2DHB Maternity and Neonatal System Plan

December 2021

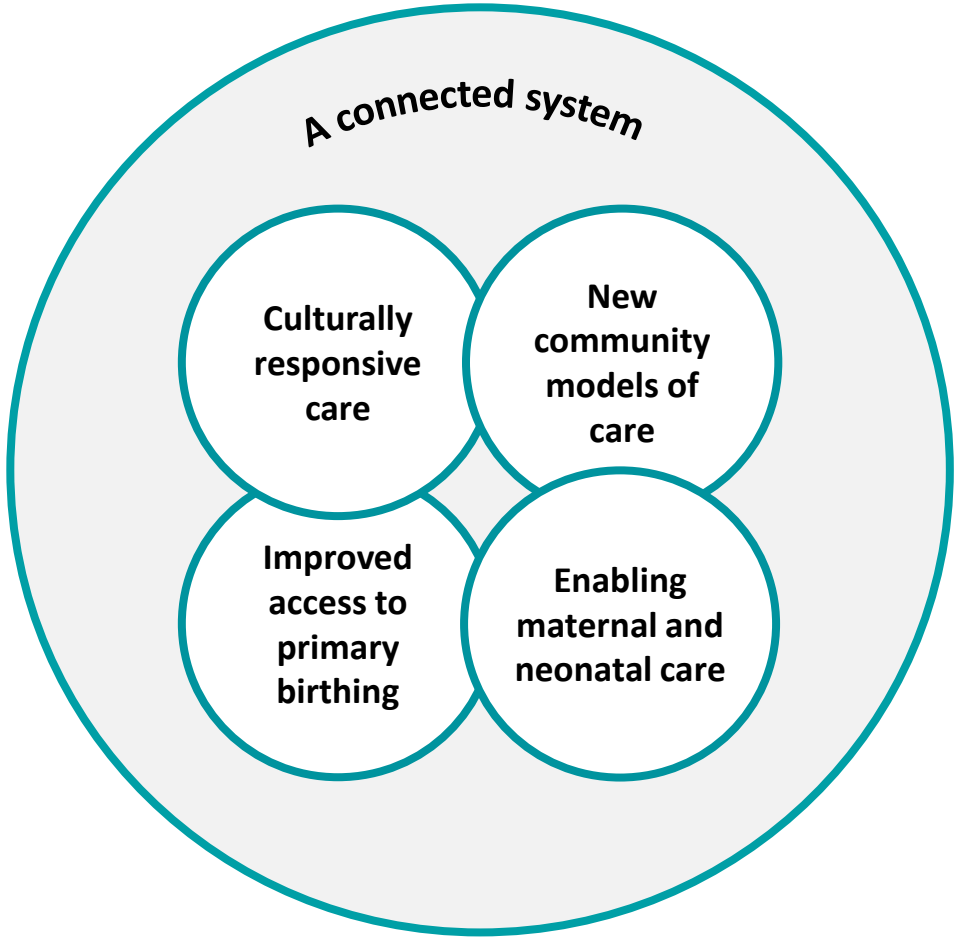
ENDORSED by the 2DHB Board

Contents

Introduction

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

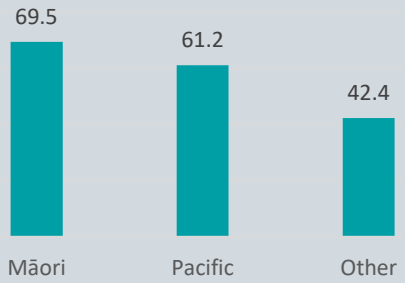
- **2,214 (45%) of women were first time mothers**. This is higher to the proportion of first time mothers nationally (approximately 41% in 2020).

What does the community look like in the future?

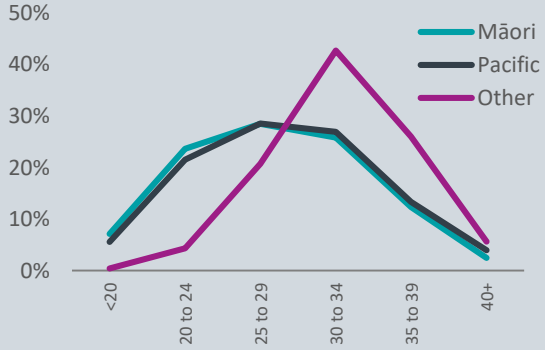
As there is a larger number of Māori mothers having children younger, current projections indicate there will be significant growth in the Māori population by 2030 than non-Māori. Pacific people will follow a similar trajectory.

- 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



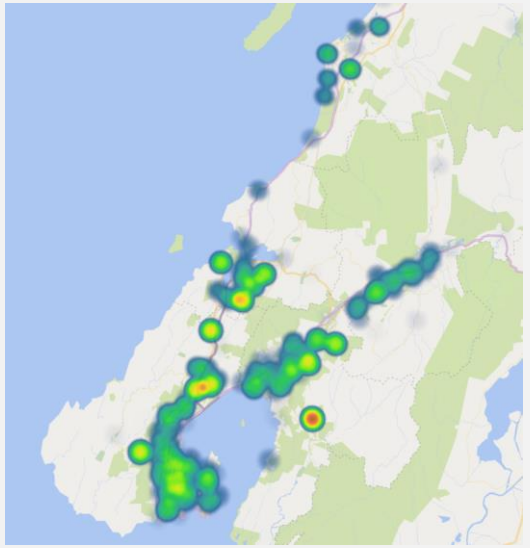
- Across our DHBs, our **younger mothers are more likely to be Māori or Pacific**. Younger mothers from other ethnicity have births later in life.



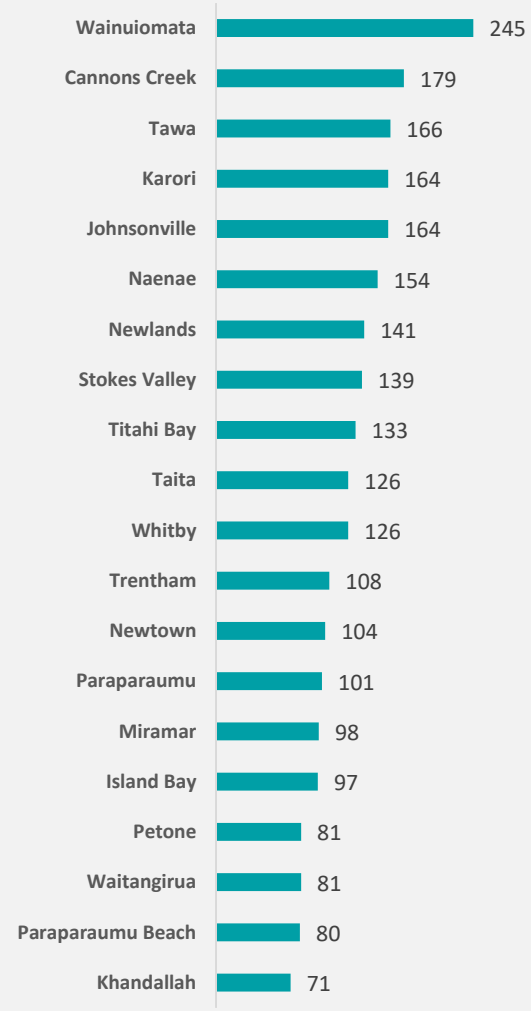
Where do women having babies live?

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

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



2DHB Top 20 suburbs where Mothers gave birth



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."

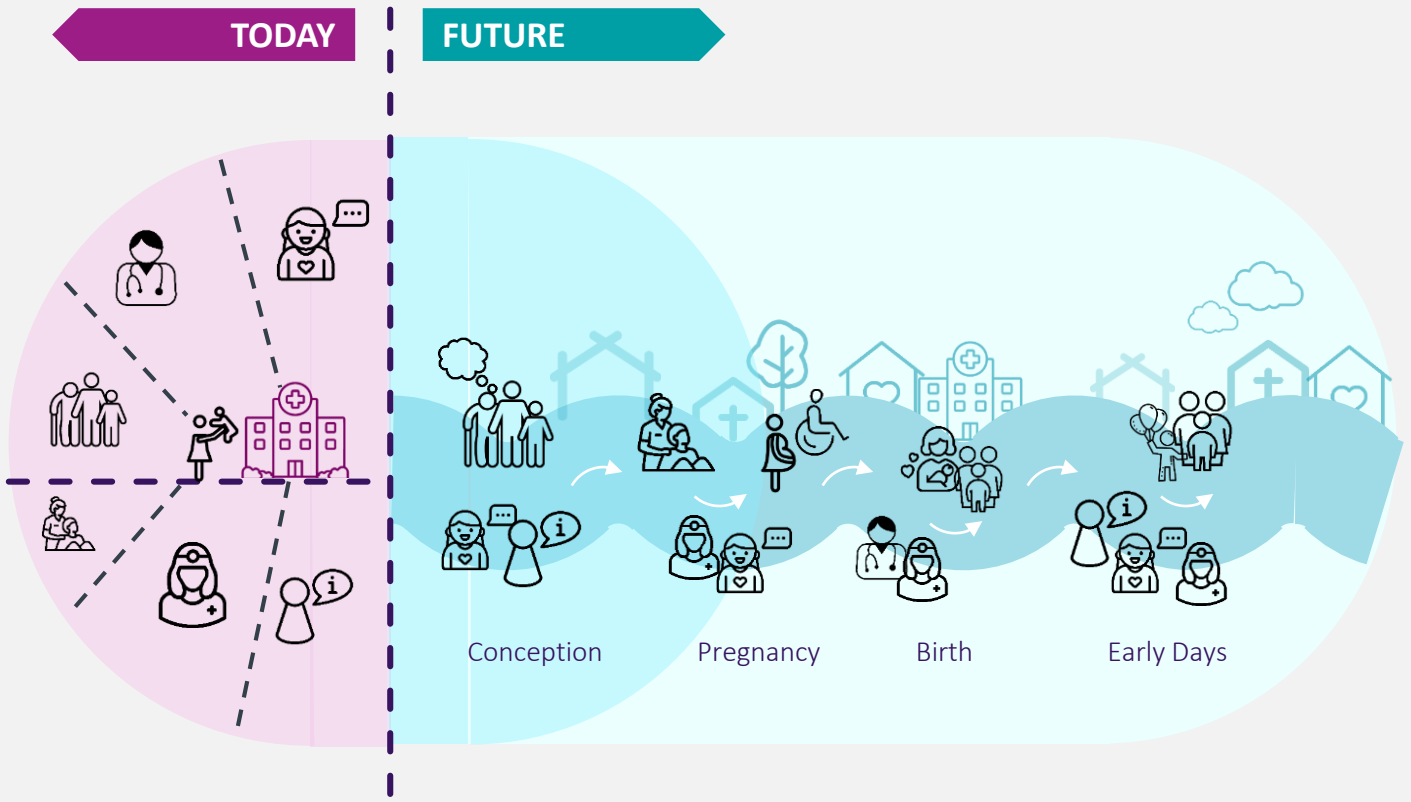
"I will have support to keep me and my family healthy."

"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



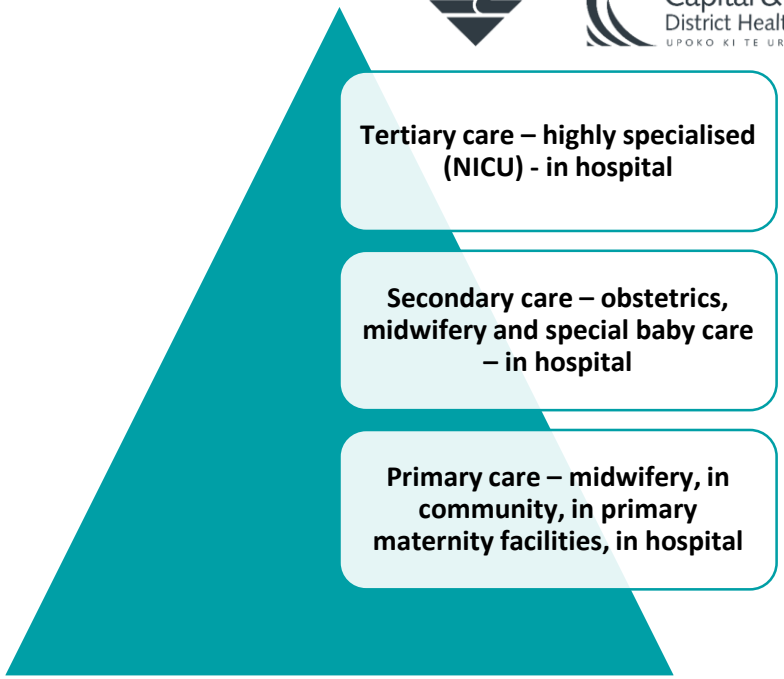
We are creating a future that:

- 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

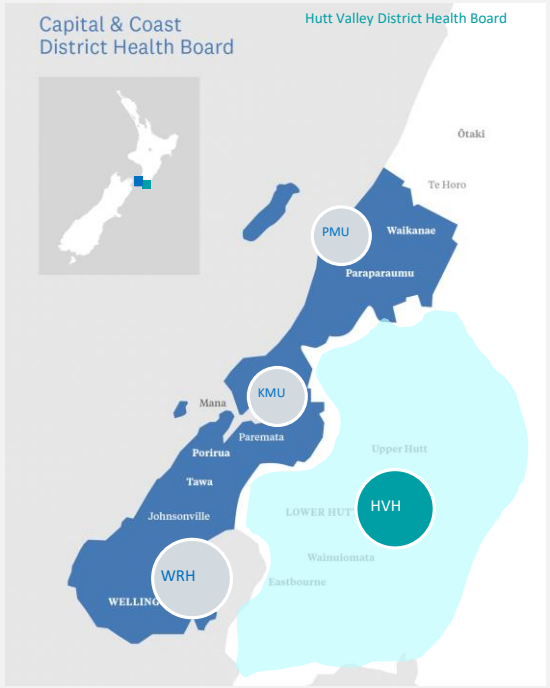
Primary care… Specialist care for mum and baby… Maternal wellbeing and mental health support… Social and cultural support…

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

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.

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

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

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

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

The system is challenging to navigate and understand.

Our future state

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.

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

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.

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

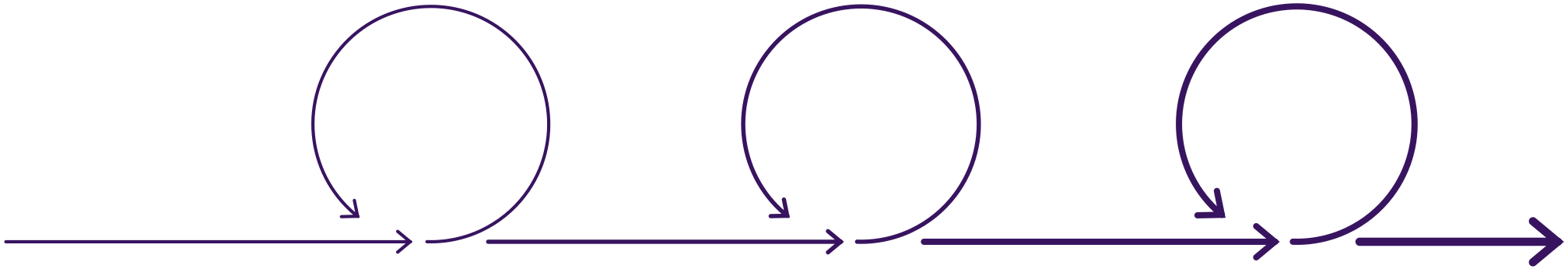
Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.

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

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

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

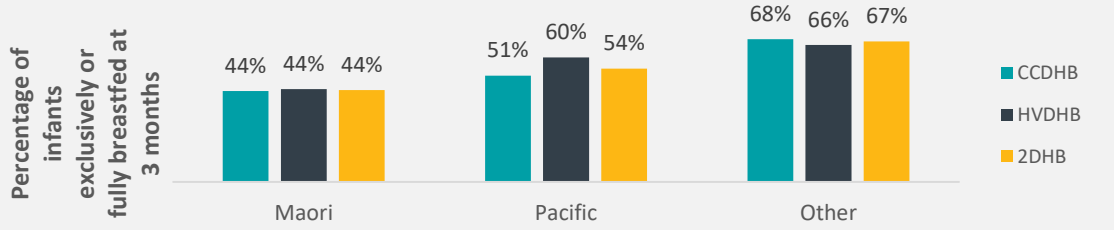
As a DHB we are refining our pro-equity commissioning approach and strengthening relationships with providers and partners across the community. We have some existing examples of great performance and effective innovation that this Plan seeks to adapt and scale.

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).

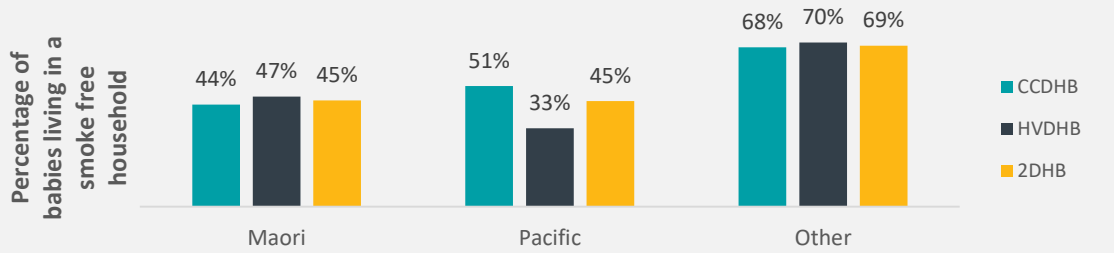
But it is not producing equitable outcomes

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	

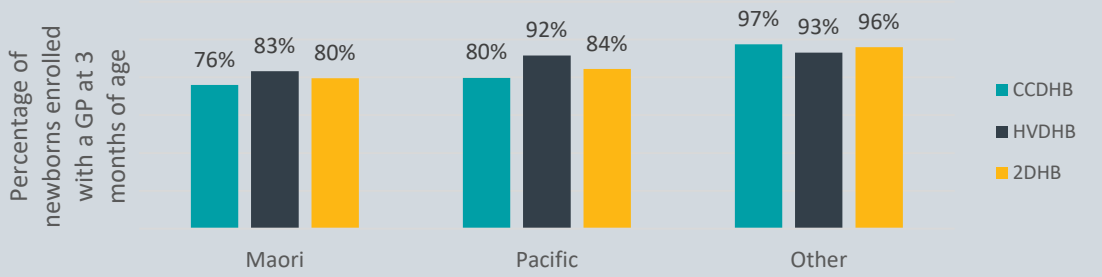
- There are "alarmingly **higher rates of maternal suicide that Māori whānau** are experiencing" (Source: PMMRC 14th report)
- **Foetal and infant death rates are up to 6x higher for Pasifika children** and **4x higher for Māori children**.
- For our 2DHB population, **Māori babies are more likely to 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

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

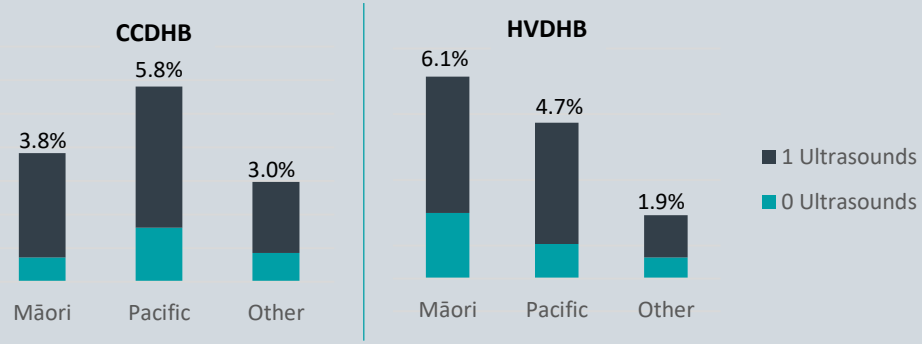


62 Māori babies had no GP at 3 months age (51% of all babies without a GP)
- **37 in CCDHB**
- **25 in HVHDB**

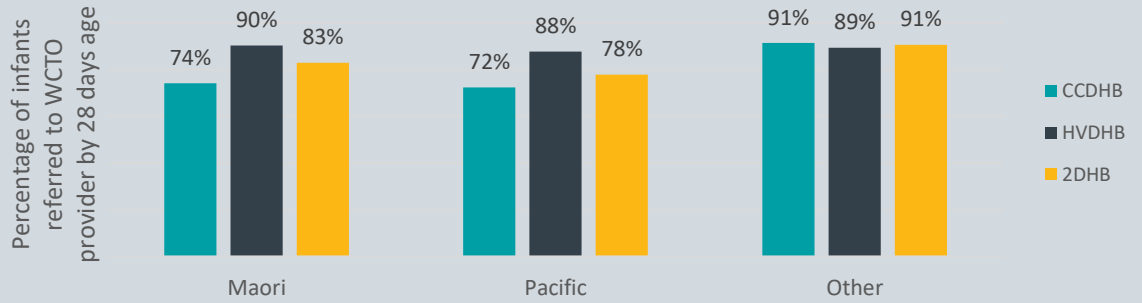
23 Pacific babies had no GP at 3 months age (39% of all babies without a GP)
- **18 in CCDHB**
- **5 in HVHDB**

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

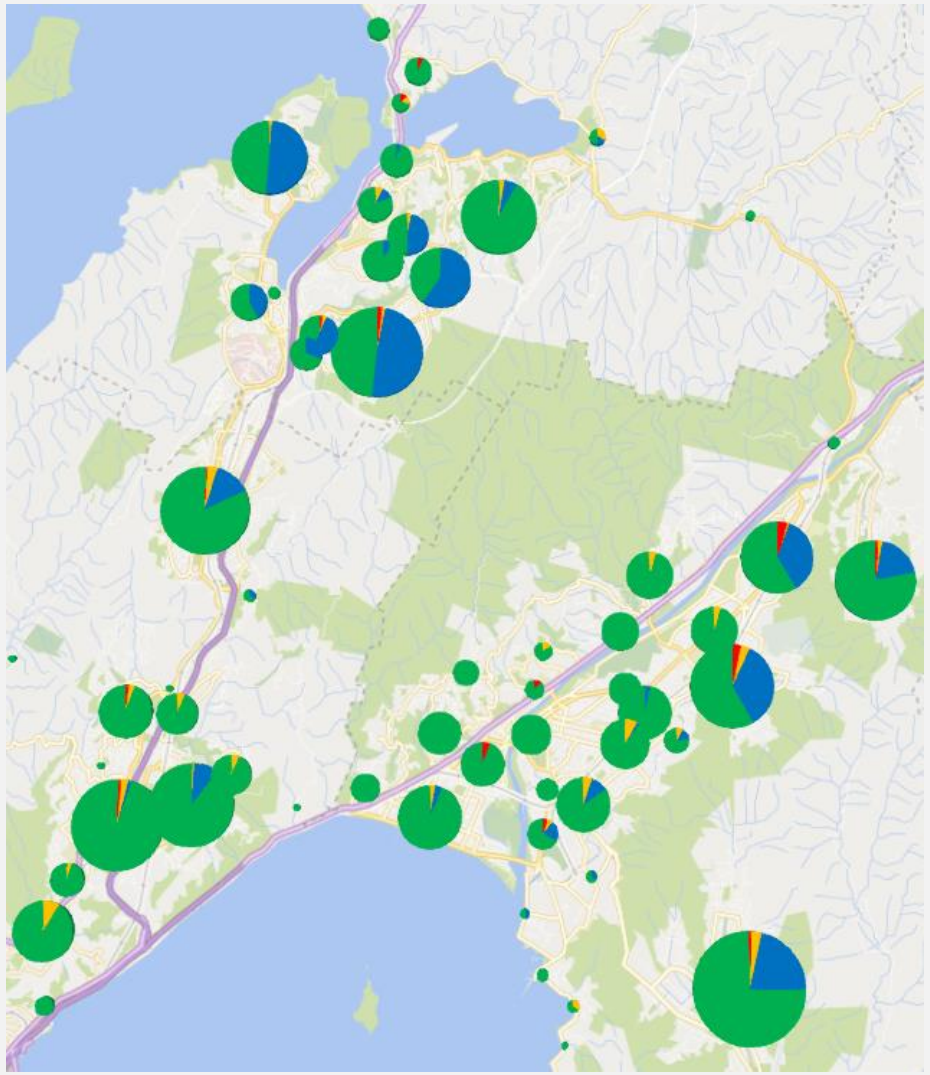
We know where the greatest need is

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

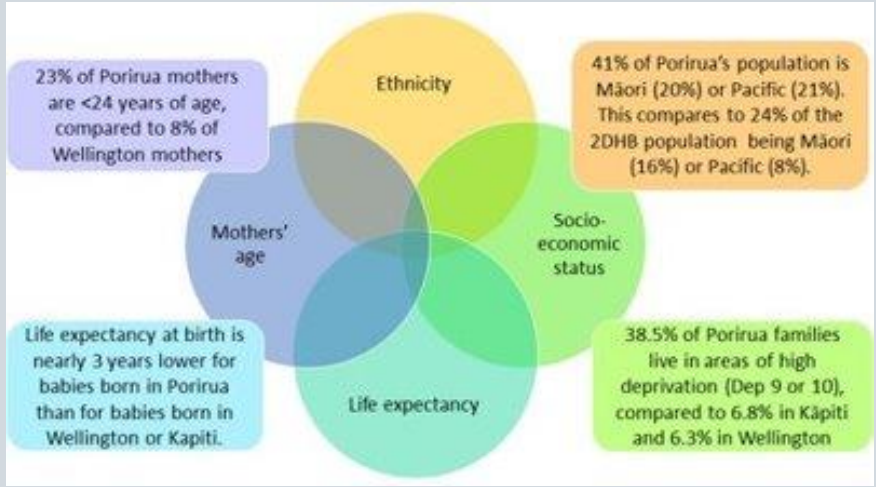
- **Wainuiomata, Naenae** and Eastern Porirua suburbs of **Cannons Creek and Waitangirua** are places with high number of births as well as a high proportion and volume of mothers needing social support.
- Clinical complexity was similar across all suburbs, with slightly elevated rates in Upper Hutt.



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

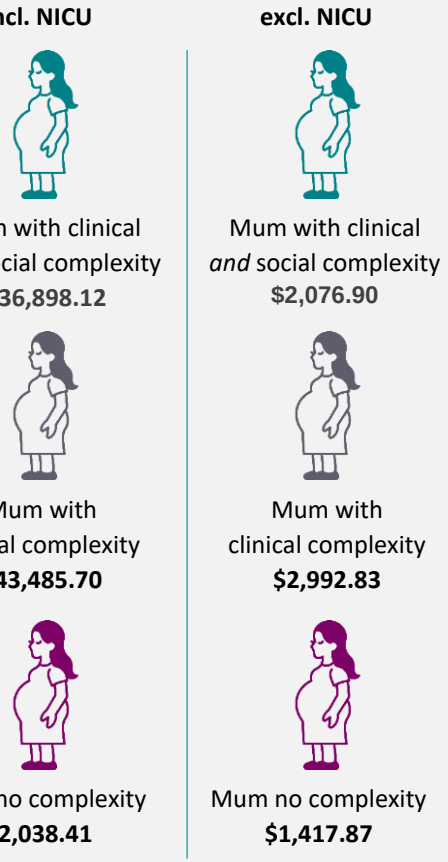
- There is a mix of Ministry of Health funded, District Health Board funded and privately funded care.
- LMC midwifery care is funded directly by central government. This funding cannot be accessed by DHBs who provide midwifery services to women who cannot find a community midwife.
- Therefore, **growing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

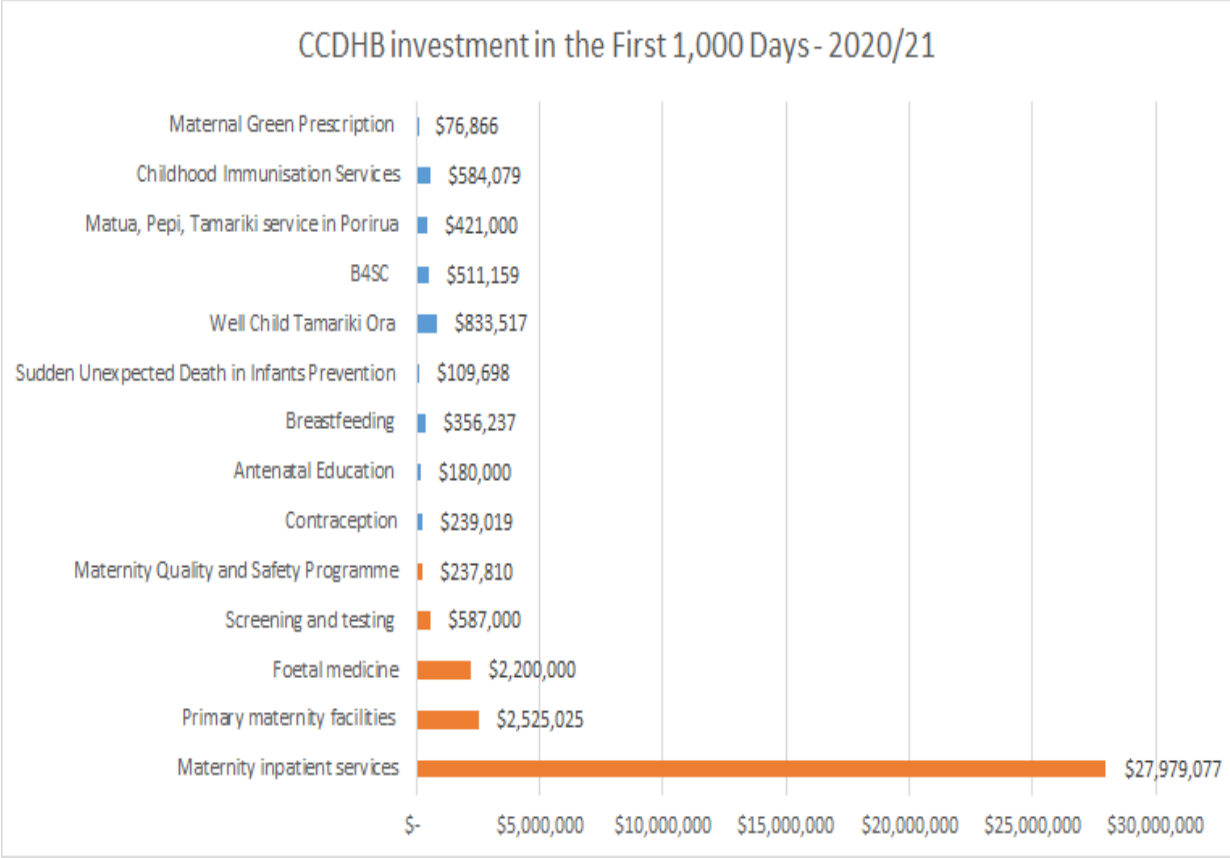
- **$1,295** is the cost of an uncomplicated vaginal delivery.
- **$5,159** is the cost of an uncomplicated caesarean.

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.



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)

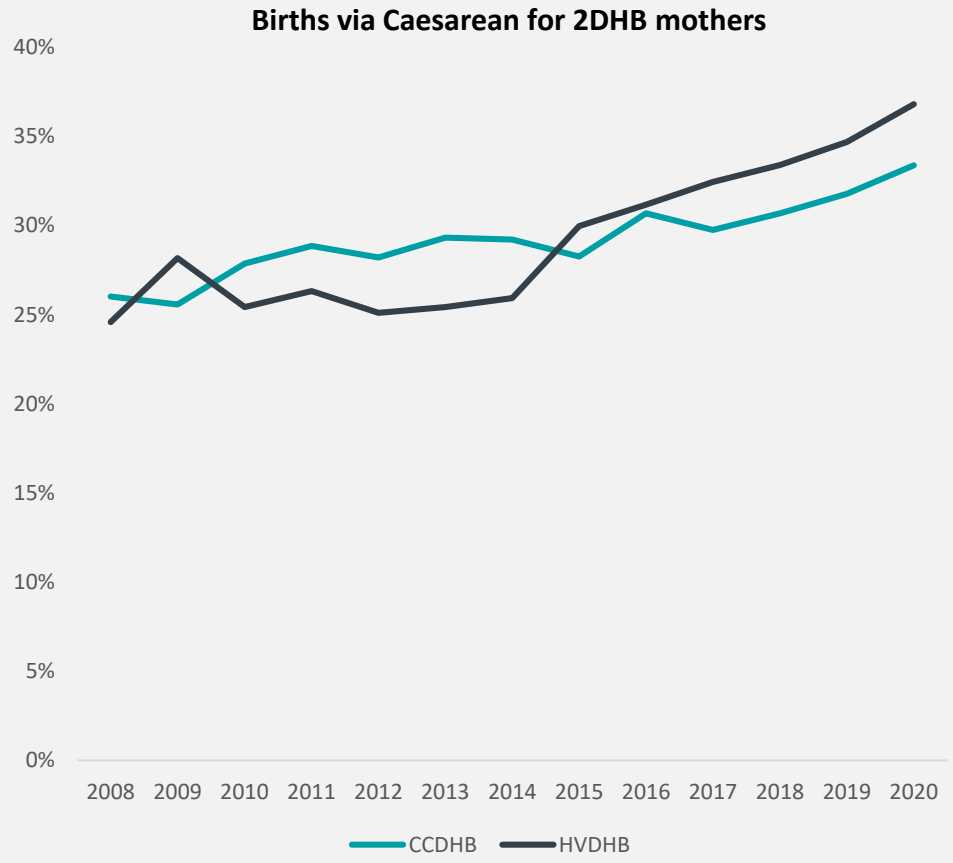
Women value midwifery care from a midwife who shares their culture

"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)

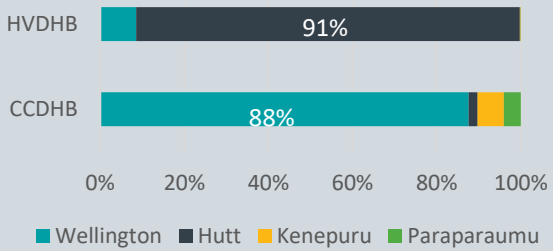
People do not always access birth care at the clinically appropriate level

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.

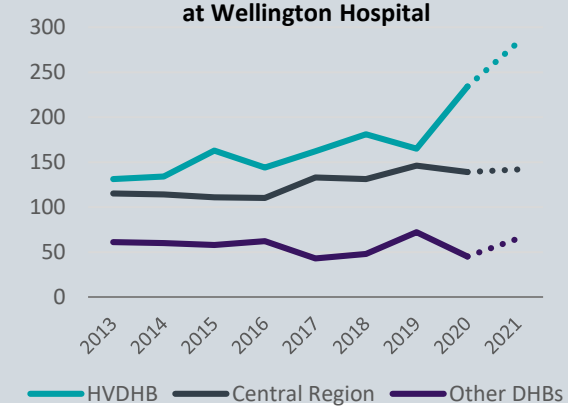
Births by Facility for 2DHB mothers



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.

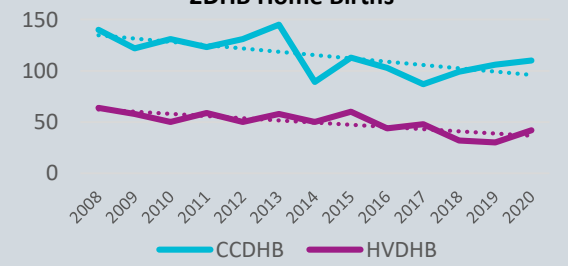
CCDHB mothers are most likely to give birth in Wellington Hospital, however an increasing number of affluent, middle aged non- Māori and non-Pacific Hutt Valley mothers are choosing to birth at Wellington Hospital. This increase is most notable in 2020 and is forecast to continue in 2021.

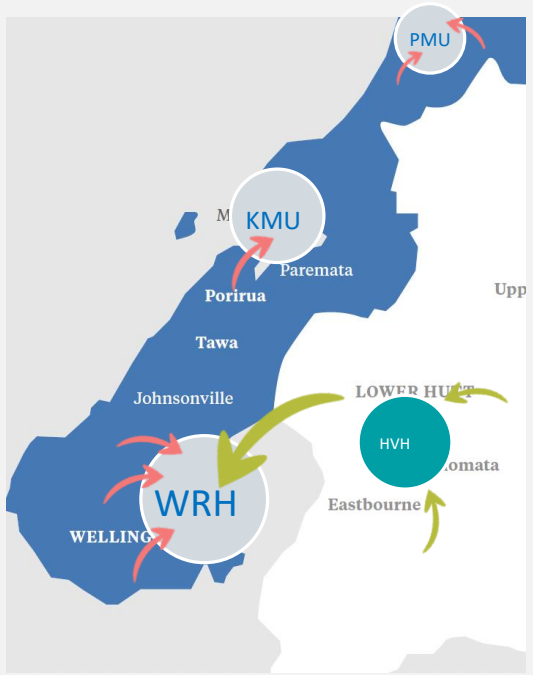
Domicile of mothers birthing at Wellington Hospital



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

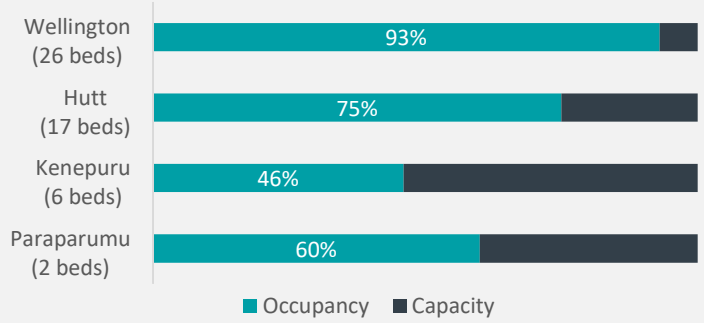




Who is birthing outside of their DHB?

- 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 that, for Māori women who were clinically good candidates for birth in any setting, 44% would prefer 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

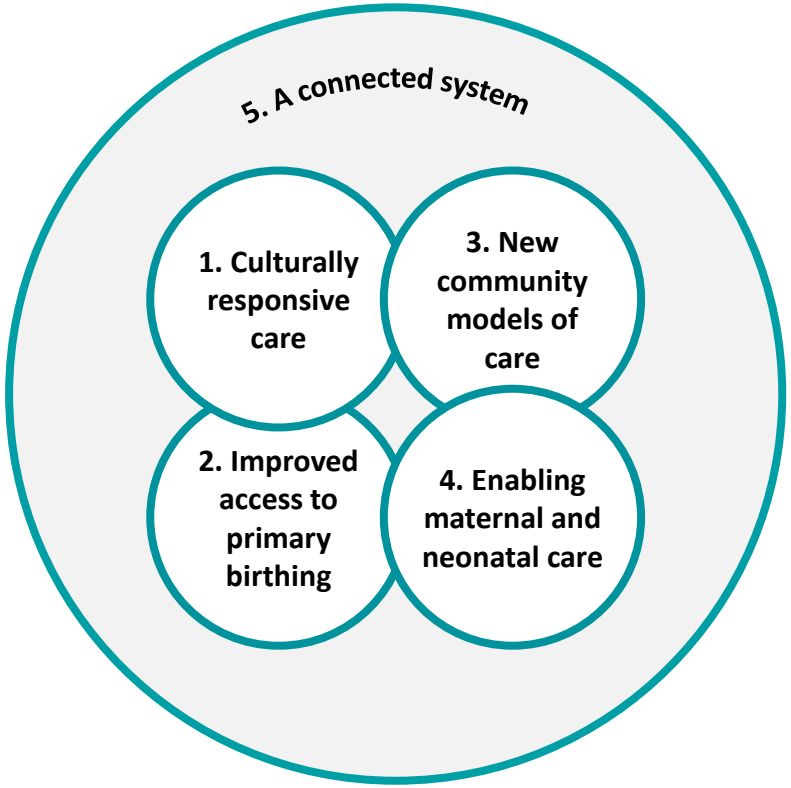
Disabled women and families with children with impairments receive accessible and inclusive care that enables good lives.

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.

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, provide support to healthcare providers, and develop care plans that extend from the neonatal period through to children's services.

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.

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

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.

Change principles

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

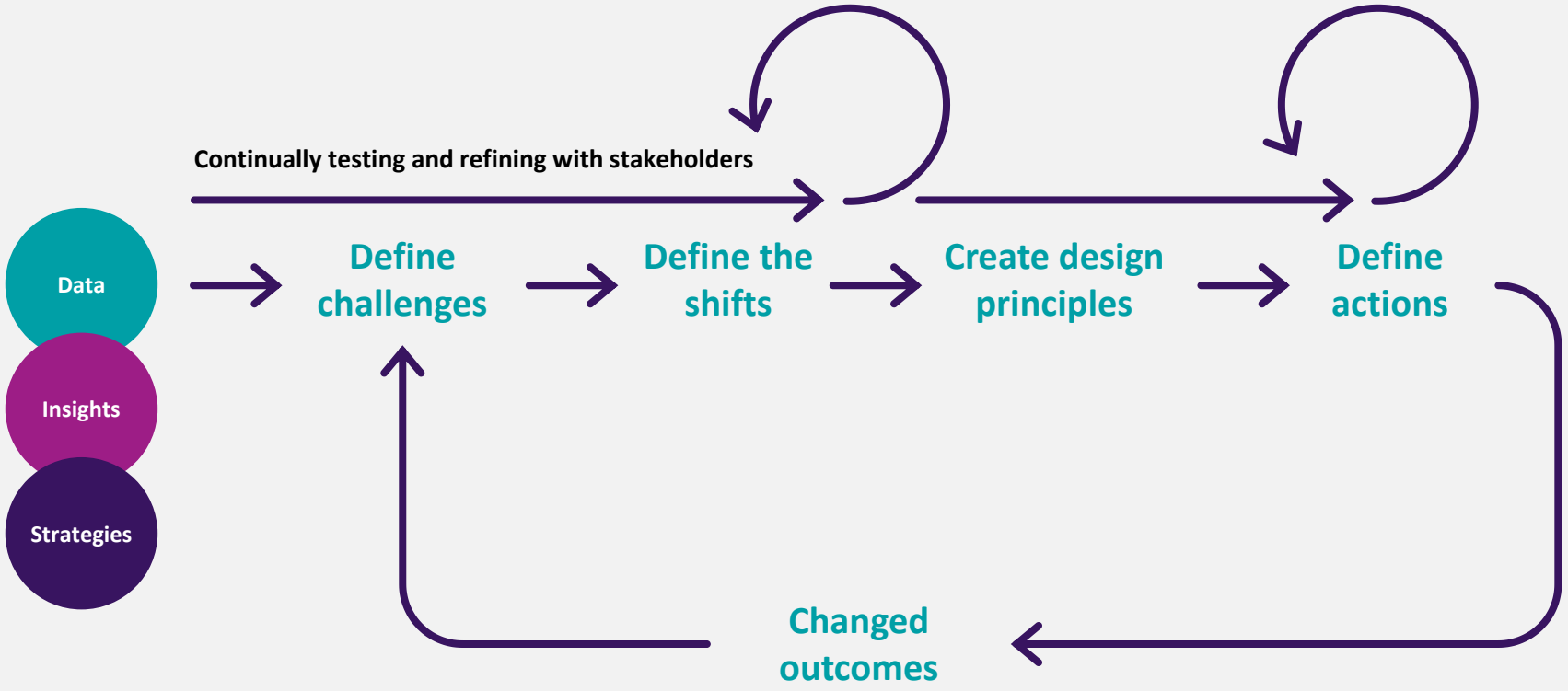
- Defines concrete actions to create change

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.

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

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

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

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)