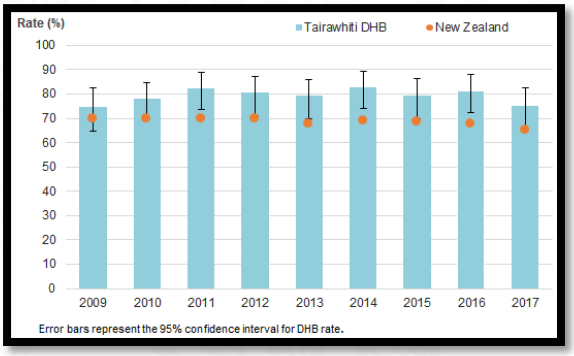
INDICATOR:	PERFORMANCE:	
Clinical Indicator 1: Registration with a Lead Maternity Carer (LMC) in the first trimester of pregnancy	2013:	46.8%
	2014:	53.9%
	2015:	59.7%
	2016:	62.8%
	2017:	61.1%

Our percentage has increased significantly since 2009, though it has essentially levelled off over the last three years. The New Zealand average is 72.3%. Our levelling off is in line with a levelling off of the New Zealand average over the last three years. This is an area which we continue to try and improve. We continue to distribute information widely through GP offices and other primary care settings. Materials include a pamphlet "Book with a Midwife before you are 10 weeks pregnant". This pamphlet, along with LMCs cards, are also being kept in sonographers' premises and given to women who come for a dating scan. We are introducing this information to our local laboratory to be displayed for the women who come for antenatal bloods. Women can also access information on local LMCs on our DHB website.



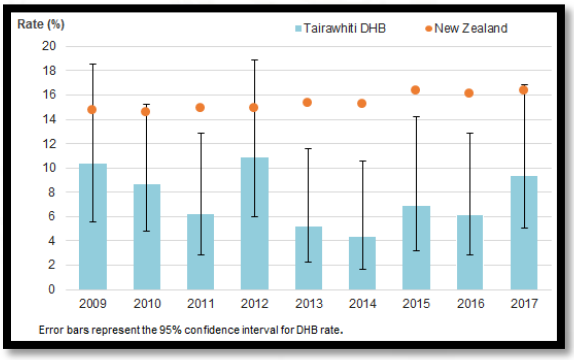
Clinical Indicator 2: Standard primiparae who have a spontaneous vaginal birth	2013:	80%
	2014:	83%
	2015:	79.5%
	2016:	80%
	2017:	75%

We continue to be among the highest in New Zealand for indicator 2. Our 95% confidence Interval (CI) is above the New Zealand median giving validity to this value despite our low delivery numbers.

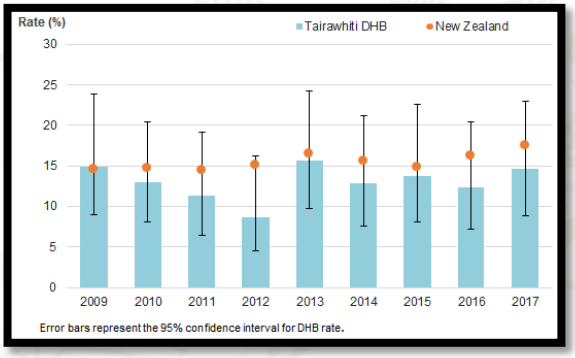
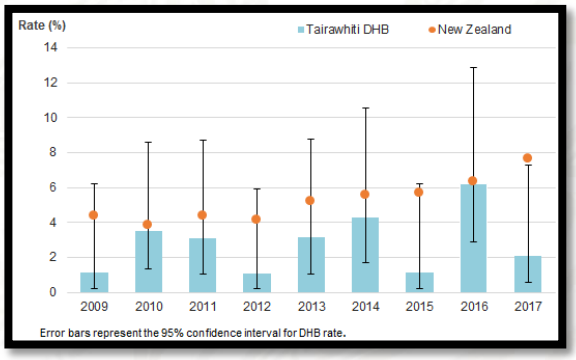
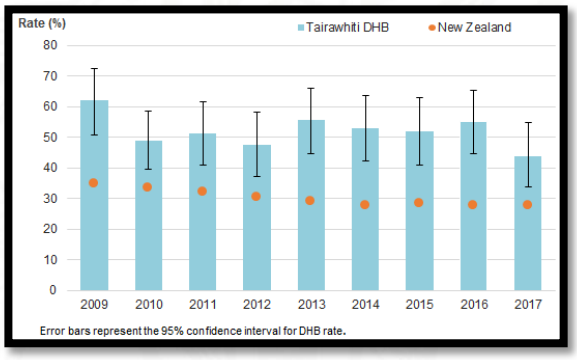
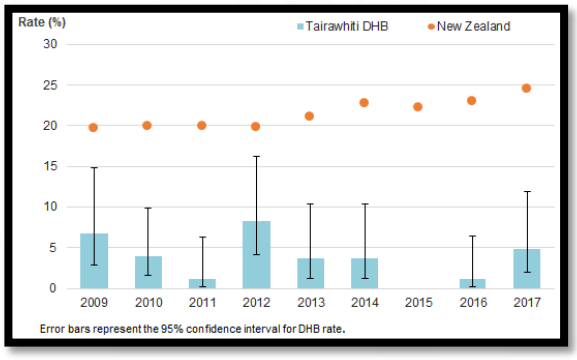


Clinical Indicator 3: Standard primiparae who undergo an instrumental vaginal birth	2013:	5%
	2014:	4%
	2015:	6.8%
	2016:	6.7%
	2017:	9.8%

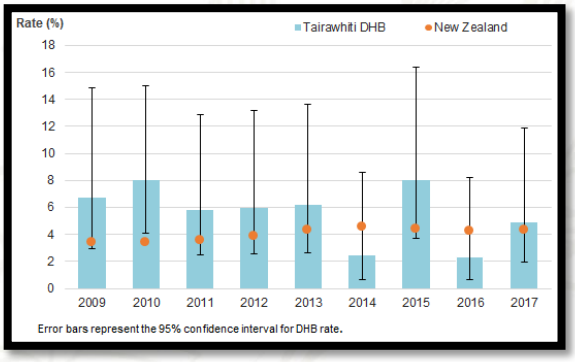
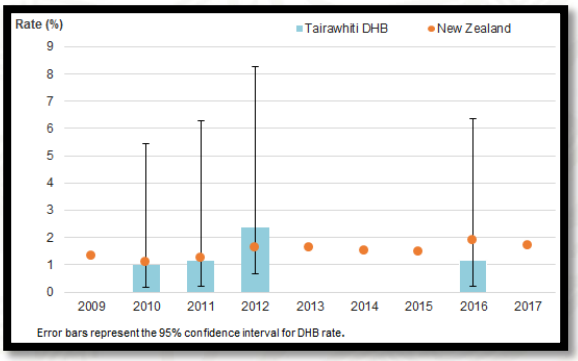
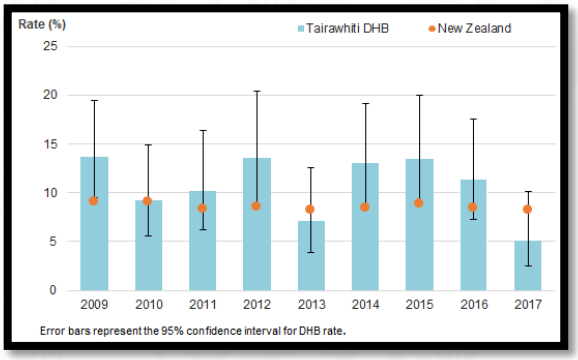
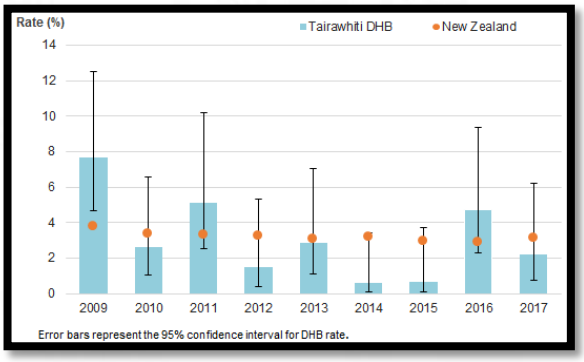
We remain well below the average for secondary and tertiary facilities of 19.5% for instrumental deliveries. This reflects good midwifery intrapartum care.



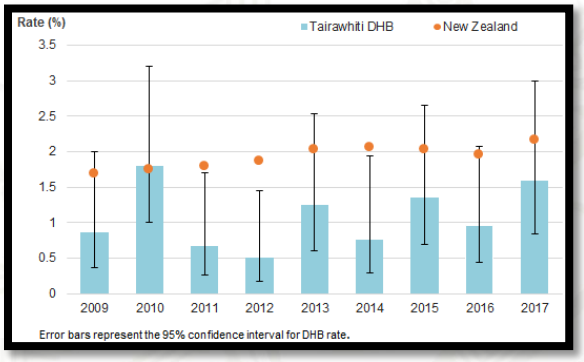
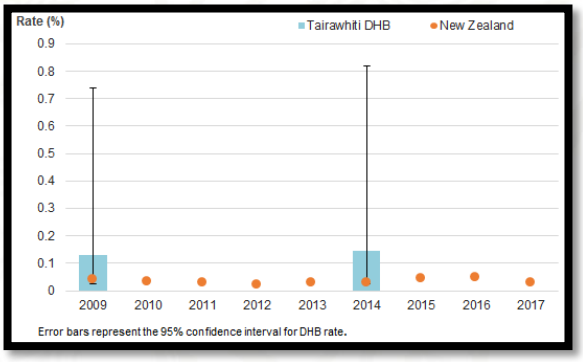
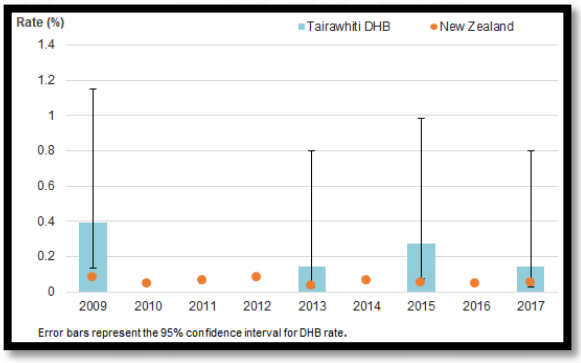
Source of graphs: New Zealand Maternity Clinical Indicators 2017 Publication

INDICATOR:	PERFORMANCE:	
Clinical Indicator 4: Standard primiparae who undergo caesarean section	2013: 14.6% 2014: 12.8% 2015: 13.63% 2016: 13.5% 2017: 15.2% As with New Zealand our average continues to slowly rise. Our 95% CI crossed the New Zealand median of 17.6% but is well below the 21.0% average for secondary and tertiary facilities. We continue to monitor our primary caesarean sections for appropriateness at our weekly Multidisciplinary Quality Meetings.	
Clinical Indicator 5: Standard primiparae who undergo induction of labour	2013: 4.3% 2014: 4.3% 2015: 1.1% 2016: 6.7% 2017: 1.1% We are again lowest in New Zealand (NZ) for indicator 5. We monitor inductions for guideline compliance and consistency of care. We attempt to avoid "social" inductions in general.	
Clinical Indicator 6: Standard primiparae with an intact lower genital tract (no 1st- to 4th-degree tear or episiotomy)	2013: 54.9% 2014: 53.7% 2015: 52.6% 2016: 53.2% 2017: 42.3% Though lower than prior years we continue to be well above the average of 19% for secondary and tertiary facilities in NZ. Our 95% CI is above the 75% giving validity to this value. This low rate of perineal trauma reflects the excellent intrapartum care given by our LMC's and core midwives.	
Clinical Indicator 7: Standard primiparae undergoing episiotomy and no 3rd- or 4th-degree perineal tear	2013: 3.7% 2014: 3.4% 2015: 0 2016: 1.3% 2017: 5.7% Our rate of episiotomy is consistently low. The NZ average for secondary and tertiary facilities is 30%. Our 95% CI is below the 25% giving validity to this value.	

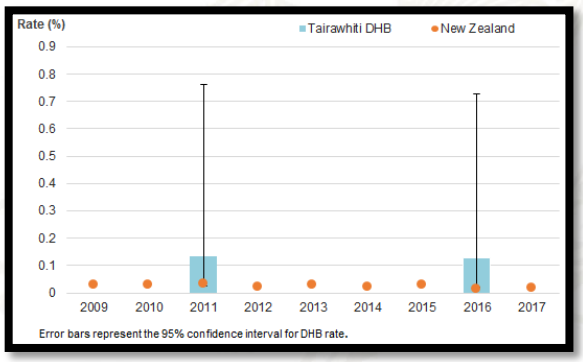
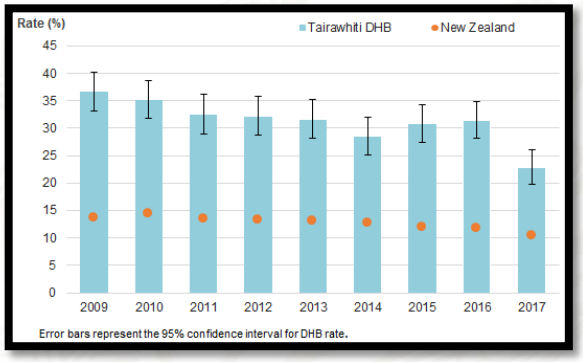
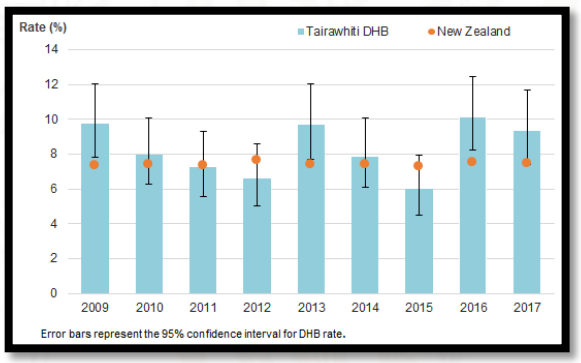
Source of graphs: New Zealand Maternity Clinical Indicators 2017 Publication

INDICATOR:	PERFORMANCE:	
Clinical Indicator 8: Standard primiparae sustaining a 3rd- or 4th-degree perineal tear and no episiotomy	2013: 6.1% 2014: 2.4% 2015: 7.9% 2016: 2.6% 2017: 5.1% The NZ average for secondary and tertiary facilities is 4.2%. Our 95% CI cross both the 25% and the 75%. Due to our small numbers the percentage can appear to change dramatically year to year. A running 5 or 10 year average would better reflect our OASIS rate.	
Clinical Indicator 9: Standard primiparae undergoing episiotomy and sustaining a 3rd- or 4th-degree perineal tear	2013: 0 2014: 0 2015: 0 2016: 1.3% 2017: 0 Our episiotomy percentage among standard primiparae is consistently low leading to a low rate of extension to 3rd or 4th degree tears. The overall NZ rate remains low as well at 1.7%.	
Clinical Indicator 10: Women having a general anaesthetic for caesarean section	2013: 7.1% 2014: 13% 2015: 13.5% 2016: 9.7% 2017: 3.8% The NZ average this year is 8.2%. Our 95% CI crosses the median implying we are in line with the national average. GA caesarean sections were audited following the 2016 clinical indicator release. All appeared to be appropriate and no anaesthesia or obstetric trends were identified.	
Clinical Indicator 11: Women requiring a blood transfusion with caesarean section	2013: 3% 2014: <1% 2015: <1% 2016: 3.4% 2017: 2.3% As our 95% CI crosses the median. We are in line with the NZ average of 3.1%. Our continued aggressive use of oral and IV iron therapy for iron deficiency anaemias in pregnancy has resulted in better maternal haemoglobins at the time of labour or caesarean section.	

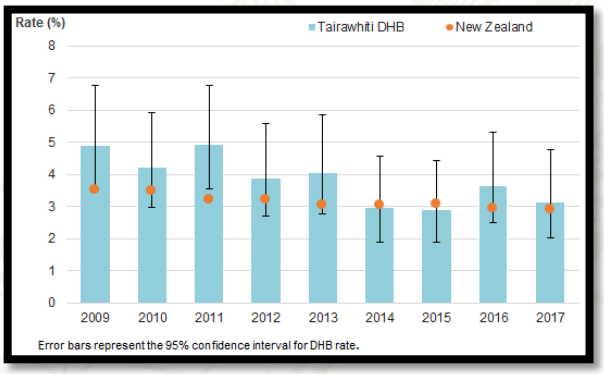
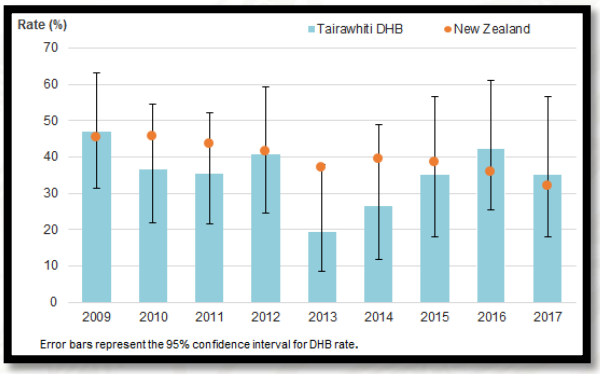
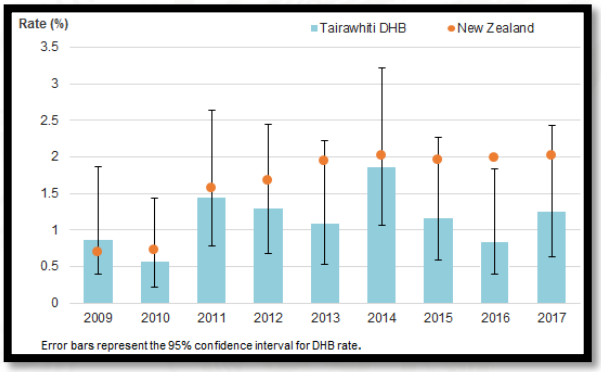
Source of graphs: New Zealand Maternity Clinical Indicators 2017 Publication

INDICATOR:	PERFORMANCE:	
Clinical Indicator 12: Women requiring a blood transfusion with vaginal birth	2013: 1.2% 2014: 0.8% 2015: 1.2% 2016: 1.0% 2017: 1.7% The percentage of women who require a blood transfusion with a vaginal birth is again below the national average of 2.2% but with a wide 95% CI. Recognising that postpartum haemorrhage (PPH) is a potential life threatening emergency is something that we continue to emphasise. This includes requiring all midwifes and obstetricians to attend our PROMPT courses yearly. We follow the national PPH guideline and have instituted a Massive Transfusion Protocol. All women are now risk scored for PPH continuously during labour with the incorporation of standardized measures in an attempt prevent PPH.	
Clinical Indicator 13: Diagnosis of eclampsia at birth admission	2013: According to national data one Tairāwhiti woman suffered eclampsia during 2013. This was a coding error. There were no women who actually had this problem. 2014: 0% 2015: 0% 2016: 0% 2017: 0% Early recognition of impending eclampsia is covered in PROMPT. Magnesium sulphate use in severe PET and strict blood pressure control protocols are consistently used with hypertensive disorders of pregnancy. The new Hypertension in Pregnancy national guideline is currently being implemented at our facility.	
Clinical Indicator 14: Women having a peripartum hysterectomy	2013: 1 case 2014: No cases 2015: 2 cases 2016: No cases 2017: 1 case Our peripartum hysterectomy rate has been consistently higher than the NZ average over the last 5 years. All cases of peripartum hysterectomy from 2013 to present will be reviewed and an audit performed to look for any trends or learning points.	

Source of graphs: New Zealand Maternity Clinical Indicators 2017 Publication

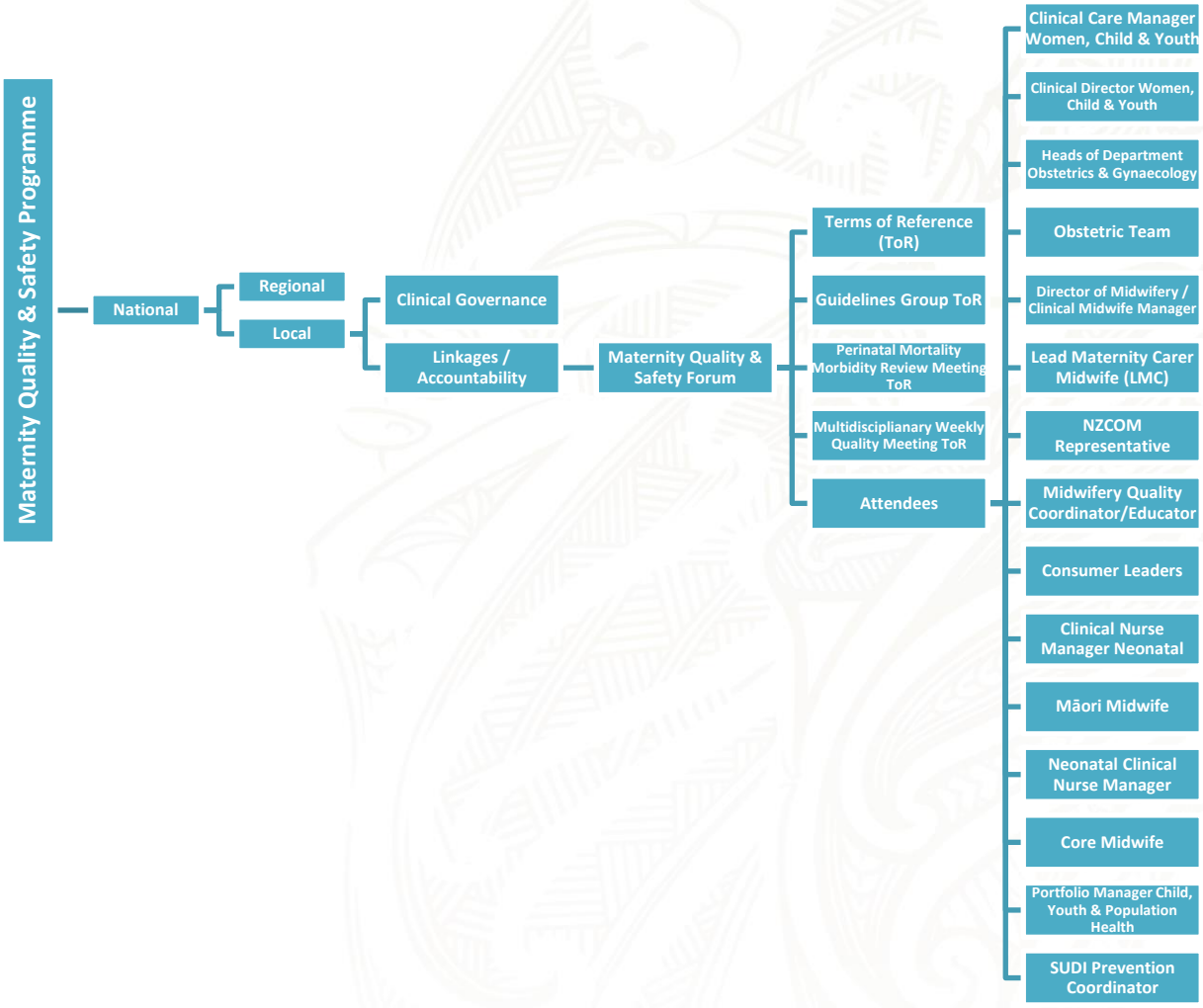
INDICATOR:	PERFORMANCE:	
Clinical Indicator 15: Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period	2013: No cases 2014: No cases 2015: No cases 2016: No cases 2017: No cases No cases again reported at Gisborne Hospital. The rate for NZ is quite low at 11 cases in 59,648 deliveries.	
Clinical Indicator 16: Maternal tobacco use during postnatal period	2013: 31.4% 2014: 28.5% 2015: 30.6% 2016: 29.2% 2017: 21.7% We persistently have among the highest rates of smoking among pregnant women in New Zealand. The national average is 10.5%. This is an area of great concern and considerable effort has been put forth to decrease the rate of tobacco use in pregnancy with only mild success to date. We will continue our efforts to reduce tobacco use in our pregnant and non-pregnant women.	
Clinical Indicator 17: Preterm birth	2013: 9.7% 2014: 7.6% 2015: 5.6% 2016: 10.5% 2017: 9.2% We are above the NZ average of 7.5% but our 95% CI does cross the median. An audit of 2018 preterm deliveries was conducted this year. An overall preterm delivery rate of 8.4% was found. Combining the audits of 2013, 2015 and 2018 the combined preterm delivery rate was 6.9%, more in line with the NZ average. The audit did show that antenatal steroids were offered and used consistently when clinically appropriate. Due to the significant impact of preterm delivery on neonatal morbidity and mortality, periodic audits will be performed to monitor our local performance.	

Source of graphs: New Zealand Maternity Clinical Indicators 2017 Publication

INDICATOR:	PERFORMANCE:	
Clinical Indicator 18: Small babies at term (37–42 weeks' gestation)	2013: 4.0% 2014: 2.9% 2015: 2.8% 2016: 3.8% 2017: 3.3% The NZ average is 2.9%. Our 95% CI is quite wide reflecting our small number of deliveries. We promote the use of customised GROW charts with appropriate use of ultrasound to diagnose growth restriction when the GROW charts indicate small for gestational age or a slowdown in fetal growth.	
Clinical Indicator 19: Small babies at term born at 40–42 weeks' gestation	2013: 19.2% 2014: 26.3% 2015: 35.0% 2016: 37.5% 2017: 35% The NZ average is 31.9% but our 95% CI is quite wide. We are currently auditing our ultrasound estimated fetal weights to ensure they are within the accuracy range expected.	
Clinical Indicator 20: Babies born at 37+ weeks' gestation requiring respiratory support	2013: 1.1% 2014: 1.8% 2015: 1.1% 2016: 0.8% 2017: 1.2% Our numbers continue to remain below the NZ average of 2.0% but with a wide 95% CI. Neonatal nursery admissions statistics are presented at Maternity Quality and Safety meetings and appropriate clinical records are reviewed by a multidisciplinary committee for learning outcomes and quality improvements.	

6.0 Maternity Quality & Safety Programme

Governance Structure



Responsibility for Maternity Quality and Safety

Maternity Quality Safety Programme Committee

The Maternity Quality and Safety Programme (MQSP) Committee meets monthly.
The aim is to maintain and improve the quality and safety of the care we provide to all women, babies and their whānau. We will achieve this through our commitment to continuously drive forward by reviewing what we do.

The MQSP broadens our vision on what we can do as a community 'together', when we can do it, and what we can achieve now and in the future. Our main focus is on ensuring that our services are women and baby focused, equitable, accessible and engaging, starting from increasing the number of pregnant women who engage early with their Lead Maternity Carer (LMC) Midwives through to the discharge of a happy and healthy mother and baby.

The maternity quality and safety programme work is shared amongst managers, clinicians, consumers, community midwives and community agencies.

MQSP Committee
Pictured (from left): Barbara Reid (Clinical Nurse Manager Neonatal), Dr Sean Pocock (Obstetrician), Dr Shireen Heidari (Obstetrician), Puna Schwenke (admin support), Kaniwa Kupenga-Tamarama (Mokopuna Ora SUDI Prevention & Safe Sleep Coordinator), Dr Christina Dave (Obstetrician), Jess Claffey (Consumer Leader), Liz Lee Taylor (Director of Midwifery/Clinical Midwife Manager), Dr Margot McLean (Clinical Director Women, Child & Youth), Judi Murphy (Maternity Project Coordinator), Iidil Merlini (Midwifery Educator/Quality Coordinator)
Absent: Nicki Dever (Clinical Care Manager Women, Child & Youth), Dr Diane Van de Mark & Dr Bill Weiderman (HoD Obstetrics & Gynaecology), Nicholette Pomana (Portfolio Manager), Carla Clement (Core Midwife), Belinda Evans (Core Midwife), Holly Casey (Māori LMC Rep)

Hauora Tairāwhiti

Highlights and Achievements from 2018/19

6.0 Highlights and achievements 2018/19

Hauora Tairāwhiti

Director of Midwifery member of the Neuroencephalopathy Fetal Heart Monitoring Education Programme working group

Lowest rate in NZ for standard primiparae who undergo induction of labour

New Mokopuna Ora SUDI prevention Coordinator recruited

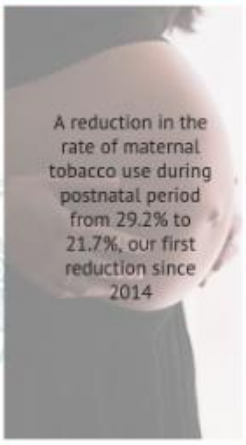
Continued high rate of standard primiparae with an intact lower genital tract following a vaginal birth

We remain below (3.8%) the national rate (8.2%) for women requiring a general anaesthetic for a caesarean section

Only 1.7% of standard primiparae required a blood transfusion following a vaginal birth , which remains below the national average of 2.2%

Long acting contraception available for women post birth prior to discharge from the maternity unit

Antenatal steroids used consistently when clinically indicated for women who had a preterm birth



A reduction in the rate of maternal tobacco use during postnatal period from 29.2% to 21.7%, our first reduction since 2014

All women have a contemparaneous PPH risk assessment when in labour

85% of all employed midwives have successfully completed their Quality Leadership Programme portfolio

Fully implemented new maternity Severity Assessment Code (SAC) rating and triage tool for adverse event reporting

Health Quality & Safety Commission New Zealand

Successful world breastfeeding celebration

Big Latch On

Working to support women and whanau maternity journey with a whole of system, 'no wrong door' and a 'whatever it takes' approach

Work progressing on implementation of national hypertension guideline

One of the highest spontaneous vaginal birth rates in New Zealand for the standard primiparae

Learning outcomes identified during case reviews have been actioned. This ensures continuous improvement in services

Whāia te hauora i roto i te kotahitanga | A healthier Tairāwhiti by working together

Summary of Maternity Quality & Safety Programme Projects 2017/18

Project One – SUSTAINABLE WORKFORCE		Status
Rationale	There has been a large increase in acuity in the services over the past 12months. Ensuring capacity meets the demand is an ongoing and serious issue with the current FTE workforce. This has huge implications for sustainability of the current workforce. Therefore this is a project that is of extreme high priority for Puawai Aroha Maternity unit.	
Actions	1. Review of the current workforce including Trendcare to go live (October/November 2018) as all inter-rater reliability testing will be complete	
	2. Business case for increase in midwifery FTE to be completed and submitted to CEO	
	3. Review applicants and interview	
	4. Recruit successful candidates (2)	
	5. MERAS Safe Staffing recommendations reviewed	
	6. Audit ward attenders weekly with monthly reports	
	7. Review role of shift coordinator	
	8. Review recruitment and what we offer	
	9. Liaise with WINTEC re: number of student midwives in Tairāwhiti and what support is required to improve retention during training and to match training with local requirements	
	10. Arrange evening for local people interested in becoming a midwife	
	11. Review new graduate midwife recruitment	
	12. Review obstetrician capacity and demand	
	13. DOM now on WINTEC Employer Partnership Groups (EPG). Attends quarterly meetings	
	14. 1 student midwife recruited for 2019 intake	
Issues	1. Delay in release of Trendcare version 3.6 locally 2. No new grad midwives until 2020 and then potentially only one	
Risks	Reduced midwifery workforce if recruitment unsuccessful	
Future	1. IRR testing to take place in December 2020 2. Extend recruitment advertising to overseas 3. Continue with advertising for casual/permanent midwives 4. Trendcare version 3.6 to be implemented over next few months, then GO LIVE. DOM attending nationally Trendcare meeting, champions attending update training on new version this month 5. Review O&G capability & demand 6. Recruit registered nurse to specialise in maternity	

Project Two – CHOICE, EQUITY & ACCESS		Status
CLINICAL INDICATOR NO.1 **Registration with an LMC in the first trimester of pregnancy.** In 2016 it was reported that only 62.8% of women registered with an LMC in the first trimester. We understand this is possibly now higher following a recent consumer survey, which reported the number to be 66%. However, we remain under the national average of 71.9%. We continue to work on this with LMCs.		
Rationale	To improve the number of women engaging with an LMC in the first trimester	
Actions	1. Renew the 'Book with a Midwife before you are 10 weeks' leaflet so that it reflects the current LMC workforce and review the distribution list for wider circulation and accessibility for women. Include which LMCs offer free pregnancy tests**.**	
	2. Revise our website so women can access a contact list for all local LMCs and provide basic information on recommendations for early pregnancy.	
	3. Any new LMC to be encouraged to join the 'Find Your Midwife' website	
	4. Organise an evening to update local GPs (primary and secondary maternity care providers hui) on care of women in early pregnancy and the importance of early registration with an LMC.	
Issues	Continued challenge to increase number of women engaging early with LMC	
Risks	Missed opportunity for women who fail to engage with an LMC to access recommended care in early pregnancy	
Future	1. LMC aiming to complete in next quarter. Photo obtained but needs one person photo shop in 2. Review the success of the primary and secondary maternity care providers hui and implement any recommended outcomes from this suggested by our primary colleagues	
CLINICAL INDICATOR NO.2 **Maternal tobacco use during the postnatal period**		
Rationale	To reduce the number of pregnant and postnatal women using tobacco	
Actions	1. Work closely with the smoking cessation providers and meet quarterly	
	2. Consistency in our change from an opt-in referral pathway to smoking cessation services for all women to an opt-out	
	3. To be audited monthly from MCIS and reviewed 6 monthly	
	4. Review quarterly reports from the smoking cessation provider to confirm if what we are doing is having an impact or not	
	5. Review the outcomes from the LMC team who have just become smoking cessation coaches – March 2019 to enable them the opportunity to see the results	
	6. Staff to be informed of revised documentation requirements so we can audit referrals	
	7. Speak to LMCs for update on success of becoming quit coaches	
Issues	Change over in link contact person	
Risks	Risk to women and babies from continued tobacco use	
Future	1. All midwives have smoking cessation as a KRA in appraisals with aim to follow opt out rather than opt in referral pathway 2. Contact Smoking cessation provider for quarterly reports 3. Encourage more LMCs to become smoking cessation providers	

CLINICAL INDICATOR NO. 17 (ALSO PMMRC RECOMMENDATION) Preterm Birth		
Rationale	Aim to reduce the rate of preterm birth by targeting the high risk groups	
Actions	1. Perform an audit of preterm births to identify any local contributing factors that are amendable and include ethnicity, socio-economic status and age to review equity and access to services	
	2. Reduce rates of women smoking in pregnancy (see clinical indicator 2 for actions)	
	3. Continue and fully implement the national hypertension guideline (addressed separately below under NMMG recommendations)	
	4. Early registration with an LMC who can make a referral to smoking cessation provider (see clinical indicator 2 for actions) , screen and treat any sexually transmitted diseases and/or urinary tract	
	5. LMCs refer women with risk factors for preterm birth to the consultant within the first trimester; this information can be included in the audits	
	6. All women with risk factors for preterm birth who are referred to the consultant are to be seen within the first trimester	
	7. Review our prevention of preterm birth guideline to ensure this is current	
	8. Continue use of partosure for all women with signs and symptoms of preterm birth, so that preterm birth can be confirmed or excluded and a management plan agreed and implemented which will include corticosteroids and magnesium sulphate and early transfer to a tertiary unit if less than 32 weeks gestation. This can be captured in the audit. The NNMG have recommended auditing corticosteroid use, particularly looking at administration by ethnicity and age	
	9. Sexual Health Educator has provided workshops on syphilis and recommendations on screening and treating sexually transmitted diseases (STDs)	
Issues	Engaging women to book early	
Risks	If women do not engage early with an LMC they miss the opportunity of receiving care to reduce the risk of preterm birth	
Future	1. Introduce a follow up service for women to be able to be seen and debriefed about their experience of preterm birth and outline recommendations for the next pregnancy and early registration with an LMC 2. Request regular updates from those LMCs who have become smoking cessation providers.	
NMMG RECOMMENDATION		
Rationale	Postpartum contraception options including long-term acting reversible contraceptives (LARC) should be discussed with all postpartum women. Women should be given a range of options, comprehensive information about risks and benefits and they should have equitable access to the contraception of their choice.	
Actions	1. Obtain stock of Jadelle which is easily accessible in maternity	
	2. Compile a competency package for those midwives interested in being able to offer this	
	3. O&G to train the midwives. This will be on going depending on the opportunities available for midwives to train	
	4. All midwives to observe an insertion of a Jadelle so they can explain the procedure to women as part of their contraception advice prior to discharge. This will be on going	
	5. Audit 6 monthly the number of Jadelle insertions including ethnicity and age	
Issues	Slower than expected progress in training midwives to insert Jadelles due to timing of opportunities. Work in progress	

Risks	None	
Future	1. The O&G continues to train midwives when the opportunity arises. We now have the midwife educator who has completed her training; she will now also be available to train midwives 2. Midwives to continue to take advantage of opportunities as they arise 3. Audit planned to be completed by March 2020	
IMPLEMENT THE NATIONAL HYPERTENSION GUIDELINE LOCALLY		
Rationale		
Actions	1. O&G team to review the guideline together to compare with what we have in place currently	
	2. Clinical Director, O&G team, Director of Midwifery and Midwifery Educator to meet to discuss implications on secondary and primary services. Include GP liaison in discussions	
	3. Meeting to take place with Planning & Funding to look at any additional resources required in the implementation of this guideline and how these can be met	
	4. LMC to provide current process & costings for additional community PN visits to woman's home for BP monitoring	
	5. MCIS management plans and discharge letter for GP to be reviewed to ensure correct information provided for ongoing care in the community	
	6. Clinical Director to produce business case for Chief Executive with above information but also the additional costs to women for GP visits PN for BP monitoring	
	7. Provide education for all relevant health professionals including GPs	
	8. Fully implement the guideline by end of 2019	
Issues	Financial funding for primary care required has to be agreed and arranged	
Risks	None	
Future	1. To update local guideline to ensure clarity of pathway of care for postnatal women with preeclampsia or eclampsia 2. MCIS management plans and discharge letter for GP to be reviewed to ensure correct information provided for ongoing care in the community to be launched at primary and secondary maternity providers hui in October 2019 3. All staff to be informed of new pathway by November 2019	

Project Three – HĀPŪ WĀNANGA (ANTENATAL/BIRTH PREGNANCY AND PARENTING EDUCATION)		**Status**
Rationale	A review of all pregnancy and parenting education options will be completed to ensure there are equitable opportunities for women to access across Tairāwhiti.	
Actions	1. Explore Hapū Wānanga programme in Midland – localise to Tairāwhiti	
	2. Advertised for expressions of interest to run Hapū Wānanga programme in Tairāwhiti	
	3. Successful applicants initiated programme in January 2019	
	4. Conduct an evaluation of the classes	
Issues	None	
Risks	None	
Future	1. Evaluation of new local Hapū Wānanga Pregnancy and Parenting Information and Education Programme by January 2020 2. Provide ongoing midwifery support to these programmes across the district	

Project Four – SUDI PREVENTION & SAFE SLEEP		Status
Rationale	Service delivery needs to sit as close to whānau as possible to shift their understandings about risk, safe practices and safe sleeping places.	
Actions	1. Working with Midlands Regional DHB SUDI prevention and safe sleep group to progress regional SUDI plan	
	2. Recruit Mokopuna Ora SUDI Prevention Coordinator	
	3. Continue to monitor Pēpi Pod distribution	
	4. Prevention of shaken baby workshop update by National Shaken Baby Prevention Coordinator	
Issues	None	
Risks	None	
Future	1. Work closely with Mokopuna Ora SUDI Prevention Coordinator 2. Continue to ensure all women receive the appropriate health advice on SUDI prevention, safe sleep and prevention of shaken baby	

PROJECT STATUS LEGEND	
	Work has been completed and/or in business as usual phase
	Work is in progress/underway and nearing completion
	There is still a significant amount to achieve before completed

For Hauora Tairāwhiti's Progress Update in Relation to the Implementation of 12th PMMRC Report Recommendations see appendix 1.

Future Project Plan

Initiative/priority	Rationale	Action	Expected Outcome	Measure	Timeframes
1. Complete the implementation of the 'Diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in New Zealand: A clinical practice guideline"	1. National and local requirement to ensure appropriate care provided for women with diagnosed hypertensive disorders in pregnancy and postnatally	1. Launch the revised discharge letters to GPs for recommended postnatal care and follow up for women with hypertensive disorders 2. Monthly meetings to discuss progress and implementation 3. Investigate how women can receive postnatal follow up at home or an appropriate alternative venue and how this will be funded if additional LMC/GP visits required 4. Look at funding so there is no additional cost for follow up care for the women once discharged from the hospital 5. Update the local guideline to meet national recommendations 6. Educate all providers 7. Develop an audit tool. 8. Undertake an audit 9. Review data collected and identify any learning actions. 10. Implement learning actions if applicable.	1. Business as usual and guideline fully implemented 2. Equity of care for all women diagnosed with a hypertensive disorder in pregnancy	1. All women with hypertensive disorders in pregnancy are correctly diagnosed and receive the recommended care and follow up.	1. Launch revised discharge letter at Primary/ Secondary Maternity Services providers Hui 16th October 2019 2. Monthly meetings on-going until full implementation 3. All health professions fully aware of recommended care and new guidelines by Dec 2019 4. Full implementation by January 2020 5. Undertake an audit 6 months after full implementation of guideline (July 2020)
2. Fully implement maternity CCDM	1. National requirement 2. Ensure safe staffing of maternity services 3. Capacity to meet demand	1. Continue to work with hospital wide CCDM team including MERAS and Midwifery CCDM coordinator 2. Trendcare update training 3. Annual Trendcare IRR testing to ensure accuracy of data collection	1. Monthly meeting which includes CCDM council, Core data and variance response meetings. 2. Training planned for Oct/Nov 2019 3. Repeat IRR testing in Nov 2019 4. Fully implemented by July 2021	1. Safe staffing levels on each shift 2. Capacity meeting demand 3. Recruitment of additional staff if data shows evidence of need to maintain safe staffing levels within maternity	1. All completed and business as usual by July 2021

	Initiative/priority	Rationale	Action	Expected Outcome	Measure	Timeframes
3.	Repeat PPH audit	1. To review if what was implemented has made a positive difference in reducing PPH rate	1. Prepare audit tool 2. Collect data 3. Evaluate data 4. Present findings	1. Reduced rate of PPH, in particular massive PPHs 2. Maintain quick and effective response to PPH incidents therefore reducing morbidity	1. Compare statistics from previous audit prior to implementation of measures to prevent/reduce risk of PPH	1. Prepare audit tool Dec 2019 2. Commence and complete audit in January 2020 3. Implement any changes required 4. Present findings at PMMRC meeting in February/March 2020
4.	Fully implement MEWS	1. Improve the outcomes for women by avoiding or limiting severity of morbidity.	1. As per project charter submitted to HQSP committee MEWS Project Charter Hauora July 2	1. All pregnant women and up to 42 days postnatally are commenced on a Maternity Vital Signs Chart if admitted to any ward in the hospital 2. Any abnormal vital signs are escalated using the escalation pathway correctly 3. Women receive the appropriate care in a timely ,manner therefore reducing the risk of morbidity	1. Compare Pre and post implementation audits results	1. Regular zoom conferences with HQSC 2. Progress through MEWS project charter and implementation plan
5	Identify if there is any inequity in perinatal mortality for young mothers under 20 years of age here in Tairāwhiti and apply corrective actions if identified	1. As per PMMRC recommendation if this exists it needs to be addressed so that all mothers regardless of age receive the same high quality, safe care to reduce morbidity and mortality	1. Develop an audit tool to capture all pregnant women under 20 years of age specifically looking at smoking status at beginning and end of pregnancy, any infections screening/ diagnosis during pregnancy and if treated, any screening for IUGR 2. Undertake the audit Jan 2020 3. Review data collected and report back on findings 4. Implement any identified learning actions 5. Re-audit after 12 months to compare findings	1. All young mothers have equal access to appropriate screening and care during their pregnancy in order to achieve equitable health outcomes	1. All young mothers are identified as having been offered and received appropriate screening and care during their pregnancy	1. Prepare audit tool Jan2020 2. Commence and complete audit in February 2020 3. Implement any changes required 4. Present findings at PMMRC meeting in March/April 2020

	Initiative/priority	Rationale	Action	Expected Outcome	Measure	Timeframes
6	Review all cases of peripartum hysterectomy from 2013	1. Evaluate indications and outcomes and identify any learning outcomes	1. Develop an audit tool 2. Undertake the audit Mar 2020 3. Review data collected and report back on findings 4. Implement any identified learning actions	1. All cases were appropriately managed	1. Reduction in number of peripartum hysterectomy 2. Appropriate actions taken to prevent peripartum hysterectomy	1. Prepare audit tool by Feb 2020 2. Commence and complete audit by Mar 2020 3. Implement any changes required 4. Present findings at PMMRC meeting in April/May 2020

National Maternity Monitoring Group (NMMG) Priorities

Preterm Birth	
Current activities to reduce preterm birth and associated inequities, and follow up services and attendance rates (including by ethnicity);	Prevention of preterm birth guideline updated, all guidelines relating to preterm labour and birth have been consolidated into 1 guideline with easily accessible section. Free dental care offered to women during pregnancy who meet E Tipu E Rea criteria.
Processes in place to follow up women with previous preterm birth (noting this is a major risk factor for preterm related perinatal death);	Planned primary and secondary maternity care providers hui. Following any preterm birth, women to be offered postnatal follow up with O&G and GP to be informed of this event and any recommendations for future pregnancies.
Processes in place to ensure early engagement of women with a midwife	Work in progress. See page 21.

Maternal Mental Health	
What are the criteria for admission to a secondary care service?	Through Psychiatrists Moderate to severe / enduring mental illness Receive referrals from Te Kuwatawata (noted a decrease in referrals) GPs referring to Pinnacle/PHO
What proportion of referrals are accepted or declined due to lack of service provision or because they would be more appropriately managed in the community?	Don't decline referrals/Te Kuwatawata in place/triaged by TKWW pick up within 7 days
What facilities are available for inpatient care, and is there provision for babies to stay if appropriate?	Mum and baby separated between inpatient ward and Paediatric ward
What challenges are making pathways difficult?	"One size does not fit all" Not sharing critical information across sector
How is primary care being supported to manage women with mild to mode depression during pregnancy and postpartum?	LMCs doing screening All women should be screened who are pregnant
Are mechanisms being implemented that raise awareness/deliver education among midwives so they feel safe/confident to discuss/address mental health wellness with women and their whānau?	Mental Health service offer training (Perinatal Anxiety and Depression training) for sector/PADA – case discussions/2x year/opportunity to talk about cases Perinatal and Infant Mental Health Network Forum – to be held in Gisborne in September. Mothers Helpers (Anxiety and Depression) training – wants to start a group in Gisborne.
What systems are in place to ensure midwives/maternity health services are well supported, particularly those midwives who have consistently looked after women with complex mental health un-wellness, who are experiencing suicidal tendencies, or who have committed suicide?	Maternal Mental Health (MMH) worker and LMC/midwife partnership. Can call complex case review – get together with whānau and people supporting to bring together and discuss (sits in policy) Primary linkages Health Broker role

Equitable access to contraception	
What percentage of women has a contraception plan as part of their birth plan?	In general birth plans are completed in partnership with their LMC. This is currently not included in the MCIS records but we aim to request for this to be included so we can capture this information.
What services are being provided to meet the contraceptive needs of women prior to discharge from hospital or from a primary birthing unit, and how well does this service meet the demand?	Introduction of Jadelle upskilling for core midwives – 2 obstetricians and 1 midwife currently able to insert Jadelle for inpatients, 3 more midwives half way through credentialing programme, daytime weekdays always available, also usually available at least 2 weekends out of four.
What percentage of women leave our birthing unit with contraception?	Need to design audit for this.
What percentage of women leave our birthing unit with a LARC? ○ **if a LARC service is provided for postnatal women in the community, what percentage of women are referred to this service, and what percentage access it? To what extent is the service reaching Māori and Pasifika women and women under 25 years of age?**	Increasing numbers of women receiving Jadelle prior to post-natal discharge from unit. Data not available yet. Other women have access to the Community Clinic where the service is also offered for free Specific stats not collected by the Community Clinic.
Request DHBs to report on processes for supporting women to make informed choice and services available that support women to enable their choice of contraception	Information is part of routine discharge discussions (care plans), Jadelle and prescriptions available for all inpatients, tubal ligation possible whilst still an inpatient or a follow up arranged.

Clinical Guidelines	
Progress on the implementation of the 'Diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in New Zealand: A clinical practice guideline'.	Discharge information: agreed pathway for discharge letter to GPs from Maternity Clinical Information System (MCIS), go live 16th October. Awaiting clarification regarding funding for additional postnatal visits required. Clinical guideline for secondary service to be updated. Information for primary care providers (GPs) to be shared in October.

7.0 Our Maternity Facilities

Secondary Birthing Facility: Gisborne Hospital - Puawai Aroha Maternity Unit

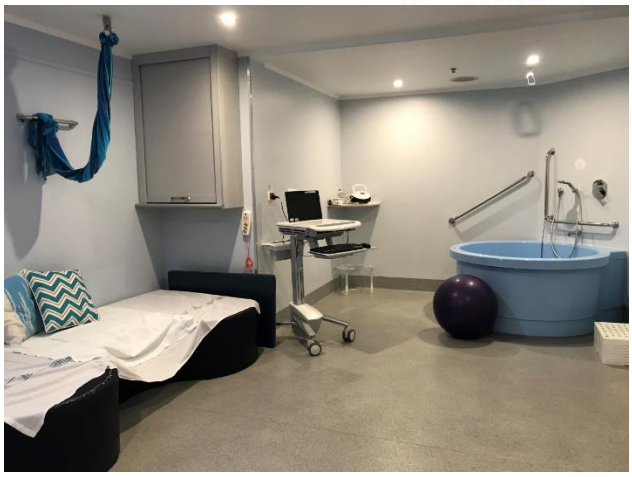
Puawai Aroha Maternity Unit is located at the Ormond Rd Campus of Hauora Tairāwhiti (Gisborne Hospital) next to the main entrance of the Hospital and consists of 5 birthing rooms, including an active birthing room with pool facilities and 8 post/antenatal rooms. We also have a whānau room. We had 676 births in 2018.

Reception area

Puawai Aroha Maternity Unit

Neonatal Unit

The Neonatal Unit is situated within the Gisborne Hospital maternity unit. The unit provides a Level 2 neonatal special care service. Two neonatal staff have completed advanced new-born life support education. The six-bed unit is modern and well equipped. The staff in the Neonatal Unit helps to support Maternity Services, assist with twin caesarean sections and the wider Women, Child and Youth services when needed.



Active birthing pool room

Neonatal Unit

Antenatal Clinic

The Antenatal clinic is situated in the Women's Health Clinic at Gisborne Hospital and consists of 2 clinic rooms and a reception office. Appointments are made by the Lead Maternity Carer caring for the woman directly to the dedicated antenatal clinic midwife. All core midwives have been orientated to the running of the Antenatal Clinic to ensure the service can be covered at all times.

Antenatal Clinic

Te Puia Springs Hospital – Ngāti Porou Hauora

Te Puia Springs Hospital

The birthing facility at Te Puia Springs Hospital is run by the Ngāti Porou Hauora Charitable Trust. It is about 104kms north of Gisborne. The hospital was established in Te Puia Springs in 1907.

There is 1 Lead Maternity Carer (LMC) midwives based at Te Puia Springs Hospital. She provides care to pregnant women from Hicks Bay down to Tolaga Bay. 36 babies were born in Te Puia Springs birthing unit during 2018. These numbers do not reflect the work that goes on in this small unit as women attend for antenatal appointments and often drop in if they have concerns about their pregnancy. Any women requiring more complex care are referred to the team at Puawai Aroha Gisborne Hospital Maternity unit and sometimes require transferring during or following the labour and birth.

Each year the team from Gisborne travel to Te Puia and run a PROMPT course. This is well attended by the hospital and community staff and the local ambulance crew and local GPs. This enables everyone to be more prepared for those challenging emergency events in a rural area and enables the women being transferred to Gisborne to arrive in a more stable condition.

This maintains a collegial and supportive relationship between the two units.

8.0 Our Maternity Services Workforce

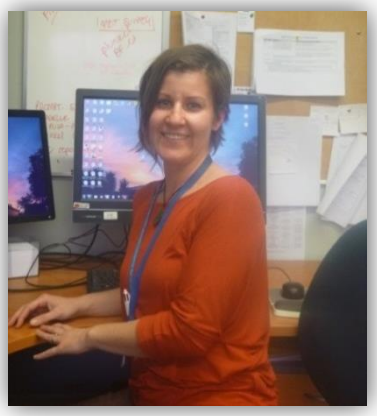
Director of Midwifery/Clinical Midwife Manager

Liz Lee Taylor has been the Director of Midwifery/Clinical Midwife Manager since 2017 and says it is a pleasure to come to work each day with such a positive team to lead and work alongside. Liz reports that the unit has grown so much in the past 9 years since she started here as the midwifery educator in June 2011 and continues to grow and improve.

Liz has remained committed and dedicated as a leader who ensures the maternity services are of the highest standards and meets the needs of our local population so that we can achieve the best outcomes for our māmā and pēpi in our community and Hauora Tairāwhiti. This is often reflected in the feedback we receive from our annual maternity consumer's survey. We also try to ensure that the workforce reflects the population it serves, with employed and LMC Māori midwives who help us to maintain cultural safety. Liz is also a deputy chair of the hospital Clinical Governance committee and a member of the Te Kahui Whakahaere (leadership group) and ensures a strong midwifery voice is heard. Liz is passionate about her role, her team and services and always has an open door for a friendly chat if any staff member or an LMC has any concerns they wish to discuss privately or seek advice. She takes any complaint seriously and will arrange to contact or see the complainant and/or whānau personally as soon as possible. Any learning outcomes from these discussions and/or meetings are shared and implemented.

Hauora Tairāwhiti offers flexibility to midwives who wish to return to work, such as fixed term reduced working hours when returning from maternity leave and the option to work in the antenatal clinic where the midwife can bring along her baby to work with her. We have a room for expressing and storage of breast milk for any staff member from maternity or across the hospital. All staff are attending training in 'Speaking up for Safety, which will enable them to effectively communicate concerns to colleagues about potential harm to any of our woman or babies.

Midwife Educator/Quality Coordinator



Iidil Merlini works hard to maintain the highest standards of quality and safety in the maternity services provided in Tairāwhiti and ensures all the team have access to the education and training they require to remain safe practitioners.

Iidil is also a trained lactation consultant and supports māmā and pēpi with breastfeeding difficulties in the unit and offers advice to the midwives and LMCs. She is also responsible for ensuring we maintain the BFHI standards and is now certified to insert Jadelle (LARC).

Core Midwives

We have a great team of dedicated core midwives employed by Hauora Tairāwhiti who provide primary and secondary care in a collegial and supportive environment. Hauora Tairāwhiti employ 19 core midwives, which is the equivalent of 13.9 full time positions, however with some recent changes in the workforce we are in the process of recruiting to current vacancies. We also employ 1 casual midwife who supports the team when required with part time midwives picking up extra shifts when required. All midwives work in partnership with the women of Tairāwhiti and their whānau, alongside their LMC midwives. The focus is on women centred care so that we always deliver high quality care to the woman and her whānau to maximise her birthing experience, health and well-being. All core staff are encouraged to submit a Quality Leadership Programme (QLP) portfolio with 85% achieving this. All midwives have an annual appraisal known as 'You Time" as the individual midwife will lead her appraisal with Key Result Areas (KRA's) developed and agreed. Every midwife has a minimum of one quality activity that they are responsible for and able to complete in 'downtime' or have protected time allocated on the roster. The workplace culture is reported to be very positive, with everyone working as one team with mutual respect and supporting each other.

Lead Maternity Carer Midwives (LMC)

LMC midwives provide antenatal visits regularly throughout a woman's pregnancy journey and refer to the Hauora Tairāwhiti obstetric team as needed. Visits vary between midwifery practice but usually occur monthly until around 28-30 weeks, fortnightly to 36-37 weeks and then weekly until birth. Most women attend their antenatal appointments in the clinic rooms where the midwives are based. Women and their babies are seen postnatally every day they are in hospital, within 24 hours of discharge from hospital at home and then a minimum of 5 home visits until 4-6 weeks postnatally with referral to Well Child Provider Plunket or Tūranga Health who continue visits from 6 weeks. We currently have 10 LMC midwives practicing in Tairāwhiti, who work in 3 practices based in Gisborne City and provide full antenatal, labour, birth and postnatal care to women in Tairāwhiti who may choose to birth at home or at Puawai Aroha. There are to be some changes within the practices but there will still be 10 LMCs in total who are able to provide the services required for our population. A focus for LMC's has been to increase the number of women booking with them in their first trimester of pregnancy, this is quite challenging but we continue to focus on this. We are slowly seeing positive results in this area with an increase in women booking with their LMC in their first trimester, especially now that LMCs can offer free pregnancy tests. We have a primary/secondary care hui arranged for next month to maintain and improve the relationship between our local GPs, LMCs, hospital midwives and obstetricians which will enhance the woman's journey through all of our services from conception to the postnatal discharge.

There is one midwife working up the East Coast based at Te Puia Springs Hospital in the small birthing unit. She provides antenatal, labour, birth and postnatal care to women living rurally from Tolaga Bay to Hicks Bay. These women may choose to birth at home or at the primary unit based at Te Puia Springs Hospital or come to Puawai Aroha Maternity Unit.

Obstetricians

We have 3 full time obstetricians working within Hauora Tairāwhiti, with 2 Heads of Department who job share a full time equivalent role, month on, month off. All are experienced practitioners and active members of their professional colleges. They provide specialist obstetric services to Tairāwhiti meeting the service delivery specifications and provide appropriate and timely advice to staff and management on obstetric matters, and on professional standards of practice. They all participate in the professional and quality assurance activities required of senior medical staff.

Dr Bill Weiderman, Dr Shireen Heidari, Dr Diane Van de Mark, Dr Sean Pocock. Not pictured – Dr Christina Dave

Perinatal Maternity Mortality Review Committee

The local Perinatal Maternal Mortality Review Committee has been supported by a coordinator who had attended national training each year. This quality role is currently vacant. A monthly inter-disciplinary meeting is held and includes event reporting and reviews of cases and an opportunity for clinical discussions and sharing of information which is well attended by the multi-disciplinary team.

Hauora Tairāwhiti Vulnerable Pregnant Women (VPW)

Maternal Wellbeing and Child Protection Multidisciplinary (MDT) Hui

Maternal Wellbeing and Child Protection Multidisciplinary (MDT) Hui

Aimee facilitates the VPW hui which involves taking interagency referrals for at-risk pregnant women. Group membership includes the VPW coordinator/Health Broker, VIP Coordinator, Paediatric Social Worker, a midwife liaison, Well Child providers Tūranga Health and Plunket, a teen parent school and house representative, the Oranga Tamariki hospital liaison, māmā and pēpi Kaiāwhina and a police representative.

The purpose of this group is to enable the best possible outcomes for women and their whānau identified to have vulnerabilities during the maternity care period (antenatal to six weeks post-partum). The role of the core midwife on the group is to confirm expected dates of delivery and previous obstetric issues to bring to the discussion plus obtaining and providing feedback to the LMC midwives in the community from other agencies supporting the woman.

The overall aim of the group is to strengthen whānau by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whānau in a culturally safe manner. We hold a fortnightly VPW MDT hui where we share information and review each case to ensure women are receiving the support they need. Once the woman births, checks are made to ensure the woman receives the safe sleep and shaken baby prevention education. Links to Well Child providers and community services are also put in place before the woman is formally discharged from the VPW hui/process.

Improvements 2019:

- All services are now sitting at the table for VPW MDT including police and community mental health that were absent prior.
- Stronger relationships have formed between services which has enabled smoother decision making around the safety of the unborn in support of the hapū māmā. Working with existing services such as the Children's Team has reduced the number of women on the VPW list, from 78 cases reviewed in 2017 to 29 cases reviewed in 2019.
- VPW are working with Oranga Tamariki's new kairaranga who's main role is to prevent baby's being uplifted into state care by searching wider networks for whānau and iwi placements
- There appears to have been a significant reduction in new-born uplifts

Health Broker Role

The health service broker shares information at the intersection of health, statutory care/authority and community social services. By gathering information from a somewhat fragmented health system, the broker helps piece together a picture of what is happening for whānau currently, what is needed and where the gaps in service lie. Information is gathered from DHB, NIR, oral health services, Well Child providers, public health nurses, ICAMHS, ACC, child development service and GPs. The broker contributes to decisions around escalating cases to police and Oranga Tamariki. The aim is to keep children safe and at the centre of any care plan.

As a registered nurse the health broker is able to assess what the most urgent clinical needs are and find the most appropriate referral pathway to meet these needs with a coordinated approach.

The Health Broker acts as a conduit in the feedback loop between services. She recently led a professionals hui after concerns were raised by multiple agencies around a child at a local kindy. The PHN and teacher concerns were around neglect. The GP had concerns around the mother's deteriorating health and her ability to care for her children. Agencies were considering a report of concern to Oranga Tamariki.

The Health Broker identified every professional in role including police and corrections and called them together to share information and inform a whole, holistic picture. Keeping the children safe and at the centre of the plan it was decided not to escalate to statutory care but instead to provide wraparound services. A professional was identified who had met with whānau and presented their voice at the hui. It was established that she would be the face of the team so as to reduce the number of 'cars up the driveway' and limit the chaos and confusion for whānau. Working with the whānau, professionals developed a plan which included respite care for whānau members. The result was a coordinated approach between services to lessen anxiety at a time of crisis. The team was able to advocate for the children to be in a safer environment with their whānau, supported and with protective factors in place.

Pelvic Physiotherapy Service 2018-19 Update

We have had a busy year trying to manage the many facets of work we do for both Women's and Men's health.

Our proposal and implementation of an educational class for antenatal PGP referrals in 2018 has not been as successful as we would have liked. The whole aim was to help manage referrals with the resources we had available. There was a lack of response from the women themselves as we tried to create self-responsibility to be proactive about booking into class and managing symptoms. We found the time spent by our Admin team contacting and booking and the number of attendances did not make this an efficient alternative to one on one Physiotherapy assessments.

We have suspended this class and returned to one on one contact by using outpatient Physios who have experience in this area to assist; most antenatal referrals for PGP are triaged and directed here. This also keeps our skills maintained if we have a staffing issue and I am away in future. I am currently mentoring one of our younger Physio staff members to continue her work within the obstetric area.

Therefore we now have potential ability to increase our presence in maternity again. We are working on what this will look like, to make sure anything appropriate for physiotherapy input is referred and will be seen in a timely manner. Examples are Post Caesarean with respiratory or mobility complications, 3rd and 4th degree perineal tear, bladder/bowel continence problems, PGP with mobility issues postpartum. This needs further discussion within both teams as to what is most effective going forward. We want to promote as much education around pelvic floor rehabilitation as possible for young postpartum mothers as this is the target area to engage with to protect or prevent pelvic problems as older women.

We are looking at reintroducing a booklet or handout that will have standardised pelvic floor information along with other general tips for the antenatal/ postnatal client, we are hoping to add information about exercise choices, a well-being bladder/bowel check list and how to seek help for problems, also add references to online sites that are evidenced based, recommended by either physiotherapy or continence associations and safe to use unsupervised.

We are continuing to strive to meet the needs of this health group as best we can.

Margie Humphreys
Senior Pelvic Physiotherapist
NZRP

9.0 Local Maternity Quality Improvement Activities (Closing the Loop)

Hauora Tairāwhiti Quality & Safety Initiatives 2018-19

Throughout the year we collect information on what we have done well, what we have done not so well and how we can implement improvements. This information is gathered in many ways. Some of the improvements are presented in the 'Highlights and Achievements' (section 6.0 of this report).

Multidisciplinary (MDT) Quality Meetings

Multidisciplinary Meetings are held every Wednesday morning and include Obstetricians, the Director of Midwifery/Clinical Midwifery Manager, Midwifery Educator and Quality Coordinator, Core Midwives, LMCs midwives, nursing and midwifery students, and sometimes guest speakers. At these meetings we discuss statistics for the previous week, significant incidents, the number of women offered support to quit smoking, share research articles and present any events which provide useful learning, such as cases which were well-managed and cases in which we could have done better. We also discuss any feedback from consumers. We make changes in our practice and amend our policies to reflect what we learn from these weekly meetings. In 2019 we have chosen to focus on reviewing cases of women being induced and cases of women not attempting a vaginal birth after a previous caesarean section: we want to ensure that women are making informed decisions and are supported to achieve their best outcomes.

Case Reviews

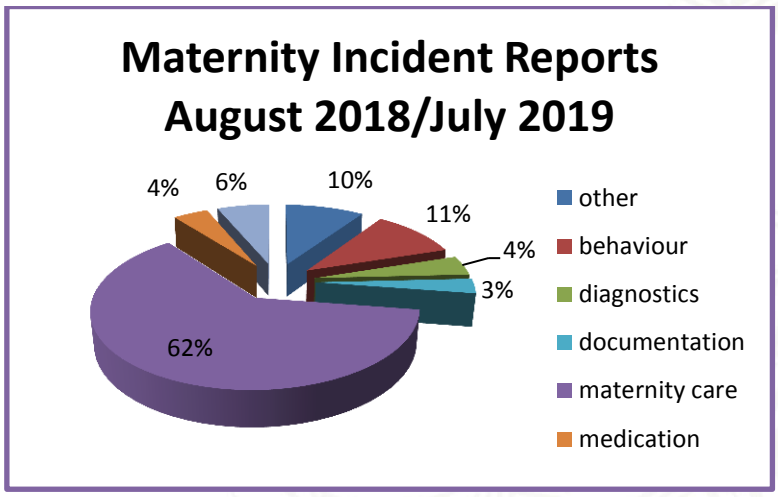
In addition to the weekly meetings, significant cases are also reviewed by the interdisciplinary team and include the woman/whānau/family affected. We act on the learnings from these case reviews and report them back to the woman involved and also report significant findings to the Hauora Tairāwhiti Clinical Governance and Maternity, Quality and Safety committees and present learning outcomes at the Perinatal meeting.

Examples of practical learning outcomes from case reviews over the last 12 months:

- Postnatal discharge letter/summary needs to include relevant information for ongoing care by GP as well – this is part of the work being done to implement locally the hypertension in pregnancy national guideline
- Guideline for antenatal anaesthesia consult currently only addresses BMI and not actual weight, this is due for review. The HoD of anaesthetists has been asked to contribute to this update. If weight 100Kg or more then woman should be on a hovermat if going to theatre or at high risk of doing so.
- Preference is for IV cannulas to be placed on the hand/wrist/forearm as this is more stable and less subject to kinking than the antecubital fossa. If emergency situations arise then infusions are inserted in the easiest part of arm.

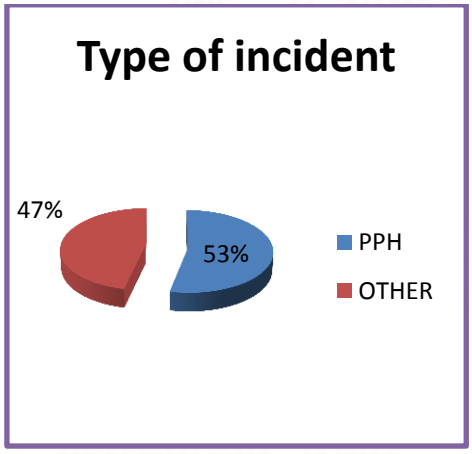
Clinical Incident Reports

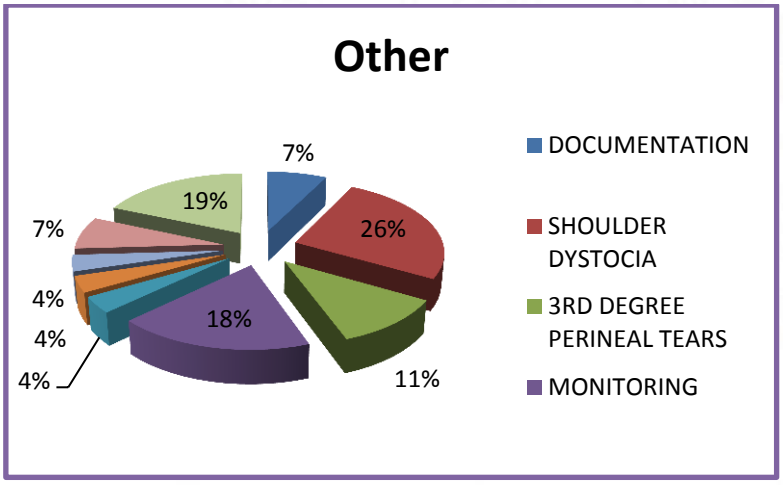
Staff are encouraged to report all incidents and near misses which we could share and learn from. In the last 12 months 98 incidents have been reported for maternity into the DATIX system. Anonymised details of incident reports and outcomes are shared during weekly MDT meetings so that the learning points can be of use to the whole team.



These reports are also used to identify trends or issues which may require particular attention or quality improvement projects.

Within the Maternity Care incident reports (which account for 62% of all maternity incident reports for the 12 months 1.8.18 to 31.7.19), the largest single issue reported continues to be post-partum haemorrhage (PPH). In the first half of 2019 we will be auditing our PPH rates to assess the impact of measures put in place in early 2018 to address what we perceived as being higher than expected PPH rates.





Guideline Group

A group of Obstetricians, the Midwifery Educator and Quality Coordinator, a Core Midwife, a Neonatal Unit Nurse, Neonatal Unit Clinical Nurse Manager and a Community Midwife (LMC) meet monthly along with a consumer representative to update the evidence based guidelines which all of those using our Maternity Unit and Neonatal Unit can follow. The group has worked hard with continued commitment to providing up to date evidence based guidelines and implementing national guidelines. In the 12 months from August 2018 to July 2019 35 guidelines have been reviewed and updated, which represents just over 30% of all of our current guidelines. We have also seen access to the guidelines be made available on the public DHB website, this has allowed local LMCs to refer to guidelines when providing care to women in the community and LMCs have told us they find this a very useful tool.

Neonatal Encephalopathy (NE) Taskforce

DOM and Project Leader were invited to join the NE taskforce working groups for Fetal Monitoring and Growth Assessment Protocol and are now active members of these groups working nationally.

Compliments and Complaints

We encourage consumers to feedback any comments they may have about their experience in our Maternity Unit. All these remarks, whether they are compliments or complaints, are fed back to the team during our Multidisciplinary weekly meetings and any issues identified are addressed straight away. By reviewing these and identifying themes we are able to inform decision making to improve our consumers' experience in maternity.

Annual Maternity Consumer Survey

This survey was designed to identify patterns/trends in the provision of maternity services at Hauora Tairāwhiti in order to guide further improvement and to ensure the needs of the local population are met, by identifying barriers to care and other issues. This survey seeks to find out women's perception of the care they received as well as their recollection of the information and advice given, some of the results may therefore not be a direct reflection of the information offered by health practitioners, but of that which women retained. The Maternity Services Survey questionnaire is adapted and updated by Liz Lee Taylor, DOM and CMM with discussion with our two maternity consumer leaders Jess Pomare and Jess Claffey, responses are collected by the consumer leaders as well as maternity unit staff. During the month of April each year, all women admitted to Puawai Aroha Maternity Unit are asked to complete a survey; the results are then collated and reviewed by Iidil Merlini, Quality Midwife.

Summary of findings

The Maternity Services Consumer Survey team has made a concerted effort this year to improve the survey response rate and been very successful achieving a 25% increase. This is commendable particular in light of the remarkably high acuity and activity levels through the month: in April 2017 42 babies were born in our unit; in April 2018 the number rose to 58, and we remarked on the increased activity level and the possible impact this had on survey outcomes. In April 2019 79 babies were born in our unit: almost twice the number born in the same month 2 years ago.

The age distribution for the 2019 respondents is very similar to the 2018 cohort, however, the extremes have widened with the youngest being 17 years old and the oldest 41 years old compared with 19 and 38 years old respectively. Potentially of note is also the increase in the <20 from 3% in 2018 to 14% in 2019.

Women felt their religious and cultural beliefs to be overall very well respected with a slight improvement for women who do not identify as Māori.

Antenatal classes attendance has dropped again: from 55% of respondents in 2017, to 40% of respondents in 2018 to only 23% in 2019. As well as an increase in the proportion of respondents stating they had already attended classes in the past, it is likely that a strong contributing factor to this low attendance rate was the temporary reduction in available classes for the last quarter of 2018. Hapū Wānanga programme commenced January 2019.

There appears to have been no improvement in the smoking cessations discussions antenatally: as in 2018, only 47% of women recall having these conversations antenatally, and 18% report having received advice to quit postnatally. Smoking cessation conversations and support must be an area of focus for all the maternity services providers in Tairāwhiti as addressing the rates of smoking would be a step closer to improving numerous other health outcomes.

On average women accessed similar resources to confirm their pregnancy as they have in previous years. Of note, remarkably less women in 2019 reported knowing that midwives provide free pregnancy tests (60% in 2017 vs 30% in 2018).

The women who birthed during April reported having more difficulties in finding a midwife to book with and this has had an impact on women's early engagement with midwifery care: 54% of the 2019 respondents first saw their midwife at <12 weeks gestation vs 66% of the 2018 respondents.

Women were overall very pleased with the care received from all professional groups during their pregnancy, birth and postnatal period and there is a marked improvement in both women feeling involved in all decision making during labour, knowing who was responsible for their care at all times and feeling that their partner and/or whānau were involved with the care of baby.

Family violence screening has improved remarkably from 66% of women in 2018 to 79% in 2019 reporting that at some point during the antenatal, intrapartum of postnatal period, they had been asked whether they felt safe.

Some feedback from women:

Thanks for everything staff in birthing unit (maternity ward) & my midwives.

Flyer suggested in maternity unit for Plunket and Tūranga Health – explaining what they do and photos of themselves

Keep up the good work you all do at the maternity

Enjoyed my labour and birth

I would like to say thank you to the staff midwife (name omitted) & to my midwife (name omitted) for delivering my baby girl on 14th April @ 12.06 pm weight 7 pound 6.5 oz and to the rest of the staff for help and support while recovering from giving birth

A special thanks to (name omitted) and all the staff who were – and have been – looking after my babies, partner and I while we adjust to the changes and get a hang of things. We really appreciate everything

It was a pleasure to meet all the midwives thank you for me and baby

Great service

Wonderful staff. Respectful and expert care was given.

Very lovely staff, thank you so much

Every single staff member we came in contact with has been amazing. So helpful, friendly and supportive of our decisions. Have had an awesome experience here, thanks to everybody in maternity

The support and care from the nurses was outstanding, felt very happy and safe and at ease. Thank you so much

Excellent care, couldn't fault anything. Extremely grateful for a beautiful birth experience

Thank you so much for your guys care and efficiency when it comes to everything that needs to be done with labour and after care. The staff here are amazing and so caring I'm so thankful for your staff being the people they are here. Best experience ever wouldn't want to be anywhere else to have my children

Getting free Wi-Fi for us mothers would be great as we are up most of the night

Enjoyed all support given and can't thank you enough

Awesome midwives and staff, felt very well looked after, thank you.

Implementing Care Capacity Demand Management (CCDM) and Trendcare

The CCDM Programme is a set of tools and processes that help DHBs better match the capacity to care with patient demand. The goal is quality patient care, quality work environment and best use of health resources. This programme is to be implemented in all DHBs by mid-2021

There are 4 key aspects to CCDM:

CCDM GOVERNANCE

CCDM governance is a permanent operational structure with processes and tools for achieving safe staffing and healthy workplaces. Governance happens at all levels of the organisation in partnership with health unions.

CORE DATA SET

The core data set is a set of 23 measures. Equal priority is placed on quality patient care, quality work environment and best use of health resources. Staff from all levels of the organisation use the core data set. Different groups monitor the core data set and reporting flows up and down.

FTE CALCULATION

The FTE calculation is a systematic, validated method for generating a recommended roster and budgeted FTE. TrendCare data from the past 12-months is used to establish an acuity based staffing model. The calculation includes the MECA entitlements and allowances. The FTE should be re-calculated annually.

VARIANCE RESPONSE MANAGEMENT

Variance response management is a set of tools and processes for organisational visibility of care capacity demand management. This includes an operations centre, electronic screens, staffing early warning system and standard operating procedures.

Trendcare

TRENDCARE is the validated acuity tool used to gather data to inform CCDM.

TrendCare has been in use in maternity for about a year but there is now an increased focus on accurate use with the aim of access to 12 months of clean data by the end of 2020. TrendCare is now monitored daily to ensure staffing as well as patient acuity is being accurately gathered and safe staffing maintained. A new escalation plan has been developed and is now available to use when required.

Maternity has some special requirements and we now have a CCDM project coordinator to ensure these needs are met and to contribute to the overall DHB project.

Introducing the Maternity Early Warning System at Hauora Tairāwhiti

Introducing the Maternity Early Warning System (MEWS) at Hauora Tairāwhiti

We are in the process of introducing the new national MEWS at Hauora Tairāwhiti. Acute deterioration can happen at any point during a pregnant woman's admission to hospital. If staff recognise acute deterioration early and respond to it appropriately, they can improve the outcomes for women by avoiding or limiting severity of morbidity. The maternity vital signs will be recorded for any pregnant or recently pregnant (within 42 days) inpatient woman requiring observations. As we use the electronic records (MCIS), the chart is to be installed in this system and used for women whilst in maternity, whilst a paper chart will be used for women if admitted to any other area in the hospital. The local escalation pathway has been developed and agreed locally in July 2019. The chart and escalation pathway has been socialised throughout the hospital during June, July and August. The next steps will occur over the coming months with full implementation aimed for the end of November. An on-going audit will then commence to evaluate the success of this implementation.

Mandatory Escalation Pathway – Maternity Hauora Tairāwhiti		
Maternity Early Warning Score	(MEWS) Action	
MEWS 1-4	Manage pain, fever or distress. Increase frequency of observations	MATY -Inform shift coordinator. ED/Adult wards - Inform SC. Consult with Maty SC
MEWS 5-7 _____ Acute illness or unstable chronic disease	Manage pain, fever or distress. Increase observations to at least every 30mins.	MATY - Inform SC (and/or CMM if available) to discuss & review. Consult HO or O&G to review within 30mins ED or Adult wards - Inform SC and/or DNM. HO/ED SMO to review within 30mins, **Consult with Maty SC for advice**
MEWS 8-9 or any vital sign in pink zone _____ Likely to deteriorate rapidly	Manage pain, fever or distress. Increase observations to at least every 15mins.	MATY – Inform SC (and /or CMM if available). Consult O&G immediately. ED or Adult wards - Immediate HO/ED SMO review. Reg review within 20mins or SMO review within 30mins if Reg unavailable **Consult with O&G on call for specialist advice.**
MEWS 10+ or any vital sign in blue zone _____ Immediately life threatening critical illness	All areas: Support ABC and provide manual uterine displacement if visibly pregnant Call 777 – Maternal Collapse	

Hypertension Guideline

A project group has worked on the implementation of these guidelines, including representation from the primary care liaison, maternity consumer representatives, LMCs, O&G and maternity. The recommendations around clinical care of the woman while in hospital have been implemented and plans updated. Our process for discharge summaries has been improved so that affected women, their LMCs and GPs will all receive a summary and follow up plan for postpartum care. An education evening 'Primary and Secondary Maternity Service Providers hui' has been organised for 16th October 2019 so that we can update GPs on clinical care in the community including risk factor assessment, recommendations for aspirin and calcium and the need for psychological care and support. The biggest challenge in implementation is that there are additional expectations of non-DHB community providers – LMCs and GPs – with no additional funding attached. In particular it is proving challenging to identify funding for the additional blood pressure monitoring post-partum which is now considered best practice. Our consumer representatives and the wider team are of the view that this is best done in the community or home by the woman's LMC. We continue to work on resolving this issue. A researcher in women's health from Victoria University of Wellington is completing her PhD on the implementation of this clinical guideline and we are one of her study sites.

Improving technology in maternity services

Hauora Tairāwhiti was one of the first in New Zealand to adopt Badgernet, the Clevermed Maternity Clinical Information System (MCIS). Instead of entering information about a woman's pregnancy on paper notes, this is a computer data collection system. Laboratory reports, ultrasounds results and notes about the woman's antenatal care, labour and birth are all recorded in her computerised record. The aim is to provide a centralized record of care across the entire pregnancy, which should improve outcomes. Records in MCIS can also be accessed for audit purposes and quality control. The woman's records can also be accessed at other DHBs who have also implemented MCIS should the woman attend there for care at any point in her pregnancy. We have already seen the benefit of this on many occasions.

We are about to complete 5 years using the Maternity Clinical Information System. We remain one of few DHBs having fully adopted the system and we remain heavily involved in its continued development.

This past year has seen considerable developments in several areas of documentation, in particular: a fluid balance record and chart, a comprehensive epidural observations chart and the development and finalizing of the Maternity Early Warning System (MEWS) chart to allow implementation of the HQSC National MEWS programme.

We have also seen the development of a booking information interface between Badgernet and other platforms: this allows information recorded by LMCs in other, community based, and electronic systems to be shared with the hospital electronic record. Only a limited number of details can currently be shared this way but this work is progressing towards the full booking information being shared.

Work is nearing completion on an interface between MCIS and our cardiotocograph (CTG, used to monitor babies' heart beat and mothers' contractions) monitors – this will allow the automatic upload and storage of this information to the electronic system, allowing clinicians to review the information without being at the bedside but also allowing safer storage of this information for longer as the paper print outs fade and perish.

Some work has also been happening to strengthen the working relationships between DHB, Badgernet and the Midwifery Maternity Provider Organisation (MMPO) who provide and maintain the community based Badgernet application.

Work is also underway with the Information Systems department at the DHB to develop further interfaces with other current systems in use in the DHB to allow for more efficient communication and information sharing with other disciplines and with primary care.

Compiled by Iidil Merlini, Midwife Educator and Quality Coordinator

The Growth Assessment Protocol (GAP)

The GAP programme was first implemented at Hauora Tairāwhiti in 2016 with the aim to reduce stillbirth rates by increased detection of small for gestational age (SGA) babies. It is based on three main elements

1. Training and accreditation of all staff involved in clinical care
2. Adoption of evidence based protocols and guidelines
3. Rolling audit and benchmarking of performance

Saving Babies Lives in New Zealand (SaBiNZ) is a project to ensure the robust implementation of the GAP programme in all District Health Boards across New Zealand. SaBiNZ provided an excellent opportunity to appoint a core midwife to be the designated clinical lead who will work in collaboration and be responsible to the NZ GAP lead, supported by the Perinatal Institute in the UK. The role is funded by ACC to support local implementation of the GAP programme, which is part of the ACC neonatal encephalopathy reduction strategy. Cascade training was introduced as a refresher update to core midwives, LMC's, obstetrician and sonographers. Cascade training is face to face and scenario based, refresher training ensures all staff correctly utilise the GAP programme including risk assessment, detection and correct management with the aim of improving outcomes.

The role fulfils critical functions:

- Plan, implement and evaluate SaBiNZ project
- Training multi professional staff in the GAP programme
- Facilitate baseline audit data collection of all births to identify SGA, referral and detection rates prior to full implementation of the programme
- Implement the standardised clinical outcome review and evaluation audit of missed SGA cases on a six monthly basis
- Liaise with the New Zealand specialist midwives and GAP lead on a regular basis and provide updates on progress
- Monitor any service provision issues

Management of SGA babies is guided by the New Zealand Maternal Fetal Medicine (NZMFM) Small for Gestational Age Guideline. Developing a local version of this guideline is underway with specific resources that are relevant to the community and services.

Compiled by Kendra Mackey, Midwife & GAP Champion

Audit Outcomes

Elective Repeat Caesarean Section Audit for 2018

Review of Gisborne Hospital statistics from 2017-2018 showed an increase in overall cesarean sections from 19.4% of total births to 25%. Of these 56 were elective cesarean sections (CS) in 2017 and 69 elective CS in 2018. While there are factors contributing to elective CS that cannot be changed, the goal of this audit was to identify any modifiable trends toward elective repeat cesarean section instead of trial of labour with potential for VBAC. **36 women with a history of only one prior CS underwent elective repeat CS at Gisborne Hospital last year**. Each of these cases was reviewed and the findings summarized below. Women who had prior normal vaginal births (NVB) and vaginal births after cesarean section (VBAC) were looked at individually as these women had the highest chance of a successful VBAC if trialed. Cases that I feel had good potential for successful VBAC are noted in bold type.

Further observations:

3 women had a relative contraindication to VBAC. 2 had a history of pelvic fracture or hip abnormalities, and one had a breech infant that was IUGR (final weight 2660 gm).

8 had complicating medical or fetal conditions that came with recommendations for delivery before or by due date, precluding any option for longer expectant management. 2 developed severe PET and were delivered before 37 weeks, one of those with twins. 2 more were IUGR, 1 chronic hypertension, 1 poorly controlled diabetes, 1 other set of twins with SGA. 1 was AMA at age 45 as noted above. **1 had suspected macrosomia which turned out to be inaccurate.** An audit of ultrasound results for estimated fetal weight over a six month time period was done as a result.

Conclusion:
Of the 36 women who had elective repeat c-sections when not in labour, only 5 appeared to have good potential for VBAC had they laboured prior to c-section and agreed to TOLAC. Strategies for improving chances for TOLAC include continued safe expectant management until the 41st week of pregnancy. Stripping of the membranes, or cervical "sweeps", has been shown to increase rates of spontaneous labour. Starting sweeps from 37 weeks on in these women who do not have an option for induction of labour may increase their chance for TOLAC.

Refer to appendix 2 for full audit report.

Preterm Delivery Audit (for Calendar Year 2019)

An audit was undertaken to identify all preterm deliveries from Jan 1 2018 through 31 December 2018. Forty nine mothers delivering 57 preterm infants were identified on MCIS during this time frame. The preterm delivery rate for 2018 was 8.4%, an increase from the 5.3% rate seen in 2015. Two deliveries were inductions for intrauterine fetal demises and one was an induction for Trisomy 13. Eliminating these three preterm deliveries gives a preterm delivery rate of 7.9%.

Conclusion:
As per most audits at Hauora Tairāwhiti, low numbers make interpretation difficult. The audit does show that we are efficient at transferring women with preterm labour between 23 6/7 and 31 6/7weeks to Waikato. Only two women delivered here between those gestational ages, one with chorioamnionitis and one with PPROM and rapid onset of labour. But compared to the preterm audit of 2015 our preterm delivery rate increased from 5.3% to 8.4%, our median BMI rose from 24.8 to 28.1, the use of tobacco rate rose from 32.4% to 41% and our attendance in Antenatal Clinic of those referred for prior preterm delivery declined from 57%

to 40%. On the positive side, combining the audits from 2013, 2015, and 2018 our overall preterm delivery rate for the three years audited was 6.9%, in line with the historic 2000-2010 Hauora Tairāwhiti rate of 6.3%.

As with many of our adverse pregnancy outcomes in Tairāwhiti, early registration with an LMC, early referral to Antenatal clinic, and effective counselling for modifiable lifestyle factors could improve the preterm delivery rate. We should continue to work on those areas where we can make a positive difference in outcome for our women.

Refer to appendix 3 for full audit report.

Twins Delivery Audit (2015-2018)

In 2014 and 2017 audits were performed on all twin deliveries that took place in Gisborne Hospital. The initial audit in 2014 looked at twin deliveries from 2009 to 2013 which showed that the caesarean delivery rate was 78%. This was much higher than what was found in review of literature, which suggests approximately 60% of twin pregnancies have caesarean deliveries. The findings of this audit led to several practice changes which included recommending that twins that are cephalic/non-cephalic that deliver in theatre rather than labour rooms and having a lower threshold to have a second obstetrician in attendance.

A second audit was done in 2017 looking at the twin deliveries in 2015 and 2016 to determine if these practice changes affected our caesarean delivery rates. The findings from the 2017 audit showed that significantly fewer women had caesarean deliveries in 2015 and 2016 – 50% compared to 78% in 2009 to 2013. This finding was particularly pronounced for cephalic/non-cephalic presentations which had a caesarean delivery rate of 37% (down from 87%). But, we also saw a decrease in caesarean deliveries for cephalic/cephalic presentation with a caesarean rate of 30% (down from 50%).

This audit is a follow-up to see if these practice changes continue to affect our caesarean delivery rates of twin pregnancies delivered at Gisborne Hospital in 2017 and 201

Conclusion:
Women pregnant with twins are much more likely to have a vaginal delivery at Gisborne Hospital than they were prior to 2014. Combining data from the 2017 audit with 2017 and 2018 data, we continue to see that significantly fewer women had caesarean deliveries in 2015 to 2018 – 65% compared to 78% in 2009 to 2013. Everyone that was eligible for a trial of labour was offered one. Vaginal delivery for cephalic/cephalic twins much more likely now (75%) compared to prior to 2014 (25%). And when trial of labour is attempted – success rate is 85% overall!

Refer to appendix 4 for full audit report.

Nulliparous Induction Audit 2018

Inductions of labour for nulliparous women are important for several reasons. Obviously the goal is to have a healthy mother and baby. Ideally these will be achieved in a way that does not limit a woman's options in future pregnancies. For most women a normal delivery is the preferred outcome. Inductions of labour for nulliparous women often take some time and are quite resource intensive. For most women the ultimate goal is to achieve a normal delivery in the most efficient way possible. Ideally this would be during the daytime or early evening when hospital resources are most easily mobilized.

We conducted an audit of all nulliparous women who were induced at Gisborne Hospital in 2018. The goals of this audit were to get a better understanding of the indications for induction in this population as well as

outcomes. Additionally, it was hoped that we could obtain some insights into our methods and identify areas that could be improved. Given the low number of deliveries at Gisborne Hospital, we recognized that it will likely be difficult to draw firm conclusions about some of these issues.

Conclusion:
We were surprised to find that 31% of nulliparous women who deliver at Hauora Tairāwhiti have inductions. However, overall it is reassuring that all of the women had clinical indications for their inductions. The overall c-section percentage of 30 for these women does not see unreasonable as percentages higher than this are quoted in the literature.

When we look at our results in a stratified way we have to remember that our numbers are small and we need to be careful with our conclusions. PROM outcomes are as expected. The c-section percentage was 27. It is interesting that time to delivery was much faster with oxytocin than with Cervidil. Perhaps we should consider using oxytocin as the first line induction agent for women with PROM. Especially as 40% of the women who received Cervidil initially still needed oxytocin.

As is appropriate, all of the women without PROM, had cervical ripening since they all had unfavourable cervixes. At least initially, none of them received oxytocin with unfavourable cervixes before Cervidil was tried. Cervidil was the initial ripening agent for all of these inductions. Thirty-five percent laboured on Cervidil alone. A further 26% had favourable cervixes after one dose of Cervidil. So one dose of Cervidil was successful in achieving at least cervical ripeness for 61% of women. The average time to delivery for women who laboured on Cervidil was 14:36. This could have implications for what time of day we place Cervidil. They had a c-section percentage of 22. For the 26% who didn't labour after 24 hours of Cervidil, but had cervixes favourable for oxytocin, the c-section percentage was 29. As is logical, the average time to delivery increased to 26:26. Of interest, the average time on oxytocin was 9:04. This means that, on average, if women with favourable cervixes have oxytocin started first thing in the morning they have a good chance of delivering during the daytime. This is advantageous as daytime deliveries, especially on weekdays, have the lowest risk of complications while using fewer resources. Of note, one woman (4%) had hyperstimulation on Cervidil and had an emergency c-section in early labour.

As is true everywhere, the labours that are hardest to manage are for the group of women who do not respond to the initial ripening agent. For the 35% who did not respond to Cervidil, the average time to delivery was 35:18. This does not include the increased time for the two women who had their inductions paused after a second dose of Cervidil. Given our small numbers it is difficult to say what is the best way to proceed for these inductions. Giving a second Cervidil or starting oxytocin were not particularly effective and, an average, lead to longer inductions. However, we didn't use other methods enough to clearly establish which one is better.

All in all this audit reassured us that we have reasonable outcomes for labour inductions for nulliparous women. We may want to consider how we manage PROM and what time of day we start inductions. We will also discuss how to proceed with women who don't respond to the initial cervical ripening agent. We will also continue to work on the time initiation of oxytocin for women with favourable cervixes.

Audit Action Plan:
As above, this audit has given us some things to think about. However, it's overall purpose was to characterize our situation rather than to establish a baseline for change. If we do decide to make any significant changes it would then be worth repeating the audit in the future.

Refer to appendix 5 for full audit report.

10.0 Supporting our Māmā & Pēpi

Pregnancy & Parenting Education – Hapū Wānanga

Hapū Wānanga o Te Tairāwhiti is an antenatal education curriculum, developed by Maori midwives of Tairāwhiti. Holly and Christina Casey have developed a programme as there is a need to provide culturally appropriate education, relevant to the birthing population of Tairāwhiti. These wānanga will aim to provide culturally safe pregnancy and parenting education for women and their whānau. The wānanga was been developed in accordance to the MOH maternity services-DHB funded- Pregnancy and Parenting Information and Education tier level two Service Specifications, 2015.

The programme (wānanga) was inclusive to all women who have either been referred by health care professionals, LMC practices or self-referral. We aimed to attract 20-25 women per month to attend these wānanga.

Addressing inequities in maternal health

The programme had a strong kaupapa Maori foundation, acknowledging Maori and Pacific Island whānau and facilitating the protection of the partnerships and therefore maintaining trust and relationship with our most vulnerable whānau/families within Te Tairāwhiti, though not being limited to.

The programme aimed to reduce the inequalities in health outcomes amongst Maori, Pacific Island and vulnerable whānau, with a focus on the reduction of the prevalence of smoking, SUDI, teen pregnancy, breast feeding statistics, domestic violence and drug and alcohol abuse. It emphasised the importance of uptake of health care by our most vulnerable whānau and aim to reduce/remove the barriers in accessing health care. These were achieved through recognition, discussion and offering referral to social services within our communities.

The programme was facilitated in a holistic manner, where Maori Models of Health care are incorporated into the curriculum and the delivery of content, such as Te Whare Tapawha, and Te Wheke. These models of health are well known and we acknowledge not only the benefits of holistic care to Maori, but all ethnic groups, such as Pacific Island, European, and Asian etc. By implementing such models of health care, we acknowledge all aspects of a woman/client and their whānau. Thus being physical health, emotional health, mental health and whānau health.

As midwives, our practice is also guided by the Tūranga Kaupapa, established by Nga Maia to guide the application of culturally competent care, although this is developed with a Kaupapa Maori framework or view we acknowledge that it is not limited to the application to Maori only women/whānau, and will ensure all attendees receive holistic care.

We have great networks within our communities through working with vulnerable whānau and the community services required to encompass our most vulnerable whānau/population groups, these who identify as, but limited to low socio economic, teen pregnancy, high risk social whānau. We tailored the classes to suit the requirements of the whānau attending.

Linking ways of working

Maternity Consumer representation - current maternity consumer leads were linked to antenatal classes so women were aware of who is representing them as the consumer and how they can access or have communication with consumer representatives.

Social services such as vulnerable pregnant woman social workers, having a link between the social workers and the women. The women are more aware and educated on what the VPW group is able to support and assist women/whānau. Family Violence screening and relationship services such as counselling will be available for women and whānau to be aware of who provides this service.

Whānau Ora programmes such as E Tipu E Rea, Māmā & Pepi, PHO's Maori health Tūranga Health, Ngāti Porou Hauora and Hauiti Hauora being the three main PHO's in our region. SUDI programmes, Takakura and safe sleep initiatives, Healthy homes and other relevant services in the community that are working alongside the woman and her whānau.

Teen Parent services, Te Aka Ora teen parent home and Te Whare Whai Hua teen parent school for women who identify as teen parents. How teen parents can access this service.

Drug and addictions and maternal mental health services such as Te Hiringa Matua, Te Kuwatawata, explaining and educating women and whānau who may need to be referred to these services, so woman feel safe to engage. Being clear of the current maternal mental health pathway and process.

Smoking cessation services, having links and a referral process through the current smoking cessation providers, using the referral pathway that captures statistics of the Tairāwhiti region, as well as providing cessation support or referring to a cessation provider.

NGO's including the Ministry of Social development, IRD, Smart Start Services to link MSD services, Housing New Zealand, Oranga Tamariki and how we can link women and whānau into these services as needed.

Well Child Providers/Tamariki Ora- Nurses and Kaiawhina were aware of the programme and how we link the parenting classes into a post-natal module to support and educate women and whānau postnatally. Tūranga Health Tamariki Ora nurses and Plunket Nurses, working alongside to link women into these services.

Lactation consultants - community and hospital LC services, these will be linked in the woman's care and the breastfeeding journey, aiming to improve breastfeeding statistics in Tairāwhiti, in particular in Maori and Pacific Island women and babies.

Postnatal screening such as audiology, oral and dental health, immunisation education, linking women and babies into these services to prevent baby's being missed.

Contraception- Having open discussion of options of contraception, what is available, what is subsidised and where women are able to access contraception such as the community clinic, GP, Practice nurse, gynaecologist, LMC, an opportunity to educate women on woman's health, including smears informing women of the importance of her health.

Yoga instructors and physiotherapy, diet/nutrition and exercise, being aware of the hospital and community services that provide these to women postnatally.

The first Tairāwhiti Hapū Wānanga for 2019 was an informative, success. We had 14 women registered on this wānanga, 8 (60%) attended with their partner's and support people, in total over the two days 14 people attended in total over the two days, which made the class's small but interactive.

Of those who attended, 8 (60%) were of Maori ethnicity and 6 (40%) were of NZ European ethnicity.

Day one involved whakawhānaungatanga (getting to know each other), day one covered pregnancy, labour and birth. This was facilitated by Holly.

We started with karakia and whakatau- welcoming everyone to our first Hāpu Wānanga for the year.

Interactive games and group work started our day, with a power point of slides to follow. This gave the couples a chance to get to know each other, in group work around a circle table. Good discussion and questions about pregnancy stages, being healthy in pregnancy and keeping active were a big component of the morning.

Day two covered everything postpartum. The morning consisted of the life of new born, group activities of what changes baby needs to make, hormonal changes for mum and baby, skin to skin and breastfeeding, baby examinations, roles of support people and partners, what mum's expectations are of their support person etc.

We talked about the well child services in the Tairāwhiti, Plunket and Tūranga Health, immunisations and the immunisation schedule, GP registration, audiology and oral health. Pamphlets and resources were given to the couples.

The dads were involved to talk if needed, especially as they were new dads, we gave out ''dad's resources''. For future classes we would like to consider inviting fathers to come in and talk to the dads about their experiences, fathers are often forgotten.

We got to have a tour of maternity before lunch. The couples were able to look through all the rooms and be familiar with the unit.

Ngā mihi
Holly and Christina Casey

Tūranga Health Māmā & Pēpi Service – addressing the needs of our local population

Te Hauora ō Tūranganui a Kiwa Ltd
Turanga Health
Kia Whai Oranga-a-Whānau Mō Ngā Whakatipuranga
Building family wellness for future generations

Tūranga Health provides kaiāwhina support to hapū māmā and whānau. This happens at any time whilst a māmā is hapū and may continue after baby is born. All māmā referred to Tūranga Health Māmā and Pēpi service are visited by kaiāwhina to complete registration and an initial assessment. The registration process affords the opportunity to ensure all māmā are registered with an LMC, a primary practice and that they have access to transport to

appointments with their LMC or Obstetrician. From the assessment, needs are identified and an agreed plan is established with whānau. The plan may include:

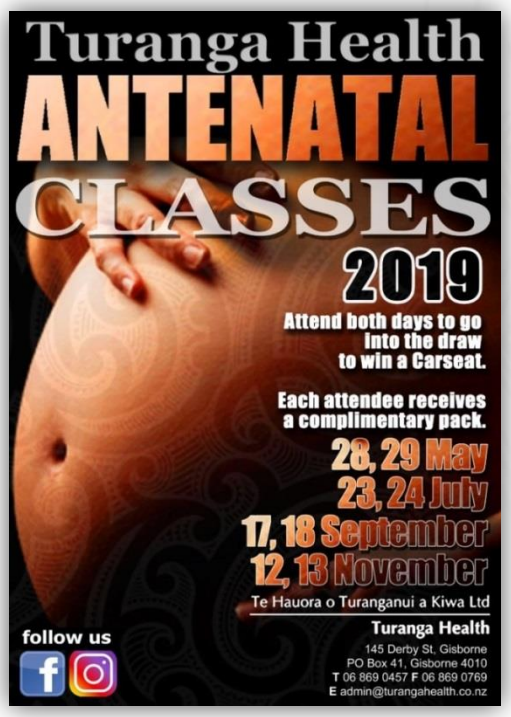
- Smoking Cessation support
- Healthy Homes kaiāwhina support
- Hapū māmā oranga niho programme
- Wahakura workshop
- Child Restraint access
- 2MEKE/ Mums n Bubs classes

Whānau are able to discuss further access to resources through E Tipu E Rea and Little Sprouts.

Attending Antenatal wānanga is also an option for the care plan for whānau. Wānanga occur bi-monthly across two full days covering a variety of topics and interactive activities. Hapū māmā and whānau can access the wānanga through a variety of pathways including their LMC, social media, whānau and friends.

Each year 70 -80 hapū women and up to the same number of whānau attend the wānanga. Up to 90% of those attending identify as Māori with the largest age group falling between 16 – 25 yrs.

Evaluation of the sessions continues to indicate interactive activities are the most popular. We are constantly reviewing the wānanga to reflect this feedback.



Antenatal education and postnatal care space creates real time useful links and relationships between the primary and secondary space that can have a positive effect. Hauora Tairāwhiti midwives present at antenatal wānanga with current experience and the māmā/whānau may see her when they give birth. Pregnancy Immunisations are offered at Antenatal wānanga as an additional wrap around service.

The Tamariki Ora team includes Well Child Tamariki Ora nurses who work alongside the Māmā and Pēpi kaiāwhina. This provides a holistic, seamless transition from the prenatal stages to postnatal.

Mokopuna Ora SUDI Prevention Safe-Sleep Programme

The past year has seen the development of programmes and agreements with community based Māori provider services to deliver wānanga to weave a wahakura. While whānau are attending the wānanga there is opportunity to provide health promotion and education regarding safe-sleeping pēpi, breastfeeding, smokefree whānau and the WellChild Tamariki Ora checks; as well as a range of other relevant health messages.

Each wānanga includes an expert kairaranga (weaver) to tutor the weaving from harvesting harakeke (flax), prepping to weaving a wahakura. Woven into this is the practises, tikanga and kawa that are part of traditional Māori approaches to weaving; all of which encompass a holistic and connected approach inclusive of whakapapa, histories, stories and connections to each other, our atua – gods, and our environments).

The providers include Ngāti Porou Hauora (coastal communities), Hauora Hauiti (Tolaga Bay – Ūawa area), and Tūranga Health (Tūranganui-A-Kiwa Gisborne city) urban and the western rural areas. The three providers offer a range of health services; inclusive of clinical services, kaiāwhina support, health promotion and education as well as other which work alongside of social services supports.

In addition the development of a network of local weavers from within the Tairāwhiti communities is an additional asset; there are several weavers who prefer to weave for the supply of wahakura for those māmā and whānau not able to weave their own. An offshoot of this is seeing the development of future weavers to retain the craft and practise as Tairāwhiti weavers.

There have been several wānanga to date which have captured the interest of both whānau and other attendees (workforce as well as interested community), and our intentions are to weave into these wānanga Pregnancy Parenting Education sessions for hapū māmā particularly. Working with LMCs, WCTO services, Māmā & Pēpi teams, E Tipu E Rea – Integrated Child Health services, Whānau Ora, Hospital based Maternity services and other maternal and infant health organisations as well as social service sector.

Finally, a key component of the Mokopuna Ora programme is the appointment of our Coordinator who is based within our Population Health DHB team. Kaniwa Kupenga-Tamarama formerly an LMC joined the team in May this year. Kaniwa has been working on developing her relationships with services and leads in this area and will continue to lead the development of a Breastfeeding Actions Plan for Tairāwhiti as well as working across all key parts of the Mokopuna Ora SUDI Prevention and Safe-Sleep programme which are;

- Haumaru Moe: Safe-sleeping Pēpi
- Tukpea Kore: Smokefree māmā - whānau, whare and waka
- Whangai Ū: Breastfeeding
- Integration of Services – Maternal, Infant & Child Health Services
- Workforce Development – Kaimahi
- Communications and Health Messaging

The programme for the remainder of the year will focus its approaches on improving the coordination across a range of activities in order to complement each other, but to enable whānau to be empowered to parent and grow the happies healthiest tamariki in the world.

Refer to Mokopuna Plan in appendix 6.

Safe Sleep Champion in Maternity Unit

The safe sleep champion in maternity and neonates provides education to staff, and women and their whānau, distributes pēpi-pods from within the unit, makes follow-up phone calls to the woman, liaises with the Director of Change for our Children, and enters data that links into the Midlands Safe Sleep Program. The data for this reporting period come from two data sets: Change for Our Children data for July – December 2018 and the MoH required data for January – July 2019.

To date, all midwives and nurses on maternity and neonates have been trained to distribute pēpi-pod. Training sessions have also been provided for all community midwives, Plunket and Tūranga Health who distribute Pēpi-pods in the community.

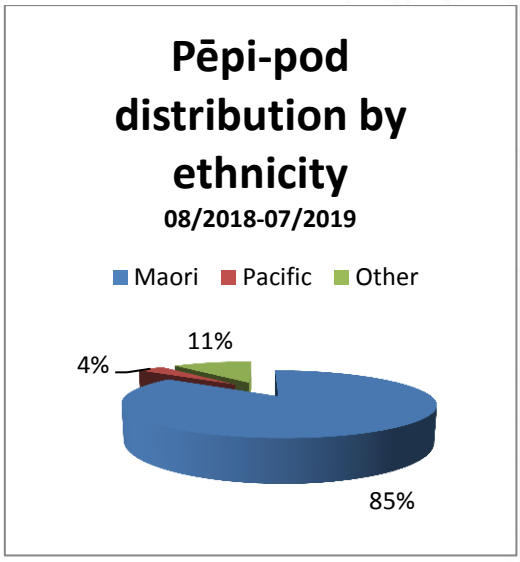
With each pēpi-pod issued, education on safe sleep, breastfeeding, shaken baby prevention, safe hands, general health and healthy eating is provided.

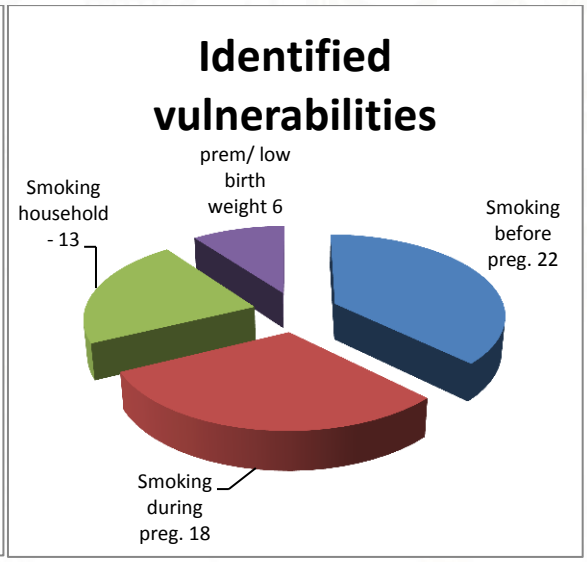
Puawai Aroha Maternity Unit Pēpi Pod Annual Report – July 2019

In the 12 months from August 2018 to July 2019 we have issued 77 pods. These are given out by Maternity and Neonatal Unit staff and the māmā and whānau receive full education about how and why to use the pod. Other agencies such as Plunket and Tūranga Health (Well Child Tamariki Ora providers) also distribute Pēpi pods out in the community.

All Maternity and Neonatal Unit staff are trained in the education of whānau about the pēpi-pods and in the safe sleep/shaken baby information that we also discuss. We have folders with written information and videos that all women are offered to view.

Below are two figure tables highlighting our pēpi-pod distribution by ethnicity and by the reason this was offered for the 5 months August 2018 – December 2018.





In the 7 months January 2019 to July 2019 maternity distributed 77 pēpi-pods. No other data is currently available for this data set.

All women are contacted when baby is a couple of months old and asked how they are finding the pēpi pod, whether baby is sleeping in it and if they want to keep it. This process can be time consuming as paperwork is

not always completed well and women are often hard to contact but we know that getting feedback is an important part of the process and we try hard to contact everyone and feed the information into the national data base.

Education around Safe Sleep and gentle handling of babies (Shaken Baby Prevention) are priorities for us and we make sure all whānau have the information and support they need to raise a healthy and safe baby.

Coping with a crying baby – shaken baby prevention

All babies cry and some babies cry a lot. We are committed to making sure that all mothers and whānau have the information they need to know what to do and how to get help when they feel they are not coping.

It is our responsibility as professionals, to share information with families with young babies about how to prevent shaken baby syndrome.

Pictured: Grace Shallard – National Coordinator for Shaken Baby

On 16-17 July 2019 Grace Shallard (National Coordinator for Shaken Baby Prevention) held 8 Shaken Baby Prevention workshops. These were held at Gisborne Hospital, Gisborne Ministry of Education and Te Puia Springs Hospital. 69 people from a range of organisations attended.

All staff have been requested to complete an online update.

Information is available to parents on line: https://www.kidshealth.org.nz/never-ever-shake-baby

Te Hiringa Matua

Helping hapū (pregnant) māmā who are struggling with drug and alcohol problems is what Te Hiringa Matua is all about.

Te Hiringa Matua is a pregnancy and parenting support service based on a successful pilot at Waitemata District Health Board. Waitemata offered an intensive programme of support to pregnant women and/or whānau with children under three, who have serious addiction issues. The women were generally not well connected to social and health support services.

In this region, the service has a uniquely Tairāwhiti approach to providing that support and connection. Mahi a Atua (using indigenous knowledge of Māori gods to make sense of a situation), is a way of working that has been developed in Tairāwhiti. Mahi a Atua is the foundation of the Te Hiringa Matua service and the people who facilitate this approach are called Mataora.

Ngati Porou Hauora is the lead provider for the Te Hiringa Matua service which is across Te Tairāwhiti. The service reports to a governance group with membership from Tūranga Health, Hauiti Hauora, Hauora Tairāwhiti and Ngāti Porou Hauora.

The name Te Hiringa Matua is taken from Te Oriori (lullaby) mo (for) Tuuteremoana, an ancient birthing karakia that describes the phenomenon of human procreation and the instinct to care for children.

I taatai ai te puhi ariki

And blessed upon this young person

Te Hiringa matua

Was the power to parent

Te Hiringa tipua

A magical power

Te Hiringa tawhito-o-rangi

Te Kuwatawata

Tairāwhiti health professionals have listened to a call for a more effective response to mental health and addiction distress that affects too many Tairāwhiti families.

Te Kuwatawata is a unique and ground breaking response to that call. It is about applying indigenous mātauranga (knowledge/understanding) to reframe the way we talk about a person's experience and to find a pathway forward for people experiencing distress.

A groundswell of people – indigenous knowledge experts, local GPs, community groups and mental health professionals - have been learning about using stories to look at all the characteristics of Māori deities and how they interacted with each other. This helps us to understand our own interactions and behaviours. "Mātauranga enables us to move away from only using western ideology to categorise distress while staying critical in our thinking as health professionals. We are not abandoning western psychiatric approaches; we are just putting other principals - such as relationships and community voice - forward as an immediate response. This helps us to respond quicker, closer to where people live and most importantly this makes people feel connected, rather than disempowered."

Te Kuwatawata has been supported by the New Zealand Ministry of Health with their "Fit for Future" Innovation Funding pool.

Te Pā Harakeke

"Impact of Te Pā Harakeke – summary July 2019
From Nicolas Barrington – Children's Team Director

Considerable collective progress has been made over this past year in response to enabling a whanau centric integrated approach which meets the needs of tamariki and their whanau in this community. As a result our Governance Group Manaaki Tairāwhiti has reached agreement with Oranga Tamariki that Te Pa Harakeke our Tairāwhiti Children's Team will transition to a community lead model. This transition is currently being effected.

Meanwhile operationally our Tairāwhiti Hub (direct online referral pathway) is also proving a very positive point of difference from the other Children's Teams. Our ability to receive direct referrals ensures we are promptly responding and moving referrals through our Hub portal to an appropriate (usually Te Pā Harakeke) pathway. We are able to actively gather further information from our referrer and service brokers, and through the Manaaki Tamariki hui quickly build an initial assessment picture including who is in role (collective understanding in the systems language) that is grounded in whānau voice. This is an area that warrants further exploration by Manaaki Tairāwhiti in the context of the service re-design work as it is enabling whānau to receive timely and immediate support, fit for purpose planning and services, and is decreasing duplication of effort.

Finally however most importantly…

Thank you one and all for your continued commitment to our kaupapa that with *relentless optimism* we pursue our vision:

Kia tipu te rito o Te Pa Harakeke
For all Tairāwhiti tamariki to: be loved, be nurtured, be treasured and belong."

Smokefree Pregnancy in Tairāwhiti

Staying Well Programme Pinnacle Midlands Health Network

Report from Selena Batt, Staying Well Programme Lead for the Pinnacle Midlands Health Network.

Below is information relating to hāpu māmā referred to our stop smoking programme "Once and for all" in Tairāwhiti.

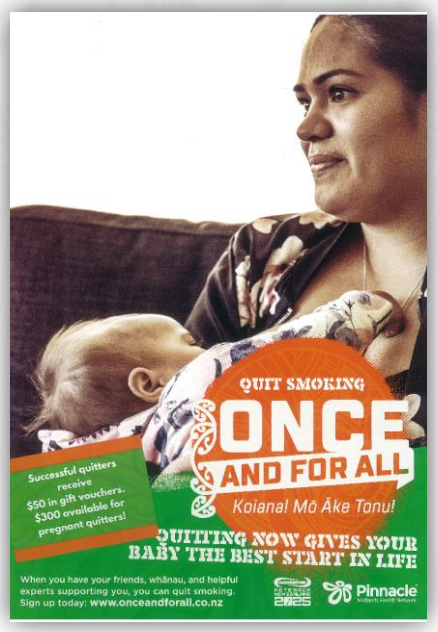
Tairāwhiti

Quarter	Referred	Enrolled	Quit	Quit Rate	# Māori	% Māori
Q1	13	6	3	50%	12	92
Q2	41	33	21	63.3%	40	97
Q3	48	36	27	75%	43	89%
Q4	24	15	8	53.3%	20	83%

Referral source

OTHER HEALTHCARE	126
Secondary	3
Self-referred	1
Primary	5
Referrals other	13
Other healthcare	16
LMC	60
Workplaces	1

The biggest difference for our Hapū Māmā service has been the team at Hapū Ora Midwives and the return of Lana Mua as a coach. Our quit rate for hapū māmā is around 65.6% which is significantly higher than any other priority group, not to mention the reach to Māori proportion is a massive 91%!!



Mauri ora

Selena Batt | Staying Well Programme Lead

MoH: Smoking kills more people in NZ each year than road crashes, alcohol, other drugs, suicide, murder, drowning and earthquakes – all put together!

Lactation Consultant Service

Hauora Tairāwhiti Community Lactation Consultant Service

Reporting Summary 2019

Provided by

Janet McGuinness T/A MāmāPukeko

See Agreement 349268/07

The Hauora Tairāwhiti Lactation Consultant Service, established in 2011, provides community-based Lactation Consultant support to women experiencing breastfeeding difficulties who require specialist care. Under the contract, referrals are capped at 240 per year, which currently meets demand and the availability of Lactation Consultants. **In the past year the service has cared for 204 women and their babies.**

The service is currently provided by one IBCLC: Janet McGuinness who is also a trained midwife.

The lactation service aims to meet the needs of Māori and Pacific Islanders as well as other New Zealanders. Referrals of Māori and Pacific Island mothers to our service are always encouraged.

LMC's (Lead Maternity Carers), as usual, make up most of the referees to the service. Consistently, more than 2/3 of babies referred over the last 5 years have been seen between birth and 6 weeks of age. The average age of babies at referral is 4 weeks old. However, referrals have been received for babies as old as 16 months.

Breastfeeding problems are most often complex, usually presenting with multiple connected symptoms which can result in more than one diagnosis. As in all previous years, Anatomy, consisting of mostly ankyloglossia (tongue tie) and lip tie but not excluding torticollis or breast hypoplasia, is the most common reason for referral. The number is increasing most likely due to an increased awareness of tongue-tie in our community.

There is a concerning increase of supply issues over the last two years. This may be due to increasing maternal age seen within the service as well as an increase in hormonal issues affecting supply.

Most mothers are under the care of the service for an average of 8 weeks or more. It is encouraging to see an increase in exclusive breastfeeding rates on both entry and exit this year. Perhaps increased efforts to support breastfeeding in the community by all sectors is responsible. Hopefully this trend will continue.

The service sees women struggling to breastfeed due to several issues, sometimes late in the struggle and for some even after treatment and assistance it can be either physically impossible for them to exclusively

breastfeed or the struggle is just too great. While the service is not able to help all mothers to continue to breastfeed exclusively, we know from feedback received via our website that there are many mothers who have found the service to be extremely helpful in supporting their breastfeeding journey:

'If I had not worked with the Lactation Consultant, I would have given up on breastfeeding very quickly. Thanks to her support and knowledge I've now made it to 1 year of breastfeeding with my daughter.'

'The lactation consultant service was a critical part of the success of my breastfeeding journey. I was given really good practical advice and my consultant was super helpful. She regularly checked in with how I was going and made sure I had the support and resources I needed.'

'It has enabled me to breastfeed for 10 months and counting. I would have stopped breastfeeding after 3 months if it wasn't for the lactation consultant.'

'Thanks to my lactation consultant I was able to continue to feed my boy. She made my journey much more enjoyable and positive. I cannot rate her highly enough!!'

Our website: "Wai U Tairāwhiti" www.breastfeedingeastcoast.nz contains helpful breastfeeding information, informative videos, comprehensive breastfeeding care plans and tongue-tie treatment information.

All website content is IBCLC approved, adheres to relevant WHO codes and is freely available for health professionals and mothers to download, print or view online. It is also linked onto the 'BreastFedNZ' app. Business cards with the website address are provided to all WCTO providers, LMCs, and our IBCLCs to distribute to mothers in our area as required.

The 'Mother Friendly Tairāwhiti' poster: To promote the 'norm' of breastfeeding in public, we developed the poster with over 55 businesses registered as being breastfeeding friendly with baby friendly facilities. The poster is updated yearly, available on our website and circulated widely. Most shops have an easily identifiable sticker on the front and the poster is being used frequently by mothers and even commented on via social media by visiting mothers from other cities.

World Breastfeeding Week celebrations: The Big Latch On: This service, in collabouration with hospital IBCLC and funded by Population Health, held the 10th Global Big Latch on. We had a record turn out with 48 latching mothers and babies supported by many members of the public as well as representatives from all the WCTO services. It was a great celebration of the gift of breastfeeding as well as a perfect opportunity to normalize breastfeeding in public.

We greatly appreciate Hauora Tairāwhiti's commitment to the lactation service, and to supporting breastfeeding mothers in our district.

Ko te whāngote he taonga oranga taketake.

Breastfeeding, the gift that lasts a lifetime.

A report written by one of the mothers who accessed our service in 2019:

My first encounter with Tongue Tie was 6 years ago.

My daughter was born with a grade 4 tongue tie and when she was 10 days old at Gisborne Hospital. They cut her tongue tie which then re-joined. I was then referred to a lactation consultant who suggested I travel to Hamilton and have my daughters tongue tie water lasered. This was done twice and both times the tongue tie re-joined.

There was no follow up from the lactation consultant, back then, and I felt really isolated, especially being a first-time mum.

My daughter had severe scaring, so when she turned five her tongue tie was re cut and this time was successful.

Six years on and I now have another daughter with a tongue tie. My midwife referred me to a Lactation consultant, Janet, who gave me a call and booked me in for a consultation. Janet diagnosed my 2nd daughter with a grade 4 tongue tie. This made me very nervous as I remember the traumatic experience that my 1st daughter went through.

Janet was very professional and made me feel really at ease with the whole experience. Janet talked me through all of my options and gave me all the information I needed to make an informed decision.

I choose to wait and see ENT, Julian Avisenis, at the Hospital.

I had a 4 week wait and between this time wait; Janet would ring me and check on how feeding was going and if I had any concerns. The day before my daughter had her tongue tie cut; Janet gave me a call and checked with me to see if I had watched the videos for the tongue exercises? Janet also checked if I felt confident in doing the exercises and if I had any questions.

At ENT the staff were lovely and talked me through the process. My daughter was very content, and the process was very quick, and she recovered very fast.

When my 1st daughter had her tongue tie water lasered she was screaming when they were doing the procedure. I believe the process done by ENT is far better than the water laser, and much less painful.

A week later I had a follow up appointment and Janet checked to ensure the tongue was good and not re-joining. We had one more follow up and checked process was still going well.

Through this whole process Janet has gone above and beyond in the process, checking all was going well with feeding and showing the exercises etc. I really wish this service was available 6 years ago.

I will definitely be recommending this service to anyone that has any feeding issues.

Jessica O'Dwyer

Immunisation

Indicator: Increased Immunisation 8 Months

DHB: Tairāwhiti
Reporting period: 01/04/2019 – 30/06/2019
Contact (role and name): Janine Brown – Immunisation Coordinator
Target Definition
Percentage of eligible children fully immunised at eight months of age for total DHB population, Māori and Pacific; achievement requires that the target is met for the total population and significant progress for the Māori population group (and where Relevant) Pacific population group has been achieved.

Summary of results: coverage at age 8 months

Target: 95%	Total	Māori	Pacific	Dep 9-10	Decline	Change: total	Change: Māori
Q1 2018/19	85%↓2%	84%↑1%	83% ↑3% (1 child)	79%↓3%	9.4↑3.4%	↓2%	↑1%
Q2 2018/19	84%↓1%	82%↓2%	100%	80%↑1%	8.2↓1%	↓1%	↓2%
Q3 2018/19	82%↓2%	73%↓9%	100%	78%↓2%	9.7%↑2%	↓2%	↓9%
Q4 2018/19	85%↑3%	84%↑11%	100%	83%↑5%	6.1%↓4%	↑3%	↑11%

Progress Report:

- Our decline rate continues to fluctuate and at present has decreased. Outreach Immunisation nurses continue to have discussions around the safety of the immunisation programme.
- OIS has been given an extra day per week which has started to make an impact on the 8 month rates and also the waiting list. We are now able to better prioritise children that are needed to be done sooner than later.
- Discussion to commence with Well Child Tamariki Ora (WCTO) on how OIS and WCTO can better work together for families that are not accessing Primary care and declining OIS
- Immunisation Coordinator and NIR administrator continue to provide support to practices that need extra help advice with their pre-calls/re-calls, overdue reports and timely referrals to OIS.
- We have noted an increase in "GP unknown "at 6 weeks of age. These whānau are directly referred from NIR to OIS. Discussions around looking at ways to improve this by working with maternity around notification to GP and WCC sooner than at time of birth have commenced and has been added to the DHB annual plan.
- Some whānau are declining OIS and electing to attend primary care in their own time (delaying) Education is given to whānau around timely immunisation however care is taken not to put them under pressure as we have had whānau who have elected not to immunise at all rather than be allowed to manage the timing.
- Immunisation week promotion went well particularly around the electronic promotional board. More communication is going out to the public particularly if we have vaccine preventable disease e.g. Whooping Cough in the community or what's happening nationally with measles via Hauora Tairāwhiti Facebook page, Gisborne Herald etc.,

Hapū Māmā Oranga Niho – Maternal Oral Health

Our Hapū Māmā programme is in its second year, and once again we have seen the benefits of providing oral health care to our wahine.

More than 40 women have been referred to the program with a 50% attendance rate. Our hapū māmā all receive an examination, hygiene and dental treatment with high quality of care. On average, our wahine will receive treatment over 3-6 appointments. The commitment from our wahine to show up has been tremendous.

We continue to look at improving access and responsiveness. We are looking at other opportunities to engage and encourage our wahine to attend their appointments. We continue to receive support from our Kaiawhina, iwi providers and LMC's. With our collaborative approach, we will strive to achieve reducing the barriers our wahine face, to provide a more equitable program

Moana Reedy getting her teeth checked by Dr Nitish Surathu

11.0 Appendices

Appendix 1 - PMMRC Recommendations Progress Report

1. Strategies to reduce preterm birth

Women with a previous preterm birth before 34 weeks are at increased risk of neonatal death. The PMMRC recommends that LMCs and DHBs employ strategies to reduce preterm birth by targeting this high-risk group, including:

a) Counselling at the time of a preterm birth to outline the strategies likely to be recommended for their next pregnancy, and advice to present for antenatal care as soon as they know they are pregnant.

It is routine for us to counsel women at the time of discharge after a preterm birth regarding strategies for a future pregnancy. They are advised to contact an LMC in the first trimester, talk about their risks for pre-term birth and discuss management plans, which will include Antenatal Clinic visits with an obstetrician. In addition, we are developing a new discharge letter for all women which will be sent to the GP on discharge after a pre-term birth and which will include recommended advice in future pregnancy for the primary care doctor to discuss with the woman.

b) Ensuring that antenatal care is available to allow women to register as early as possible, and ensuring that early antenatal care includes attention to modifiable risk factors such as smoking, sexually transmitted infections, and urinary tract infections

Early engagement with an LMC is an ongoing issue for us. All LMCs are on Find a Midwife and information is on our website too. We are planning to hold a meeting with GPs and LMCs later this year and will include the importance of early engagement with an LMC and will be including the importance of attention to modifiable risk factors such as smoking, sexually transmitted infections, and urinary tract infections. LMCs are already aware of this.

c) Ensuring referral for specialist consultation in the first trimester to facilitate discussion of treatment options, which might include cervical cerclage or vaginal progesterone treatment and monitoring of cervical length using transvaginal ultrasound.

We have a prevention of preterm labour guideline which all LMCs use as a guide, which is accessible on DHB website https://www.hauoratairawhiti.org.nz/assets/Uploads/Preterm-labour-and-birth3.pdf

d) Counselling around signs and symptoms of preterm birth and how to respond to these to optimise outcome.

This will be discussed by the LMC and the O&G when consulting with a woman with known risk factors

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2. Birth outcome information

The PMMRC recommends DHBs make available appropriate information, including appropriate counselling, for parents, families and whānau about birth outcomes prior to 25 weeks gestation to enable shared decision-making and planning of active care or palliative care options.

This is discussed on an individual basis with women and involves the paediatric team. We do not plan to birth women here at Tairāwhiti at that gestation and make every effort to transfer them the tertiary unit. Please see results from a recent audit in appendices.

3. Antenatal corticosteroid administration

The PMMRC recommends that DHB maternity services audit the rates of antenatal corticosteroid administration, including repeat doses when indicated, to mothers of neonates live born at less than 34 weeks gestation, including auditing whether administration is equitable by ethnicity, DHB of residence, and maternal age.

See audit results in appendix 3 and guideline on DHB website:
https://www.hauoratairawhiti.org.nz/assets/Uploads/Administration-of-AN-Corticosteroids.pdf .

4. Benchmarking survival rates at the unit level
The PMMRC recommends that tertiary obstetric and neonatal intensive care units investigate and address the difference between units in survival rates amongst infants born at 23 to 26 weeks gestation as part of their benchmarking and quality and safety initiatives.

N/A - we are not a tertiary unit or neonatal intensive care unit. We only have babies over 32 week's gestation as a secondary care facility. All other babies if born here would be retrieved and transferred to Waikato.

5. Staffing ratios and acuity tools

The PMMRC recommends that the Ministry of Health and DHBs have a responsibility to ensure that midwifery staffing ratios and staffing acuity tools:

a) Enable active observation of mothers and babies who are undertaking skin-to-skin contact in the postnatal inpatient period

The initial skin to skin usually occurs in the immediate post-natal period when the woman's LMC is in the room providing care for the first 2 hours after birth. If the birth has been in theatre, there will be a midwife or nurse responsible for the baby, and therefore initiating and observing skin to skin in theatre, on transfer to recovery and then to the postnatal ward. Care is then handed over to a colleague on the ward who takes over this responsibility with whānau present to observe and be advised of the importance of watching baby while skin-to-skin. We advise all women and whānau that a baby is to be observed whenever skin to skin.

b) Allow for the identification of, and additional needs of, mothers who have increased risk factors for sudden unexpected death in infancy (SUDI)

We are about to introduce the acuity tool Trendcare into maternity and Care Capacity Demand Management (CCDM). We advise all women and whānau that a baby is to be observed when skin-to-skin and always if the midwife is not in the room. The initial skin to skin often occurs when the woman is still under the care of her LMC and therefore the LMC is in the room providing care for the first 2 hours following a birth. In theatre there is a midwife or nurse who is responsible for the baby and therefore initiating and observing skin to skin whilst still in theatre and then when transferred to recovering and then to the postnatal ward. Care is then handed over to a colleague on the ward who would take over this responsibility with whānau present. We are fortunate in being able to encourage a support person to stay with the woman overnight so they can support and observe when the mother has her baby in bed to feed, or have it skin to skin. We educate all mothers and whānau on safe sleep and the prevention of shaken baby and SUDI. If this does not occur in the hospital due to a quick discharge home, then this becomes the LMC's responsibility. We also have a Safe Sleep guideline and offer all babies at risk or who do not have a safe sleep device at home a pēpi pod. We report this information to the MoH quarterly.

See guideline on DHB website: https://www.hauoratairawhiti.org.nz/assets/Uploads/Safe-Infant-Sleeping-Birth-to-1-Year.pdf

6. Access to a safe sleep place

The PMMRC recommends that LMCs and DHBs ensure that every baby will have access to a safe sleep place on discharge from the hospital or birthing unit, or at home, that is their own place of sleep, on their back and with no pillow. If they do not have access to a safe sleep place, then a wahakura or pēpi-pod must be made available for the baby's use prior to discharge from hospital.

Hauora Tairāwhiti has recently appointed a Mokopuna Oral SUDI Prevention Coordinator who is also a midwife. She is already working with weavers in the community so that we will have access to an increased supply of wahakura as well as the alternative of a pēpi pod so that we can ensure that every baby has access to a safe sleep place on discharge from hospital, which is also culturally appropriate. We risk assess every mother and baby before discharge and offer and provide a pēpi pod both in the maternity unit and NNU and Well Child services also have access to these. Copy of recent report to MoH attached. LMCs can access a pēpi pod for a home birth if required. All midwives are currently completing a refresher online training module on SUDI prevention recommended by the Mokopuna Ora SUDI Prevention Coordinator and we have Prevention of Shaken Baby refresher training this month which has been widely distributed to all health professionals to attend.

Smoking increases the risk of SUDI; we know that we have had the highest rate of hapū māmā who continue to use tobacco during their pregnancy. We now have an opt out rather than an opt in referral pathway to smoking cessation support and have a team of LMCs who have become ONCEANDFORALL Programme providers (smoking cessation) and are seeing some great successes of women quitting under their care. We work closely with the Coordination Support – Stop Smoking Coordinator and offer every woman who comes into our maternity services smoking cessation support and NRT.

NHI of mother (the NHI of the mother who a SSD was offered)	NHI of baby (The NHI number of the baby if a SSD was offered postnatally)	Date of assessment (Date that the mother/baby was assessed as requiring a SSD)	Family accepted safe sleep device (Please select from drop down box)	Type of safe sleep device provided (please select from drop down box)	Date safe sleep device was provided
		24/04/2019	Accepted	Pepi-Pod	24/04/2019
		27/04/2019	Accepted	Pepi-Pod	28/04/2019
		29/04/2019	Accepted	Pepi-Pod	29/04/2019
		29/04/2019	Accepted	Pepi-Pod	29/04/2019
		01/05/2019	Accepted	Pepi-Pod	02/05/2019
		13/05/2019	Accepted	Pepi-Pod	13/05/2019
		23/05/2019	Accepted	Pepi-Pod	23/05/2019
		09/04/2019	Accepted	Pepi-Pod	26/05/2019
		26/05/2019	Accepted	Pepi-Pod	26/05/2019
		03/06/2019	Accepted	Pepi-Pod	03/06/2019
		07/06/2019	Accepted	Pepi-Pod	08/06/2019
		14/06/2019	Accepted	Pepi-Pod	15/06/2019
		23/06/2019	Accepted	Pepi-Pod	23/06/2019
		22/06/2019	Accepted	Pepi-Pod	24/06/2019
		24/06/2019	Accepted	Pepi-Pod	24/06/2019
		16/06/2019	Accepted	Pepi-Pod	30/06/2019
Notes					
1. DHB subcontracted providers will provide the monitoring information to DHBs					
2. DHBs will consolidate the data and submit it sudi@moh.govt.nz via this template.					

7. Inequity in perinatal mortality for young mothers

Maternity and primary care providers need to be aware of the increasing risk of perinatal mortality for mothers under 20 years of age in New Zealand. Inequity in perinatal mortality for babies born to mothers

under 20 years of age needs to be actively addressed. The PMMRC recommends the Ministry of Health and DHBs:

a) Develop, in consultation with young mothers, acceptable and safe methods for mothers under 20 years of age to access and engage with care in order to achieve equitable health outcomes

During 2018 24 women (3.6%) of all pregnant women who birthed in Tairāwhiti were under the age of 20, with one aged only 16 years old. All booked with an LMC. The majority birthed at term. Some of these young women were well wrapped around with whānau support. Others were referred to E Tipu E Rea, a supportive network of agencies/services who engage with them, assess needs and provide support as needed.

b) identify and adequately resource evidence-based solutions to address risks for mothers under 20 years of age, paying attention to smoking cessation, screening and treatment for infections, screening for fetal growth restriction, and providing adequate information about the causes and symptoms of preterm labour

LMCs assess risks, counsel the young women regarding smoking, importance of adequate diet, causes and symptoms of preterm labour and other risks of pregnancy in young mothers. They are also offered referral to Antenatal clinic run by obstetricians. We are also trying to encourage family planning in these young women under 20. We now have obstetricians and midwives who will insert levonorgestrel implants (jadelles) prior to discharge in women who have given birth, and would like to have long-acting reversible contraception.

Also note E Tipu E Rea as above and the service Te Hiringa Matua for women who are using drugs and alcohol during their pregnancy (and in the postnatal/early childhood period). Both of these services are targeted at younger mothers and have a kaupapa Māori approach.

c) Consider how they can support LMCs caring for mothers aged under 20 years.

During 2018 3.6% (24) of all pregnant women who birthed in Tairāwhiti were under the age of 20 (23 aged 17-19yrs old and 1 aged 16 years old). These young women would be referred to E Tipu E Rea who are a supportive network of agencies/services who will wrap services around a young pregnant woman. LMCs will monitor teenage pregnant women closely, the majority birth at term. This is an area that we still need to work on. These programmes and approach are part of the Mokopuna Ora strategy for Hauora Tairāwhiti.

Appendix 2 - Elective Repeat Cesarean Section Audit for 2018

Review of Hauora Tairāwhiti statistics from 2017-2018 showed an increase in overall cesarean sections from 19.4% of total births to 25%. Of these 56 were elective cesarean sections (CS) in 2017 and 69 elective CS in 2018. While there are factors contributing to elective CS that cannot be changed, the goal of this audit was to identify any modifiable trends toward elective repeat cesarean section instead of trial of labor with potential for VBAC. **36 women with a history of only one prior CS underwent elective repeat CS at Gisborne Hospital last year**. Each of these cases was reviewed and the findings summarized below. Women who had prior normal vaginal births (NVB) and vaginal births after cesarean section (VBAC) were looked at individually as these women had the highest chance of a successful VBAC if trialed. Cases that I feel had good potential for successful VBAC are noted in bold type.

RESULTS:

AGE

Range: 21-45

Mean: 31.3

Median: 31

GRAVITY

2-7

PARITY

1-6

BMI

Range: 20.9-48.9

Average: 29.8

GESTATIONAL AGE

Range: 35+3 to 41+5

Average: 39+2

Prior NVB or VBAC:

3 women had normal vaginal births prior to their first c-section.

-- Of the women above, two were scheduled for repeat c-sections due to breech presentation and one was scheduled due to history of fourth degree laceration with prior vaginal birth, with current pregnancy being complicated by GDM.

6 women had a successful VBAC after their first c-section prior to the repeat c-section.

--Of these women:

1. **One had a NVB of an infant 4423 gm, followed by a c-section for breech, then a VBAC 3118 gm, then a repeat c-section at 39+3, infant weighed 4140 gm.**
2. One had a history of primary section for failure to descend, infant weighed 4360 gm, followed by a successful VBAC, infant weighed 4260 gm, complicated by post-partum endometritis and perineal wound infection. Repeat c-section then done, infant weighed 4000 gm.
3. One woman had a primary c-section for fetal distress/SGA (2975 gm), followed by a successful VBAC, infant weighed 3200 gm. Her third pregnancy was complicated by ITP and SGA. She desired a TOLAC but did not go in to labor before recommended delivery by EDD and repeat c-section was performed at 40 weeks.
4. One woman had a primary c-section for failure to progress, failed induction of labor, infant weighed 4252 gm, followed by a successful VBAC, infant weighed 4082 gm. Third delivery was repeat c-section for non-reassuring fetal heart tones, polyhydramnios, and presumed LGA, infant weighed 4160 gm.
5. One woman had a primary section for unclear cause, infant weighed 3660 gm, followed by successful VBAC, also 3600 gm. Her repeat c-section was at 38 weeks for twin pregnancy complicated by SGA.
6. One woman had a primary section for breech, followed by a successful VBAC, infant weighed 3500 gm. Her repeat c-section was done at 37+5 weeks for IUGR with breech presentation, infant weighed 2660 gm.

3 women had two or more successful VBACs after their first c-section prior to the repeat c-section.

1. One woman had a primary section for unclear reason, followed by 2 successful VBACs (pelvis proven to 3232 gm. Repeat c-section was then done at 35+3 weeks for severe pre-eclapmsia, infant weighed 2420 gm.
2. One woman had 3 NVB prior to her first c-section for breech, followed by VBAC x 2 with pelvis proven to 4989 gm. Repeat c-section was done at 41 weeks, pregnancy was complicated by GDM, poor compliance and poor attendance to care. Infant weighed 5820 gm.
3. **One woman had a primary section for failure to progress and fetal distress, infant weighed 3570 gm. She subsequently had 3 successful VBACs, pelvis proven to 3660 gm. She desired a TOLAC but did not labor before recommended delivery at 40+4 weeks for advanced maternal age (45 years old). Infant weighed 3120 gm.**

<u>Desired TOLAC:</u>

Review of women in this cohort showed 9 women did desire a TOLAC, but did not labor prior to repeat c-section. Gestational age at time of c-section for these women ranged from 39+2 to 41+5 weeks.

39+5 weeks, prior c-section for FTP, this infant weighed 160 grams more

41+5 weeks, prior c-section for failed IOL, foley bulb and low dose Syntocin attempted, no labor, infant weighed 535 gm more

39+2 weeks, prior c-section for twins, this infant weighed 3900 gm

39+4 weeks, prior c-section for failed IOL, GDM, this infant weighed 540 gm less

41+5 weeks, prior c-section for PROM, failed IOL, foley bulb attempted, no labor, infant weighed 360 gm more

39+6 weeks, prior c-section for FTP, this infant weighed 660 gm less

40+4 weeks, prior c-section for FTP/fetal distress, infant weighed 450 gm less (woman was AMA as noted above)

40+6 weeks, prior c-section for FTD, infant weighed 420 gm more

41+4 weeks, prior c-section for fetal distress, infant weighed 120 gm less

1 other woman had SROM prior to scheduled section and did not desire TOLAC. She delivered at 37 weeks, no antenatal care, infant weighed 340 gm less than her first c-section.

Further observations:

-3 women had a relative contraindication to VBAC . 2 had a history of pelvic fracture or hip abnormalities, and one had a breech infant that was IUGR (final weight 2660 gm).

-8 had complicating medical or fetal conditions that came with recommendations for delivery before or by due date, precluding any option for longer expectant management. 2 developed severe PET and were delivered before 37 weeks, one of those with twins. 2 more were IUGR, 1 chronic hypertension, 1 poorly controlled diabetes, 1 other set of twins with SGA. 1 was AMA at age 45 as noted above. **1 had suspected macrosomia which turned out to be inaccurate.** An audit of ultrasound results for estimated fetal weight over a six month time period was done as a result.

Conclusion:

Of the 36 women who had elective repeat c-sections when not in labor, only 5 appeared to have good potential for VBAC had they labored prior to c-section and agreed to TOLAC. Strategies for improving chances for TOLAC include continued safe expectant management until the 41st week of pregnancy. Stripping of the membranes, or cervical "sweeps", have been shown to increase rates of spontaneous labor. Starting sweeps from 37 weeks on in these women who do not have an option for induction of labor may increase their chance for TOLAC.

Appendix 3 - Preterm Delivery Audit for Calendar Year 2019

Preterm birth is defined as birth between 20 0/7 weeks and 36 6/7 weeks gestation. It is the leading cause of neonatal mortality and a major contributor to short and long term morbidity in infants and children. The preterm birth rate in New Zealand is approximately 6%. There are numerous risk factors for preterm birth. Some risk factors are modifiable with treatment or lifestyle changes and others are not. Inappropriate preterm inductions, tobacco use, antenatal clinic referral, antenatal progesterone use and antenatal steroids are potentially modifiable. Identification of risk factors prior to conception or in the first trimester of pregnancy could lead to treatment or intervention options that could potentially decrease the rate of preterm birth.

An audit was undertaken to identify all preterm deliveries from Jan 1 2018 through 31 December 2018. Forty nine mothers delivering 57 preterm infants were identified on MCIS during this time frame. The preterm delivery rate for 2018 was 8.4%, an increase from the 5.3% rate seen in 2015. Two deliveries were inductions for intrauterine foetal demises and one was an induction for Trisomy 13. Eliminating these three preterm deliveries gives a preterm delivery rate of 7.9%.

All charts were screened for maternal age, gravidity, parity, gestational age at delivery, BMI, tobacco use, history of preterm labour, history of prior cervical surgery, referral to antenatal clinic and gestational age at referral, whether progesterone or antenatal steroids were used or offered, whether tocolysis was attempted, singleton versus multiple gestation, induced or spontaneous delivery, and the diagnosis leading to/causing preterm delivery. The gestational age distribution of preterm deliveries were as follows:

Weeks of gestation	Number of deliveries
20 0/7 – 23 6/7	5
24 0/7 – 25 6/7	1
26 0/7 – 31 6/7	1
32 0/7 – 33 6/7	13
34 0/7 – 36 6/7	37

Of the 5 deliveries at <24 weeks, 2 were demises, 1 abruption with onset of labour, 1 preterm labour of unknown cause and 1 labour resulting from E Coli chorioamnionitis. The one delivery at 24 weeks was the foetus with Trisomy 13.

Fourteen deliveries were induced (29%) and 35 were spontaneous (71%). The following are the diagnoses and percentages for the inductions:

Diagnosis	Number	Percentage of inductions
Lethal anomalies/demise	4	36%
Severe PET	3	27%
SGA with abnormal dopplers	2	19%
PPROM	1	9%
Eclampsia	1	9%

The median age was 29years with a range from 18 to 43. The median BMI was 28.1 with a range of 20.9 to 48.7. 14% of the preterm delivery women had a BMI ≥30≤39.9 and 5% had a BMI ≥40 for a total of 19% with an elevated BMI. Eight women were primigravids (16%) and 41 were parous (84%). Two women had one prior LLETZ. Unfortunately 41% of the preterm delivery women used tobacco regularly.

A history of prior preterm delivery was present in 11 women (22%). All women who registered with an LMC were referred to Antenatal Clinic but only 5 attended. Ten women were candidates for vaginal progesterone

use. Six did not attend Antenatal /clinic. Three of the remaining women did not qualify for subsidised vaginal progesterone and did not use it. One woman with a history of a 22 6/7 week loss qualified and used vaginal progesterone. She delivered at 36 3/7 weeks. All of the women <35 weeks who add adequate time for administration received antenatal steroids. Of the women ≥35 weeks and <37 weeks (26) only two received antenatal steroids. This likely reflects the current controversy over use of antenatal steroids over 34 6/7 weeks.

There were 8 sets of twins representing 16% of the preterm deliveries. One set was mono-di and 7 were di-di. Two were successful vaginal deliveries (25%) and 6 had a c section (75%).

As per most audits at Hauora Tairawhiti, low numbers make interpretation difficult. The audit does show that we are efficient at transferring women with preterm labour between 23 6/7 and 31 6/7weeks to Waikato. Only two women delivered here between those gestational ages, one with chorioamnionitis and one with PPROM and rapid onset of labour. But compared to the preterm audit of 2015 our preterm delivery rate increased from 5.3% to 8.4%, our median BMI rose from 24.8 to 28.1, the use of tobacco rate rose from 32.4% to 41% and our attendance in Antenatal Clinic of those referred for prior preterm delivery declined from 57% to 40%. On the positive side, combining the audits from 2013, 2015, and 2018 our overall preterm delivery rate for the three years audited was 6.9%, in line with the historic 2000-2010 Huaora Tairawhiti rate of 6.3%.

As with many of our adverse pregnancy outcomes in Tairawhiti, early registration with an LMC, early referral to Antenatal clinic, and effective counselling for modifiable lifestyle factors could improve the preterm delivery rate. We should continue to work on those areas where we can make a positive difference in outcome for our women.

Appendix 4 - Twin Delivery Audit 2015-2018

Background:
In 2014 and 2017 audits were performed on all twin deliveries that took place in Gisborne Hospital. The initial audit in 2014 looked at twin deliveries from 2009 to 2013 which showed that the caesarean delivery rate was 78%. This was much higher than what was found in review of literature, which suggests approximately 60% of twin pregnancies have caesarean deliveries. The findings of this audit led to several practice changes which included recommending that twins that are cephalic/non-cephalic that deliver in theatre rather than labour rooms and having a lower threshold to have a second obstetrician in attendance.

A second audit was done in 2017 looking at the twin deliveries in 2015 and 2016 to determine if these practice changes affected our caesarean delivery rates. The findings from the 2017 audit showed that significantly fewer women had caesarean deliveries in 2015 and 2016 – 50% compared to 78% in 2009 to 2013. This finding was particularly pronounced for cephalic/non-cephalic presentations which had a caesarean delivery rate of 37% (down from 87%). But, we also saw a decrease in caesarean deliveries for cephalic/cephalic presentation with a caesarean rate of 30% (down from 50%).

This audit is a follow-up to see if these practice changes continue to affect our caesarean delivery rates of twin pregnancies delivered at Gisborne Hospital in 2017 and 2018.

Results: 2015 - 2018

Total Twin Deliveries – 49
Cesarean Deliveries – 32 - 65% caesarean rate for twins (It was 78% in the 2009 – 2013 time period)
Cephalic/Cephalic twins – 4/16 had caesarean delivery (25%) – it was 50% during 2009 - 2013
Cephalic/Non-cephalic twins – 10/15 had caesarean delivery (67%) – it was 87% during 2009 – 2013

Not good candidates for Trial of Labour – 24 out of 49 were not good candidates
Reasons:
Malpresentation 1st twin – 18
Malpresentation 2nd twin in preterm labour – 1
Fetal Distress – 1
Multiple prior caesarean deliveries – 1
Preterm with growth restriction/abnormal dopplers and/or Severe PreEclamspia - 3

Candidates for Trial of Labour – 25 out of 49 were good candidates

Cephalic/cephalic twins – 12/16 had vaginal delivery (75%)
Despite extensive counselling 2 women choose to have a caesarean delivery despite being an excellent candidates. Other reasons for electing not to have trial of labour: 2 prior caesarean deliveries.

Had trial of labour – 12/13 successful (92%) – 1 was unsuccessful due to abruption with 2nd twin – 89% had successful trials in 2009 - 2013

Cephalic/non-cephalic – 14 total women

7/14 attempted a trial of labour (50%) – 2 required caesarean delivery for 2nd twin – compared to 2009 – 2013 only 33% of the women who were candidates actually had a trial of labour
7/14 elected for caesarean delivery (50%)

The women who elected to not try for a trial of labour due to:

- History of traumatic tear/PTSD
- Abnormal dopplers in mono-di twins
- Previous caesarean delivery
- Severe Pre-Eclampsia

Had vaginal delivery of Baby A and then vaginal delivery of Baby B

Cephalic/cephalic twins – 12/13 = 92% successful trial of labour
Cephalic/non-cephalic twins – 5/7 = 71% (both women that were unsuccessful had emergency caesarean for transverse presentation of 2nd twin)

Conclusion:

Women pregnant with twins are much more likely to have a vaginal delivery at Gisborne Hospital than they were prior to 2014. Combining data from the 2017 audit with 2017 and 2018 data, we continue to see that significantly fewer women had caesarean deliveries in 2015 to 2018 – 65% compared to 78% in 2009 to 2013. Everyone that was eligible for a trial of labour was offered one. Vaginal delivery for cephalic/cephalic twins much more likely now (75%) compared to prior to 2014 (25%). And when trial of labour is attempted – success rate is 85% overall!

Appendix 5 – Nulliparous Induction Audit 2018

Introduction:

Inductions of labour for nulliparous women are important for several reasons. Obviously the goal is to have a healthy mother and baby. Ideally these will be achieved in a way that does not limit a woman's options in future pregnancies. For most women a normal delivery is the preferred outcome. Inductions of labour for nulliparous women often take some time and are quite resource intensive. For most women the ultimate goal is to achieve a normal delivery in the most efficient way possible. Ideally this would be during the daytime or early evening when hospital resources are most easily mobilized.

We conducted an audit of all nulliparous women who were induced at Gisborne Hospital in 2018. The goals of this audit were to get a better understanding of the indications for induction in this population as well as outcomes. Additionally, it was hoped that we could obtain some insights into our methods and identify areas that could be improved. Given the low number of deliveries at Gisborne Hospital, we recognized that it will likely be difficult to draw firm conclusions about some of these issues.

Results:

According to our MCIS, 98 nulliparous women delivered at Gisborne Hospital in 2018. Of these, 30 (31%) had inductions. Thirty percent had c-sections, while23% had operative deliveries. All of the women had indications for induction. They are listed as follows with the c-section percentage for each indication in brackets:

-Prelabour rupture of membranes (PROM) – 7 (29%)

-Cholestasis – (0%)

-Diabetes – 2 (50%)

-IUGR – 1 (100%)

-Oligohydramnios – 1 (100%)

-Post Dates – 8 (38%)

-Preeclampsia – 8 (25%)

Since women with PROM typically respond to inductions differently than those without, we separated out those 7 women. The numbers are very small but it is notable that women who were placed on oxytocin straight away delivered in an average of 7:40 hours, while those who received Cervidil averaged 20:54. Forty percent of the women who received Cervidil initially still needed oxytocin. The overall c-section percentage was 27.

The c-section percentage for the 23 women without PROM was 30. All of them received Cervidil for unfavourable cervixes. There were 4 haemorrhages. The largest of these was one litre. 91% of 5 minute APGARs were > 6. No other complications were noted.

One woman had hyperstimulation in early labour and had an emergency c-section.

Eight of the 23 laboured on one dose of Cervidil. The c-section percentage was 22. The average time to delivery was 14:36 hours.

Fourteen women did not labour on Cervidil. However, 6 (43%) did have favourable cervixes after one dose of Cervidil. All of these women were started on oxytocin. Two (29%) had c-sections. Four had vaginal deliveries although 2 were operative. The average total time to delivery was 26:26. The average time of being on oxytocin was 9:04. Five of the six delivered after less than 12 hours of syntocinon.

The other 8 women had unfavourable cervixes after a dose of Cervidil for 24 hours.

-1 had a transcervical catheter and oxytocin and had a normal delivery

-4 received oxytocin despite having unfavourable cervixes. 50% did not have normal deliveries. One did not progress and the oxytocin was stopped and she received Prostin. Three continued on oxytocin. One had a normal delivery, one a c-section and one an operative vaginal delivery.

-3 women had another Cervidil and none of them laboured on the Cervidil. The other two inductions were aborted and resumed several days later. One of them did have oxytocin and ultimately had an operative vaginal delivery. Her total induction time was 54:04.

The average time to delivery for the women with unfavourable cervixes after receiving Cervidil was 35:18. This does not include the days for the two women who had their inductions paused.

Conclusion:

We were surprised to find that 31% of nulliparous women who deliver at Hauora Tairāwhiti have inductions. However, overall it is reassuring that all of the women had clinical indications for their inductions. The overall c-section percentage of 30 for these women does not see unreasonable as percentages higher than this are quoted in the literature.

When we look at our results in a stratified way we have to remember that our numbers are small and we need to be careful with our conclusions. PROM outcomes are as expected. The c-section percentage was 27. It is interesting that time to delivery was much faster with oxytocin than with Cervidil. Perhaps we should consider using oxytocin as the first line induction agent for women with PROM. Especially as 40% of the women who received Cervidil initially still needed oxytocin.

As is appropriate, all of the women without PROM, had cervical ripening since they all had unfavourable cervixes. At least initially, none of them received oxytocin with unfavourable cervixes before Cervidil was tried. Cervidil was the initial ripening agent for all of these inductions. Thirty-five percent laboured on Cervidil alone. A further 26% had favourable cervixes after one dose of Cervidil. So one dose of Cervidil was successful in achieving at least cervical ripeness for 61% of women. The average time to delivery for women who laboured on Cervidil was 14:36. This could have implications for what time of day we place Cervidil. They had a c-section percentage of 22. For the 26% who didn't labour after 24 hours of Cervidil, but had cervixes favourable for oxytocin, the c-section percentage was 29. As is logical, the average time to delivery increased to 26:26. Of interest, the average time on oxytocin was 9:04. This means that, on average, if women with favourable cervixes have oxytocin started first thing in the morning they have a good chance of delivering during the daytime. This is advantageous as daytime deliveries, especially on weekdays, have the lowest risk of complications while using fewer resources. Of note, one woman (4%) had hyperstimulation on Cervidil and had an emergency c-section in early labour.

As is true everywhere, the labours that are hardest to manage are for the group of women who do not respond to the initial ripening agent. For the 35% who did not respond to Cervidil, the average time to delivery was 35:18. This does not include the increased time for the two women who had their inductions paused after a second dose of Cervidil. Given our small numbers it is difficult to say what is the best way to proceed for

these inductions. Giving a second Cervidil or starting oxytocin were not particularly effective and, an average, lead to longer inductions. However, we didn't use other methods enough to clearly establish which one is better.

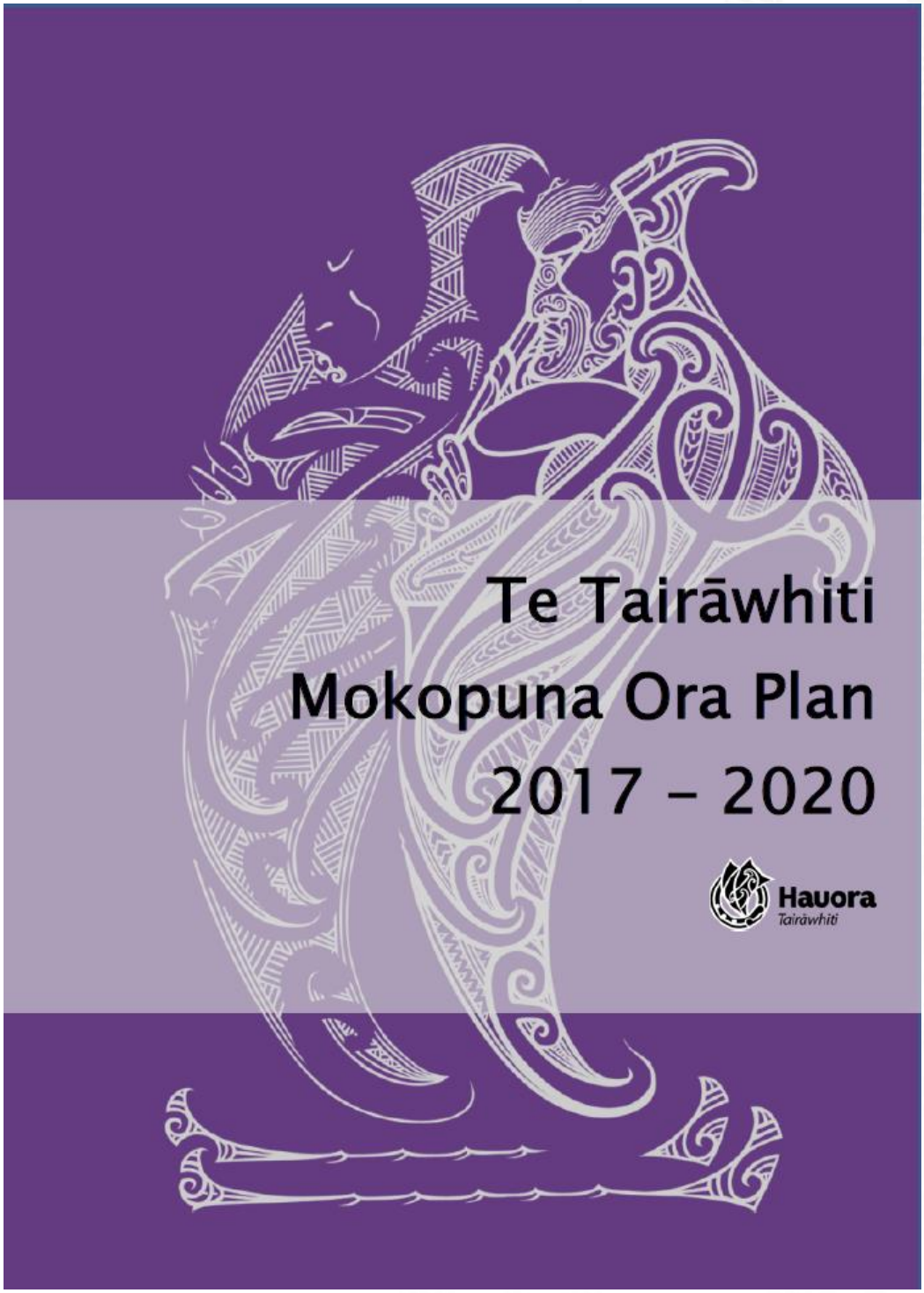
All in all this audit reassured us that we have reasonable outcomes for labour inductions for nulliparous women. We may want to consider how we manage PROM and what time of day we start inductions. We will also discuss how to proceed with women who don't respond to the initial cervical ripening agent. We will also continue to work on the time initiation of oxytocin for women with favourable cervixes.

Audit Action Plan

As above, this audit has given us some things to think about. However, it's overall purpose was to characterize our situation rather than to establish a baseline for change. If we do decide to make any significant changes it would then be worth repeating the audit in the future.

Hauora Tairāwhiti

Appendix 6 - Mokopuna Ora Plan



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Tena Tatou Katoa,

The first draft of the Tairāwhiti Mokopuna Ora Plan was written in 2016 following the *Mokopuna Ora* symposium. It marked the 10-year anniversary of the Wahakura Project led by Dr David Tipene-Leach and the Tairāwhiti Nukutere Weavers in 2006. One hundred Wahakura were woven as a Māori solution to Safe-sleeping Pēpi in response to the high rates of SUDI (Sudden Unexpected Deaths in Infancy) within Tairāwhiti at the time.

This updated version of the *Mokopuna Ora Plan* reflects the new discussions, information and introduction of the Ministry of Health (MOH) National SUDI Prevention Programme (NSPP 2017). The current SUDI rate in New Zealand is approximately 0.7 in every 1,000 babies born and 1.59 for every 1,000 Māori babies born. The NSPP aims to reduce the rate to 0.1 in every 1,000 births by 2025.

Mokopuna Ora is our goal, our vision and our dream for the future, underpinned by a Whānau Ora model where whānau are supported and empowered to realise their own health needs and aspirations drawing on a 'Mokopuna / Whānau' centred methodology. We use the term Mokopuna Ora for the plan as a strengths based approach to support parents and whānau to be confident, capable loving parents/caregivers. SUDI Prevention and Safe-sleeping are core factors of the plan; alongside of other equally important and beneficial outcomes for Pēpi such as, *Tupeka Kore* (Tobacco free) whānau and *Te Whāngai U i to Pēpi* (Breastfeeding baby).

The combination of these four components we are confident that our babies will be born healthy, will thrive and be part of whānau that love and care for them. That they are safe in their own sleeping spaces and places, are nurtured and nourished, live in homes that are tobacco free, are warm dry and healthy, and are receiving all of their health checks on time. In order for these things to occur, whānau must be supported, informed and guided by health and social services workforce that are capable and competent, and are health literate in SUDI Prevention and Safe-sleep practises.

Our mokopuna are precious and fragile; particularly so in their first year of life. The whakatauki reflects the seriousness and implications of SUDI;

"Maroro kokoti ihu waka tau"
The small fish crosses the path of death

The 10-year anniversary of the Wahakura Project and subsequent hui, workshops and planning sessions to date have mobilised the communities by raising their awareness of SUDI and the prevention of it. This is a significant kaupapa to undertake, as Hauora Tairāwhiti we are committed to improving Child Health outcomes for all; nevertheless we recognise the inequalities which exist for Māori with respect to the SUDI rates within Tairāwhiti. For the past 12-years all SUDI in Tairāwhiti have all been specific to whānau Māori.

Within the plan we focus on six key priorities that we believe will contribute to our overarching goal of Mokopuna Ora, and in the process will reduce SUDI in Tairāwhiti;

KEY AREAS OF PRIORITY

1. Moe Haumaru - Safe Sleep
2. Tupeka Kore – Tobacco Free

3. Te Whāngai Ū i to Pēpi – Breastfeeding baby
4. Services are inclusive, accessible and effective
5. The workforce is competent, confident and consistent
6. Everybody is talking about mokopuna ora

The plan aligns with the two key SUDI risk factors which are, being exposed to tobacco smoke during pregnancy and baby is in their own bed and make sure every sleep is a safe sleep. We acknowledge that these are not the only risk factors, and that tobacco is not the only stimulant or drug that has been associated with SUDI deaths. However, for the purposes of this plan we are aware that the extensive use and harm of tobacco by Māori women during pregnancy has to be addressed as a priority.

We're using the wahakura as our framework for this plan. The base of the wahakura requires three strands (or whiri) to be interwoven and locked together for strength and stability. Our three whiri represent the domains of ***Pae Ora*** – Mauri ora, Whānau ora and Wai ora.

We look forward to the implementation and developments that a resourced SUDI Prevention and Safe-Sleep programme will achieve. Mokopuna Ora is about all of our babies, and all of our whānau; we all have a shared responsibility for protecting our most precious taonga.

Mauri Ora

Mokopuna Ora, Whānau Ora, Mauri Ora: Tairāwhiti 2006, 2016 – 2018

"We have made massive gains in reducing SUDI rates, but there is still a long way to go. We can credit most of our success to the introduction of safe-sleeping devices like the wahakura and the associated safe sleeping messages"

"The wahakura is a woven basket that creates a safe distance between baby and their parents in or near the bed. Along with the plastic pepi-pod, the wahakura has been distributed to thousands of young parents around the country."

Dr. David Tipene-Leach (2016)
Mokopuna Ora Symposium – Gisborne/Turanganui-A-Kiwa)

Whakatauki - Proverb

Hutia te rito o te harakeke,
Kei whea te kōmako e kō?
Kī mai ki ahau;
He aha te mea nui o te Ao?
Māku e kī atu, he tāngata, he tāngata, he tāngata

If the heart of the harakeke was removed, where will the bellbird sing?
If I was asked what was the most important thing in the world;
I would be compelled to reply.

It is people, it is people, it is people.

What does success look like for Mokopuna Ora?

Our Whānau

- Whānau are empowered, supported and are able to determine their health needs and aspirations
- Hapūtanga is a time when māmā and pēpi are healthy, supported and loved during development
- Mokopuna are born at full-term and are of a healthy birth weight
- Whānau have a positive birth experience and are supported post-birth
- Whānau have the knowledge, confidence and support to breastfeed pēpi fully and exclusively to at least 6-months
- Whānau have their own wahakura for pēpi to sleep in from birth
- Whānau have the knowledge and confidence to ensure every sleep for pēpi is a safe sleep
- Whānau are tupeka kore within the whānau, their whare and waka (vehicle)
- Whānau are loving and enjoying their new pēpi
- Mokopuna and Whānau are at the centre of their extended whānau, hapu, iwi and communities; and celebrate their whakapapa

Our Marae

- Our marae are tupeka kore
- Our marae are supporting our whānau to be a tupeka kore place
- Our marae have their own pa harakeke for weaving wahakura
- We are able to learn how to weave a wahakura on our marae
- We support local marae to develop their Kairaranga collectives
- Our marae have wahakura for pēpi that are sleeping on the marae
- Our marae have weavers that are supported to help teach the whānau how to weave wahakura
- Every sleep for pēpi on the marae is a safe sleep
- Our marae whānau understand the gift of breastfeeding and support mum to breastfeed pēpi

Our Services

- Services are responsive and supportive to the needs of mum, dad, pēpi and the wider whānau
- Services are supported by a centrally coordinated hub to ensure activities, resources and training are enabled, efficient and accessible to whānau and the workforce
- Pēpi receives all their checks and immunisations on time
- Support for breastfeeding is accessible and available
- Information is provided to mum, dad and the whānau in ways that they best understand
- Mum, dad and whānau know where to access support and help for any concerns
- The programme collects information to measure its effectiveness of services and activities, against the NSPP SUDI Outcomes framework

Our Community

- There are wahakura available for whānau through wananga, from Kairaranga or the central hub
- Wahakura are in our marae, kohanga reo, day-care centres
- Our kohanga reo and kura are breastfeeding friendly and tupeka kore spaces
- Kaimahi receive up to date training and education on breastfeeding, safe sleep and tupeka kore
- There are safe sleep, tupeka kore and breastfeeding policies in all our key settings
- Mum is able to continue breastfeeding pēpi once she returns to work
- There are breastfeeding friendly spaces and places in our community
- There are tupeka kore spaces and places for pēpi and tamariki in our community
- Kairaranga experts "Tohunga" implement a kaitiaki quality standard for wahakura

Our Dreams

- Our mokopuna know their whakapapa
- Our mokopuna are at ease on their turangawaewae
- Our mokopuna speak their language
- Our mokopuna are excelling in all education pursuits including in kohanga reo, kura and wharekura
- Our mokopuna are utilising their unique gifts and talents and embracing life to the fullest!

The Three Domains Of PAE-ORA

Mauri Ora - HEALTHY Individuals

Population Statement *The mauri of our pēpi and whānau are strong, vibrant and energised*

OUTCOME STATEMENTS	POPULATION INDICATOR
Whānau are connected to their marae. Whānau are able to participate in marae, hapū and iwi activities.	Proportion of whānau who participate in their marae, hapū and iwi activities and wider cultural activities
Whānau are confident in their own identity Whānau know their whakapapa	Proportion of whānau who know their whakapapa, marae, hapū and iwi
Te Reo Māori is spoken in the home.	Proportion of whānau who speak Te Reo Māori in the home
Mokopuna are participating in education – including Kohanga Reo, TKKM and Wharekura.	Proportion of taiohi/tamariki/pēpi attending Te Kohanga Reo, Te Kura Kaupapa Māori and Wharekura

Wai Ora - HEALTHY Environments

Population Statement *Whānau live in environments that support us to be well*

OUTCOME STATEMENTS	POPULATION INDICATOR
Whānau live in homes that are warm, dry and not crowded	Proportion of whānau utilising the healthy homes programme
Pēpi have their own wahakura (or safe sleeping space) for every sleep	Proportion of pēpi with a wahakura or safe sleeping space
Whānau are able to access health services such as a doctor, midwife, antenatal education, well child tamariki ora nurse and close to where they live	Proportion of whānau enrolled with a GP
	Proportion of hapū wahine enrolled with an LMC by 12 weeks
	Proportion of mokopuna enrolled with a WCTO provider
	Number of first time hapū wahine completing antenatal education

Whānau Ora - HEALTHY Families

Population Statement *Whānau are supported to achieve their maximum health and wellbeing*

OUTCOME STATEMENTS	POPULATION INDICATOR
Wahine Māori are entering pregnancy strong, healthy and confident	Proportion of hapū māmā that have pregnancies to full term
Hapū wahine receive wrap-around care and support throughout their pregnancy	Proportion of pēpi born of a healthy birth weight
Hapūtanga are smoke, tobacco and alcohol free	Proportion of hapū māmā that are offered help to quit smoking

Māmā are supported and confident to breastfeed their pēpi	Uptake of cessation support by hapū māmā to quit smoking
	Proportion of māmā that are smokefree at 2 weeks postnatal
	Proportion of pēpi exclusively, fully and partially breastfed in their first two years of life
Whānau are safe-sleeping their pēpi in a wahakura from birth	Proportion of whanau who have a wahakura and are using it at their 6wk, 3month and 6month WCTO check

ACHIEVING THE OUTCOME STATEMENTS

Me awheawhe noa tēnā mahi ka oti
That work should be done as a group and then it will be completed.

Activity One: MOE HAUMARU – Every Sleep is a Safe-sleep

WHAT CAN WE DO?	WHOSE HELP DO WE NEED?	WHY?	HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE?	HOW READY ARE WE TO COMPLETE THIS ACTIVITY?
Pēpi have their own wahakura (or their own safe sleep bed) to sleep in; **Key Messages:** **PLACE** pēpi in their own baby bed in the same room as their parent or caregiver **POSITION** baby flat on their back to sleep – face clear of bedding	▪ NSSP – Hāpai Te Hauora ▪ Māmā and Pēpi ▪ Iwi Hauora ▪ Runanga ▪ MWWL ▪ Weavers ▪ Marae ▪ Toihoukura ▪ TWOA/EIT ▪ LMC's ▪ Maternity ▪ WCTO	Wahakura are our preferred choice for a safe bed for pēpi. The evidence that wahakura can reduce the risk of SUDI is well documented. The community and the local weavers will work together in an integrated project to provide wahakura through wananga for whanau, or will have wahakura available for every pēpi in our rohe.	▪ LMC feedback/data ▪ #of pēpi with a wahakura at first WCTO core visit ▪ #of pēpi with a safe sleep bed at first WCTO core visit	▪ The wahakura project is a major component of this Mokopuna Ora plan and will be coordinated through the E Tipu E Rea service. ▪ The engagement of weavers through the Mama and Pepi 'Wahakura' programmes based within the three Maori health service providers Te Hauora o Te Turanganui a Kiwa, Ngati Porou Hauora and Te Aitanga A Hauiti Hauora. As well as through the network of Tairāwhiti Kairaranga (weavers) collectives.
Whānau are knowledgeable and confident on safe sleep principles and practice	▪ LMC's ▪ Māmā and Pēpi ▪ Maternity ▪ WCTO ▪ Weavers ▪ Marae	Whānau understanding of safe sleep principles and practices is crucial to SUDI prevention. We want whānau to feel confident in being able to give pēpi a safe sleep not only in their own home but also when staying with whānau, visiting friends, or on the marae.	▪ #whānau provided with safe sleep education in antenatal classes ▪ #whānau provided with safe sleep education in maternity ▪ #whānau provided with safe sleep education by LMC ▪ #whānau provided with safe sleep education by WCTO at core 1. ▪ Whānau feedback	▪ Services are already providing safe sleep education as part of their core requirements. Workforce development is a crucial component of this and we will ensure that all health services are trained appropriately. ▪ Training opportunities will be extended out to other sectors – social services, early childhood, Whangaia, Pa harakeke, community based groups Ka Pai Kaiti, E Tu Elgin, Maori Women's Welfare League etc.

A marae-based iwi-led holistic wahakura programme is developed and implemented	▪ Weavers ▪ Marae ▪ Hauora ▪ Māmā and Pēpi ▪ Runanga ▪ MWWL ▪ Toihoukura ▪ TWOA/EIT ▪ Hāpai Te Hauora ▪ Te Puni Kokiri ▪ DHB	A marae-based wahakura programme is one of our approaches. The goal is to have pēpi sleeping in their own wahakura, woven by their whānau, taught by their whānau, using harakeke from the pa harakeke of their own marae. A connection of a pēpi to their turangawaewae is powerful! The programme would provide opportunity to korero about breastfeeding, tupeka kore, parenting, relationships and safe sleep, child health checks (WCTO i.e. Immunisations)	▪ Programme will be developed and implemented on marae or community based setting ▪ Stakeholder feedback ▪ Whānau feedback ▪ #wahakura Wananga completed ▪ #wahakura woven	▪ This is a community identified approach which enables engagement with whanau at an extended level, and communities. Coordination of this will be supported through the three key Māori health provider services and their Wahakura programmes. ▪ Weavers will be engaged to tutor weaving wahakura from marae whanau. ▪ Developing Safe-sleep policy and guidelines for the marae will be implemented with a wahakura gifted from a wananga to the marae.
Safe sleep advice and a check is completed by LMC's and WCTO providers at first visit	▪ LMC's ▪ WCTO ▪ Māmā and Pēpi	Ministry requirement that SUDI information and a check is completed at the first WCTO core visit	▪ #checks completed by provider ▪ Stakeholder feedback	▪ Nationally and regionally approved 'Key Safe-sleep and SUDI Prevention messages' will be utilised ▪ Ensure workforce are up to date in safe sleep training, online SUDI Prevention training via Hāpai Te Hauora (NSSP) and Change for our Children
There is a pathway available for whānau to access wahakura / safe sleep beds	▪ LMC's ▪ WCTO ▪ Māmā and Pēpi ▪ Maternity	Ensure a source of wahakura and/or beds are available for whānau in special circumstances, and for those unable to participate in wananga.	▪ # wahakura being distributed by LMC's, maternity units, WCTO,E Tipu E Rea - Māmā and Pēpi for whānau unable to access one ▪ # wahakura distributed after WCTO core 1 visit (WCTO required to	▪ Referral pathways developed and included in communications and resources for key provider services ▪ Monitoring of distribution from when wahakura is provided and across the handover, 6wk, 3mth and 6mth checks via LMCs WCTO services, as well as other child health services ▪ Resourcing weavers will be

			physically sight pēpi bed)	coordinated through the E Tipu E Rea hub.
A quality assurance process for wahakura will be implemented through a 'specialised / expert' Kairaranga group	▪ Weavers ▪ Kaumatua ▪ Toihoukura ▪ TWOA ▪ Health professionals	Ensure that the quality of the wahakura is of a high standard in terms of safety, strength, tikanga and value	▪ Quarterly forum with weavers, kaumatua and other experts ▪ Stakeholder / provider feedback ▪ Whanau	▪ Develop a quality assurance checklist which includes safety standards for Safe-sleep i.e. weave durability, harakeke preparations, dimensions, mattress, maintenance and care etc (refer to Dr David Tipene-Leach & Nukutere Wahakura Guidelines)

Activity Two: TUPEKA KORE - Pēpi lives in tobacco free environments

WHAT CAN WE DO?	WHOSE HELP DO WE NEED?	WHY?	HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE?	HOW READY ARE WE TO COMPLETE THIS ACTIVITY?
Implement a cessation pathway that works for hapū wahine and their whānau to be a smokefree whanau, with smokefree whare and waka **Key Message:** **ELIMINATE** smoking in pregnancy and protect baby with a smokefree whanau, whare and waka.	▪ LMC's ▪ Māmā and Pēpi ▪ Hāpai Te Hauora ▪ Cessation Service Providers (OAFA) ▪ Taki Tahi Toa Mano ▪ Health services	Our current maternal smoking rates during pregnancy are still high. Nearly 220 newborn babies are exposed to cigarette smoke during pregnancy. We need to continue ABC and support uptake of cessation support by hapū wahine is only about 30%.	▪ Cessation pathway in place by Jan 2017. ▪ # of hapū wahine offered ABC ▪ Uptake of cessation services by hapū wahine ▪ % of wahine smoking during pregnancy (need to check what data is available currently) ▪ % of women smokefree two weeks postnatal	▪ Improve pathways to support hapū mama and whanau to access smoking cessation services, include Maori models and perspective into the pathways ▪ Build incentives into smoking cessation services, as individuals or whanau groupings ▪ All health services engaging with hapū mama will be having the ABC conversations ▪ Build on smoking cessation services tailored specifically for hapū mama and whanau i.e. Te Aka Ora (Teen/young parents), Radiology, Pinnacle PHO (General Practises), Maternity, LMCs etc
Ensure the tobacco control workforce are up to date with safe sleep training	▪ Taki Tahi Toa Mano ▪ Health and social services	Workforce development is a key component of this plan and as such ensuring our tobacco control workforce is up to date with safe sleep is essential.	▪ # of participants that have completed safe sleep training ▪ Database of all organisations or services that need to complete safe sleep training and track participant numbers at each training session.	▪ Hāpai Te Hauora will provide from April 2018 the revised online SUDI training ▪ Child Health service training days/ workshops planned for range of educational sessions i.e. SUDI Prevention, Shaking Baby, Breastfeeding, Immunisation etc
Review current key Smokefree messages and information that are included in antenatal and parenting education programmes.	▪ Māmā and Pēpi ▪ Hāpai Te Hauora ▪ Taki Tahi Toa Mano	Smokefree messages have always been included in our antenatal education programmes. Reviewing these messages may give us some insight into how whānau are receiving these messages, is it working, and are there any new approaches or information we can include?	▪ #participant evaluation on completion of antenatal education ▪ #referral numbers into cessation services from antenatal classes	▪ Work with population health teams, HPA, Hāpai Te Hauora and tobacco control sector
Support the priorities and activities outlined in the Tairāwhiti Tobacco Control Plan	▪ All stakeholders, communities and whānau	The DHB plan highlights maternal smoking during pregnancy and healthy environments as key priorities within the plan.	▪ Outlined in plan	▪ Key prioritisation for Hapū Mama highlighted with plan ▪ Redevelop new plan to include SUDI Prevention and Safe-sleep messages
Undertake a pilot for smoking cessation for alternative quitting approaches i.e. Vaping / E-cigarettes	▪ Taki Tahi Toa Mano ▪ All stakeholders, communities, hapū mama and whanau	Communities have taken up the Vaping / E-cigarette with reports that this has supported them on a quitting journey. Awaiting national guidance, but will explore through other DHB networks where Vaping is being utilised	▪ Include in Tobacco Control Plan 2018 – 2021 ▪ Service Mapping of Tobacco services for Tairāwhiti	▪ Progress discussions with Smoking Cessation services to pilot/trial using vaping as a quitting support strategy with hapū mama and whanau ▪ Undertake a service mapping of all Tobacco Control services in Tairāwhiti to inform the new plan ▪ Complete and implement a Tobacco Free 'Tupeka Kore' Outcomes RBA Framework with Taki Tahi Toa, Cessation Services, key stakeholders facilitated by SheaPita & Associates

Activity Three: TE WHĀNGAI Ū I TO PĒPI – Pēpi is breastfed

WHAT CAN WE DO?	WHOSE HELP DO WE NEED?	WHY?	HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE?	HOW READY ARE WE TO COMPLETE THIS ACTIVITY?
Complete a breastfeeding review so we know exactly what is happening in this space (who, what, where, how, why) **Key Message: Encourage** and support breastfeeding and gentle handling of baby.	▪ DHB Planning and Funding ▪ LMC's ▪ Maternity ▪ Māmā and Pēpi ▪ WCTO ▪ Lactation Consultants	A review of breastfeeding services across the district would enable a comprehensive understanding of what is available to mothers and whānau to support breastfeeding. Will support planning for the workforce training needs. Informs our funding models for service agreements Links to: MQSP, WCTO Quality Improvement Plan, DHB Māori Health Plan	▪ Key informant interviews ▪ Stakeholder interviews ▪ Whānau interviews ▪ #pēpi exclusively and fully breastfed at key milestones	▪ Develop with MQSP, WCTO, LMCs, Lactation services, Mama & Pepi and other maternal/child health stakeholders ▪ Work with Healthy Families East Cape to support 'Breastfeeding Friendly Environments and supports required' ▪ WCTO Quality Improvement project identifying Breastfeeding as a key priority for 2018/19 & 2019/2020 year (utilise PDSA).
Breastfeeding education and support is accessible, appropriate and available (antenatal, postnatal, at home)	▪ LMC's ▪ Māmā and Pēpi ▪ Lactation Consultants ▪ Maternity ▪ WCTO	Breastfeeding education and support is required at different stages and in different forms. Support breastfeeding continuum and that we collectively work together to support mums and their whānau to be able to breastfeed pēpi exclusively and for longer. We need to ensure that whānau are able to access this support regardless of their	▪ #pēpi exclusively and fully breastfed at key milestones	▪ Expand on breastfeeding education capability is increased, currently Māmā and Pēpi services include breastfeeding in their antenatal education classes, maternity support mums with establishing breastfeeding, LMC's and WCTO support mums in the home and the Community Lactation Consultant is available for complex and specialised breastfeeding support and intervention.

		location (rural, urban etc.)		▪ Promote the referrals to specialised Mamapukeko Community Lactation services, specifically increasing referrals for Maori wahine, to reduce current disproportion in utilisation of service.
Māmā are able to continue breastfeeding pēpi on return to work or study	▪ DHB Healthy Workplaces Facilitator ▪ Human Resources ▪ Tertiary training institutes ▪ Teen Parent Education Services ▪ Employers	We continue to see a drop off in our breastfeeding rates at 3 months. This coincides with the end of paid parental leave and mums needing to return to work and/or study. Working with local employers and education providers to ensure mums are able to continue breastfeeding their pēpi will help ensure the protective factors of breastfeeding on SUDI risk reduction can continue	▪ #pēpi exclusively and fully breastfed at 3 months and 6 months. ▪ Feedback from mums ▪ Feedback from stakeholder	▪ Engage with key stakeholders to outline ways in which breastfeeding mama are supported for work or study.
Breastfeeding is supported in public spaces and places	▪ MQSP ▪ Maternal stakeholders ▪ WCTO ▪ HFEC ▪ HPA ▪ Breastfeeding Advocates / Champions	We continue to be aware that in some public spaces and businesses breastfeeding is not supported. We need to 'normalise' breastfeeding as being an everyday and healthy way to nourish and nurture our babies	▪ Annual Latch-on events and promotional opportunities	▪ Planned events and resources that support breastfeeding ▪ Work with key stakeholders to develop a Breastfeeding Friendly Community Initiative in line with Breastfeeding Friendly Hospital Initiative ▪ Promote breastfeeding friendly cafes, restaurants, public spaces – stickers and social media profiling.

Activity Four: SERVICES ARE INCLUSIVE – Accessible, effective and timely

WHAT CAN WE DO?	WHOSE HELP DO WE NEED?	WHY?	HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE?	HOW READY ARE WE TO COMPLETE THIS ACTIVITY?
Ensure antenatal education and parenting classes are available to all whānau across the district	▪ E Tipu E Rea ▪ Māmā and Pēpi ▪ LMC's ▪ Te Aka Ora	Appropriate and accessible antenatal and parenting education helps ensure better birth, postnatal and health outcomes for pēpi, mum, dad and their whānau. Our Māmā and Pēpi services deliver antenatal education from a kaupapa Māori perspective in city, rural and coast communities and reach a large number of our first time mothers and Māori/Pacific hapū wahine. We also have our DHB funded antenatal education classes that deliver to a largely mainstream population. We need to ensure that all hapū wahine throughout the district have access to antenatal education.	▪ # first time mothers completing antenatal education ▪ # teen hapū wahine completing antenatal education ▪ # Māori/Pacific wahine completing antenatal education ▪ # hapū wahine completing antenatal education by domicile ▪ # referrals into antenatal education from ETER	▪ Review all ante-natal education and information that is currently utilised. Identify the gaps by availability of classes, location, effectiveness/appropriateness for all groups ▪ Implement the HEAT tool to identify if there are any inequalities within the review ▪ Update and inform MQSP and other key stakeholders of key issues, gaps, successes and recommendations from review ▪ Research evaluated Maori ante-natal models to inform the review process
Services continue to support whānau to ensure all pēpi are enrolled with a PHO and that WCTO and immunisations are completed on time	▪ E Tipu E Rea ▪ Māmā and Pēpi ▪ WCTO ▪ General Practice ▪ Maternity /NCHIP	Universal services that support and promote the healthy development of children and the whānau from birth to five years. Additional services are available according to need.	▪ Newborn PHO enrolment rates by ethnicity ▪ WCTO enrolment rates by ethnicity and deprivation ▪ # Babies receiving all core contacts in their first 12 months. ▪ % babies fully immunised	▪ WCTO Quality Improvement Programme. There are MOH targets for these indicators which we use to track coverage, enrolment rates and completion of core checks. We are tracking under for most of our targets. Including these in our mokopuna ora plan helps bring a greater

	▪ LMC's ▪ MWWL		at key milestones by ethnicity and high deprivation.	understanding of these targets and engages services and communities to ensure these are completed on time.
Confirm agreed regional safe sleep policy for implementation into health settings	▪ DHB ▪ Maternity ▪ Māmā and Pēpi ▪ WCTO ▪ Iwi Hauora ▪ PHO ▪ LMC's ▪ Hāpai Te Hauora	A safe sleep policy that is inclusive of all Tairāwhiti service providers that support and care for pēpi, mothers and their whānau is needed for our district. Policies already exist as part of BFHI but it would be useful and meaningful to take a collaborative approach and develop a policy that can be used across our different health services (DHB, Hauora, PHO etc.).	▪ Policy is developed, agreed and implemented across the district ▪ Feedback and agreement on the policy from: ▪ Maternal and infant health providers ▪ NSSP – Hāpai Te Hauora ▪ Clinical leaders in maternal and infant health ▪ Whānau input and advice	▪ Liaise with the Regional Midland DHB SUDI Prevention & Safe-sleep Group on review and update of policies and guidelines for health service settings ▪ Seek input and feedback on redeveloped policy across maternal and child health services
Progress and quality improvement is monitored including one clinical audit of safe sleep practice in a health service setting. Cultural audits could also be explored	▪ DHB ▪ Maternity ▪ Māmā and Pēpi ▪ WCTO ▪ Iwi Hauora ▪ PHO ▪ LMC's	As part of quality improvement activity and to ensure our activities continue to improve health outcomes for pēpi, mum and their whānau. Clinical audit to ensure compliance with safe sleep policy and to offer an opportunity for review and reflection.	▪ Findings of clinical audit and/or cultural audits if agreed.	▪ Include as part of safe sleep policy development.
Establish a community-based, iwi-led kaitiaki roopu to provide guidance and advice on the activities outlined in this plan	▪ All	The kaupapa of Mokopuna Ora belongs with whānau, their marae and their community. DHB and other government agencies are there to support, enable and respond accordingly. Leadership of this plan belongs with the community. Whānau know what works best.	▪ Kaitiaki group established, progressing and supported by agencies.	▪ Identify key stakeholder groups with identified/recommended members to join a broader Child Health Services forum ▪ Particular focus on specialist / experts, kaumatua, Kai Raranga, health leaders and marae, Te Kohanga Reo & ECE to be invited to attend regular forums

Activity Five: THE WORKFORCE IS COMPETENT – Confident, consistent and health literate

WHAT CAN WE DO?	WHOSE HELP DO WE NEED?	WHY?	HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE?	HOW READY ARE WE TO COMPLETE THIS ACTIVITY?
Develop and deliver a training package that encompasses Safe Sleep, Tupeka Kore, Breastfeeding, WCTO – Immunisations, Nutrition & Physical Activity within a Te Ao Māori context for the local workforce (paid and voluntary)	▪ Hāpai Te Hauora ▪ Lactation Consultants ▪ Tobacco Control/Cessation Providers ▪ Māori Birth Educators ▪ LMCs ▪ Māmā and Pēpi	We need to ensure that all those working with whānau are competent and confident in delivering messages within a Te Ao Māori context. Health literacy is crucial. Training is opportunistic at present. A collaborative and coordinated workforce development plan will help ensure everyone is on the 'same page'	▪ Training package developed ▪ Workforce development plan developed ▪ # training sessions delivered ▪ # participant numbers by organisation and role (e.g., clinical, community, kaiawhina) ▪ Whānau feedback	▪ Priority for new kaimahi, and refresher for current workforce. ▪ The coordination and planning of the training package and its implementation would require a working group to develop. ▪ Funding requirements to be identified in order to support as ongoing workforce development programme. ▪ In-house training review undertaken with services, to map and calendar shared training opportunities
Explore training needs of other sectors (i.e. early childhood, kohanga reo, social services, iwi services) in safe sleep, breastfeeding and tupeka kore	▪ Kohanga Reo ▪ Kura Kaupapa Māori ▪ Social services ▪ Iwi services	Whānau connect to a range of people from different services and settings such as kohanga reo, kura, iwi services etc. A training package to support kaimahi from these settings would help ensure we are all consistent and confident in our messaging and conversations with whānau.	▪ Training package developed ▪ Workforce development plan developed ▪ # training sessions delivered ▪ # participant numbers by organisation and role	▪ Same comments as above
Introduce a Mahi-A-Atua approach into training/education sessions. Building on the models of wananga and drawing from our Tairāwhiti purakau	▪ Mahi-A-Atua ▪ Te Kura Huna ▪ E Tipu E Rea ▪ Population Health Hauora Tairāwhiti	Workforce within Tairāwhiti are able to benefit from a unique model of learning, three key principles include • Indigenising your space • Being an active learner	▪ Uptake from a wide range of Maternal and Child Health services in wananga ▪ Participant feedback	▪ Develop with stakeholders an overarching Child Health Services training and education calendar, that supports community delivered workshops, online training, support and mentoring through

Activity six: EVERYBODY IS TALKING – "About Mokopuna Ora"

WHAT CAN WE DO?	WHOSE HELP DO WE NEED?	WHY?	HOW WILL WE KNOW WE ARE MAKING A DIFFERENCE?	HOW READY ARE WE TO COMPLETE THIS ACTIVITY?
Identify safe sleep champions/kaitiaki within each community that can advocate and promote key messages and activities	▪ Whānau ▪ Marae ▪ Runanga ▪ Iwi Hauora ▪ Health Promotion ▪ Māmā and Pēpi ▪ WCTO ▪ Hāpai Te Hauora ▪ MWWL	Kaitiaki keep us safe and give us guidance, awhi and tautoko. Kaitiaki are respected within their whānau and communities. We have some amazing people in Tairāwhiti who have provided support and awhi to whānau for many years. These people would be ideal advocates for mokopuna ora.	▪ Feedback from kaitiaki about what they're seeing and hearing from their communities ▪ Whānau feedback	▪ Identify resources and people interested in becoming community champions/spokespeople and the support processes for them ▪ Utilise nationally, regionally developed resources and information
Identify whānau that are keen to become involved in local activities	▪ Whānau ▪ Marae ▪ WCTO Māmā and Pēpi ▪ Hāpai Te Hauora ▪ MWWL	Whānau stories and experiences are a powerful tool in community awareness and health promotion campaigns. Our community responds strongly to local stories from whānau they can connect and recognise with.	▪ Whānau feedback ▪ Social media response	▪ Work with provider sector and community-based groups i.e. MWWL etc that would like to be involved...
Use Safe Sleep Day as our key promotional campaign day	▪ All	Provides direction and a key event for all to work towards. Links in with activities and resource at a national level. Whānau recognise this day and it earns considerable media coverage.	▪ # activities and events completed on safe sleep day ▪ Whānau feedback ▪ stakeholder feedback	▪ Collaborate with Health Promotion, providers and community groups for event. ▪ Identify resources available to support activities.
Develop a communications plan that includes regular	▪ Hāpai Te Hauora	To ensures a strategic, collaborative and coordinated	▪ Communications plan developed and	▪ Engage communications expertise to support development of a plan

updates on social media, print media, radio and community events	▪ DHB ▪ Iwi ▪ Hauora ▪ Community ▪ MWWL	response across our district.	implemented ▪ Community feedback ▪ Media feedback	▪ Social Media and other means of communicating effectively with whanau as well as services that work with whanau
Promote the skill and expertise of our local weavers i.e. Nukutere Weavers Collective as a sustainable business model.	▪ Weavers ▪ Hāpai Te Hauora ▪ Toihoukura ▪ MWWL	Our weavers are a taonga. The knowledge, skill and creativity they weave into each creation is invaluable. The work they have done with wahakura has been celebrated nationally and we need to continue to support and enable them to do the great work they do.	▪ # weavers helping to teach whānau how to weave wahakura ▪ # weavers participating in local activities ▪ # weavers funded to weave wahakura ▪ Community feedback	▪ Work with Hāpai Te Hauora and national Māori media on coverage of the wahakura project and the weavers after the Mokopuna Ora ▪ .