PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 24 November 2021 Location: Zoom Zoom meeting ID: 878 1795 0109 Time: 9am

2DHB COMBINED HEALTH SYSTEM COMMITTEE

	ITEM	ACTION	PRESENTER	PG
1	**PROCEDURAL BUSINESS**			
1.1	Karakia		All Members	2
1.2	Apologies	**RECORD**	Chair	
1.3	Continuous Disclosure – Interest Register	**APPROVE**	Chair	3
1.4	Confirmation of Draft Minutes from meeting dated 29/09/2021	**APPROVE**	Chair	6
1.5	Matters arising from previous meetings	**NOTE**	Chair	13
1.6	Work Programme	**DISCUSS**	Chair	14
2	**STRATEGIC PRIORITIES**			
2.1	2DHB Maternal and Neonatal Health System Plan	**ENDORSE**	Chief Executive 2DHB Director Strategy, Planning and Performance	15
2.2	Commissioning in Localities	**NOTE***	2DHB Director Strategy, Planning and Performance	26
3	**OTHER**			
3.1	COVID-19 Response	**NOTE***	Chief Executive	
3.2	General Business	**NOTE**	Chair	

DATE OF NEXT HSC MEETING:
Wednesday 16 March 2022Boardroom, Level 11 Grace Neill Block, Wellington Regional Hospital

**** No paper at the meeting – presentation only***

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

2DHB Health Systems Committees

Interest Register

24/11/2021

Name	Interest
Sue Kedgley *Chair*	• Member, Consumer New Zealand Board
Dr Roger Blakeley	• Board Member, Transpower New Zealand Ltd • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd

Ria Earp	• Board Member, Wellington Free Ambulance
	• Board Member, Hospice NZ
	• Māori Health Advisor for:
	  ○ Health Quality Safety Commission
	  ○ Hospice NZ
	  ○ Nursing Council NZ

	○ School of Nursing, Midwifery & Health Practice • Former Chief Executive, Mary Potter Hospice 2006 -2017
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Member, E tū Union • Commentator, Sky Television
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Member, Muscular Dystrophy New Zealand (Central Region) • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner
Paula King	•
Sue Emirali	• Nil
Fa'amatuainu Tino Pereira	•
Kuini Puketapu	• Trustee or manager at Te Runanganui o Te Atiawa • Director of Waiwhetu Medical Group
Teresea Olsen	•

Bernadette Jones	• Director, Foundation for Equity & Research New Zealand • Co-Chair, Tāngata Whakaha Roopu, Subregional Māori Disability Group • Co-Chair, 3DHB Sub-Regional Disability Advisory Group • Executive Committee member Muscular Dystrophy Central Region • Board member, My Life My Voice Charitable Trust • Member, Health Research Council NZ, College of Experts • Senior Research Fellow, University of Otago Wellington • Husband, Tristram Ingham, is a board member of CCDHB • Director, Miramar Enterprises Limited

Minutes of the Health System Committee

HUTT VALLEY AND CAPITAL AND COAST DISTRICT HEALTH BOARDS
Held on Wednesday 29 September 2021 at 9:00am
Location: Zoom
PUBLIC

Due to Covid 19 alert level (level 2) only the Chair and limited staff attended in person (in person marked with * and all others on zoom).

PRESENT

COMMITTEE:	Sue Kedgley, Chair* Ken Laban, Deputy Chair Josh Briggs Richard Stein Vanessa Simpson Chris Kalderimis Ria Earp Sue Emirali Paula King Ana Coffey
APOLOGIES	Keri Brown Bernadette Jones Fa'amatuainu Tino Pereira David Smol Roger Blakeley
STAFF:	Fionnagh Dougan, Chief Executive Officer * Rachel Haggerty, Director Strategy, Planning and Performance* Joy Farley, Director Provider Services* Chris Kerr, Director Nursing * Junior Ulu, Director of Pacific People's Health Sally Dossor, Board Secretary * Meila Wilkins, Board Liaison Officer

1 PROCEDURAL BUSINESS

1.1 Karakia
All participated in the Karakia.

1.2 APOLOGIES
Noted as above.

1.3 CONTINUOUS DISCLOSURE

1.3.1 Interest Register

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Health System Committee meeting held on 28 July 2021 were confirmed as a true and correct record.

Moved:	**Seconded:**	
Josh Briggs	Chris Kalderimis	**CARRIED**

1.5 ACTION LOG

Noted that the Chief Executive will update on the transition to Health New Zealand in general business section of the meeting.

1.6 WORK PLAN

The Committee noted the workplan for 2021 and 2022.

Moved:	**Seconded:**	
Sue Kedgley	Vanessa Simpson	**CARRIED**

2 STRATEGIC PRIORITIES

2.1 PLANNED CARE PERFORMANCE AND IMPACT OF COVID-19 LOCKDOWN IN 2021
Director Provider Services and 2DHB Director Strategy, Planning and Performance presented.

The Committee noted

(a) the increasing service delivery and financial risks within Planned Care services at both Capital & Coast and Hutt Valley DHBs.

Moved:	**Seconded:**	
Ria Earp	Richard Stein	**CARRIED**

Notes:

- This paper identifies the funding for planned care and notes that the benefits were captured in Hutt but not Capital & Coast because of the impact of Covid, RSV and acute demand (as a tertiary).
- Drivers of performance – the vast majority of Hutt Valley is delivered in house, and at Capital & Coast delivered outsourced and depends on availability.
- Pre- the recent Covid lockdown we were seeing a recovery in performance.
- We are signalling an impact on delivery for 2021/22 which is a risk to 2021/22 numbers.
- Questions asked about the capacity of the private sector and our ability to outsource – the private sector is impacted the same way public sector. Their priority is recovering their private lists – and they suffer the same constraints (staff and resource).
- No fixed and formal contracts for service (private to public) which gives limited certainty in terms of volumes. However we are in a 2DHB RFP at present to build in more certainty. Also have wet-lease arrangements (where we effectively lease space and extend our facilities).
- Discussion on how we compare nationally – CCDHB in upper 1/3 in terms of performance, but HVDHB not so high. This is included in the financial and operational performance report to the Board.
- Theatre capacity is an issue and we are working on capacity of ED (Front of Whare) and bed and theatre capacity. Looking at short term solutions including some surgery in the weekends. We have increased acute surgery capacity so that acute is not displacing planned care.
- Discussed the backlog of 700 and the constraints on clearing the caseload given constrained capacity. It is continually reviewed and some patients may no longer require surgery.
- Bed and theatre capacity project is to determine the strategic investment without Covid – but an additional piece of work in terms of working with Covid is required going forward.
- Key focus is also workforce needs going forward to service the current model and in addition the new capacity in the system.
- HNZ will be dealing with bids for growth across the system.
- It was noted that cancer surgeries are prioritised as acute.

2.2 INTEGRATED PRIMARY CARE AND ACUTE DEMAND

Director Provider Services and 2DHB Director Strategy, Planning and Performance presented.

The Committee noted the presentation.

Impact of primary care on acute demai

Moved:	**Seconded:**	
Richard Stein	Chris Kalderimis	**CARRIED**

Notes:

- This presentation has its genesis in the questions that were raised in the 26 May 2021 presentation on acute care and the impact of 'primary care on acute flow'.
- Outlined the data on users of primary care.
- Noted the impact of RSV and the significance of impact on paediatric care and surgery.
- Demand for primary care falling for lower socio economic areas which is concerning.
- Impact on primary care of Covid has been significant because of testing and vaccination.

- Demand for Kenepuru A&M decreasing over time.
- Older people –and area of focus and our patterns are consistent with the rest of the population.
- Mental Health presenting with higher degrees of acuity, and in particular younger people.
- Diabetes patients increased, and renal speciality patients.
- The only decreasing figure is respiratory given closed borders.
- What is the relationship between this information and our strategic priorities:
    - New investment for Māori and Pacific peoples for long term conditions
    - Community Health Network development
    - Improving access to comprehensive A&M services across our localities
    - Increasing investment in community radiology to build capacity and capability
    - Continuing to implement across our localities whole of system responses for older people:
        - CHOPI
        - AWHI/Early Supported Discharge
        - Community acute responses (e.g. Ambulance diversion)
- Questions asked about workforce issues and the pipeline for a health career development and in particular targeting youth. Locally the Wellington position is challenging because of cost of living and remuneration. Pay parity across the system is a major challenge for HNZ.

3 REPORTING

3.1 MINISTRY OF HEALTH NON-FINANCIAL REPORTING – QUARTER 4 2020/2021

The 2DHB Director Strategy, Planning and Performance presented

The Committee noted:

(a) that this report provides a summary from two key reports:

i. CCDHB and HVDHB's Ministry of Health (MoH) Non-Financial Quarterly Monitoring Report for Q4 2020/21 (April to June 2021).

ii. CCDHB and HVDHB's Q4 2020/21 Health System Plan and Vision for Change dashboard.

(b) that for the 56 indicators rated by MoH this quarter, CCDHB received 1 'Outstanding' rating, 30 'Achieved' ratings, 18 'Partially Achieved' ratings and 7 'Not Achieved' ratings. This is an improvement on CCDHB's Q3 result.

(c) that for the 56 indicators rated by MoH this quarter, HVDHB received 1 'Outstanding' rating, 28 'Achieved' ratings, 19 'Partially Achieved' ratings and 8 'Not Achieved' ratings. This is similar to HVDHB's Q3 result.

(d) that specific action plans are in place to improve performance against the 'Not Achieved' performance measures, including strategies to improve our immunisation and smoking cessation advice results.

(e) that the recommissioning of immunisation services is now being considered, alongside quality improvement initiatives.

(f) overall results for CCDHB and HVDHB demonstrate:

i. performance deterioration in immunisation targets reflecting the impact of a timing change in the age for MMR immunisations and a greater number of declines to vaccination offerings;

ii. a community health system delivering well for the majority of indicators with a persistent pressure points posing challenges; and,

iii. a hospital system working hard under the pressures of increased seasonal acute demand and bed pressures.

(g) that both CCDHB and HVDHB received 'Outstanding' ratings for the 'Engagement and obligations as a Treaty partner' indicator, which is recognition of our efforts in this area.

(h) that both CCDHB and HVDHB improved their performance rating for the 'Shorter Stays in Emergency Departments' indicator, which moved from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4.

(i) that the recent Alert Level 3 and 4 lockdown period is likely to impact performance in the Q1 2021/22 results, as some activities cannot be performed during lockdown and resources have also been temporary diverted into swabbing and vaccination efforts

Moved	**Seconded**	
Chris Kalderimis	Ria Earp	**CARRIED**

Notes:

- the paper taken as read and questions were asked about outreach services for immunisation. PHO's and mana whenua partners are involved.

4 OTHER

4.1 COVID-19 RESPONSE

The Chief Executive and the Director Strategy, Planning and Performance presented.

The Committee noted the presentation.

2DHB Covid programme - 29 Sep

Moved	**Seconded**	
Sue Kedgley	Richard Stein	**CARRIED**

Notes:

- Outlined the different aspects of the covid response:
  - Regional Public Health
  - COVID Surveillance
  - COVID Vaccination
  - Managed Isolation.
- Noted the support of our workforce office, and occupational health and safety.
- Testing and surveillance testing capacity.
- Vaccination programme is a commissioned programme and Maori providers are making a significant contribution. We are currently the highest 1st dose DHB in the country and are leading the pathway on Pacific programme. We are 1st for Maori at 64%– but note this is still too low.

- Vaccination rates are slowing and we are working and leveraging our community relationships.
- Young people are the group with the greatest challenges, and school based programmes have a Māori and Pacific provider.
- Kapiti a little slower from a locality perspective and this is being addressed.
- We will have reached targets by the end of the year, however there will be ongoing need for resource - top up vaccination likely and have surge capacity for testing.
- MIQ going forward will change as hotels are no longer available – and will move to 'community isolation' – which has not been defined. This is different to the 'home isolation' trial that was announced last week.
- The Committee thanked the Regional Public Health team and the Covid response team – and noted that the strategy not to call on provider arm staff (and place pressure on 2DHBs hospitals).
- Stand up and surge capacity discussed and the Committee noted the significant contribution of Community and PHO providers.
- ICU and workforce capacity and surge workforce – we did not increase our beds (beyond increases) and have 38 negative pressure beds (which is proportionately higher than the rest of NZ).
- Discussed ICU capacity (nurses and beds) and struggle with capacity for base flows. Have been adding 1 ICU bed per year ($1M). Can stand up additional beds for surge capacity if necessary (conversion of beds and training of staff to provide care). Practical reality of surge capacity is that it is not an ongoing and sustainable service (Covid discussion).
- There has not been investment in ICU capacity, other than surge/ emergency capacity. We have people on the national working group which is involving clinical leads.

'Ana Coffey left the meeting at 11am

4.2 CENTRAL REGION EATING DISORDER SERVICE

The Executive Director MHAIDS and the Executive Clinical Director MHAIDS presented.

The Committee noted the contents of the report

Moved:	**Seconded:**	
Sue Kedgley	Richard Stein	**CARRIED**

Notes:

- The increasing number of referrals and kind of presentation.
- Waiting lists and demand discussed, and how to manage the challenge of need for care.
- In-patient beds are not always required, but could always do with more bed capacity.
- At the current time we deliver more service than we are funded to.
- Seeing people more quickly is a priority.
- Lobbying for additional resource for the Region (i.e. 6 DHBs) which requires a specialist services framework, where beds might be for specialist care.
- This is a national issue and a long term issue requiring resource and funding, workforce issues (upstream).
- There is a Ministry Leadership Group to develop a longer term strategy and this will feed into HNZ.

4.3 HOMELESSNESS, HEALTH AND COVID-19

The Director Strategy, Planning and Performance presented.

The Committee noted:

(a) This update on homelessness and how the 2DHBs contribute to addressing this important issue.

(b) Homelessness is part of a wider issue in a housing continuum that faces significant challenges. Working towards a solution requires coordinated cross agency collaboration.

(c) A strategic priority project around emergency housing is a priority this year. Emergency housing is considered a subset of homelessness.

Moved:	**Seconded:**	
Ken Laban	Josh Briggs	**CARRIED**

Notes:

- It was acknowledged that Homelessness is a persistent issue, and that it is surging.
- Homelessness, emergency housing, and healthy homes is a major contributor to health outcomes.
- Linked to policing response to emergency housing and the mental health requirements of those that are being housed.
- Our role is to assist and support the work of Councils, Kainga Ora and other government agencies.
- Presentations to ED have increased and we do our best to connect to social support and we have good relationships to assist.
- Questions asked as to what the 2DHBs can do in the next 6 months as move forward to HNZ
- Preparing work for early next year for budget bids

4.4 GENERAL BUSINESS

It was noted that the Boards of HNZ and MHA have been announced and the Chief Executive roles advertised. The Transition unit is calling for membership of the groups working on the NZ Health Plan (8 streams). The Commissioning model will determine what is delivered on the continuum of care and will drive better outcomes. Discussed future advisory and consultative 'Boards' as noted in the cabinet paper and the development of a consumer engagement model by the Quality and Safety Commission.

The meeting concluded at 12: 25pm

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting

DATED this .....day of.....2021

Sue Kedgley
Chair, Health System Committee

HSC ACTION LOG AS AT 24/11/2021

Action Number	Date of meeting	Due Date	Status	Assigned	Public or PE	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
HSC21-07	26-May-21	Ongoing	In progress	Board Secretary	Public	1.6	Draft Annual Work Plan	Committee members requested that management consider how members will be kept updated on Transition matters over the next 12 months. Management to advise how it will keep the Committee (and Board) advised of Transition matters.	Staff will give a verbal update on matters relating to the transition to Health New Zealand during the general business section of remaining HSC meetings.

HSC WORK PLAN 2021/22 AS AT 24/11/2021		
	16 March 2022 Hutt Valley 9am – 12pm	**Placeholder meeting (TBC) 8 June 2022 Capital & Coast 9am – 12pm**
Strategic Priorities		
Our Hospitals		
Commissioning and Community	Complex Care and Long-term Conditions.	
	Community Network Development	
	Locality Integration	
	Intersectoral priorities	
Enablers	**TBC**	
Integrated Performance Reporting		
Regional Public Health Report	Regional Public Health Report (note last report 28 July 2021).	
System and Service Planning		
Non-Financial MOH Reporting - CCDHB & HVDHB	2021/22 – Quarter 1 2021/22 – Quarter 2	
Annual Plan (for both DHBs)	Planning process for 2022/2023 – subject to confirmation of process required for Health New Zealand.	
Matters arising and other items		

Health System Committee - Public

24 November 2021

2DHB Maternal and Neonatal System Plan

Action Required

Health System Committee notes:

(a) the description of the proposed evidence-based maternity system to be developed and funded across both DHBs going forward.

(b) a whole of system approach, defining care and experience across the maternal care service continuum has been adopted to develop the above. This has created specific interdependent actions that need to be implemented in order to realise the shifts outlined in the strategy.

(c) we have taken a pro-equity approach to creating the Plan. This means the actions defined as "culturally responsive care" and "enabling maternal and neonatal care" have been prioritised for implementation.

(d) the Plan outlines over 50 actions that have been developed in partnership with the community and clinicians and reflects what they believe will make a meaningful change for all women and families having babies across the 2DHB region.

(e) DHB leads are of the view that it is possible to drive many of the initiatives within existing resources (refer to high level action plan, section 8) by December 2022.

(f) that to fully realise the changes outlined in the strategy, additional investment in new services will be required.

(g) that to achieve a significant increase in access to primary birthing (refer to Appendix 1, slide 31), additional capital investment is required. This would need to be considered by Health New Zealand.

The Health System Committee endorses:

(a) the 2DHB Maternal and Neonatal System Action Plan to 2DHB Boards.

Strategic Alignment	This initiative is aligned with Taurite Ora, Te Pae Amorangi, 3DHB Pacific Health, and Wellbeing Plan, the NZ Disability Strategy, CCDHB's Health System Plan 2030 and HVDHB's Our Vision for Change.
Authors	Heather LaDell, Principal Commissioning Manager, Families and Wellbeing Rachel Pearce, General Manager, 2DHB Commissioning, Families and Wellbeing
Presented by	Fionnagh Dougan, Chief Executive Officer Rachel Haggerty, Director, Strategy, Planning and Performance
Purpose	This paper supports the presentation of the 2DHB Maternal and Neonatal System Plan
Contributors	Not applicable
Consultation	This plan is the outcome of a strategic design process including stakeholder engagement (refer to Engagement and Consultation section below)

Executive Summary

In July 2021 the Executive Leadership Team selected eleven priorities, including development of a 2DHB Maternal and Neonatal Health System Plan. This paper provides an update for the HSC on the design

process that has culminated in a 2DHB Maternal and Neonatal System Plan, and seeks HSC's endorsement of this ahead of the 1 December 2021 Board meeting.

The Plan articulates a whole-of-system approach to improving maternal and neonatal care for all families in our region, underpinned by a pro-equity approach to improve outcomes for Māori and Pacific whānau and families, and disabled women and babies with impairments. The planning process was underpinned by a research and discovery approach to define a framework intended to prioritise what high quality care looks like across the care continuum. We identified the gaps in the current state; and articulated the actions required to deliver consistent high quality care for all families going forward.

The Plan outlines over 50 actions that have been developed in partnership with the community and clinicians and reflects what they believe will make a meaningful change for all women and families having babies across the 2DHB region. The suite of inter-dependent actions will improve all families' experience and support more equitable outcomes for Māori, Pacific and women with disabilities and babies born with impairments. The Plan has been informed by current strategies, evidence, insights and the voices of service users and providers, to help us imagine what better maternity and neonatal care could look like.

The actions are spread across specific domains:

- Culturally responsive care
- Improved access to primary birthing
- Enabling maternal and neonatal care
- New community models of care
- A connected system

There is a mix of resourcing required to fully implement the Action Plan (refer to section 9 of this paper), including:

- actions we can take now within existing resources;
- recommended investment priorities from 2022/23; and
- longer term capital requirements.

Section 8 of this paper outlines a high level implementation plan, focussing on what is achievable within existing resources using a pro-equity approach which means starting in the "culturally responsive care" and "enabling maternal and neonatal care" domains.

Section 9 of this paper outlines the actions that will require additional funding, and indicates some of the funding avenues the Project Team is yet to explore to secure this funding. However, it is likely that some of these actions will need to be considered in the context of 2022/23 budget setting processes.

Strategic Considerations

Service	If endorsed, this Action Plan will both DHBs' women's health services to implement changes to their staffing models and service delivery.
People	Recommendations include establishing new roles as well as reconfiguring existing service, including both DHBs' Community Midwifery Teams.
Financial	There are activities described that can be delivered within existing, endorsed budgets/revenue streams, and additional recommendations that are recommended for investment consideration in 22/23.
Governance	The 2DHB ELT has been the oversight group for this work.

Engagement/Consultation

Patient/Family	The Lived Experience Advisory Group who guided the development of the Plan included Māori and Pacific mothers and mothers of children with impairments. In addition, the strategy built on insights work recently commissioned to better understand the experiences of Māori, Pacific and disabled mothers and mothers of children with impairments
Clinician/Staff	A broad range of clinicians contributed to the development of the Plan including: Midwifery, Obstetrics, Neonatology, Ultrasound, Service Managers, Charge Midwives, Primary Maternity Unit managers, Disability Team, Māori Health, Pacific Health, Allied Health, Perinatal Mental Health, Lactation Consultant.
Community	A broad range of community leaders and partners contributed to the development of the Plan including: Hutt Maternity Action Trust, Birth Hub, and Hutt Families for Midwives; Iwi partners and providers, LMC midwives, breastfeeding supporters, antenatal education providers.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	Not applicable				

Attachment/s

1. Appendix 1 – 2DHB Maternal and Neonatal System Action Plan

1 Why develop a maternal and neonatal health system strategy and action plan?

The 2DHB Boards have endorsed a proposal to make maternity and the First 1000 days a priority for development of a plan for improvement and investment. This has been done in recognition that investment at the beginning of life has lifelong health benefits to individuals and at a population level. Conversely, a failure to invest in equitable outcomes drives financial and social costs that have a compounding impact across the lifespan.

This builds on CCDHB's *Health System Plan 2030,* and it is based on the premise that drawing on the strengths of the community, adopting pro-equity approaches, and bringing more services out of the hospital and into the community, creates an environment where both service users and providers of care can thrive.

If we do not act to realise changes in the maternal care system, we will continue to see:

- Inequitable outcomes across the life course for Māori and Pacific whānau and families, and for disabled women and children with impairments
- Shrinking midwifery workforce
- Rising rates of unnecessary intervention including caesarean sections
- Overburdened hospital services
- Dissatisfaction with choices available

2 Who will the Plan deliver improvements for?

The 2DHB Maternal and Neonatal System Plan articulates whole-of-system improvements in maternal and neonatal care for all families in our region, underpinned by a pro-equity focus to improve outcomes for Māori and Pacific whānau & families, and disabled women and babies with impairments.

The Plan will also drive improvements for providers of maternity and neonatal care, with additional support and education, supporting growth of community-based and out-of-hospital providers, create more innovative models of care, and enhance interprofessional practice.

3 Why adopt a Pro-Equity approach?

Māori and Pacific mothers and babies and disabled women and families with babies with impairments experience worse outcomes because the system fails to provide care that fits their needs.

- In CCDHB and HVDHB, rates of foetal and infant death are up to 6 times higher for Pasifika babies/children and up to 4 times higher for Māori (see Action Plan, page 20).
- Wāhine Māori have statistically significant higher rates of maternal mortality than New Zealand European women (PMMRC, 14th Report, 2021).
- A combination of issues, such as discriminatory attitudes, limited skills and knowledge of healthcare professionals, resource constraints and limited availability of services, prevent disabled women and women who have babies born with impairments from accessing maternity care that responds to their individual needs (Creating enabling maternity care: research report. Imagine Better, 2021).

4 What does a high quality continuum of maternal care look like?

Women and families should have access to safe and respectful universal maternal and neonatal services from conception and right through the early years. The Ministry of Health specifies that all families should have access to primary maternity (including community midwifery care, and services at primary maternity facilities and hospitals) and secondary and tertiary level care (including midwifery, nursing, obstetric, neonatal and anaesthetic care, and care at hospitals).

Women and families should be able to access a connected continuum of safe, evidence-based maternal and neonatal services from providers and facilities that are known and trusted. The majority of care can be supported in the community and delivered by community providers, with access to specialist and inpatient care when required. Avoiding unnecessary hospitalisation also reduces the risk of unnecessary interventions.

5 What was our approach to developing the Plan?

This design process represents gold standard pro-equity planning, commissioning and engagement. Highlights of the process include:

- **End to end Pro-Equity approach** including equity analytics; a Pro-Equity project aim; a Project Team with equity leads for Māori Health, Pacific Health and Disability; Pro-Equity approach to investment and implementation.
- **Human-Centred Design** process including utilising design experts ThinkPlace, and focusing on experiences of women and families.
- **Insight-Driven,** building on existing knowledge about what is and isn't working across the system and working with lived experience advisors to develop the strategy and actions.
- **Bias toward Action,** defining concrete actions to create change
- **Building engagement and trust,** utilising an Advisory Group and wider stakeholders to test and refine challenges, the desired future, design principles, and specific priorities for action**.**

Throughout the design sprint process we worked based on the advice of our Advisory Group, and through focused design hui we connected with over 50 cultural, clinical, provider, community and lived experience experts.

6 What are we currently doing that works well?

As DHBs we are refining our pro-equity commissioning skills and strengthening relationships with providers and partners across the community, and are well placed to adapt and scale existing successful initiatives and approaches. Some examples of innovation and great performance across the current continuum of services in our region include:

- Examples of innovative, community-based midwifery and obstetric services, including at marae.

- Delivering through integrated service models (hubs) across the First 1,000 Days, such as Ora Toa's Mātua, Pēpi Tamariki model in Porirua.
- Examples of the DHB supporting LMCs to practice in the community, for example CCDHB supporting the creation of Te Ao Marama. This group of five LMCs working in Porirua is already decreasing pressure on DHB services and the Community Midwifery Team, and increasing utilisation of Kenepuru Maternity Unit.
- Kaupapa Māori, Pacific specific and youth led antenatal education options.
- Well progressed HealthCare Home model and Networks which provide great infrastructure for hubs.
- Strong community providers who are trusted faces for families in high needs communities.
- Primary maternity birthing facilities and services are valued.
- Some growing Māori and Pacific midwifery practices.
- Progressive models of care are already being considered and developed (e.g. transitional model of care).

7 What are the key service gaps and challenges in our current system?

While all components of the continuum of maternal and neonatal health services are present in our 2DHB region, the consultation and design process identified barriers for some women and families accessing the following components of the care continuum:

- Information about options for care (eg fit for purpose websites, apps), especially for women in the Hutt Valley
- LMC midwifery care, especially for Māori and Pacific families
- Access to scans at appropriate times, especially for Māori and Pacific women
- Early and adequate social and cultural support
- Birth care in homelike environments.
- Breastfeeding support, especially for families using the Special Care Baby Unit (SCBU) facility.
- Out-of-hospital support for babies who need extra care
- Enabling care for disabled women and babies with impairments across the care continuum

The design process synthesised the challenges in 6 key areas:

1. Māori and Pacific women, babies and whānau and families are less likely to be able to access care that they are entitled to, from people and places that they trust, and that meets their needs.
2. Disabled women, and families who have a baby with an impairment, are not always receiving enabling respectful care.
3. The current system is highly dependant on having an LMC to help navigate and access services.
4. Not everyone who has birth or postnatal care in hospital requires hospital-level care.
5. People's birth and postnatal experiences in hospital services are not always positive, and maternity facilities struggle to provide adequate staffing to match demand.
6. The system is challenging to navigate and understand.

8 How does the Plan and set of actions describe and provide a response to these gaps and challenges?

The project team and our stakeholders synthesized the evidence, insights, and voices of service users and providers to identify the key shifts that need to occur in order to transform the maternal and neonatal health system to deliver better outcomes.

As a result, seven design principles were developed that can be used to guide and inform decision-making now and in the future. Together, these seven design principles describe the future direction.

1. **Trusted faces in trusted places**: Māori wāhine, pēpi and whānau, and Pacific women, babies and family, can choose a range of maternity care from trusted Māori and Pacific providers in places that feel safe and familiar.
2. **Enabling and respectful**: All people, including disabled women and families who have a baby with impairments, experience responsive care that is enabling and respectful.
3. **Right-level care, closer to home**: Women and families are supported to receive maternity care at home and in the community, with access to specialist care when required.
4. **Intensify for those who need it most**: Women and families who have greater care needs are supported early in their journey to access bespoke maternity care from providers who have Te Ao Māori, Pacific cultural, and clinical knowledge.
5. **Informed choices**: Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.
6. **Connected, proactive providers**: Women and families get care from connected and proactive providers during the first 1,000 days, especially when they have more complex care needs.
7. **Whānau centred**: Care is centred around supporting the wellbeing of the māmā, pāpā, pēpi and their whānau, and their whakapapa.

Actions (page 28 – 34 of Appendix 1)

The maternal and neonatal system is complex and co-dependent. Multiple changes executed in a coordinated way will be required to deliver change. The Plan therefore articulates the most powerful next steps (actions) we can take on the pathway toward that desired future. The actions described below were confirmed by over 60 stakeholders as being relevant to the challenges and likely to make meaningful change.

They are:

- Culturally responsive care
- Improved access to primary birthing
- Enabling maternal and neonatal care
- New community models of care
- A connected system

9 Implementation approach

We will create a (fixed term) Maternal and Neonatal System team to drive the implementation of the Plan. It is anticipated this team will be in place between January and 30 June 2022. The team would be comprised of:

- 1 FTE Change and Programme Manager
- 0.5 FTE Senior Advisor, Communication and Engagement
- 1 FTE Programme Coordinator

The following high level implementation approach is achievable within existing resources. A pro-equity approach has been taken to the creation of the implementation plan; we will start in the "culturally responsive care" and "enabling maternal and neonatal care" domains.

Action/s (refer page 28 – 34 of Appendix 1)	Indicative timeframe for completion
Culturally responsive care	
Fund and recruit to the new Hauora Māori leadership role	April 2022
Fund and recruit the new Pacific leadership role	April 2022
Workforce support and education programme, including the development of a resource library and training package for all professionals across the continuum	Sept 2022
Grow the Māori and Pacific workforce	Requires longer term investment
Support indigenous, traditional and cultural birthing knowledge and practice	June 2022
Enabling maternal and neonatal care	
Fund and recruit to the new Disability equity leadership role	April 2022
Breastfeeding pathways are disability and impairment positive	June 2022
Antenatal education is enabling	June 2022
Information is gathered than can drive further improvement	June 2022
Policies and guidelines are enabling	June 2022
Workforce support and education programme	June 2022
Disability advocacy and support for maternal and neonatal care	Requires longer term investment
New community models of care	
Enable the development of Hapu Whānau hubs	Specification developed by March 2022. Fully commissioning will require longer term investment.
Kaiāwhina model of care development	June 2022
Community Midwifery Team new model of care	Sept 2022
Support LMCs to enter and stay in practice	July 2022
Perinatal wellbeing and mental health model of care	Requires longer term investment
Improved access to primary birthing	
Increase access to primary maternity facilities	June 2022
Increase access to utilisation of current primary maternity units	June 2022
Enable home birth choice and knowledge	June 2022
Define a physiological pathway of care for women birthing in hospitals	June 2022

8

A connected system	
Resources for families	April 2022
Integrated Network of right place, right care services	June 2022
Safe sharing of clinical information across the continuum of care	June 2022
Whānau friendly policies and support	June 2022
Enabling access to high quality pregnancy and ultrasound	June 2022
New models of care for newborns requiring extra support	Requires longer term investment
Progress further investment bids	Requires longer term investment
Stakeholder and relationship management including Hub development	Requires longer term investment
Community and staff facing communications and engagement activities	Requires longer term investment

10 Funding Implications

A detailed resourcing plan is being developed, including a description of recommended investment priorities for 2022/23 and longer term capital requirements.

10.1 We can progress a significant number of actions within existing resources, particularly the pro-equity actions.

The level of activity and progress achievable within existing resources is largely driven by:

- The 2020/21 2DHB Board decision to invest in "Equity – Mothers and Babies". While this funding was largely allocated last year to address cost pressures across our Well Child Tamariki Ora providers, significant increases in Well Child Tamariki Ora Crown Funding Agreement has freed over $300k across the 2DHBs in 20212/22.
- Increased investment in our DHBs' midwifery leadership has created more capacity to lead transformational change. In particular, the creation of the following Associate Director of Midwifery roles:
    - Equity and Workforce;
    - Primary; and
    - Secondary.

10.2 Fully realising strategic shifts across the service continuum will require additional investment for new and expanded services

The following actions are not able to progressed within existing resources. The Maternal and Neonatal System team will endeavour to identify new, alternative approaches to funding these areas, including critically reviewing the investment within provider arm services. However, these will need to be considered in the context of 2022/23 budget setting processes.

These new investments would deliver the changes that are most visible to our communities and staff – holistic Hapu Whānau hubs; LMC support; and Kaiāwhina/advocate roles to shift the way care is delivered for Māori, Pacific and women with disabilities.

Action area	Investment required
Enabling maternal and neonatal care	
Disability advocacy and support for maternal and neonatal care	This is a new, FTE based service that will require additional funding
New community models of care	
Enable the development of Hapu Whānau hubs	Additional investment will be required to commission new services.
Support LMCs to enter and stay in practice	Funding would also be required to support LMCs with clinic space.
Perinatal wellbeing and mental health model of care	Funding is required for additional maternal mental health services.
Increase access to primary birthing	
Define a physiological pathway of care for women birthing in hospitals	Kaiāwhina birth support will require new, additional investment
A connected system	
Safe sharing of clinical information across the continuum of care	Will require change management and CAPEX investment to implement
Whānau friendly policies and support	Additional investment required for travel and accommodation support.
Enabling access to high quality pregnancy and ultrasound	New, additional investment required to increase ultrasound access.
New models of care for newborns requiring extra support	Additional investment is required for new community based services for babies requiring additional support and for lactation support for SCBU babies.

10.3 To fully optimise primary birthing, capital investment is required

It is possible to develop a business case this financial year, for Health New Zealand consideration for implementation after 1 July 2022. The business case would be seeking investment in both upgrades to existing primary maternity facilities and the potential development of a new primary maternity facility/services.

11 Implementation Opportunities

The Plan has been developed in the context of the imminent transformation of New Zealand's health system and 'gets ahead' of the reform by proposing actions that bring to life key reform priorities. These include:

- Te Tiriti-led approach: Actions are led by Haoura Māori leadership, Māori health providers, iwi, hapū and Māori communities that reflect Māori health needs and invest sustainably in 'by Māori, for Māori approaches.
- Locality-based approach: Actions that emphasise integration and location of interprofessional teams in community-based hubs; rather than a proliferation of hospital based, DHB provided services.
- More consistent, equitable access to specialist services: Actions that smooth the pressure across our hospital services by delivering 'right care, right place' services, closer to home.
- Co-commissioning with communities: Commissioning approaches that defer to the experience and wisdom of the women and families who use services.

- Alignment to Community Network approach: Devolving integration and coordination to community-led hubs.

12 Implementation Risks

Risk	Mitigation Strategies
The risk that the strategy is partially funded leading to an inability to realise system change and strategic shifts across the continuum of care.	• Working collaboratively across SPP teams to identify all possible funding opportunities including within provider arm and the mental health and addictions portfolio.
Not delivering on community expectations, reducing community trust and credibility in the maternal care system.	• Communications and engagement role has been identified as part of the implementation team. • Actions related to community and provider information sharing, including websites and apps. • If fully funded, a strategic shift toward delivery in community supporting people to connect with 'trusted faces in trusted places'.
Failure to lead change (clinical, operational and community)	• Maternal and neonatal health system team established to lead the programme of work. • Appointment to high quality candidates within the new midwifery leadership structure. • Shared Maternity Quality Safety Programme to strengthen 2DHB oversight and leadership across clinical delivery.
Ambitious pace	• Equity Lead roles prioritised. • Change and Programme Management Lead roles funded. • New Associate Director Midwifery roles will provide additional professional leadership.

13 Next steps

The 2DHB Maternal and Neonatal System will be presented to the 2DHB Board on 1 December 2021.

The Project Team will provide an update to the Advisory Group before the end of the calendar year.

Detailed implementation planning and recruitment to new roles will commence immediately after the Christmas and New Year break.

END OF REPORT.

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

2DHB Maternity and Neonatal System Plan

24 November 2021

Contents

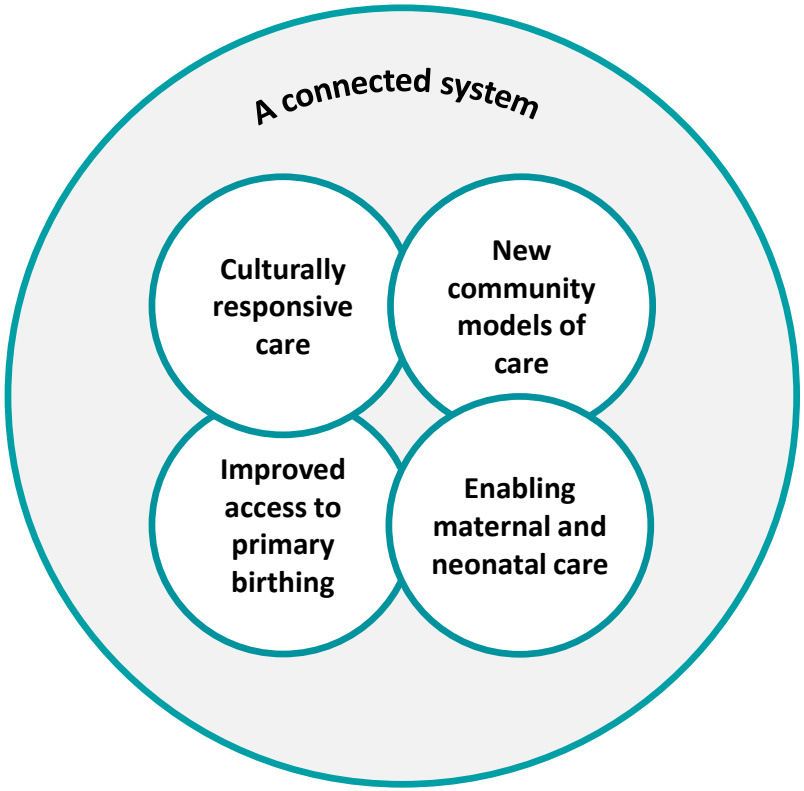
Introduction

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Who is this Plan for?

This plan articulates a whole-of-system approach to improving maternal and neonatal care for all families in our region, with a pro-equity focus to improve outcomes for Māori and Pacific whānau & families, disabled women and babies with impairments.



Who are we serving?

- In 2020, **5,132 women** gave birth in 2DHB maternity facilities. 4,917 (96%) were mothers domiciled in the 2DHB region.
- **Māori women make up 22%** (1,140) of women giving birth in our region, and **Pacific women were 9%** (499) (of all known ethnicities). This is slightly higher percentages than the general population.

1,140 Māori

499 Pacific

3,591 Non-Māori, non-Pacific

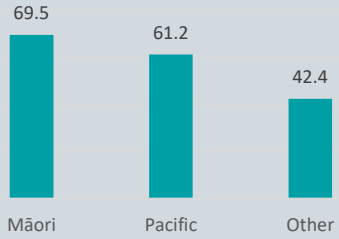
- **2,214 (45%) of women were first time mothers**. This is higher to the proportion of first time mothers nationally (approximately 41% in 2020).

What does the community look like in the future?

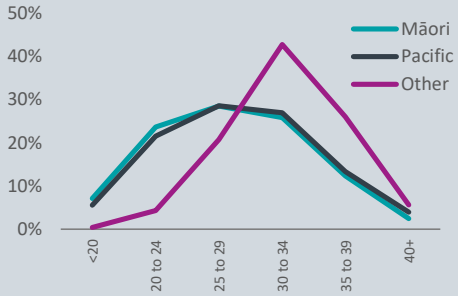
As there is a larger number of Māori mothers having children younger, current projections indicate there will be significant growth in the Māori population by 2030 than non-Māori. Pacific people will follow a similar trajectory.

- A **greater proportion of Māori and Pacific women give birth each year**. This further strengthens the need for a pro-equity approach.

2DHB birth rate per 1,000 of reproductive age



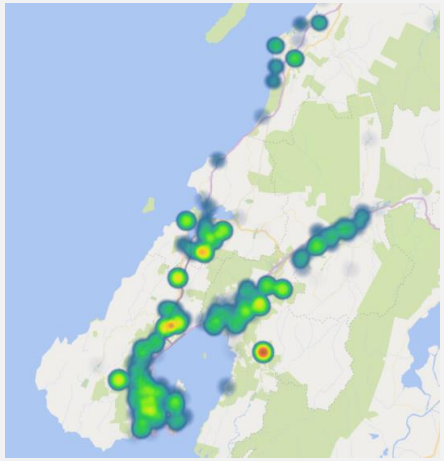
- Across our DHBs, our **younger mothers are more likely to be Māori or Pacific**. Younger mothers from other ethnicity have births later in life.



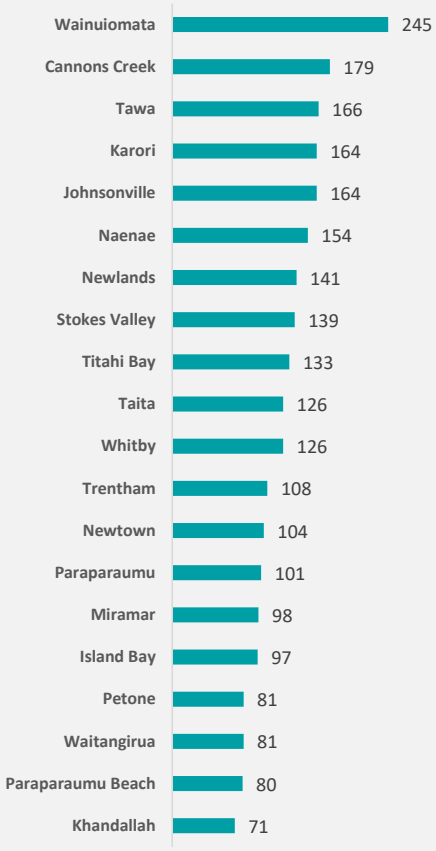
Where do women having babies live?

We have some suburbs with high volumes of mothers, which provides opportunities to create hubs in communities.

The top suburbs in 2018 were **Wainuomata** (245 mothers), **Cannons Creek** (179 mothers) and **Tawa** (166 mothers).



2DHB Top 20 suburbs where Mothers gave birth



5

Why is this important

The *Health System Plan 2030* says we need a maternal and neonatal model of care that supports all mothers, families and whānau, to have healthy babies and to provide the best start to life.

This approach is designed to improve outcomes, achieve equity, and make the experience of having babies better for families and whānau.

What will be different for me?

"I will know what to do when planning my pregnancy, having a child and/or caring for small children."

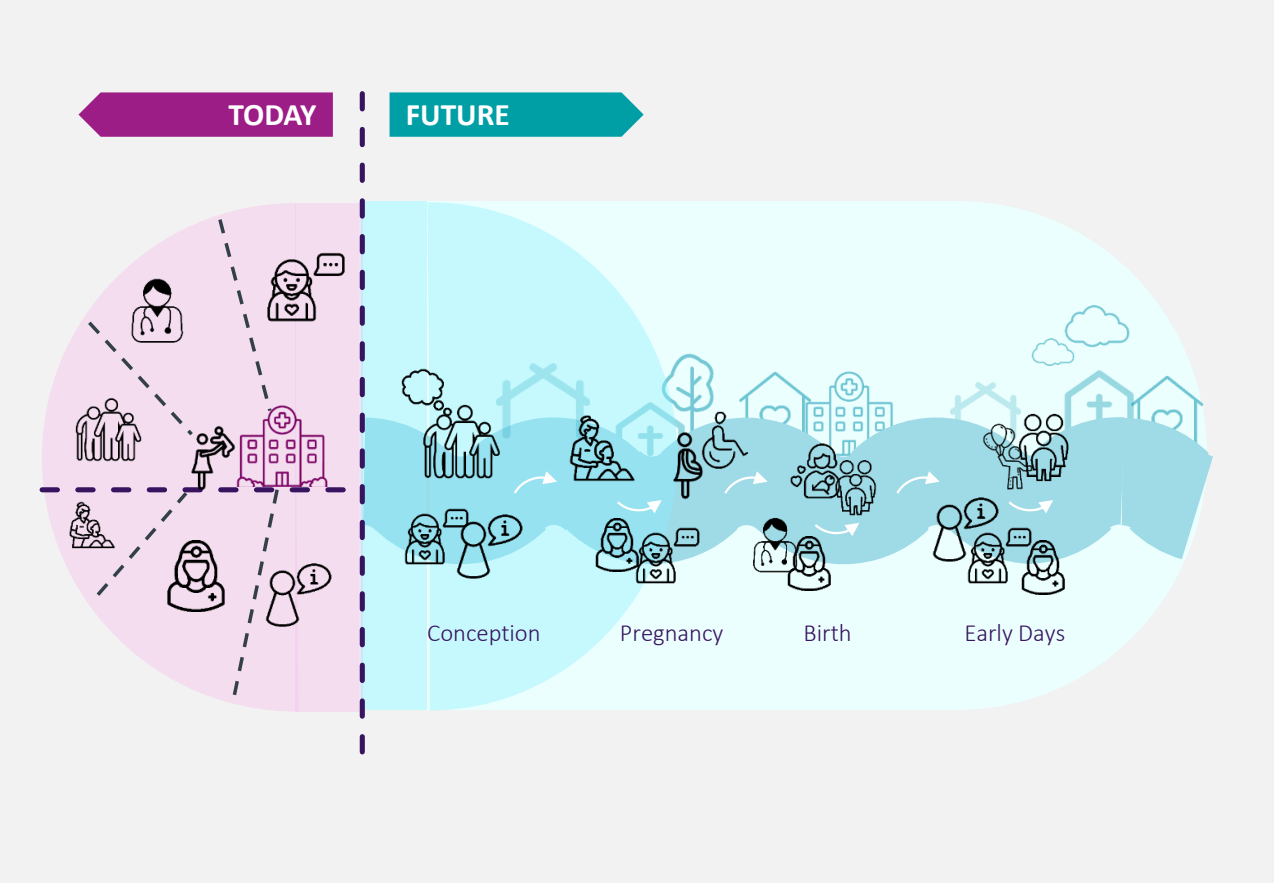
"I will have support to keep me and my family healthy."

"I will have access to a range of birthing options."

"I will have care that meets me where I am, to match my clinical, cultural and social needs."

- Health System Plan 2030

Our future state



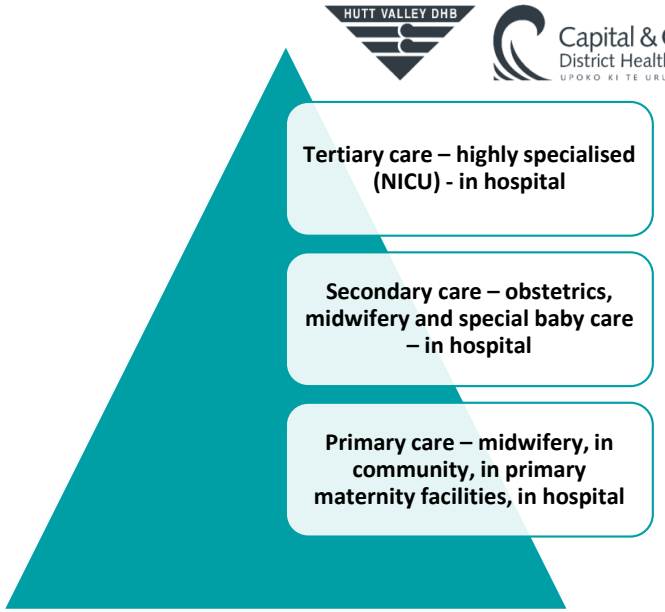
We are creating a future that:

- Is easy to learn, understand, and navigate.
- Is highly accessible via “any door”.
- Celebrates Māori and Pacific culture
- Enables good lives for disabled women and families with babies with impairments.
- Is full of individuals and services who reflect the community they serve and act as connectors.
- Is focused on a continuum of care from conception to 2 years old.
- Enables real choice that allows women and families to exercise their rights and agency.
- Meets people where they are, in the community.
- Moves from maternity as a journey towards hospital, **to** maternity as a journey within a community, with access to hospital as needed.
- Builds long-lasting trust and partnership with communities, families and providers throughout the region.

What services should be available across the maternal and neonatal continuum?

Women and families should have access to **safe and respectful** universal maternal and neonatal services from conception through the early years. The Ministry of Health specifies that all families should have access to **primary maternity** (including community midwifery care, and services at primary maternity facilities and hospitals) and **secondary and tertiary** level care (including midwifery, nursing, obstetric, neonatal and anaesthetic care, and care at hospitals).

The core service components of a high-quality, **universal continuum of maternal care** is outlined below. At any stage along the continuum, **specialist care** should be equitably accessible to those who have high clinical complexity, and **LMC midwifery and comprehensive social and cultural support** prioritised for those who have high social complexity.



Pregnancy
- Antenatal education
- LMC Midwife
- Labs and scans

Birth
- LMC Midwife
- Home birth, primary birth or hospital birth
- Inpatient care from midwives, nurses, specialists as needed

Postnatal
- LMC Midwife
- Breastfeeding support
- Maternal mental health (if needed)

Early Years
- Well Child Tamariki Ora
- Immunisation services

Primary care… Specialist care for mum and baby… Maternal wellbeing and mental health support… Social and cultural support…

8

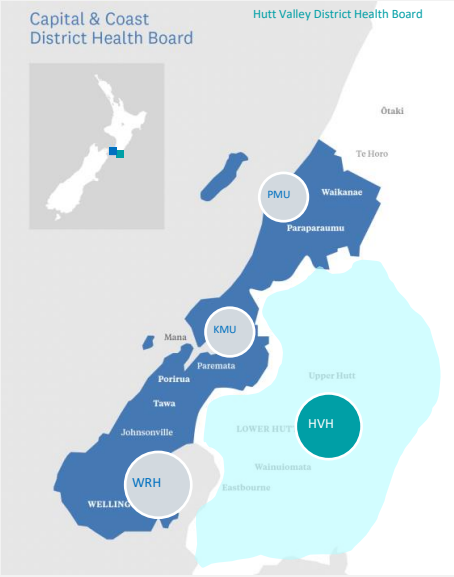
What care is currently available to families?

Who provides maternity care?

- **Lead Maternity Carer:** LMCs can be midwives, private obstetricians or GPs. LMC services are funded by the Ministry of Health through Section 88. LMC midwives provide continuity-of-care throughout pregnancy, birth and 4-6 weeks after baby is born. A key role of the LMC is to help women and families access additional care and support, and help women and families make informed choices.
- **Hospital midwives:** providing care in hospital to women who need antenatal care in hospital, and to women and babies during birth and postnatal stay, for women who birth in hospital.
- **Community Midwife Team:** operating out of both DHBs. These teams provide care for women who can't find a Lead Maternity Carer.
- **Obstetricians:** become involved in mothers care when she or her baby have more clinical needs. Women can choose to be cared for by a private obstetrician.
- **Neonatal Specialists:** Provide clinical support to babies who have additional clinical needs.
- **General Practitioners:** Many women see their GP when they first suspect they are pregnant. GPs may confirm pregnancy, provide initial pregnancy health assessment and advice, refer women for blood tests and scans, and refer women to midwifery care.
- **Community Health Service Providers:** Ora Toa, Taeaomanino Trust.

- **Well Child Tamariki Ora nurses:** Provide health and wellbeing assessments and support for children and whānau from birth to five years.
- **Lactation consultant:** DHB, Plunket, or privately funded support for women in the hospital and at home if needed.
- **Tohunga:** expert practitioners of specific cultural practices, e.g. rongoa and mirimiri practitioners.
- **Additional support:** acupuncture, massage, homeopathy, naturopaths.
- **Pregnancy ultrasound**: **Sonographers** use sound waves to create a picture of the baby in the uterus ("ultrasound scan"), to check baby's growth and development. The picture is checked by a **Radiologist** who interprets the picture and provides advice.
- **Pregnancy, birth and parenting educators**: Provide information to support parents to make informed choices during pregnancy, birth, and parenting.
- **Fertility services:** Publicly funded or private support for families who are having difficulty conceiving.

Where can and do people birth?



Birthing options

- **Home –** Home births are usually attended by an LMC midwife and backup midwife who support the woman, newborn and family. If there are complications at home, the midwife can refer the mother and/or baby for urgent care in hospital.
- **Kenepuru maternity unit (KMU)** is a midwifery-led primary birthing unit located in the Kenepuru Community Hospital at Porirua, a 20-minute drive (25km) from WRH. It has 2 birthing rooms and 6 single post-natal rooms.
- **Paraparaumu maternity unit (PMU)** is a midwifery-led primary birthing unit located at Kāpiti Health Centre, a 50-minute drive (55km) from WRH. It has 1 birthing room and 2 single post-natal rooms (with a shared toilet).
- **Wellington Regional Hospital (WRH)** has 12 delivery suites and 38 ante-natal and post-natal rooms. It has Level 3 Neonatal Intensive Care Unit (NICU) and a tertiary-level Maternal-Foetal Medicine service.
- **Hutt Valley Hospital (HVH)** has 8 delivery suites and 21 post-natal rooms It has Level 2 Special Care Baby Unit (SCBU).

Benefits of LMC midwifery care

Continuity of care improves safety and satisfaction with care with a trusted relationship through pregnancy, birth, and the newborn period.

Provide customised care to match the woman and families' needs and choices. Can provide birth care in a hospital, primary birthing unit, or at home

Where are we now?

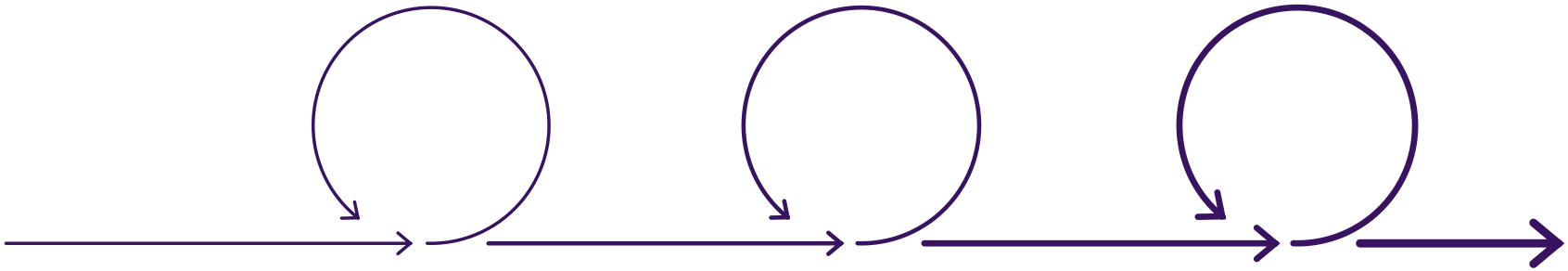
Today's challenges	Our future state
Māori and Pacific women, babies and whānau and families are less likely to be able to access care that they are entitled to, from people and places they trust, and that meets their needs.	Māori wāhine, pēpi and whānau, and Pacific women, babies and family, can choose a range of maternity care from trusted Māori and Pacific providers in places that feel safe and familiar.
Disabled women, and families who have a baby with an impairment, are not always receiving enabling, respectful care.	All people, including disabled women and families who have a baby with impairments, experience responsive care that is enabling and respectful.
The current system is highly dependent on having an LMC to help navigate and access services.	Women and families who have greater care needs are supported early in their journey to access bespoke maternity care from providers who have Te Ao Māori, Pacific cultural, and clinical knowledge.
Not everyone who has birthed or received postnatal care in hospital requires hospital-level care.	Women and families are supported to receive maternity care at home and in the community, with access to specialist care when required.
People's birth and postnatal experiences in hospital services are not always positive, and maternity facilities struggle to provide adequate staffing to match demand.	Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.
The system is challenging to navigate and understand.	Women and families get care from connected and proactive providers during the first 1,000 days, especially when they have more complex care needs.
	Care is centred around supporting the wellbeing of the māmā, pāpā, pēpi and their whānau.

Creating the plan

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

We created this Plan with our community



Formed our Project Team and Advisory Group

Formed **Pro-Equity Project Team** with Equity Leads for Māori Health, Pacific Health and Disability.

Developed a stakeholder map, engagement and communications plan.

Formed an **Advisory Group** of 32 clinical, cultural, provider and lived experience experts.

Testing with Advisory Group and wider stakeholders

Advisory Group Hui: Provided an overview of Strategy aim and Design process. Tested and refined Design Principles. Got advice on other stakeholders to involve in testing priority areas.

Wider stakeholder Design Hui: Tested and refined priority programmes and actions with approx. 60 cultural, clinical, provider, community and lived experience experts.

Refinement and approval with Project Team and Advisory Group

Project team reviewed feedback from Advisory and Design Hui to refine the Plan.

Advisory Group Final Hui: Shared and tested the refined strategy (challenges, principles, actions) with Advisory Group.

Refined actions and prepare for Board review and implementation.

Board approval

Present to **Board** on 1 December for endorsement.

Project Team and Advisory Group Members

Rachel Pearce, Chair, GM Commissioning, Families and Wellbeing
Heather LaDell, Project Lead, Principal Commissioner Families and Wellbeing
Nikita Hunter, 2DHB Māori Health Equity Lead, Project Team
Michelle Graham, Disability Equity Lead, Project Team
Candice Apelu-Mariner, Pacific Health Equity Lead, Project Team
Victoria Parsons, Maternal and Child Health Commissioner, Project Team
Korena Wharepapa-Vulu, Māori Health Planning and Integration, Project Team
Sipaia Kupa, 2DHB Principal Advisor Pacific Health
Victoria Roper, Māori Midwifery Advisor
Fana Temese-To'omega, Pasifika Midwifery Advisor
Shannon Morris, Disability Equity Lead
Milly Carter, Te Atiawa partner
Natalie Kini, Ngāti Toa partner
Larissa Davidson, NET Māori
Joy Sipelli, NET Pacific
TeRina Michaela, Lived Experience Advisor
Dr Carey-Ann Morrison, Researcher and Lived Experience Advisor
Sieni Thetadig, Lived Experience Advisor

Melehina Kilino-Lapana, Lived Experience Advisor
Meg Waghorn, Chair, Hutt Maternity Action Trust
Orapai Porter-Samuels, Hutt LMC/ Hutt Maternity Action Trust
Vida Rye, BirthHub Wellington
Suzi Hume, BirthHub Wellington
Carolyn Coles, Director of Midwifery, CCDHB
Wendy Castle, Acting Director of Midwifery, HVDHB
Rose Elder, Obstetric Clinical Lead, CCDHB
Meera Sood, Obstetric Clinical Lead, CCDHB
Rosemary Escott, Nurse Manager, NICU CCDHB
Sagni Prasad, Nurse Manager, SCBU HVDHB
Cherie Parai, LMC Liaison, MQSP
Rachel Carian, LMC Liaison, MQSP
Noreen Roche, Charge Midwife Manager, Paraparaumu PMU
Jenny Quinn, Charge Midwife Manager, Kenepuru PMU
Shelley James, Service Manager, Women's & Children's Health, HVDHB
Simone Curran-Becker, Service Manager, Women's & Children's Health, CCDHB
Mal Joyce, General Manager, Children's Health, CCDHB

HUTT VALLEY DHB
Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

What informs this kaupapa?

Te Tiriti o Waitangi

Strategies

- Taurite Ora
- Te Pae Amorangi
- Pacific Health Strategy GRW
- Our Vision for Change
- NZ Disability Strategy
- NZ Health Strategy

Insights

- First 1000 Days
- Māmā, Pēpi Tamariki Research Findings
- Creating enabling maternity care: dismantling disability barriers
- Wellington Primary Birthing Consultation and Feasibility Review

This plan builds on a substantial body of research, insights and analytics work that tells us what our community want and need in their maternal care system

2DHB Maternity & Neonatal Plan

Design Principles

Actions

Developing the 2DHB Maternity & Neonatal Plan

Living Te Tiriti o Waitangi principles

How this Plan lives Te Tiriti o Waitangi principles:

- **Tino rangatiratanga** provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of healthcare services. The Plan included actions that create and invest in Hauora Māori leadership.
- **Equity** requires the Crown to commit to achieving health outcomes for Māori. The Plan adopts a pro-equity approach to prioritising actions that will deliver equitable outcomes for Māori.
- **Active Protection** requires the Crown to actively pursue and do whatever is necessary to ensure the right to tino rangatiratanga and to achieve equitable health and social outcomes for Māori. The Plan creates actions to devolve leadership and delivery to Māori.
- **Partnership** seeks to the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health services. In this Plan, Māori and iwi are recognised as co-designers and co-delivers of health care services for Māori.
- **Options** requires the Crown to provide for and provide resource for kaupapa Māori health services. This Plan provides action to ensure that maternal care is provided in culturally appropriate ways that recognise and support the expression of hauora Māori models of care.

Our pro-equity approach

Māori and Pacific mothers and babies and disabled women and families with babies with impairments experience worse outcomes *because the system fails to provide care that fits their needs.*

- In CCDHB and HVDHB, foetal and infant death rates are up to **6x higher for Pasifika babies/children** and up to **4x higher for Māori children** (see page 19).
- Wāhine Māori have statistically significant **higher rates of maternal mortality** than New Zealand European women (PMMRC, 14th Report, 2021).
- Certain groups are at higher risk of serious adverse outcomes. These include babies of **Māori, Pacific and Indian mothers; and babies of mothers aged less than 20 years** (PMMRC, 14th Report, 2021).
- A combination of issues, such as **discriminatory attitudes, limited skills and knowledge of healthcare professionals, resource constraints and limited availability of services**, prevent disabled women and women who have babies born with impairments from accessing maternity care that responds to their individual needs. (Creating enabling maternity care: research report. Imagine Better, 2021).

Alignment with health system transformation

This plan has been developed in the context of the imminent transformation of New Zealand's health system

The Plan 'gets ahead' of the reform by providing actions that bring to life key reform priorities. These include:

- **Te Tiriti-led approach:** Actions are led by Hauora Māori leadership, Māori health providers, iwi, hapū and Māori communities that reflect Māori health needs and invest sustainably in 'by Māori , for Māori approaches.
- **Locality-based approach:** Actions that emphasise integration and inter-professional teams in community-based hubs; rather than a proliferation of hospital based, DHB provided services.
- **More consistent, equitable access to specialist services:** Actions that smooth the pressure across our hospital services by delivering 'right care, right place' services, closer to home.
- **Co-commissioning with communities:** Commissioning approaches that defer to the experience and wisdom of the women and families who use services.
- **Alignment to Community Network approach:** Devolving integration and coordination to community-led hubs.

Current State

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

The current system has strengths

Every year, our maternal care system supports over **5,000 women** across the 2DHB region.

Our DHBs support and deliver a range of quality services including:

- primary maternity facilities at Kenepuru and Paraparaumu
- hospital-level care for mothers and babies at Hutt Valley Hospital and Wellington Regional Hospital
- specialised Maternal Foetal Medicine service supports a wider region, out of Wellington Regional Hospital
- commissioned services delivered in the community including antenatal education and breastfeeding support

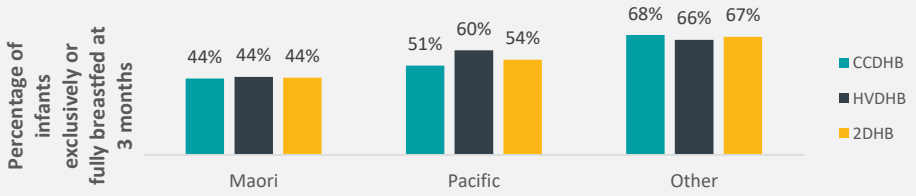
As a DHB we are refining our pro-equity commissioning approach and strengthening relationships with providers and partners across the community. We have some existing examples of great performance and effective innovation that this Plan seeks to adapt and scale.

Existing examples of great practice include:

- Innovative, **community-based** midwifery and obstetric services, including at marae.
- The early stages of **integrated service models** (hubs) across the First 1,000 Days, such as Ora Toa's Matua, Pēpi Tamariki model in Porirua.
- Pilot of **DHB support of LMC practice in the community**, to decrease the number of women relying on the Community Midwifery Team and increase utilisation at Kenepuru Maternity Unit.
- Kaupapa Māori, Pacific specific and youth-led **antenatal education options**.
- Well progressed Healthcare Homes and Community Health Networks which provides **infrastructure for community based hubs**.
- **Strong community providers** who are trusted faces for families in high needs communities.
- **Primary maternity** birthing facilities and services are valued.
- Some **growing Māori and Pacific midwifery** practices.
- **Progressive models of care** are already being considered and developed (transitional model of care).

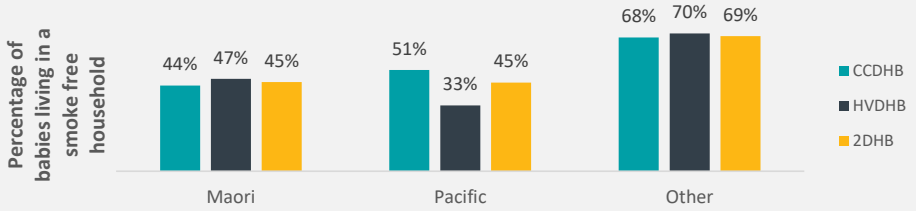
But it is not to producing equitable outcomes

Māori and Pacific babies are **less likely to be breastfed at 3 months**. The equity gap for **Māori** in our DHBs is significant – our breastfeeding rate for the total population is above the national rate; however, our rates for Māori are lower than the national average.



214 Māori babies were not breastfed at 3 months of age (42% of all babies not breastfed)	**79 Pacific babies were not breastfed at 3 months of age (42% of all babies not breastfed)**	**520 babies of other ethnicities were not breastfed at 3 months**
109 in CCDHB; 105 in HVDHB	**52 in CCDHB; 27in HVDHB**	**24% of all babies**

Māori and Pacific babies are less likely to live in smoke free homes.



321 Māori babies did not live in a smoke free home (39% of all babies not in smoke free homes)	**148 Pacific babies did not live in a smoke free home (39% of all babies not in smokefree homes)**	**562 babies of other ethnicities were not living in smokefree homes; 22% of all babies**
161 in CCDHB; 160 in HVDHB	**84 in CCDHB; 64 in HVDHB**	

- There are "alarmingly **higher rates of maternal suicide that Māori whānau** are experiencing" (Source: PMMRC 14th report)
- **Foetal and infant death rates are up to 6x higher for Pasifika children** and **4x higher for Māori children**.
- For our 2DHB population, **Māori babies are more likely to be transferred to NICU** than babies of any other ethnicity.
- Rate of babies admitted to **NICU were highest for mothers who lived in Upper Hutt**.

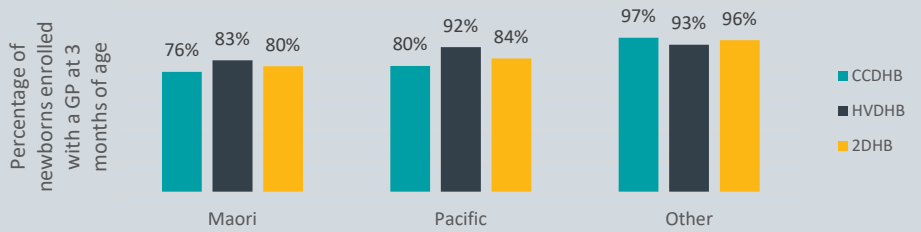
	CCDHB			HVDHB		
	Maori	**Pacific**	**Other**	**Maori**	**Pacific**	**Other**
SUDI rate (2012 - 2016)	2.02	1.6	0.61	1.01	0	NA
Foetal death rate per 1,000 (2015)	4.1	12.6	5.9	3.3	4.7	8
Infant death rate per 1,000 (2015)	4.1	12.7	1.1	3.3	0	6
Registration with an LMC in first trimester (2018)	64%	42%	78%	43%	42%	%64

20

And not currently meeting needs across the continuum of care

"It was quite hard to find classes when I was pregnant... like there wasn't much out there that was time suitable for me anyway... There were none that I heard of with my second one, like there were none that were going on... and I would've loved to go to that cause my partner is a first-time dad, he doesn't know what to expect..."
Mother
(Māmā Pēpi Tamariki research)

Timely enrolment with primary care is important to ensure families are proactively reminded and supported to access core primary care services, such as immunisations. Māori and Pacific babies were less likely to have a GP at three months of age

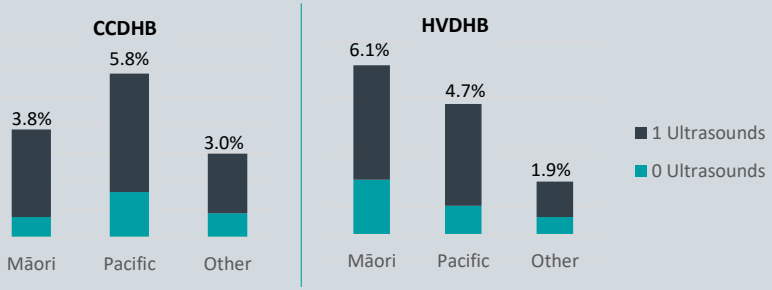


62 Māori babies had no GP at 3 months age (51% of all babies without a GP)
- **37 in CCDHB**
- **25 in HVHDB**

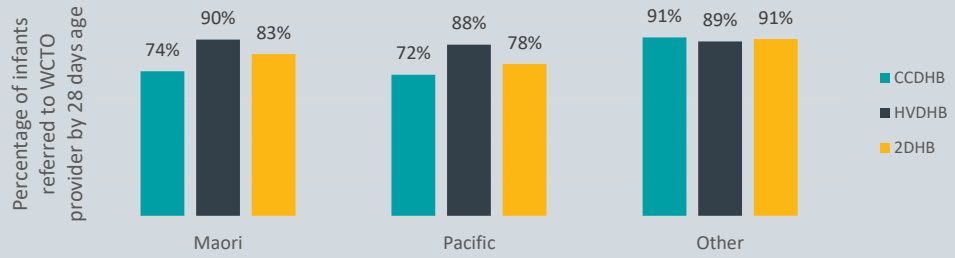
23 Pacific babies had no GP at 3 months age (39% of all babies without a GP)
- **18 in CCDHB**
- **5 in HVHDB**

40 babies of other ethnicities had no GP

On average, Māori and Pacific women access fewer scans in pregnancy than non-Māori , non-Pacific women



Māori and Pacific babies are less likely to be referred to a Well Child provider, especially if they live in the CCDHB area.



69 Māori babies were not referred to a WCTO provider by 28 days age (35% of all babies not referred)
- **48 in CCDHB; 21 in HVHDB**

40 Pacific babies were not referred to a WCTO provider by 28 days age (46% of all babies not referred)
- **32 in CCDHB; 8 in HVHDB**

119 babies of other ethnicities were not referred

21

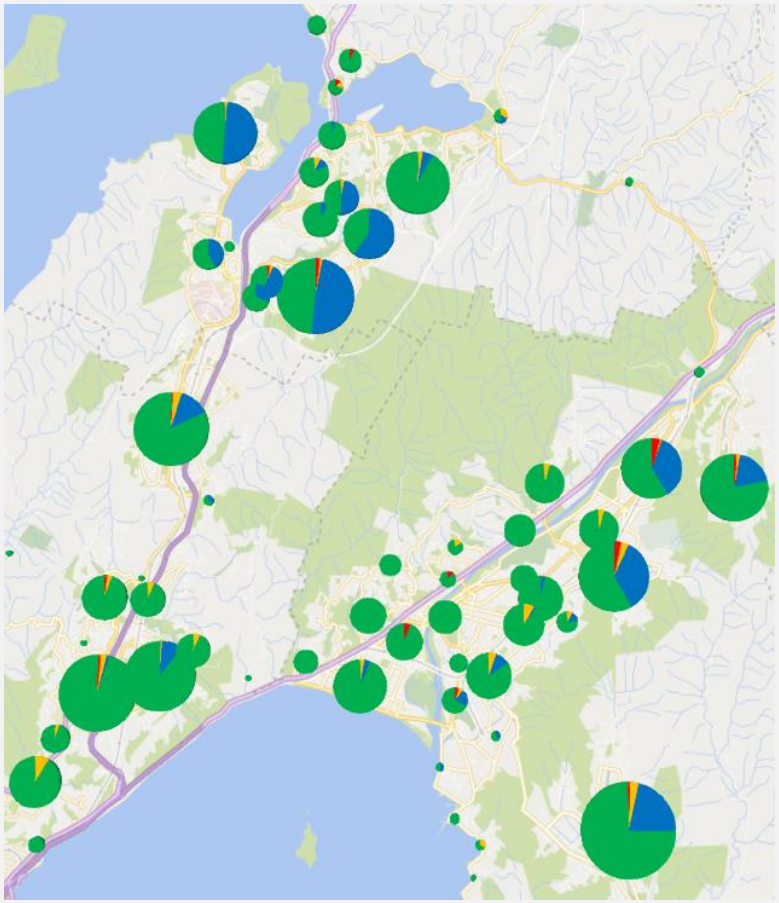
We know where the greatest need is

Each suburb is represented by a circle. The **size of the circles** reflects the volume of women having babies each year. The **blue shading represents women** with high social complexity.

Bigger circle = more birthing women

More blue in the circle = more social complexity need

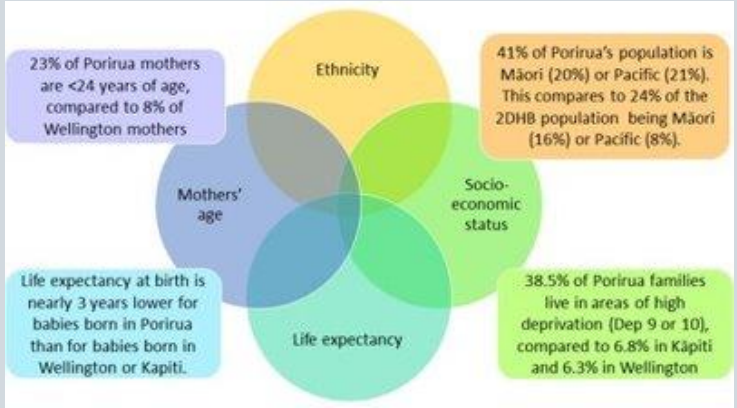
- **Wainuiomata, Naenae** and Eastern Porirua suburbs of **Cannons Creek and Waitangirua** are places with high number of births as well as a high proportion and volume of mothers needing social support.
- Clinical complexity was similar across all suburbs, with slightly elevated rates in Upper Hutt.



Intersectionality,

The concept of 'intersectionality' recognises the intersecting nature of systems of oppression. Ethnicity, socioeconmic status, gender, age, ability and nationality are not distinct, mutually exclusive entities. They overlap, combine and compound to impact on people's lives over a lifetime.

Intersectionality of risk factors for mothers and babies are disproportionately seen in some localities.



But the current investment does not follow where the need is greatest

Note: The analysis on this slide relates to CCDHB activity only. HVDHB does not contribute to the National Costing Collection, so detailed analytics is not possible for HVDHB activity at this time.

LMC funding

- There is a mix of Ministry of Health funded, District Health Board funded and privately funded care.
- LMC midwifery care is funded directly by central government. This funding cannot be accessed by DHBs who provide midwifery services to women who cannot find a community midwife.
- Therefore, **growing the community LMC midwifery workforce increases the government funding for maternity to our communities.**

Birthing costs

Normal, primary births cost less than secondary births (e.g., caesareans)

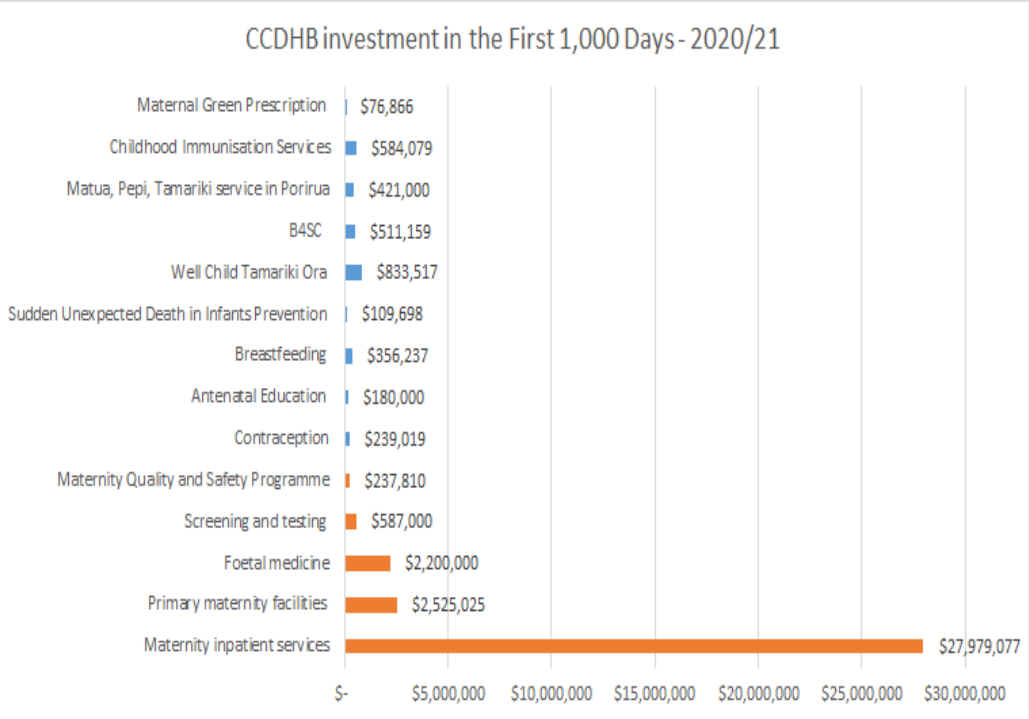
- **$1,295** is the cost of an uncomplicated vaginal delivery.
- **$5,159** is the cost of an uncomplicated caesarean.

Our maternity system is responsive to clinical complexity, but less responsive to the needs of women with social complexity. As a DHB, we spend more on clinical complexity than social complexity, even when women have both social and clinical complexity.

	incl. NICU	**excl. NICU**
	Mum with clinical *and* social complexity **$36,898.12**	Mum with clinical *and* social complexity **$2,076.90**
	Mum with clinical complexity **$43,485.70**	Mum with clinical complexity **$2,992.83**
	Mum no complexity **$2,038.41**	Mum no complexity **$1,417.87**

The graph below shows the range of investment across the maternal care continuum at CCDHB.

Approximately **three quarters of all CCDHB maternity funding goes toward maternity inpatient services.**



There are workforce challenges

What does midwifery care look like in 2020? How does it deliver to mothers' needs ?

- There are **240 DHB employed midwives** (including DHB employed Community Midwifery Team midwives).
- There are approx. **69 LMCs self-employed**, of whom **6 are Māori**, and **4 Pacific**.
- **LMCS attend roughly 3,500 of the 5,132 births across the DHBs**. This number has decreased significantly over the past 5 years due to LMC shortages, increasing demand for DHB-provided midwifery care.
- The 2DHB **Community Midwifery Teams (CMT) look after approximately 1,600 mothers per year**. These women are looked after by a team of CMT midwives. Mothers attend a combination of home and hospital antenatal visits, birth at the hospital with support from a hospital midwife, and receive postnatal care from the CMT team.

Who is missing out on LMC care?

- **Each year, approximately 1,600 mothers won't be able to find an LMC.** In addition, many women report wanting a midwife that reflects their ethnicity. Of the 1,139 Māori mothers birthing annually, an estimated 839 of these Māori mothers will be unable to find a Māori LMC, as will 300 of the 499 Pacifica mothers.
- Only 10 LMCs are Māori or Pasifika midwives working in the community.

Supportive midwifery care matters

"There's a lot of information on parenting a blind child but not a lot on parenting as a Blind person. My midwife ended up finding another Blind mum in Christchurch who had done it blind and gave me her number. She gave me some tips and tricks and I felt really supported the whole way through."
Mother
(Creating Enabling Maternity Care)

"We are providing more and more care to women with very complex health needs that probably 20 years ago they were told that they couldn't have a baby. The focus has to be on the person… It is about fostering all the good things and looking at the individual."
CMT midwife
(Creating Enabling Maternity Care)

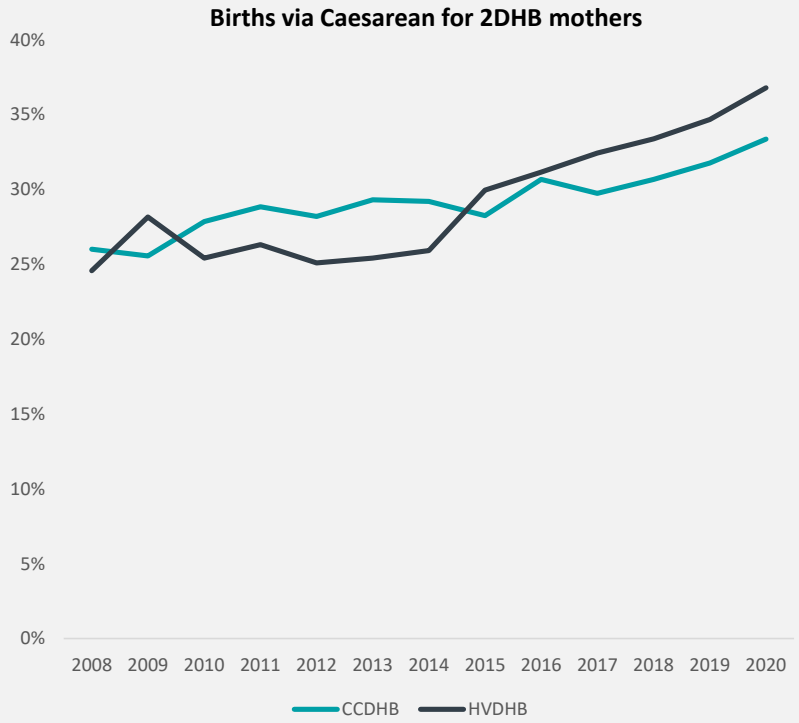
Women value midwifery care from a midwife who shares their culture

"Māori are more aware that it's not just that person that's pregnant... I think that just comes from being Māori."
Mother
(Māmā Pēpi Tamariki research)

"I know when I was pregnant with D, we did that whole look and find a midwife and we found one and she was very clinical and did everything that you needed to of a midwife, but I think with N (Māori midwife), you just felt a little more encompassed culturally and she was aware of all of that stuff."
Mother
(Māmā Pēpi Tamariki research)

And rising birth intervention rates

2DHB mothers have some of the highest rates of intervention including caesareans, and the rate of intervention is increasing. 33% of Hutt Valley and 31% of Capital & Coast mothers give birth via caesarean The national average is 27%.



Babies born in obstetric units, also had higher risk of admission to a neonatal intensive care unit, longer stay and recovery for mother and long-term health implications, as well as higher care costs
Davis et al (2011)

Research shows **women planning to give birth in an obstetric unit had higher rates of caesarean sections**, assisted deliveries and intrapartum interventions than in primary birthing units or at home.
Davis et al (2011)

Primary Birthing Units (*PBUs, also known as community birth centres*) have been found to have comparably lower intervention rates and similar neonatal wellbeing outcomes, higher breastfeeding rates and low postpartum haemorrhage rates.
Davis et al (2011)

Amongst women who birthed across CCDHB facilities in 2017, breastfeeding rates on discharge were significantly higher for women who gave birth at a Primary Birthing Unit.
Davis et al (2011)

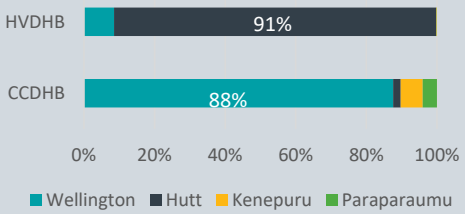
People do not always access birth care at the clinically appropriate level

Number of available beds at DHB funded maternity services

- Hutt Hospital: **17 postnatal beds**
- Wellington Regional Hospital: **26 antenatal and postnatal beds**
- Paraparaumu Maternity Unit: **2 postnatal beds**
- Kenepuru Maternity Unit: **6 postnatal beds**

While many mothers choose to birth at a hospital, under current policy parameters **1682 mothers who do birth in hospital, do not have a choice but to birth at hospital** due to inability to get LMC care to provide birth care at home or at primary maternity unit.

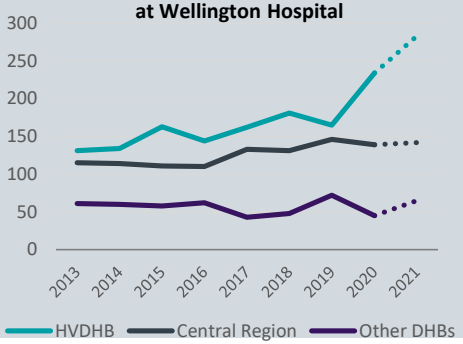
Births by Facility for 2DHB mothers



Women giving birth at our DHBs' hospitals have a slightly **longer length of stay than the national average**. Both CCDHB and HVDHB have an average LOS of 2.1 days, compared to the national average of 1.9 days.

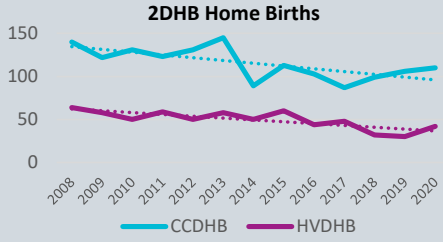
CCDHB mothers are most likely to give birth in Wellington Hospital, however an increasing number of affluent, middle aged non- Māori and non-Pacific Hutt Valley mothers are choosing to birth at Wellington Hospital. This increase is most notable in 2020 and is forecast to continue in 2021.

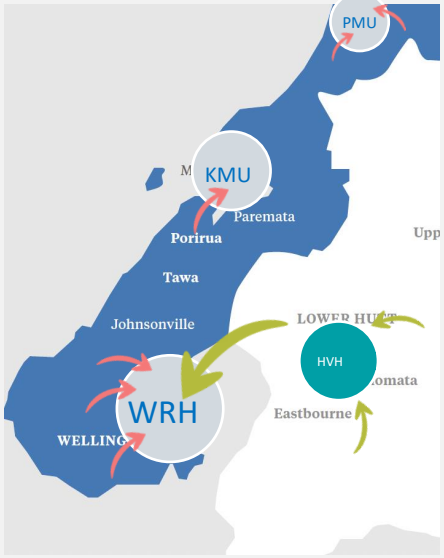
Domicile of mothers birthing at Wellington Hospital



In 2020, 152 mothers in the 2DHB region gave birth at home (3% of all births, which is lower than some other regions). Over time, the rate of home births has been decreasing.

2DHB Home Births

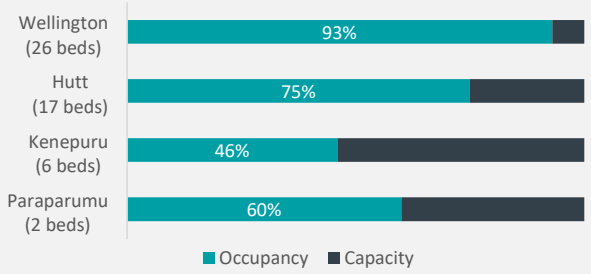




Who is birthing outside of their DHB?

- Since 2019 there has been a significant increase in the number of women who live in HVDHB who are birthing at WRH. These women are more affluent, non-Māori and non-Pacific mothers.
- Mothers who birth at KMU are primarily from Cannons Creek and Linden.
- PMU primarily had mothers birthing there who lived locally. HVH primarily had mothers from Naenae and Taita.

2DHB Birthing Facility Occupancy



- This is one factor contributing to the **imbalance in the distribution across the 2DHB facilities**, with some facilities such as KMU and PMU with capacity, while WRH experiencing frequent overcapacity and staffing shortages.

What maternity care do mothers and families want?

Where do mothers want to receive maternity care?

- **Midwifery care close to home:** Most women and families prefer to receive antenatal and postnatal care at home or close to home.
- **Community birth options:** There is demand for alternatives to hospital birthing locations.
    - A 2014 study (Dixon et al.) shows an increased **preference for Māori mothers to birth at home or in a primary birth unit**. It has also been identified that Māori women make greater use of primary birthing facilities.
    - In 2018 a survey of the consumers and midwives about a potential Wellington Primary Birthing Unit:
        - 70 percent of pregnant consumers agreed they would use a Primary Maternity Unit
        - 73 percent of all consumers said they would use the unit for self/family/whānau/organisation
        - 91 percent agreed they would be 'interested', in transferring to a primary birthing unit for postnatal care
        - About two-thirds of consumers said they would want a birth and postnatal environment that was relaxed, restful, comfortable, homelike and pleasant. They said they wanted support and privacy in a less rushed, less clinical environment that would result in less interventions.

Continuity of care and choices

"Our women struggle to find an LMC, and if they do have an LMC, it's not a consistent one, they get different ones throughout their pregnancy…and then when it comes to giving birth, they think they can birth at Kenepuru but they have to go to Wellington Hospital…"

Health care provider, Taeaomanino Trust
(Evaluation of Antenatal Education Services Report)

Help with gaining knowledge and confidence

"A lot of them don't know what information is out there, you know, so I just sit with them and talk about what things they can learn about when they are pregnant."

Health care provider, Taeaomanino Trust
(Evaluation of Antenatal Education Services Report)

Consistent support

"We see them here at hospital and at home, for that continuity and we support them through that and then once the midwifery side is finished there are the other providers like Plunket and we would support that transition so they can continue that support, to their GP, or other specialists, and so not just run away – make sure somebody else is there, whether that is a medical person or a social service person."

CMT midwife
(Creating Enabling Maternity Care)

Actions

Overview and objectives

1. Culturally responsive care

a. As the indigenous people of Aotearoa, Māori experience care that is reflective of their indigenous knowledge and is culturally responsive and safe.

b. Pacific families access care and services that is culturally responsive and safe.

2. Improved access to primary birthing

a. Women and families can choose community models of birth and postnatal care.

b. Women and families who birth in hospital have support to experience a healthy normal birth.

3. Enabling maternal and neonatal care

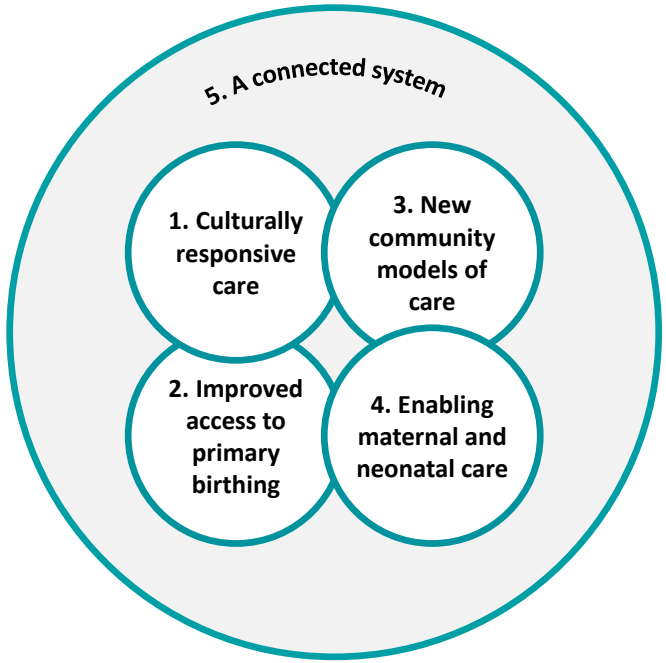
Disabled women and families with children with impairments receive accessible and inclusive care that enables good lives.

4. New community models of care

Mothers, fathers, families and whānau access a range of care connected within their community from trusted faces in trusted spaces.

5. A connected system

We deliver a connected continuum of maternal and neonatal care, at the right level, as close to home as possible, keeping families together.



Culturally responsive care

1 Trusted faces in trusted places

4 Intensify for those who need it most

6 Connected, proactive providers

7 Whānau centred

Programme objectives

A. As the indigenous people of Aotearoa, Māori experience care that is reflective of their indigenous knowledge and is culturally responsive and safe.
B. Pacific families access care and services that is culturally responsive and safe.

Hauora Māori leadership

Establish Hauora Māori leadership role which enables, supports and enhances indigenous knowledge and cultural responsiveness throughout the maternal and neonatal system of care. Support recruitment and retention of Māori workforce within maternity and neonatal care. Provide a work environment that is culturally safe and skilled in the cultures and healthcare needs of both workforce and families.

Actions:
1. Establish and resource new Hauora Māori leadership role by February 2022.
2. Recruit into Hauora Māori leadership role by April 2022.

Pacific Health leadership

Establish Pacific health leadership role which enables, supports and enhances Pacific cultural knowledge and cultural responsiveness throughout the maternal and neonatal system of care. Support recruitment and retention of Pacific workforce within maternity and neonatal care. Provide a work environment that is culturally safe and skilled in the cultures and healthcare needs of both workforce and families

Actions:
1. Establish and resource new Pacific leadership role by February 2022.
2. Recruit into Pacific leadership role by April 2022.

Workforce support and education programme

People who work within maternity and neonatal spaces, including managers, in the community and in facilities, have education and support to gain the skills and confidence to provide culturally safe care.

Actions:
1. Suite of mandatory and progressively stepped cultural responsiveness training and resource library is developed and implemented by June 2022.
2. Develop complaint and resolution pathway to support staff when they witness or experience culturally unsafe practice or behaviours, by June 2022.
3. Evaluation and audit of skills, knowledge and practice is developed and implemented by September 2022.

Grow the Māori and Pacific maternity workforce

Increase the maternity workforce that holds specific clinical and cultural skills and knowledge including:
Safe sleep, breastfeeding, kaiāwhina, mātauranga Māori, birthing tikanga, hapū wananga, mental health.

Actions:
1. Co-develop package of support to recruit and retain Māori and Pacific LMC midwives by April 2022.
2. Include support for new peer support and professional roles in hapū whānau service specification by March 2022.

Support indigenous, traditional and cultural birthing knowledge and practice

Enable the sharing, access to and growth of Indigenous, traditional and cultural birthing knowledge and practices.

Actions:
1. Establish Indigenous, Traditional and Cultural Birthing Knowledge and Practice Advisory Group by May 2022.
2. Include advice from Advisory Group in mandatory Cultural Responsiveness education by June 2022.
3. 2DHB policy and guideline developed to increase access to Indigenous, traditional and cultural birthing knowledge and practices by June 2022.

30

Improved access to primary birthing

1 Trusted faces in trusted places
2 Enabling and respectful
3 Right-level care, closer to home
5 Informed choices
7 Whānau centred

Programme objectives

A. Women and families can choose community models of birth and postnatal care.

B. Women and families who birth in hospital have support to experience a healthy normal birth.

Increase access to primary maternity facilities

Actions:

1. Articulate a 2DHB configuration of primary maternity facilities that increases access to community-based primary birth and postnatal services, by March 2022.
2. Develop a business case for investment in additional primary maternity inpatient birthing and postnatal services; and capital improvements at existing PBUs (KMU and PMU) by June 2022.
3. Contribute to Master Site Plan to consider medium-to-long term facilities needs for maternity at Kenepuru by June 22.

Increase utilisation of current primary maternity units

Increase utilisation of existing primary maternity facilities by ensuring they are fit for purpose and enable holistic, whānau-centred and safe care.

Actions:

1. Lead a design process with families to finalise short-term improvements to Kenepuru by June 2022.
2. Consider staffing models at Kenepuru and Paraparaumu to include support staff (e.g. healthcare assistants) by June 2022.

Enable home birth choice and knowledge

Homebirth is promoted and resourced as a viable option and women are given the choice, support, resources and pathways to enable this.

Actions:

1. Factual information about homebirth is included in Pepe Ora by April 2022.
2. Support LMC midwives to offer homebirth option for place of birth by providing a package of education, resources, and consumable supplies (e.g. birth pools/liners) for midwives and Kaiāwhina is developed by April 2022.

Define physiological pathway care for women birthing in hospital

Define a pathway and develop environments that promote birth without unnecessary intervention at our hospitals.

Actions:

1. Building on current "Optimising Birth" initiatives, develop a physiological birth pathway and guidelines for midwifery-led care to achieve a physiological birth without unnecessary intervention, in hospital, by April 22.
2. Develop normal-birth promoting environments within hospital maternity wards, according to physiological birth promotion principles and involving service users and community providers, by June 22.
3. Include access to birth support from Kaiāwhina (date TBD).

New community models of care

1 Trusted faces in trusted places
2 Enabling and respectful
3 Right-level care, closer to home
4 Intensify for those who need it most
6 Connected, proactive providers
7 Whānau centred

HUTT VALLEY DHB
Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Programme objective

Mothers, fathers, families and whānau access a range of care connected within their community from trusted faces in trusted spaces.

Enable development of community Hapū Whānau Maternity Hubs

Commission and develop a network of connected Hapū whānau Hubs that provide a continuum of services for the whole family, for the first 1000 days and beyond. The hubs are formed by partnering with, investing in and co-locating existing community services including LMCs, primary health and specialist services.

Actions:
1. Create a service specification for hapū whānau hubs, that builds on existing services, strengths and assets in the community by March 2022.
2. Implement a minimum of 2 iwi-led or supported Hapū whānau hubs by June 2022.
3. Enable access to specialist care closer to home including the potential for a mobile outreach clinic and telemedicine, co-located with other integrated services in the community (e.g. hubs and PBUs) by December 2022.
4. Enable access to holistic comprehensive support to meet a range of social needs (e.g. Kaimahi, social work, specialist midwifery and cultural support) by December 2022.

Kaiāwhina model of care

Develop a model of care for maternity-specific Kaiāwhina support for pregnant, birthing, and postnatal mothers and families that would provide wellbeing support and health navigation support throughout women and families' journey from conception to early years.

Actions:
1. Include Kaiāwhina within Hapū Whānau Hub service specification by March 2022.
2. Co- develop with families, cultural and clinical experts, a maternity-specific Kaiāwhina model of care and capability and support framework by June 2022.

Community Midwifery Team new model of Care

Improve access to continuity-of-care maternity care closer to home for women unable to access community LMC midwifery. Establish a well aligned and resourced team who provide culturally responsive and enabling, continuity of care.

Actions:
1. Create a new continuity of care model of care for HV and CCDHB CMTs by March 2022.
2. Implement a new model of care by September 2022.

Maternal wellbeing and mental health model of care

Improve support for wellbeing and access to appropriate services so mothers and fathers can indicate that they are experiencing distress and get appropriate support, at any time across the perinatal period. This includes support for loss, bereavement, birth trauma, and post-diagnosis of babies with impairments.

Actions:
1. Create specialist perinatal wellbeing role to support emotional wellbeing and mental health of families across the 2DHBs by September 2022.
2. Develop a package of education and resources for non-clinical roles (e.g. chaplains, kaumātua) to support families experiencing distress by September 2022.
3. Include support for emotional wellbeing in Hapū whānau Hub service specification by March 2022.

Support LMCs to enter and stay in practice

Develop a package of support for LMC midwives in the 2DHB region to enter and stay in practice including support for providing homebirth and birth in primary maternity facilities care.

Actions:
1. Co-develop and implement a package of support for new and returning to service LMC midwives by April 2022.
2. Fund clinic space for LMC midwifery practices in high needs areas by June 2022.

Enabling maternal and neonatal care

2 Enabling and respectful

4 Intensify for those who need it most

6 Connected, proactive providers

7 Whānau centred

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Programme Objective

Disabled women and families with children with impairments receive accessible and inclusive care that enables good lives.

Establish this role… **…to enable these actions**

Disability equity leadership

Establish Disability leadership role which enables, supports and enhances Enabling Good Lives principles throughout the maternal and neonatal system of care. Includes leading workforce education and support, review of policies, clinical pathways, environments, and resources for families.

Actions:

1. Establish and resource new disability role by February 2022.
2. Recruit into disability leadership role by April 2022.

Breastfeeding pathways are disability and impairment positive

All women who aspire to breastfeed receive effective, accessible and inclusive lactation support, including disabled women and mothers of babies with impairments.

Actions (dates TBD):

1. EGL education mandated to all DHB-funded breastfeeding support providers in 2DHB region.
2. Update all breastfeeding pathways and guidelines, according to EGL principles.
3. Develop specific resources to provide practical accommodations with breastfeeding for disabled mothers and families with babies with impairments.

Antenatal education is enabling

All antenatal education curricula is reviewed against Enabling Good Lives principles. Resources are developed for specific needs (e.g. mobility needs in birth, or families who have an antenatal diagnosis).

Actions (dates TBD):

1. EGL education offered to all antenatal and parenting educators in 2DHB region (date TBD)
2. Antenatal and parenting education curriculum is reviewed and recommendations consistent with EGL update (date TBD).

Disability advocacy and support service available for maternal and neonatal Care

Kaiāwhina-type role developed to support disabled women and families with a baby with impairments, to ensure environments are enabling, providing support to healthcare providers, and developing care plans.

Actions:

1. Establish and resource new role/s by April 2022.
2. Disability support service available to families by June 2022.

Information is gathered that can drive further improvement

Care, outcomes and experiences of disabled women and families with babies with impairments is collected, evaluated and creates ongoing improvement.

Actions:

1. Disability Equity Advisor role established on Maternity Quality Safety Programme Governance Groups by April 2022.
2. Guidelines for gathering and evaluation of information related to disability in maternity and neonatal space are developed by MQSP (date TBD).

Policies and guidelines are enabling

Review all 2DHB maternity and neonatal policies and guidelines to ensure rights based language and EGL principles are evident.

Ensure all resources developed reflect intersectional realities.

Actions (dates TBD):

1. Priority maternity and neonatal policies are reviewed and updated to reflect EGL principles.
2. All 2DHB policies and guidelines are reviewed with a Disability Equity lens as they come up for review.

Workforce support and education programme

People who work within maternity and neonatal spaces, including managers, in the community and in facilities, have education and support to gain the skills and confidence to provide care in line with Enabling Good Lives principles.

Actions (dates TBD):

1. Suite of mandatory and progressively stepped cultural responsiveness training and resource library developed and implemented.
2. Measures for evaluating and auditing skills, knowledge and practice, with consideration of an accreditation system are implemented.
3. Clinical coaches available to all workforce.

33

A connected system

1 Trusted faces in trusted places
2 Enabling and respectful
3 Right-level care, closer to home
4 Intensify for those who need it most
5 Informed choices
6 Connected, proactive providers
7 Whānau centred

HUTT VALLEY DHB
Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Programme objective

We deliver a connected continuum of maternal and neonatal care, at the right level, as close to home as possible, keeping families together.

Resources for families

Women, families and providers have the information they need to access the care they need, and to make decisions about their care, throughout the 2DHB region.

Actions:

1. Extend the Pēpe Ora online network of resources to include the Hutt Valley, by April 2022.
2. Expand Pēpe Ora to include information about how to make informed choices, by March 2022.
3. Ensure Pepe Ora is highly accessible and visible to women and families, by March 2022.
4. Include links to Pepe Ora in platforms used by providers including Health Pathways by March 2022.

Integrated Network of Right place-Right care Services

Connected network of care from community to specialist services. Support people to access levels of care based on needs and preferences, and integrated clinical governance is provided across the system.

Actions:

1. Contribute to the Master Site Plan to determine medium-to-long-term maternal and neonatal facility needs at Hutt, Wellington and Kenepuru Hospital sites, by June 2022.
2. Develop Right Place-Right Care pathways of care guidelines to maximize the ability for families to access care at the optimal level for their needs, as close to home as possible, by April 2022.
3. Integrate clinical governance structures across 2DHB system, including Maternity Quality and Safety Programme (MQSP) by June 2022.

Safe sharing of clinical information across the continuum of care

Select a maternity clinical information system that can be implemented across the 2DHB maternal and neonatal system, so that providers and families have access to complete clinical information across the continuum of maternal and neonatal care, to maximise safety and continuity. (This also brings the 2DHBs into compliance with Ministry of Health expectations.)

Action:

1. Develop a maternity clinical information system procurement and implementation plan by June 2022.

Whānau-friendly policies and support

Remove barriers for families and whānau to stay together throughout the maternal and neonatal inpatient journey.

Actions:

1. Involve consumers in updating all maternity and neonatal unit policies regarding support people presence to support birthing people, including strategies to minimise separation in a COVID environment, by February 2022.
2. Involve families in facility redesign/improvement work to ensure that family-friendly spaces are created, by June 2022.
3. Fund an extension to existing travel and accommodation support for families who have to travel to access inpatient maternity or neonatal care for extended periods, by April 2022.

Enabling access to high-quality pregnancy ultrasound

Remove barriers for women to access appropriate and adequate-quality scans, either in the community or in the DHB.

Actions:

1. Provide access to free ultrasound morphology scans for women who would otherwise be unable to access them, by April 2022.
2. Develop clinical governance framework to ensure uniform, high quality for all pregnancy related ultrasound services. Improve sonographers training to pick up impairments by June 2022.

New models of care for newborns requiring extra support

Implement new models of care to support babies to minimise unnecessary separation from mother and whānau, minimise unnecessary hospitalisation, and improve post-discharge support.

Actions:

1. Develop plan to implement new national Transitional Model of Care in Hutt Hospital and Wellington Hospital, to keep mothers and babies together whilst providing additional neonatal specialist input as required, by June 2022 (NB there are facilities redevelopment implications).
2. Adopt and implement Model of Care to support babies in the community who are requiring extra support but do not (or no longer) require hospitalisation, by April 2022.
3. Create a lactation support service for families who have a baby in Hutt Special Care Baby Unit (SCBU), or have been discharged from SCBU by April 2022.

34

Change principles

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Strategic approach

Pro-equity

- Project Aim
- Project Team with Māori, Pacific and Disability Equity Leads

Human-Centred

- Engaged design experts from ThinkPlace
- Focused on experiences of women and families

Insight-driven

- Builds on existing knowledge about what is and isn't working in the system.

Bias toward action

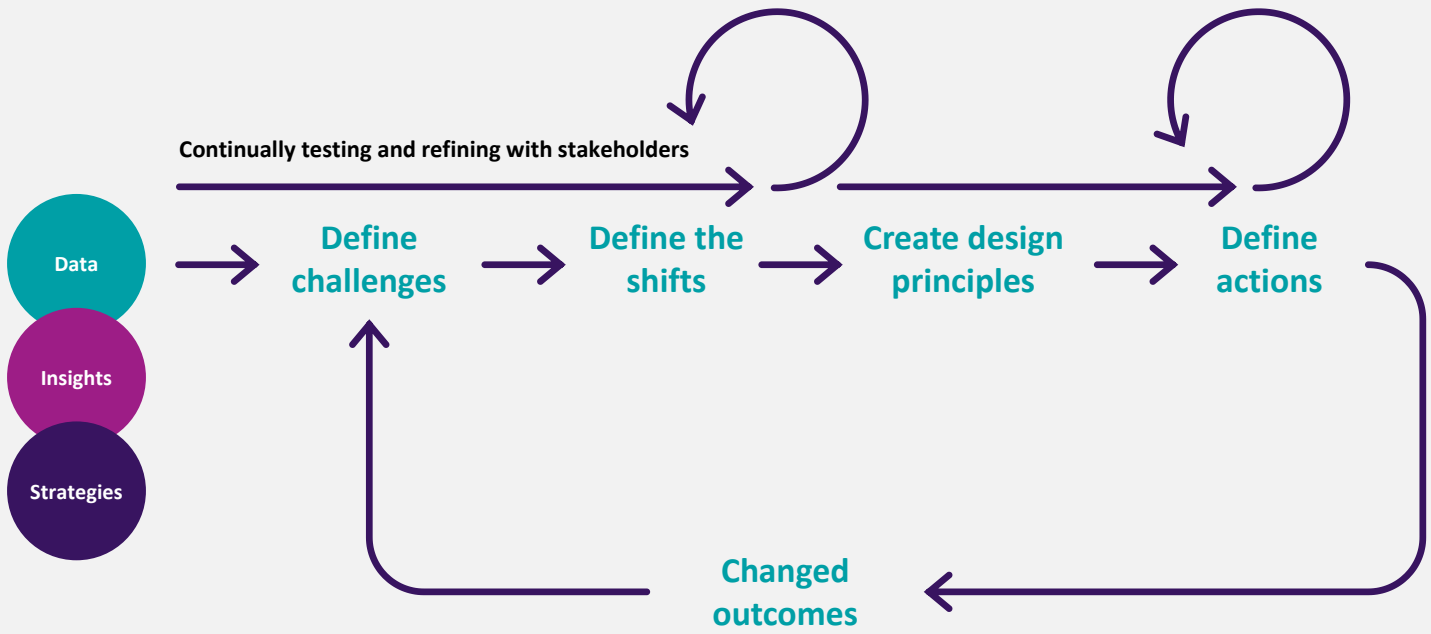
- Defines concrete actions to create change

Relationship building

- Prioritises building trust throughout the system.

Iterative

- Tests and refines using an Advisory Group and wider stakeholders who represent the people who are in the system.
- Tests thinking early and often.



The steps to design this Plan have taken us from: making sense of the data, insights, and strategies; to defining challenges; understanding the shifts required, outlining the design principles to guide decision making; defining the actions to make change; defining the outcomes that will be measurably changed, which ultimately will address the challenges we face today.

Understanding our challenges

1

Māori and Pacific women, babies and whānau and families are less likely to be able to access care that they are entitled to, from people and places that they trust, and that meets their needs.

Māori and Pacific women are less likely to have continuity-of-care midwifery care, and less likely to have the support they need to give birth to full term healthy weight babies.

"They'll go, 'here's a list of midwives, find a midwife.' Then this poor woman is left to negotiate this whole thing, often not hearing back from any services, they'll say, 'well no one got back to me, they got back but couldn't see me in the end.' I don't think that women are being served well from the very first point of contact in their pregnancy." CCDHB - MĀMĀ, PĒPI, TAMARIKI RESEARCH. DNA: 2019

2

Disabled women, and families who have a baby with an impairment, are not always receiving enabling respectful care.

The workforce is not educated or trained to provide enabling or respectful care to disabled women and babies born with impairments.

"I contacted a lot of LMCs very early on, I mean at this stage I was probably only five weeks pregnant and a lot of them didn't feel confident in taking me on, so it wasn't a case of they didn't have space – it was that they felt they didn't have the skills they needed to support me in pregnancy." Creating enabling maternity care: research report. Imagine Better: 2021.

Understanding our challenges

3

The current system is highly dependent on having an LMC to help navigate and access services.

LMC shortages means more women are not receiving continuity-of-care midwifery care, are missing out on care they are entitled to, and are not receiving intrapartum care from a midwife they know and trust.

Across the 2DHBs there is a decreasing number of LMCs, and particularly scarce Māori and Pacific LMCs.

The type of birth and care you can access is dependent on the LMC you can access and requires high effort from the women and their family to engage.

Approx. 1,600 women per year are unable to access an LMC midwife and receive their care through the 2DHB community midwifery team. These women are unable to choose to birth at a primary maternity unit or at home.

Refer to "The maternity workforce" data story on page 23 for more information.

4

Not everyone who has birth or postnatal care in hospital requires hospital-level care.

There are rising rates of birth interventions in hospital, with risks for mothers and babies and less satisfactory birth experiences, and few women in the 2DHB region have access to out-of-hospital birthing and postnatal care.

Current research and evidence supports physiological birth outside of the hospital but birthing in hospitals is common for women across the 2DHBs, and intervention rates in hospital are increasing

Refer to data story on page 24-25 for more information.

Understanding our challenges

5

People's birth and postnatal experiences in hospital services are not always positive, and maternity facilities struggle to provide adequate staffing to match demand.

An increasing number of women and families are choosing to birth in the Wellington Regional Hospital, which is experiencing capacity issues.

Some women and families are choosing to bypass Hutt Valley Hospital Maternity facilities due to perceptions around the quality and safety of the service.

"I felt was there was no empathy for mothers; new, new mothers. First time mother. They were willing to get rid of her the next day. I don't understand why I had to advocate for her, just to have a couple more days."
CCDHB - MĀMĀ, PĒPI, TAMARIKI RESEARCH. DNA: 2019

6

The system is challenging to navigate and understand.

It takes a lot of effort for individuals and families to access separate services throughout the maternal, neonatal and early years' time, and people don't always feel involved in decisions about their care.

Families really appreciate when they can get multiple services through a provider who is trusted and already known to them.

Families who don't engage in maternity services are sometimes blamed for "Not Attending" and end up missing out on care they are entitled to.

"They have had really bad experiences with conversations or experiences they've had, or whoever they wanted was unavailable, so they just thought, well, I'm not going to bother."
CCDHB - MĀMĀ, PĒPI, TAMARIKI RESEARCH. DNA: 2019

Developing principles for change

These principles are statements that can be used to guide and inform decision making now and in the future. Together, they describe the direction of change.

They have been informed by current strategies, evidence, insights and the voices of service users and providers, to help us to imagine what better maternity and neonatal care could look like.

Principle 1: Trusted faces in trusted places

The principle and what it means

Māori wāhine, pēpi and whānau, and Pacific women, babies and family, can choose a range of maternity care from trusted Māori and Pacific providers in places that feel safe and familiar.

Trusted faces means… people who are known and familiar. People will engage and respond more effectively to people they feel they can trust, especially those from their own communities.

Family means… extended family of a Pacific person. Family is an important value for Pacific people. In some Pacific cultures, "fanau" refers to the immediate or nuclear family, children, or birthing.

Trusted places means… the environments people receive care are familiar to them, close to home or in places they go regularly.

Choose means…
People know what they are entitled to and have the option to engage with something, they have agency over this interaction, it is not forced.

A range of maternity care means… access to primary care as well as specialist care, and it also means having respectful care.

The strategic shift

FROM: Clinical and hospital-based services that aren't easily accessed or affirming for Māori, Pacific or disabled communities.

TO: Well-known and easy to access clinical and cultural services that are designed specifically to proactively cater to the unique and intersectional needs of Māori, Pacific and disabled community.

FROM: Mothers and whānau experiencing care that makes them feel judged, unheard and unvalued.

TO: Mothers and whānau receiving care that is mana enhancing, kind and makes them feel understood and valued.

The rationale

Strategies:
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA

Existing successful initiatives:
- Hapū Wananga
- Anofale Fa'atupu Ola Pacific
- Te Ao Mārama

Principle 2: Enabling and respectful

The principle and what it means

All people, including disabled women and families who have a baby with impairments, experience responsive care that is enabling and respectful.

Disabled means… a person who experiences loss of opportunities to take part in society on an equal level, as a result of negative interactions that take place between a person with an impairment and the barriers in her or his environment.". *

Enabling means… people are informed, can access the highest level of care, and participate actively in all relationships. *

Impairments means… an injury, illness or congenital condition that causes or is likely to cause a difference of function. *

Responsive means… responding to requests for accommodation to enable equitable care to happen. *

Respectful means… people feel their mana and dignity is maintained by those providing care.

***** https://www.enablinggoodlives.co.nz/about-egl/egl-approach/principles/

The strategic shift

FROM: Services aren't accessible or affirming for disabled people and are delivered by a workforce who are not trained or educated in delivering enabling care.

TO: Well known, accessible and inclusive services from a workforce who are disability aware.

FROM: Parents and whānau who have babies born with impairments, or have a disability themselves, don't get the appropriate support or response from the workforce.

TO: Disabled parents and every baby that is born with impairment is cherished and the workforce knows how to respond and accommodate them.

The rationale

Strategies:
- Enabling Partnerships: Collaboration for effective access to health services. Sub-Regional Disability Strategy 2017 – 2022. Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Insights:
- Feedback from Advisory Group and Stakeholders,
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.

Existing successful initiatives:
- Enabling Good Lives education
- Twenty-one gifts partnership

Principle 3: Right-level care, closer to home

The principle and what it means

Women and families are supported to receive maternity care at home and in the community, with access to specialist care when required.

At home and in the community means… antenatal and postnatal care is delivered in the community, and coordinated through maternity hubs in specific, high needs areas, and community place of birth and postnatal care options are trusted and accessible.

Specialist care means… care from a range of professionals e.g., obstetricians, neonatologists, lactation consultants, kaiāwhina, mirimiri practitioners, and others.

Right level means… care is delivered at the right intensity to meet the person's clinical, social and cultural needs, with wellbeing-focused primary care being the norm.

The strategic shifts

FROM: Most people who give birth are accessing hospital-level care, even if they would be good candidates for community birth and inpatient postnatal care.

TO: People are able to access community birth and inpatient postnatal care, and hospital care is predominantly for women and babies who require specialist care

FROM: People travel far from home, bypassing closer services, to birth at Wellington Regional Hospital.

TO: People in Hutt Valley have a range of trusted options for place of birth and postnatal care, and only access Wellington Regional Hospital if they require tertiary-level specialist care.

FROM: Facilities are often far away from people's homes, clinical, and do not feel welcoming to mothers and their whānau.

TO: Places which are closer to home, make mothers and whānau feel comfortable, and their diversity and uniqueness celebrated.

The rationale

Strategies:
- CCDHB Health System Plan 2030;

Insights:
- Feedback from Advisory Group and Stakeholders,
- Maternity analytics: Report for Capital and Coast and Hutt Valley District Health Boards. 21 June 2020. Synergia
- Primary Birthing Unit: Capital and Coast District Health Board. Integrity Professionals

Existing successful initiatives:
- Keneperu Maternity Unit
- Paraparaumu Maternity Unit
- Supporting LMC practices

Principle 4: Intensify for those who need it most

The principle and what it means

Women and families who have greater care needs are supported early in their journey to access bespoke maternity care from providers who have Te Ao Māori, Pacific cultural, and clinical knowledge.

Te ao Māori means… a Māori worldview.

Pacific cultural means… Pacific worldviews across distinct Pacific cultures.

Clinical means… knowledge held by midwives, social workers, obstetricians, nurses, and other health professionals.

Supported early means… engaging with people proactively to ensure if they need a Kaiāwhina/navigator/resources.

Bespoke means… services designed in a different way than the status quo.

The strategic shift

FROM: Gold standard continuity of care maternity care is mostly accessed by people with less-complex social needs, and people with the highest complexity of social needs are more often missing out

TO: Specific and bespoke continuity-of-care maternity care is delivered to those who have with greater social needs

FROM: Reliance on LMC midwives to provide comprehensive wrap-around continuity of care and ensure people get access to all the care they require

TO: Well-resourced community providers with expert kaiāwhina who are able to connect hapū māmā and whānau to a range of providers and services to fit their needs

FROM: It is difficult to access culturally specific knowledge and care, and people's cultural practices and wishes are not always respected

TO: Indigenous knowledge and traditional Māori and Pacific practices and practitioners are visible and respected and easily accessible for people and whānau

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- data on who is missing out on LMC care (who is receiving CMT care, by ethnicity location and social complexity)
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing successful initiatives:
- New antenatal education services targeting young mums in Kāpiti, Māori and Pacific mothers in Porirua and Lower Hutt
- Matua Pēpi Tamariki Service

Principle 5: Informed choices

The principle and what it means

Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.

Together means… decision making is a collective, whānau inclusive process.

Advocates means… people who are supporting the women e.g., midwives, GPs, kaiāwhina.

Information and support means… people have access to unbiased, plain English guidance to know their options and make decisions.

Outcomes means… both clinical outcomes for mother and babies and cultural outcomes e.g., being able to integrate traditional practice into the journey.

The strategic shift

FROM: People are not always feeling included in the key decisions made about their care, and don't have the information or health literacy to advocate for themselves.

TO: People receiving care and their advocates receive information in a way that makes sense to them, outlining the full range of options and support pathways so they are able to make informed choices about their care.

FROM: Services are not configured to deliver evidence-based best practice such as continuity of care, closer to home care and accessibility.

TO: Services that enable gold standard, continuity of care, provided in places closer to people's homes, that align with the 2DHB accessibility charter.

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing Successful initiatives:
- Pēpe Ora
- New antenatal education services providing education on Te Ao Māori and Pacific worldviews, alongside pregnancy and birthing physiology

Principle 6: Connected, proactive providers

The principle and what it means

Women and families get care from connected and proactive providers during the first 1,000 days, especially when they have more complex care needs.

Connected means… providers are linked up, coordinated and have integrated communication channels which enable them to collaboratively care for people.

Proactive means… providers meet families where they are and actively listen to and respond to their needs, including connecting them to other sources of support and care if needed.

First 1,000 Days means… Babies are enabled to get the best start to life from the day the baby is conceived, up until 2 years of age.

Complex means… when mothers have more distinct needs, both clinical (e.g., diabetes) and/or social needs (e.g., distressing family dynamics).

The strategic shift

FROM: Relying on individuals to navigate and engage with multiple discrete providers and services who only work on specific sets of needs or time periods.

TO: Providers and advocates that are proactively connecting and linking with one and other to provide holistic care for mothers and babies from pre-conception through the early years of family life.

FROM: A fragmented array of providers who are under resourced and not working together in unison.

TO: A unified and connected range of providers who refer to and from each other, guiding the mother, her whānau and pēpi to someone they know and trust.

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing successful initiatives:
- Maternity Hubs – Wairoa
- Matua, Pēpi, Tamariki

Principle 7: Whānau-centered

The principle and what it means

Care is centred around supporting the wellbeing of the māmā, pāpā, pēpi and their whānau.

Supporting means… showing manaaki to the whānau of the person they are caring for.

Wellbeing means… healthy behaviours and relationships, and safe families.

Whānau means… people who the māmā sees as important in the journey of her and her pēpi. This could include immediate family and wider community members.

The strategic shift

FROM: An individual, biomedical perspective which only takes into account the mother and baby they are caring for.

TO: A broader perspective and understanding that includes and welcomes whānau into the journey and works with them to get the best outcomes for all involved, including māmā and pēpi.

FROM: Funding providers to provide care only to mothers and babies, rather than to everyone in the family

TO: Funding providers to assess the whole family's wellbeing (e.g. smokefree, immunisations, dental care, education).

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *CCDHB – Māmā, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing successful initiatives:
- Whānau Ora

Appendix

Advisory Group Tapa Cloth and words of encouragement References

Gifts from our Advisory Group: Tapa Cloth and words of encouragement

11/11/2021 Word Art

about:blank 1/1

References

- CCDHB Mama Pēpi Tamariki Research Findings. DNA (2019)
- CCDHB Primary Birthing Unit Report. (2018)
- First 1000 Days Partnership Project. Hutt Valley District Health Board (2019)
- Creating enabling maternity care: dismantling disability barriers. Mums and babies' experiences at the 3DHB. Research Report (2021)
- Place of birth and outcomes for a cohort of low-risk women in New Zealand: A comparison with Birthplace England. Dixon et al. (2014)
- Synergia Maternity Analytics Report for Capital and Coast and Hutt Valley District Health Boards (2020)
- Evaluation of Antenatal Service Report
- Planned place of birth in New Zealand: does it affect mode of birth and intervention rates among low-risk women? Davis, et al. (2011)
- Enabling Good Lives principles. https://www.enablinggoodlives.co.nz/about-egl/egl-approach/principles/
- Hutt Maternity Quality and Safety Programme Annual Report. (2019)
- Hutt Valley District Health Board Women's Health Services External Review (2018)