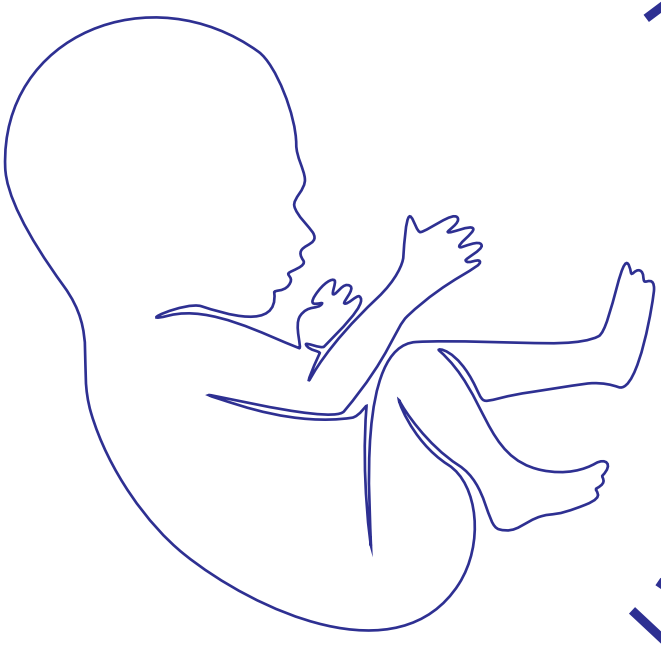
ANNUAL REPORT 2018

National Maternity Monitoring Group

The 6th Annual Report for the NMMG

National Maternity Monitoring Group



DISCLAIMER

This publication informs discussion and assists Aotearoa New Zealand's maternity policy development. The opinions expressed in the publication do not necessarily reflect the views of the Manatū Hauora | Ministry of Health. All care has been taken in the production of this publication. Data was accurate at the time of release but may be subject to change over time as more information is received. It is advisable to check the current status of figures with the National Maternity Monitoring Group before quoting or using them in further analysis. The National Maternity Monitoring Group makes no warranty, express or implied, nor assumes any legal liability or responsibility for the accuracy, correctness, completeness or use of the information or data in this publication. Further, the National Maternity Monitoring Group shall not be liable for any loss or damage arising directly or indirectly from the information or data presented in this publication. The National Maternity Monitoring Group welcomes comments and suggestions about this publication.

HE MIHI

E rere kau atu ngā whakamiha ki a koutou ngā whānau kua tohaina mai ā koutou whakaahua hei whakanikoniko i tēnei hautaka,

Thank you to all of the whānau who generously provided photos for this publication.

ABBREVIATIONS USED IN THIS REPORT

DHB	District Health Board
HQSC	Health Quality & Safety Commission
HWNZ	Health Workforce New Zealand
IOL	Induction of labour
LARC	Long-acting Reversible Contraceptives
LMC	Lead Maternity Carer
MAT	National Maternity Collection
MERAS	Midwifery Employee Representation and Advisory Service
MFYP	Midwifery First Year of Practice Programme
MMWG	Maternal Morbidity Working Group
MQI	Maternity Quality Initiative
MQSP	Maternity Quality and Safety Programme
MSAG	Maternity Strategic Advisory Group
MUAG	Maternity Ultrasound Advisory Group
NE	Neonatal Encephalopathy
NMMG	National Maternity Monitoring Group
NSU	National Screening Unit
NZCOM	New Zealand College of Midwives
PHO	Primary Health Organisation
PMMRC	Perinatal and Maternal Mortality Review Committee
POAC	Primary Options for Acute Care

NGĀ KAI O ROTO CONTENTS

ABOUT THE NMMG

HE KŌRERO NŌ TE HEAMANA
MESSAGE FROM THE CHAIR

E ngā mana, e ngā reo nō ngā hau e whā, tēnā koutou katoa i runga i ngā mihi mahana o te tau hōu nei. Tēnā rawa atu koutou katoa.

It has been a privilege to continue as Chair of the National Maternity Monitoring Group for a further year, and alongside my colleagues, working with maternity sector advisory groups to provide strategic leadership to the maternity sector, and to continue the drive to create change to improve maternity outcomes for mothers and babies. This year, key priorities have included preterm birth, maternal mental health, place of birth, workforce and equity of access.

The NMMG welcomed the opportunity to make a submission to the Inquiry into Mental Health and Addiction and participate in a Maternal Wellbeing and Children's Mental Health hui to discuss maternal wellbeing and children's mental health. The focus of our submission was that the Inquiry consider the establishment of a subgroup to look at the mental health of women who are pregnant or in the postpartum period. The NMMG recognises the importance of adopting a cross-sector approach to providing effective mental health services for women and look forward to work continuing in this area.

It remains disappointing that the sector is still not achieving the Maternity Standards in particular of concern to the NMMG is the inequities that some consumers face when trying to reach high-quality, timely maternity services. This includes (but is not limited to) access to maternity ultrasounds, first trimester care, maternal mental health services and long-acting reversible contraception (LARC). The NMMG agree with the Perinatal and Maternal Mortality Review Committee (PMMRC) on the need to focus on outcomes for Māori mothers and infants, as the inequity between Māori and non-Māori continues. There is a significantly higher, almost double, maternal mortality ratio among Māori mothers than New Zealand European mothers. Māori women are over-represented among maternal suicides and the loss of babies to very preterm labour.

The NMMG engaged with District Health Boards (DHBs) during the year seeking clarification on processes in place to ensure registered practitioners' competency in cultural responsiveness. In the DHB responses received, the NMMG were underwhelmed by the lack of representation of the mana whenua voice in many of the respective regions, and the lack of information relating to how mana whenua were included in the design, development or delivery of cultural competency training. Concern is also noted on the need to effect change and progress in Pasifika communities who have high health risks similar to tangata whenua. The NMMG will continue to support DHBs to embrace cultural responsiveness and effect change.

During 2019, the NMMG is dedicated to continuing to support the Ministry of Health in the development of the maternity work programme which will be informed by reviews currently underway, and we await the outcomes of the Health and Disability System Review, Well Child/Tamariki Ora Review, and the Child and Youth Wellbeing Strategy with interest.

My tenure as Chair comes to an end at the end of 2018, and I look forward to continuing my involvement as an ex-officio member of NMMG as Chair of the Perinatal and Maternal Morbidity Review Committee. I acknowledge outgoing NMMG members Frank Bloomfield and Rose Swindells and thank them for their commitment to improving maternity in New Zealand and the valuable contributions made during their time on NMMG. I would also like to thank the remaining sitting members of NMMG and welcome new members: Lesley McCowan, Chris McKinlay and Isis Martin-Mckay who joined the NMMG in January 2019.

Āku mihi maioha, nā
John Tait

HE KŌRERO NŌ NGĀ HĀKUI MESSAGES FROM THE NMMG CONSUMER REPRESENTATIVES

Rose Swindells

Six years ago, I joined the National Maternity Monitoring Group and in my first few meetings I remember feeling very optimistic. The Group's meetings were full of the questions I had been asking in my head since being part of the Maternity Quality and Safety Programme (MQSP) at Capital & Coast District Health Board (CCDHB). Questions like "Why is our DHB so far behind in its vaginal birth rate?" "Why are women with mental health issues falling through the cracks?" "Why are some women having to pay for Ultrasound scans?" and "why are they having so many scans?" I felt empowered as the Group fired off letters to DHBs and others in the health system. I felt like we were holding the sector to account.

Since then my optimism has waned. We have been confronted by the ongoing crisis in our maternity workforce. As a consumer, I know that a system is only as good as the individuals in the room with you when you are labouring, learning to breastfeed or needing help. These people need to be well paid and supported to do their essential, life saving and empowering work. The crisis in midwifery pay and conditions has been exasperating, for me and the rest of the group. I am heartened that this might be finally grinding towards a resolution.

My optimism was further dented by the slow realisation that — in many areas in health — public money is spent without true accountability. The NMMG consistently questions why the system is falling behind or not taking up best practice and we duly receive responses from DHBs where I am sure the staff working there are doing their best to improve things. But the lack of formal accountability mechanisms — directly connected to funding — means DHBs are not empowered to tackle the issues head on and instead we end up with problems in the system like public resources providing defacto subsidies to private medicine with little to no oversight or control. I hope that the new Government's review of the whole health system will see some more direct accountability built into health spending.

Despite these large problems, and my feelings of exasperation at the slow pace of change, I remain a huge advocate of our maternity system. Whenever I leave NMMG meetings I am inspired by the true spirit of collaboration and teamwork that exists in the maternity sector. This has also been my experience as a pregnant and birthing woman. I have personally had a C-Section, a natural hospital birth, a miscarriage and a home birth. Midwives, obstetricians, radiologists, anaesthetists, paediatricians have all looked after my family and I. The NMMG leads from the front in this regard — the lively and raucous interdisciplinary discussions at meetings crystallise into a clear purpose to continue to push for the best for all our mothers and babies around the motu.

Over my term on the NMMG we have also established a network of consumer members throughout New Zealand. It is now the norm for each DHB to have at least two consumers on their MQSP governance group and I hope that this practice gets further embedded in the maternity system. It is critical that womens' (and babies') voices are present in decision making at a local level. For the last two years I have been so honoured to be joined by Jeanine Tamati-Elliffe as the second consumer member of the group. It is with great pride that I leave the group with Jeanine as the Deputy Chair. I know Judith and Jeanine with lead the NMMG onwards into a challenging future with women and babies right at the centre.

Jeanine Tamati-Elliffe
(Kāi Tahu, Te Atiawa, Ngāti Mutunga)

Me aropapaki te whiu.
Koinā tāhaku whāika i tēnei ohu o te Manatū Hauora. Ahakoa kā piki me kā heke – me toka tū ahau hai mākai mō kā wāhine hapū, mō kā pēpi me ō rātou whānau whānui, mō tōhoku iwi, mō āhaku tamariki anō hoki. Nōhoku te whiwhi ka noho tahi ahau ki te taha o ētahi kawau mārō me kā tohuka o te whakawhānau pēpi i Aotearoa nei. Ahakoa te puehu kua tutū mai i te ao tōrakapū, ahakoa kā tautohetaka o te ao rakahau - kai te tihi o whakaaro te aroka ki te whakapiki oraka mō ā tātou pēpi me kā wāhine hapū i Aotearoa nei. Ka tika.

Ehara i te mea he māmā noa iho te mahi. Ko tētahi o kā tino taero mō te pūnaha hauora, ko te tokoiti o Kāi Māori e whakahaere ana, e whakaea tikaka Māori, whakaaro Māori i kā whare hauora, i kā hōhipera, i kā whare kōhaka hurinoa i te motu. Kia kaha tātou ki te whakatō i ēnei kākano reo Māori, tikaka Māori, mātauraka Māori ki kā kokoka katoa o ēnei whare, kia puāwai ai ā tātou pēpi. Ki te pēnei, ka whai mana taurite tātou – me aropapaki te whiu.

Be unwielding in your pursuit, like the waves that relentlessly hit the shore.

In metaphorical terms, while the winds of politics and currents of different knowledges that determine how strongly or quickly our waves of advice, recommendation or questioning might crash onto the shoreline that is the goal to improve the health, wellbeing and birthing experience outcomes for wāhine and their pēpi – it is important to remain relentless in the collective pursuit to positively influence and improve the quality and safety of maternity programmes throughout the motu.

As one of two consumer members and the only wahine Māori on the group, I have the privilege of sitting alongside some of this country's fiercest advocates, experts and specialists in maternal health. It can be a little overwhelming at times as I lose myself in the dialogue of acronyms and medical jargon, but having the opportunity to contribute to discussions, debate issues, have my questions considered and my whakaaro and experiences listened to ensures that my whānau, hapū, iwi and the communities that I am part of, are involved - and are heard. Ahakoa taku iti, he iti matā!

Over this past year we have seen our government commit to putting tamariki at the centre of their manifesto and it is wonderful to finally have the wellbeing of our pēpi at the forefront of our national priorities. However, with a major midwifery workforce issue and a maternity system at crisis point, my immediate thoughts are still centred on the approximate 13,000 pēpi who are born each year to wāhine Māori throughout the motu. With only 8% of the current midwifery workforce identifying as Māori, I am concerned that our wāhine and their whānau have even less opportunity to connect with a birthing practitioner who can better relate to and appropriately support them with the care they need and have a right to receive – as tangata whenua.

While a solution to this issue may not happen quickly, it is my hope that in the 12 months ahead, DHB's around the country will continue to prioritise strengthening their bicultural competence and confidence – particularly in the area of maternal health - so that wāhine Māori and their whānau will experience more culturally appropriate care. Embracing bicultural competence and confidence is more than using words like manaakitaka, aroha or whanaukataka – it's about truly embedding the values that these words embody into everything we do, how we do it and why we do it – supporting our ultimate pursuit for equity. Me aropapaki te whiu!

Finally, I would like to acknowledge my former fellow consumer member and partner-in-crime here on the NMMG – e tō tātou putiputi, ko Rose! Ko koe te whakatīnanataka o ēnei uara o te manaakitaka me te aroha ki te takata. Kua whakapuāwaitia i tō tātou kaupapa e tō kākau hihiri, e tō manawanui, e tō māia. Nāia āhaku puna mihi e kore e mimiti ki a koe e hoa. While I will miss your presence and contribution to our rōpū, I am also excited to welcome our new consumer member, Isis, who is no stranger to this kaupapa and has long been a strong advocate for maternal health – nau mai, tauti mai e hoa!

Mauri ora, nā
Jeanine

PHOTO CREDIT: JACOB LUND VIA STOCK.ADOBE.COM

HE AHA TĀ MĀTOU MAHI? WHAT DOES THE NMMG DO?

The National Maternity Monitoring Group (NMMG) was established in 2012 by the Manatū Hauora | Ministry of Health (the Ministry) as part of the Maternity Quality Initiative (MQI). This report is for the 12 months from January 2018 to December 2018.

The New Zealand Maternity Standards (2011) consist of three high-level strategic statements, illustrated below in Figure 1, to guide the planning, funding, provision, and monitoring of maternity services in Aotearoa New Zealand.

MATERNITY SERVICES PROVIDE SAFE, HIGH QUALITY SERVICES THAT ARE NATIONALLY CONSISTENT AND ACHIEVE OPTIMAL HEALTH OUTCOMES FOR MOTHERS AND BABIES.	**MATERNITY SERVICES ENSURE A WOMAN-CENTRED APPROACH THAT ACKNOWLEDGES PREGNANCY AND CHILDBIRTH AS A NORMAL LIFE STAGE.**	**ALL WOMEN HAVE ACCESS TO A NATIONALLY CONSISTENT, COMPREHENSIVE RANGE OF MATERNITY SERVICES THAT ARE FUNDED AND PROVIDED APPROPRIATELY TO ENSURE THERE ARE NO FINANCIAL BARRIERS TO ACCESS FOR ELIGIBLE WOMEN.**

Figure 1: New Zealand Maternity Standards strategic statements

The NMMG has major concerns that the New Zealand Maternity Standards (2011) strategic statement in relation to "all women having access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women" is not being achieved in a number of areas in Aotearoa New Zealand. For example, women are not able to access first trimester screening, ultrasound scanning, social workers and antenatal clinics.

These high-level statements are accompanied by specific audit criteria and measurements. One of the criteria is that a national monitoring group be established to oversee the maternity system and the implementation of the New Zealand Maternity Standards. [1]Ultimately, the NMMG acts as a strategic advisor to the Ministry on areas for improvement in the maternity sector, provides advice to District Health Boards (DHBs) on priorities for local improvement and provides a national overview of the quality and safety of Aotearoa New Zealand's maternity services.

1 Ministry of Health. 2011. New Zealand Maternity Standards. Wellington: Ministry of Health.

The Maternity Quality Initiative (MQI) (which included the establishment of the NMMG) was underpinned by four key priorities, illustrated in Figure 2.

1

STRENGTHENING MATERNITY SERVICES

INCLUDING MORE TIMELY ACCESS AND MORE EQUITABLE ACCESS TO COMMUNITY-BASED PRIMARY MATERNITY CARE AND SERVICES.

2

PROVIDING BETTER SUPPORT FOR WOMEN AND FAMILIES

WHO NEED IT MOST, INCLUDING BETTER HEALTH AND SOCIAL SUPPORT FOR YOUNG MOTHERS AND FOR MATERNAL MENTAL HEALTH AND SUPPORT FOR IMPROVING HEALTH LITERACY AMONG VULNERABLE POPULATIONS.

3

EMBEDDING MATERNITY QUALITY AND SAFETY

INCLUDING FURTHER SUPPORT FOR LOCAL CLINICAL LEADERSHIP AND REVIEW, AND MEETING THE MINISTRY'S OBLIGATIONS UNDER THE NEW ZEALAND MATERNITY STANDARDS.

4

IMPROVING INTEGRATION OF MATERNITY AND CHILD HEALTH SERVICES

INCLUDING IMPROVING TRANSITIONS BETWEEN HEALTH SERVICES THROUGH IMPROVED COMMUNICATION, COORDINATION, AND THE USE OF INFORMATION TECHNOLOGY.

Figure 2: Key priorities of the Maternity Quality Initiative

As well as reflecting the New Zealand Maternity Standards and the MQI, the NMMG's 2017/18 work programme is aligned to the priorities set out in the refreshed New Zealand Health Strategy[2]: Roadmap of Actions. Together, the MQI, the Maternity Standards, and the New Zealand Health Strategy provide guidance on how the NMMG and maternity stakeholders can work together in the future to ensure that women and babies live well, stay well, and get well if they are ill.

2 Minister of Health. 2016. New Zealand Health Strategy: Roadmap of Actions 2016. Wellington: Ministry of Health.

NGĀ MEMA
NMMG MEMBERS

JOHN TAIT (CHAIR)

John is a consultant obstetrician and gynaecologist and New Zealand Vice President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). He is the Chief Medical Officer at Capital & Coast DHB and continues to practise in the public sector in gynaecology. John has been involved in several expert advisory groups including the Perinatal and Maternal Mortality Review Committee (PMMRC), the Maternal Morbidity Working Group (MMWG) and developing and supporting the Maternity Quality and Safety Programme (MQSP).

JUDITH MCARA-COUPER (VICE-CHAIR)

Judith is a midwife and until recently was the Chair of the Midwifery Council and at present is the Head of Midwifery at Auckland University of Technology. Judith is an Associate Professor and Director of the Centre for Midwifery and Women's Health Research at AUT. She is involved in several research projects both nationally and internationally including maternal mental health, sustainability of midwifery practice, and place of birth. Judith regularly works in Bangladesh in midwifery education with organisations such as the United Nations Population Fund (UNFPA). She has worked in Counties Manukau Health for many years and continues to be involved in this community.

DEB PITTAM

Deb is a registered midwife with a Masters in Midwifery. She has worked in both employed and self-employed midwifery settings and in both rural and urban practice. Deb is President of the New Zealand College of Midwives, and Midwifery Director and Service Manager (Maternity Services) at Northland District Health Board. She is a member of the Neonatal Encephalopathy Taskforce and Chair of the Growth Assessment Programme, Working Group for ACC. She is committed to the midwifery profession and to the provision of high quality midwifery and maternity care for all New Zealand women, their babies, and whānau. Deb is committed to finding innovative ways to work towards and achieve equitable outcomes for all.

FRANK BLOOMFIELD

Frank is a neonatal paediatrician at National Women's Health, Auckland City Hospital, Director of The Liggins Institute, and Professor of Neonatology at the University of Auckland. He has held leadership positions with the Perinatal Society of Australia and New Zealand, the Perinatal Society of New Zealand and the Perinatal Research Society (USA). He also leads a large research group investigating perinatal care at The Liggins Institute, University of Auckland. He contributed to the Working Group on Maternity Standards.

JEANINE TAMATI-ELLIFFE

Jeanine is a mother of five tamariki and is currently working as a Kaiārahi Māori for the University of Canterbury's Office of the Assistant Vice-Chancellor (Māori). In addition, Jeanine runs her own consultancy business, Manawa Tītī Ltd providing services in a number of areas in health, iwi development and te reo Māori. Jeanine is a founding and current board member for a charity organisation focused on te reo revitalisation called Māori 4 Kids Inc and is also a trustee for both Brainwave Trust Aotearoa and Arts on Tour Aotearoa Trust.

MARY MATAGI

Mary is a self-employed midwife with a background also in nursing. Mary has held various roles within the Midwifery profession including being a DHB community midwife, a Midwife specialist, a midwifery research lead, a childbirth educator and a Pasifika Midwifery Advisor. Mary also provides midwifery and nursing consultancy work in the Pacific.

RACHAEL MCEWING

Rachael works at Christchurch Women's Hospital and in a private practice for Christchurch Radiology Group, almost exclusively in Obstetric and Gynaecology imaging. She is a Fellow of the Royal Australian and New Zealand College of Radiologists, and an advisor to the National Screening Unit on first trimester screening. Rachael is a member of the Maternity Ultrasound Advisory Group (MAUG) and the New Zealand Fetal Maternal Medicine Governance Board.

ROSE SWINDELLS

Rose is a mother with a passion for community development. She is an adult literacy tutor, antenatal facilitator, and is involved with Playcentre. Rose served as a consumer member on the Capital & Coast DHB Maternity Quality panel before joining the NMMG and sees her work in this area as part of the wider system which aims for women to feel empowered, knowledgeable, calm, and confident in their birth experience.

SUE TUTTY

Sue is a Fellow of the Royal New Zealand College of General Practitioners, Secretary for the Auckland faculty board of the College of GPs and on their National Advisory Council. She has worked as a GP in South Auckland for over 20 years and currently practices at East Tāmaki Healthcare, East Tāmaki branch. Since 2015, Sue has also been working part-time as a GP Liaison at Counties Manukau Health, primarily in Women's Health. Sue is a member of the Maternal Mortality Review Working Group of the Perinatal and Maternal Mortality Review Committee (PMMRC).

BRONWEN PELVIN (EX OFFICIO)

Bronwen is the Ministry of Health's Principal Advisor (Maternity). A midwife with more than 40 years of experience, Bronwen has worked as a domiciliary midwife, a community-based Lead Maternity Carer (LMC), a core midwife, and a maternity manager. She worked as the national midwifery advisor for the New Zealand College of Midwives; and was also the Professional Midwifery Advisor for Nelson Marlborough DHB before joining the Ministry in 2008. She has been involved in the Maternity Quality Initiative and implementing the Maternity Quality and Safety Programme in DHBs. She is currently involved in a dedicated Maternity Work programme to strengthen and stabilise the maternity system with a focus on a new funding and contracting model for community Lead maternity carer midwives.

HE TIROHANGA WHĀNUI AN OVERVIEW OF THE NMMG'S RECOMMENDATIONS FOR 2018

Several things need to happen to ensure the continued improvement of maternity services in Aotearoa New Zealand. Many of these items reflect and will support the achievement of specific actions within the New Zealand Health Strategy. Below, we outline those areas in which we expect to see action from key maternity stakeholders:

- Innovative solutions for the maternity workforce.
- Review the process of working with the sector to achieve the New Zealand Maternity Standards (2011).
- Concern that equity of contraception has not been established.
- Concern that maternal mental health issues remain unaddressed in the majority of DHBs.
- Remain concerned at the inadequate infrastructure to support place of birth.
- Encouraged by the work being undertaken by the MFM network and neonatal review.
- Encouraged by the work undertaken by the Maternity Ultrasound Advisory Group (MUAG) in developing Obstetric Ultrasound Guidelines for the maternity sector.
- Supports the MUAG recommendations which would enhance the equitable access to high quality maternity ultrasound services for all pregnant women.

PHOTO CREDIT: MAKE_STORY STUDIO VIA STOCK.ADOBE.COM

TE PŪRONGO Ā-TAU TUAONO MŌ TE NMMG THE 6TH ANNUAL REPORT FOR THE NMMG

On the following pages, we describe our work for 2018 (our workplan is illustrated in Figure 3). We explain why we chose to focus on specific topics, our findings, and areas for further improvement. We also share examples of good practice and useful statistics.

In line with our brief to oversee the New Zealand Maternity Standards, the NMMG met four times in 2018. We discussed the implementation of our work programme and our priorities to improve the quality, safety, and experience of maternity care in Aotearoa New Zealand, improve health and equity for women and babies, and support best value for public health system resources. For the third year, the NMMG work programme was aligned with the overarching objectives of the New Zealand Health Strategy.

THE NATIONAL MATERNITY MONITORING GROUP'S 2017/18 WORK PROGRAMME

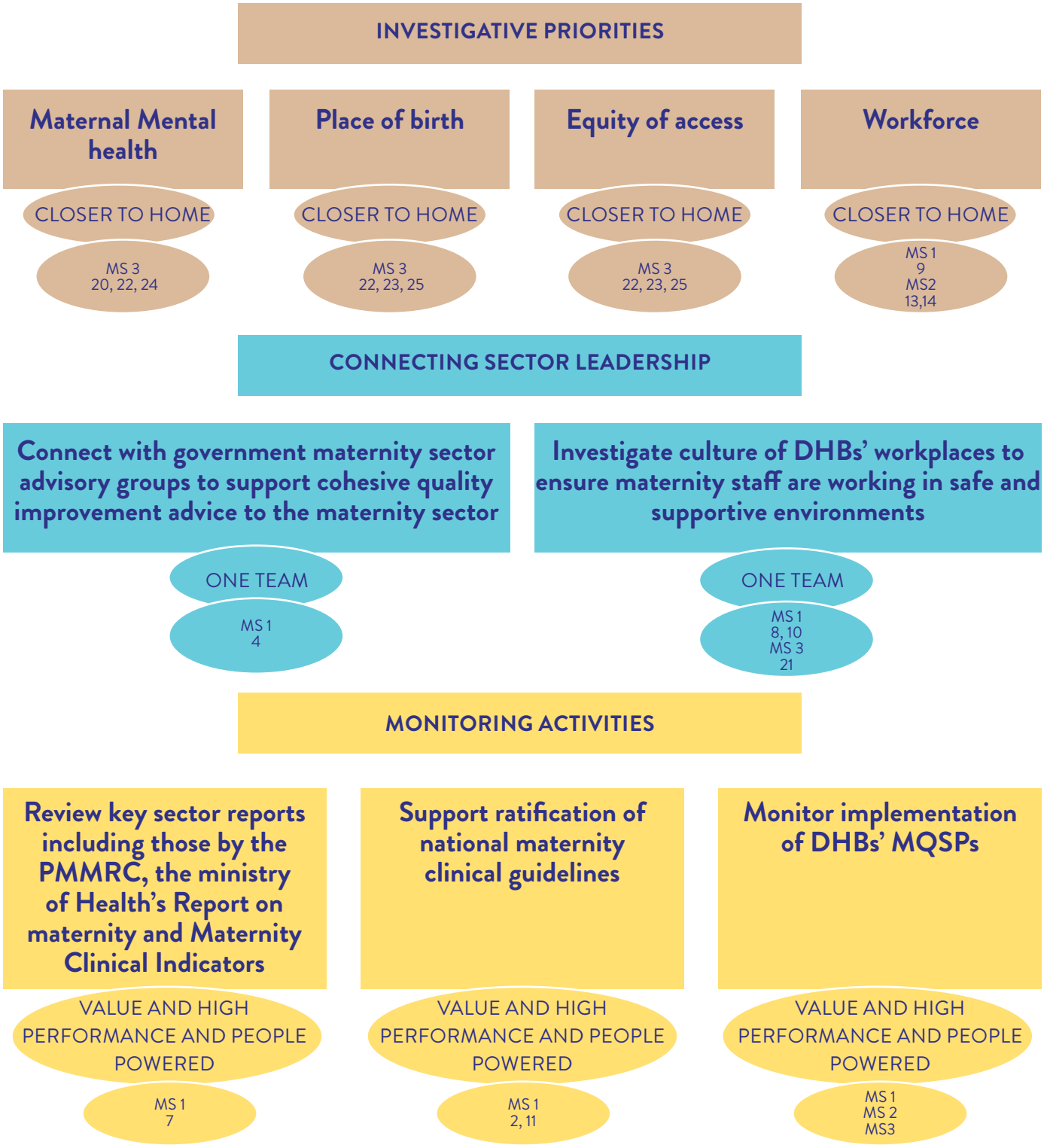


Figure 3: The NMMG's 2017/18 Work Programme

CLOSER TO HOME

PHOTO CREDIT: DRAGONIMAGES VIA STOCK.ADOBE.COM

INVESTIGATE MATERNAL MENTAL HEALTH

Our focus for 2018 was to work collaboratively to champion maternal mental health

Women need access to appropriate mental health services during pregnancy and postpartum. Women with existing mental health issues are at risk of escalation during pregnancy and in the postnatal period. For some women, access to and provision of mental health services during and after pregnancy is essential to their safety and the wellbeing of their babies. It is important that access to primary mental health (including drug and alcohol addiction services) for pregnant and postpartum women is improved to avoid unnecessary escalation to acute services.

Up to 20% of women develop a mental health problem during pregnancy or within a year of giving birth. Examples of these illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. These conditions often develop suddenly and range from mild to extremely severe, requiring different kinds of care or treatment.

In the 11th Perinatal and Maternal Morbidity Review Committee (PMMRC) report, the PMMRC noted that suicide "continues to be the leading single cause of maternal death in New Zealand'. Women remain vulnerable to poorer mental health outcomes (including postnatal depression and suicide) up to one-year postpartum. Māori women are over-represented in the number of maternal suicides, experiencing an increased risk of suicide. New Zealand's rate of maternal suicide is seven times higher than the United Kingdom. Improving access to primary mental health services as well as ensuring that services are available for serious and acute episodic mental illness is an important way to support new mothers to build wellbeing and live healthy lives for themselves, their babies and whānau.

WHAT WE DID AND OUR KEY FINDINGS

We wrote to the Chair of the Inquiry into Mental Health and Addiction

We wrote to Dr Ron Paterson, the Chair of the Government's Inquiry into Mental Health and Addiction. Our letter highlighted the importance of including maternal mental health in the Inquiry. We requested that the Inquiry consider establishing a subgroup to look at the mental health of women who are pregnant and in the postpartum period and to consider the accessibility and appropriateness of services available, including for Māori and Pasifika women and other groups in the community.

The NMMG made a submission to the Inquiry into Mental Health and Addiction

In May 2018 we made a submission to the Inquiry into Mental Health and Addiction. We noted that maternal mental health is a major public issue, not just because of the adverse impact on the mother but also because mental health issues have been shown to compromise the healthy emotional, cognitive and physical development of the child with serious long-term consequences. Pregnancy and birth/ early parenthood can exacerbate existing mental health issues, or it can result in new (or previously undiagnosed) mental health issues.

The focus of our submission was that the Inquiry should consider establishing a subgroup to look at the mental health of women who are pregnant or in the postpartum period.

Our submission also included our support for PMMRC's recommendation to establish a Maternal and Infant Mental Health Network. This recommendation was published in the 10th PMMRC report (2016). The recommendation is that a Perinatal and Infant Mental Health Network be established to provide an interdisciplinary and national forum to discuss perinatal mental health issues. An interface between services is important for the perinatal period when multiple services may be involved – primary care, maternity, general mental health, perinatal mental health, alcohol and other drugs, social services, and termination of pregnancy services. Better processes are required for sharing information and ensuring a consistent approach to care. Consistency in screening and consistency of maternal mental health access pathways are required.

This recommendation is in keeping with recommendations within the United Kingdom, including the National Institute for Health and Care Excellence (NICE) guidelines on antenatal and postnatal mental health (NICE 2014), which recommend the establishment of perinatal mental health clinical networks of perinatal clinicians and resources and other stakeholders including service users, and the Scottish Intercollegiate Guidelines Network (SIGN) guidelines on the management of perinatal mood disorders (SIGN 2012).

NMMG strongly encouraged the Inquiry to consider this recommendation, alongside the updated recommendations in the PMMRC 12th Annual Report.

We attended the Maternal Wellbeing and Children's Mental Health hui

Dr John Tait, Dr Sue Tutty and Rose Swindells represented the NMMG at a Maternal Wellbeing and Children's Mental Health hui run by the Government Inquiry into Mental Health and Addiction. The hui was an informal group discussion with the Inquiry panel and key members of other organisations related to maternal wellbeing and children's mental health.

We wrote to the Maternity Oversight Group

NMMG wrote to the Maternity Oversight Group requesting an opportunity for a subgroup of NMMG to meet to discuss the possibility of national oversight of the NMMG priorities of maternal mental health and preterm birth.

We received an update on the Permanent Suicide Mortality Review Committee

NMMG endorsed the PMMRC's recommendation from its 11th Annual Report that the Health Quality and Safety Commission establish a permanent Suicide Mortality Review Committee. The Ministry agreed to extend its funding for the Suicide Mortality Review Committee as confirmed in the PMMRC's 12th Annual Report.

Example of Good Practice

Counties-Manukau DHB have introduced an integrated service which co-locates mental health teams and general practices to improve access to assistance for mild/moderate mental health patients.

In Te Tai Tokerau / Northland Manaaki Kakano (Maternal and Infant Mental Health Service) has undergone significant change with a number of new staff and implementation of the He Tupua Waiora (pregnancy and parenting, drug and alcohol service).

A new triage and counselling service was introduced during 2018 offering consultation with a Psychologist for women with more mild mental health concerns, with post-traumatic stress symptoms or for those where the community LMC midwives were concerned about someone but unsure as to what level of service they should be referred to. In the first instance a Psychologist would run all clinics but in time and as they evolve, other mental health clinicians may do some of them.

PHOTO CREDIT: ANDY DEAN VIA STOCK.ADOBE.COM

One of the concerns noted by community LMC midwives for some time regarding access to mental health services, has been difficulty in getting access for women with mild to moderate mental health concerns. The service for those with drug and alcohol or significant mental health concerns were less of an issue as services were available for them. Midwives had found some of the women referred to maternal mental health services were not seen as they did not meet the criteria for entry to the service and felt they were left managing women for whom they had identified mental health concerns but without support from mental health services, and with minimal preparation as to how to support these women in the best way. When planning the service, the team were able to add to the referral pathway an opportunity for those women referred to mental health services that were triaged out of the service, i.e. on looking at the referral they were considered not to meet service criteria; were automatically referred for a consultation with a Psychologist. It was envisaged that these women would either be assessed as needing maternal mental health services, continue to receive a service from a Psychologist, or be referred back to the midwife with a full recommended management plan written by the psychologist and guidance as to when to re-refer if necessary.

These clinics are currently run every second week alternating between the antenatal clinic at Te Kotuku (secondary unit in Whangarei) and at Te Puawai Ora (community midwifery clinic). This provides women the option of attending the hospital or not as they prefer.

The clinics commenced in August 2018 and are already full with plans underway to increase access in the New Year. Early feedback from community LMC midwives has been very positive. Thorough psychologist assessments and ongoing care plans have given LMCs more confidence that they are offering the women the best service they can, confidence about re-referral and certainty that women are safe without further management. Having the face to face consultation also provides women with that same reassurance and they know they can ask for another consultation at any time as well.

Both maternal and maternal mental health services are very excited about this service, it is filling a gap we have been concerned about for some time and while it is limited by the resource, we are very keen to keep it going and to extend it as we are able.

THE CHANGES WE EXPECT TO SEE

The NMMG recognises the importance of taking a cross-sector approach to providing effective mental health services for women.

We would like to see the Ministry fund a Maternal and Infant Health Network as recommended by the PMMRC in their 12th report and for the network to determine a workstream detailing work to be completed by the end of 2020. The PMMRC identified potential priorities as being a stocktake of current mental health services available across New Zealand for pregnant and recently pregnant women, and a national pathway for accessing maternal mental health services.

We would like to see DHBs report on mental health referral and treatment pathways including:

- information on what challenges make pathways difficult
- implementation issue with maternal mental health pathways
- what the criteria is for admission to treatment programmes, and
- the number of people that get access and the number that are declined.

PRIMARY BIRTHING

Our focus for 2018 was to support the strengthening of primary maternity services including timely, equitable access to community-based primary maternity care

Evidence shows that, for a healthy women and baby with no complications and low risk, birthing at primary birthing units "is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit." Rates of birth at primary facilities are decreasing: the number of women birthing at primary units declined from 15.1% in 2006, to 9.9% in 2015. The NMMG is concerned that low risk women are continuing to birth in secondary and tertiary units rather than primary birthing units. Low risk women birthing in secondary and tertiary units is economically unsustainable and often leads to poorer birth outcomes for these women.

WHAT WE DID AND OUR KEY FINDINGS

We wrote to the Maternal Child and Youth Leadership Group

The NMMG wrote to the Maternal Child and Youth Leadership Group requesting them to consider convening national meetings with representatives from across the sector to discuss what can be done to support the use of primary birthing facilities. We suggested that the following topics should be discussed at the meeting:

- Consider what can be done to promote the advantages for low risk women to birth in primary birthing units
- Consider if an economic analysis is required
- The provisions of emergency transport, and
- How to support women who chose to birth at home.

We undertook a literature scan on how expectant parents determine planned place of birth

The most prevalent point emerging from the scan is that a woman's personal beliefs are extremely important to her decision about where to birth. It is important to note that if her partner has strongly-held beliefs the beliefs of the women may become secondary, and the talk of 'compromise' in every case reported in the literature resulted in the couple planning a tertiary facility delivery. Regardless of where they plan to give birth, women aim to feel safe. Feeling safe comes about in different ways, and frequently aligns with the beliefs of the woman (and/or her partner). The literature frequently noted that women felt they were given incomplete information by health professionals regarding their options for place of birth. People also felt that there is an assumption that the place of birth decision is straightforward and does not warrant considered exploration. Birth experiences of family and friends also help to determine planned place of birth but people are not uniformly influenced by a particular birth story for e.g. the story of a dramatic birth might make some people more inclined towards hospital birth whereas others might feel the hospital environment contributed to the drama and strengthen their resolve to deliver elsewhere.

PHOTO CREDIT: VRD VIA STOCK.ADOBE.COM

We encouraged the Ministry to recommence the work to establish a group to investigate rural and primary birthing

THE CHANGES WE EXPECT TO SEE NEXT

We encourage the Ministry to promote physiological birth and to better understand women's preferences about place of birth.

We would like to see support for appropriate services so that parents feel safe to deliver in non-hospital environments.

We would like to see further investigation of what determines women's preferences regarding place of birth, location of primary birthing facilities, staffing levels, and use/occupancy rates, access to primary maternity facilities in rural and remote areas, the integration of primary birthing facilities into DHB management and quality frameworks, data gaps and the guidance DHBs require to maintain and manage primary birthing units within the MQSP framework explored.

INVESTIGATE EQUITY OF ACCESS

Our focus for 2018 was to work collaboratively to improve access to maternity services for all women

The NMMG is concerned about inequities that some consumers face when trying to reach high quality, timely maternity services. This includes (but is not limited to) access to maternity ultrasounds, first trimester care, maternal mental health services, and long-acting reversible contraception (LARC).

There is currently a push for equity of access, not only for maternity, but across the wider health sector. The 11th PMMRC report highlights the need to focus on outcomes for Māori mothers and infants, as the inequity between Māori and non-Māori consumers continues. There is a significantly higher, almost double, maternal mortality ratio among Māori mothers than New Zealand European mothers. Māori women are over-represented among maternal suicides and the loss of babies to very preterm labour. The PMMRC note that the main contributory factors amongst these deaths continue to be barriers to access and/or engagement with care.

We believe that to achieve equity cultural responsiveness is important, and regretfully note some examples of insensitivity towards Māori and Pasifika women when receiving maternity services. The PMMRC recommends that regulatory bodies require cultural competency training of all individuals working across all areas of the maternity and neonatal workforce. Training should address awareness of, and strategies to reduce and minimise the impact of, implicit bias and racism.

WHAT WE DID AND OUR KEY FINDINGS

We wrote to the Medical Council, Midwifery Council and DHB CEOs seeking clarification on processes in place that ensure registered practitioners are competent in cultural responsiveness

There was concern that some of the responses received about cultural responsiveness relating to Pasifika communities had a mainly generic perspective and did not cater for Pasifika women. We wrote to DHBs expressing concern and invited their consideration on how the NMMG could work with DHBs to collectively effect change and progress the health and wellbeing in Pasifika communities.

Long-acting reversable contraception (LARC)

The Ministry provided an update on the Ministry's LARC workstream noting next steps included finalisation of the Funding Board procurement agreement, recruitment, negotiations with DHBs, completion of a Request for Proposal (RFP) for training, and the development of postpartum contraception option national guidelines. We note the timeframe for the development of guidelines may possibly be February – June 2019.

Raising awareness of LARC

The draft service specifications for funding contraception conversations and LARC insertions are now sitting with the DHBs, to be implemented by 1 April 2019. The funding does not specifically cover postnatal women but is equity focused to cover women living in quintile five areas, women with community services cards and those at high risk of unplanned pregnancy and poor health and social outcomes. There is flexibility in the contract so that women with special needs such as physical or mental health issues can also be covered. The funding for each DHB has been calculated on their number of women of reproductive age that fit these criteria and includes funding for implementation.

Guidelines and credentialing criteria are yet to be released from the Ministry with an RFP for the implementation of this expected midyear.

The NMMG asked each DHB to report on the LARC service they are providing to their postnatal women and what steps they were undertaking to improve the equity of access to this form of contraception. Many of the DHBs did not mention contraception or any LARC service in their reports so it is hoped that they will now have an increased awareness of the importance of this service. The NMMG will be asking for more specific information from the DHBs in the 2019 reports.

The funding that will become available for LARC insertions in 2019 should also help to drive this work.

Examples of Good Practice

Counties Manukau DHB have a contraception nurse specialist who administers *Jadelles* insertions two days a week and a designated midwife who administers insertions two mornings per week. Registrars and House Surgeons are encouraged to insert *Jadelles*. DHB maternity and primary care services are providing LARC insertions for women up to 3 months postpartum in primary care with the administration support from the regional Primary Options for Acute Care (POAC) service. GPs and nurse practitioners who are already competent inserters are being credentialed by the DHB to perform these insertions and removals under the POAC service.

As part of training programme set up by the PHO Maternal and Child Health Director in conjunction with the Northland DHB Midwifery Director, Northland DHB have trained two staff to insert Jadelles. Both employed and community LMC midwives from all over Northland were trained to insert LARCs in November 2016. Several midwives and primary units are now offering postpartum insertion of LARCs. Community midwife LMCs who do not currently insert LARCs refer women to the TPO community midwifery service or to local primary units to ensure women are able to gain easy access to this form of contraception. Communication to the women's GP follows each LARC insertion.

PHOTO CREDIT: TANIA HEYRICK

Examples of programmes developed to address issues such as inequity and barriers

Wānanga Hapū Programme

The NMMG recognises there are many challenges and areas for improvement within our maternity system, however there are also areas of strength. One such example, gaining support and momentum throughout Aotearoa New Zealand is the development and delivery of wānanga hapū - kaupapa Māori pregnancy, birth and parenting programmes. There is no 'one size fits all' approach to designing wānanga hapū. Each wānanga is tailored in kaupapa to meet the needs, aspirations and intentions of its' participants while considering the input and inclusion of mana whenua in respective regions where wānanga are being held.

While delivering health information is of course an important goal, it is the weaving together of both cultural narratives and Māori values alongside the delivery of important health information which makes wānanga hapū so successful. Connecting whānau to hapū and iwi narratives about pregnancy, birthing, breastfeeding and parenting alongside this antenatal education helps to ensure wāhine hapū are better empowered and confident to access health information and support when they need it. It is ultimately the embracing of mātauranga Māori (Māori knowledges) about Māori birthing and parenting practises into the programme, which provides the foundation to engage positively with wāhine hapū and their whānau.

It is this inclusive approach of combining knowledges from different cultural paradigms, underpinned by concepts such as manaakitanga, whakawhanaungatanga and aroha which make wānanga hapū so successful in supporting and engaging wāhine hapū and their whānau in a positive and uplifting way.

The NMMG wishes to acknowledge the many communities, organisations and individuals who are incorporating and implementing kaupapa Māori approaches to the delivery of antenatal education to wāhine hapū and their whānau.

Mā te tauwhiro, ka tipu te pā harakeke.

Hawkes Bay DHB consumer representation

At Hawkes Bay DHB consumer engagement is strong. Two consumers are highly involved in the governance of the MQSP, including in the restructure of the programme. The consumer members see it as their role to bring the voice of diverse women to the table. They do lots of outreach to various community organisations and they feel well supported. The consumer members are also involved with working with a team at the DHB on a maternal mental health pathway.

Hutt Valley DHB – Hapū Ora

Hutt Valley DHB established a drop-in clinic based at their local marae called Hapū Ora in August 2017. The clinic is run by midwives from the Primary Maternity Team and is a collaboration with Te Rūnanganui o Te Ātiawa. The primary aim of the clinic is to increase engagement with a lead maternity carer in the first trimester as early engagement is known to reduce inequalities in maternity care. 65 people contacted the clinic between August and December 2017, 98.5% of the women identified as Māori or Pasifika, with Māori 83% of all contacts and 63% were under 25 years of age.

The NMMG supported the Maternity Ultrasound Advisory Group's recommendations to the Ministry of Health

The Maternity Ultrasound Advisory Group (MUAG) made the following recommendations to the Ministry:

- That the Ministry develop detailed quality standards about maternity ultrasound for the maternity sector with the aim of ensuring that diagnostic ultrasound usage is clinically appropriate and uniformly of high quality;
- That the ultrasound sections of the Notice pursuant to Section 88 of the Public Health and Disability Act 2000 are reviewed;
- Investigate the feasibility of using the primary maternity top slice money to enable equity of access for all women to fully funded primary maternity ultrasound scans. The primary maternity top slice distribution also needs to be reviewed to represent current population needs;
- Maternity ultrasound scan claims are audited regularly, as are individual radiologists and medical radiation technology practitioners, to ensure compliance with Section 88;
- Ongoing review of quality standards for maternity ultrasound scans;
- Ongoing review of funding for maternity ultrasound scans;
- NSU take responsibility for scanning in connection with the detection of fetal anomalies, and monitoring of the quality of these scans;
- A stocktake of information for women and whanau is undertaken. If gaps are identified, that the MUAG recommends the Ministry of Health develop appropriate resources and;
- Regular information sharing across the sector and with stakeholders and the public.

NMMG was encouraged to learn that the Ministry has accepted the recommendation that the Ministry develop quality standards about maternity ultrasound for the maternity sector with the aim of ensuring that diagnostic ultrasound usage was clinically appropriate and uniformly of high quality.

NMMG supports the recommendations made by the MUAG and would greatly appreciate the Ministry further considering the remaining recommendations which would enhance the equitable access to high quality maternity ultrasound services for all pregnant women.

We received an update on the Maternity Ultrasound Advisory Group's recommendations

The Ministry advised that a joint working group with representatives from Integrated Service Design and the National Screening Unit has been formed and work to develop guidelines for primary maternity ultrasounds is expected to be complete by December 2018.

THE CHANGES WE EXPECT TO SEE NEXT

The NMMG would like DHBs to provide evidence in their next MQSP reports of their efforts to engage with and ensure equity of access to services for all consumers (particularly Māori, Pasifika, Asian, Middle Eastern, Latin American and African women, women with disabilities and young women). Further, we would like to see strategies developed that allow NMMG and PMMRC to support DHBs to embrace cultural responsiveness and effect change within DHBs.

We would like to see the development and ratification of the LARC guidelines. It would also be valuable to obtain data on the percentage of women requesting removal, timeframes, and the reasons why, to evaluate the efficiency of LARC.

NMMG would like to see guidelines for primary maternity ultrasounds developed and ratified as soon as possible.

INVESTIGATE WORKFORCE

Our focus for 2018 was to work collaboratively on....

There are concerns that inadequacies in maternity staffing may underpin the ability to always deliver high-quality maternity services both at a community level and in secondary and tertiary facilities. External reviews of DHBs identified that staffing is a critical success factor and recommended reviewing staffing levels to better consider the acuity and complexity of birthing women. To address concerns about midwifery staffing, the Ministry has established the Midwifery Strategic Advisory Group to provide advice to the Ministry on a sustainable midwifery workforce.

The NMMG believes that DHBs should be responsible for their own workplace culture, and that the NMMG's role is to monitor DHBs' work in this area. Workplace culture affects staff both leaving and entering the workforce and, also, women receiving care.

WHAT WE DID AND OUR KEY FINDINGS

We received updates from the Midwifery Strategic Advisory Group

We received an update on issues the midwifery workforce is currently facing. Health Workforce New Zealand's (HWNZ) predictive model has found that the rate of midwifery growth is not meeting current population growth in New Zealand and, as a result, midwifery is likely to be added to the skilled migrants list. There has also been a decline in the number of people registering for midwifery training and a higher than anticipated drop-out rate in the third year of training as well as concerns around the lack of funding to support students' clinical placements.

A report developed by HWNZ on a whole of system look at maternity recommended the following:

- Support for third year midwifery students to be increased including a financial grant to offset costs of clinical placements;
- Australian new graduate midwives' participation in the (MFYP) to be paid for through HWNZ (not through the DHBs where it is currently paid for), as under the current MFYP contract they are not funded as they are not New Zealand citizens;
- National and international campaigns to be run to attract people into the midwifery profession, and overseas midwives to New Zealand; and
- Creating a locum service for LMCs to address the current workforce crisis.

HWNZ's data also highlights acute shortages in many parts of the country, particularly in the Christmas/New Year break.

NMMG endorsed the MERAS Midwifery Safe Staffing Standards

The NMMG endorsed the Midwifery Employee Representation and Advisory Service (MERAS) Midwifery Safe Staffing Standards. The standards were initially developed as a discussion document on midwifery staffing standards for maternity facilities, with a second edition being developed following consultation with MERAS, New Zealand College of Midwives (NZCOM) and DHB Midwifery Leaders. We wrote to DHBs recommending they adopt the midwifery safe staffing standards when considering staffing for maternity care.

We attended the Ministry's Maternity Whole of Sector Workshop

We attended the Maternity Whole of Sector Workshop in July 2018 that was convened by the Ministry. The workshop brought representatives from the sector together to collectively develop a sector wide maternity work programme. Workforce was a key theme of the workshop.

Examples of good practice

Northland and Tairāwhiti DHBs are doing well in supporting a positive culture within their workplace.

Northland DHB have rolled out the Releasing Time to Care programme within five clinical care areas, including Te Kōtuku. The programme offers a systematic way of delivering safe, high quality care to patients with an aim to increase the proportion of time that midwives are able to spend in direct patient care. They started the programme by working with staff and LMCs to create a vison for Te Kōtuku. The vision for Te Kōtuku is *"Integrated and skilled workforce who are respected, valued and well supported to provide culturally appropriate, consistent high quality care within the partnership model. The environment of the unit meets the needs of women receiving primary and secondary care as well as staff. Te Kōtuku is an enjoyable, dynamic and positive workplace. Kindness is evident in all professional relationships and the care provided to women."*

Northland DHB asked staff and LMCs to identify the barriers preventing them from fulfilling the vision, what was stopping them from spending more time with patients and having a great day at work. Projects were identified from those discussions and staff members were asked to lead them to drive the changes. Some of the projects were:

- Creating an additional space for staff to enjoy their break, as the staff room was too small and often overcrowded.
- Setting up a communication book and a communication board to improve communication between staff members, LMCs and the leadership team.
- Birth room standardisation to improve consistency.
- Improvement of the staff handover process to decrease the duration and improve the quality of the information communicated.

Since introducing the programme, Northland DHB have seen an increase in ideas for change and improvement coming from staff members and a willingness to achieve the vision created for their service.

Tairāwhiti DHB aim to continue and grow their own midwifery workforce by supporting local students through the Wintec midwifery degree programme. They encourage staff to take regular leave which helps to maintain their wellbeing and has reduced the amount of sick leave required. They also offer the option of 8 and 12 hour shifts to suit individual needs, but this must also comply with the service needs, ensuring the appropriate skill mix is maintained for safe staffing.

Tairāwhiti DHB have started to develop junior midwives to become shift coordinators with promising results. They encourage midwives to develop further by offering funding and support for studies to become registered lactation consultants, and support one midwife each year to enrol on the complex care course, and others to attend conferences. Tairāwhiti DHB have a baby friendly approach for staff to enable them to return to work after parental leave, midwives are supported to bring their baby to work and are rostered to cover the antenatal clinic to enable their transition back into the workforce. Capital and Coast and Waitemata DHBs have focused campaigns for improving workplace conditions for staff.

THE CHANGES WE EXPECT TO SEE NEXT

We would like DHBs to report in their MQSP Annual Reports on what they are doing about staff engagement, workplace culture, bullying and the need to be women centred.

ONE TEAM

PHOTO CREDIT: MARION CLARK

CONNECT WITH GOVERNMENT MATERNITY SECTOR ADVISORY GROUPS TO SUPPORT COHESIVE QUALITY IMPROVEMENT ADVICE TO THE MATERNITY SECTOR

Our focus for 2018 was to provide strategic leadership to the maternity sector, to drive and create change and improve maternity outcomes.

A range of groups provide advice to the government agencies on maternity issues. This includes the PMMRC and its subcommittees, the Neonatal Encephalopathy (NE) Taskforce, and the Maternity Strategic Advisory Group (MSAG). To improve maternity services, decision-makers and maternity service providers need consistent and coherent recommendations and advice on the relative priority of implementation. The NMMG is well-placed to connect, and support coordination, of groups with responsibilities for providing maternity advice and service providers such as lead maternity carers, DHBs, consumers, and professional colleges.

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

Overview of matters discussed at Ministers' Meetings

The NMMG met with Hon Julie Anne Genter in May 2018. The meeting focused on our priorities of maternal mental health, equity and interaction with the Ministry as well as the Maternity system from a consumer perspective and interaction with DHBs.

The Chair, Dr John Tait, met with Hon Dr David Clark in March 2018. The NMMG work plan was discussed which aligns with the Minister's main aims for the direction of health care which includes inequities, primary health, mental health and workforce. We also discussed postpartum contraception, inequities, maternal mental health and holding workshops on rural and primary birthing units.

We received updates from the Maternity Strategic Advisory Group

The Ministry provided NMMG with an update highlighting the development of four programme workstreams:

- Development of the Midwifery Pipeline
- Leadership
- Stabilise the workforce through recruitment and retention, and
- Midwifery Workforce Strategic Plan.

We discussed the significant gaps in the midwifery workforce in many parts of the country and the initiative of providing support to Australian Graduate Midwives employed by DHBs. We note that a proposal was submitted to HWNZ Board making recommendations in terms of supporting Australian new graduates to work in the Aotearoa New Zealand context.

THE CHANGES WE EXPECT TO SEE NEXT

We would like to see the adoption or development of a mechanism for prioritising recommendations to DHBs.

We would like clarification from the Maternity Sector Advisory Groups regarding NMMG's responsibility for monitoring how DHBs respond to recommendations made by the PMMRC and its subcommittees.

VALUE AND HIGH PERFORMANCE AND PEOPLE POWERED

REVIEW KEY SECTOR REPORTS INCLUDING THOSE BY THE PMMRC, THE MINISTRY OF HEALTH'S REPORT ON MATERNITY AND MATERNITY CLINICAL INDICATORS

Our focus for 2018 was to continue to monitor key sector publications

Reviewing key maternity sector publications is one of the NMMG's responsibilities under its terms of reference. This includes reviewing publications such as the Ministry's Report on Maternity, and each New Zealand Maternity Clinical Indicators report, both of which provide data about mother and baby outcomes in our maternity system. Reviewing and commenting on these publications supports independent oversight of the performance of the Aotearoa New Zealand maternity sector and enables the timely identification of areas for further action.

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

We reviewed the Ministry of Health's Report on Maternity 2015

The 2015 Report on Maternity and the accompanying data tables continue to provide a wide range of useful clinical, statistical and demographic information about maternity care in New Zealand.

The report showed that women living in quintile 4 or 5 neighbourhoods are the least likely to experience either emergency or elective caesarean section; they are least likely to experience induction, epidural, or episiotomy; and they are more likely to give birth normally than women living in quintile 1, 2, or 3 neighbourhoods.

The NMMG supported the PMMRC's recommendations that relate to the MAT dataset

In its 11th annual report, the PMMRC recommended that the Manatū Hauora | Ministry of Health update the National Maternity Collection (MAT), including the ethnicity data as identified by the parents in the birth registration process. The Manatū Hauora | Ministry of Health urgently require DHBs to provide complete and accurate registration data to the MAT dataset and require the MAT dataset include complete registration and antenatal data on live and stillborn babies from 20 weeks gestation.

The NMMG has written to the Ministry to formally express support of the PMMRC's recommendation.

The NMMG provided feedback on the PMMRC's recommendation that regulatory bodies require cultural competency training for all individuals working across all areas of the maternity and neonatal workforce.

We provided feedback to the PMMRC on its recommendation from its 12th annual report acknowledging the importance of addressing the issue of cultural competency training for all individuals working across all areas of the maternity and neonatal workforce, and the need for the training to be standardised in practice and in systems. We advised the PMMRC that from a consumer perspective, this was a fundamental pillar of what is wrong with the current system and note the impact on how services are accessed and on women's' ability to access information, knowledge and support. The NMMG noted it would be beneficial to elevate the issue to support practitioners and a whole system change approach to embracing bicultural development in service provision.

THE CHANGES WE EXPECT TO SEE NEXT

We expect that DHBs will continue to review these reports themselves and consider what the recommendations mean to their own particular service area. This is necessary to ensure that key sector reports add the most value to the system.

PHOTO CREDIT: MAKE_STORY STUDIO VIA STOCK.ADOBE.COM

We reviewed the Maternity Clinical Indicator data set to determine national trends, identifying instances where DHBs continue to record significant and consistent variation from the national average, and we shared our findings with each DHB

The New Zealand Maternity Clinical Indicators are nationally standardised benchmarked maternity data. Maternity sector stakeholders rely on this data to determine whether the New Zealand Maternity Standards are being met. In 2018, the Ministry released data for 2016, making data available for both the period prior to the implementation of the MQI and immediately after implementation.

Care is needed when assessing possible relationships between maternity and neonatal outcomes and the impact of the Maternity Clinical Indicators and the Maternity Quality and Safety Programme reports. DHBs have implemented a significant range of quality improvement initiatives and a lag between the implementation of initiatives and improvements in maternity outcomes is expected in the first few years' post-implementation. Substantial change (including culture change and evidence-based improvements to clinical practice) can take time to produce results.

In 2016 the Expert Working Group removed one indicator from the Maternity Clinical Indicators: BMI over 35 – formerly Clinical Indicator 17.

Nine years of data from the New Zealand Maternity Clinical Indicators shows positive and negative trends, as illustrated in Figure 3, where positive trends are indicated by a green arrow, and negative trends are indicated by a red arrow.

↑	More women are registering with an LMC in the first trimester of pregnancy.
↑	A higher proportion of standard primiparae are having an instrumental vaginal birth.
↑	Nationally, the percentage of standard primiparae giving birth by Caesarean section increased by a full percentage point from 2015 to 2016.
↑	Standard primiparae undergoing induction of labour has been steadily increasing.
↓	Standard primiparae are less likely to have an intact genital tract following birth compared to women birthing in 2009.
↑	The number of episiotomies being performed on standard primiparae who have no third or fourth degree tear has increased to the 2014 level.
↓	Standard primiparae sustaining a third or fourth degree perineal tear and not having an episiotomy has slightly decreased resulting in a trendline that is beginning to curve downwards.
↑	Standard primiparae sustaining a third or fourth degree perineal tear and undergoing an episiotomy showed a slight increase for the first time since 2013 of 0.3 percent.
↓	The number of women requiring a blood transfusion following a caesarean section has declined significantly since 2009.
↑	The number of women diagnosed with eclampsia during birth admission has increased over time.

Figure 4 Trends over time, from the NZ Maternity Clinical Indicators 2016

The NMMG would like to include trends of neonatal admissions over 37 weeks as a future clinical indicator in the Maternity Clinical data.

THE CHANGES WE WOULD LIKE TO SEE NEXT

We expect DHBs to:

- Review the data;
- Investigate variances;
- Implement initiatives; and
- Report on outcomes.

This will address any significant variances to the national averages across each indicator. We would also like to meet with individual DHBs where there are concerns about the level of significant improvement and overall trends suggested by the Maternity Clinical Indicator data.

MONITOR THE IMPLEMENTATION OF DHBs MATERNITY QUALITY AND SAFETY PROGRAMMES

Our focus for 2018 was to continue to support the Ministry of Health to monitor the implementation of DHBs MQSPs

Each DHB produces an annual report describing maternity service delivery and work to improve maternity services in its area. Under its terms of reference, the NMMG reviews these reports to develop its understanding of how DHBs are identifying and responding to challenges in maternity and how they are responding to recommendations by sector advisory groups. Occasionally, external reviews of maternity and / or womens health services are completed. Together, these two groups of reports provide rich information to support the NMMG's monitoring role by describing service delivery and potential areas for further improvement.

We will continue to support the Ministry to monitor the implementation of DHBs' MQSPs.

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

We reviewed each DHBs 2018 MQSP Annual Report

The NMMG discussed its review of DHB MQSP reports and raised significant concern at the standard of the reports which was reflective of the stress the maternity system was under. It was noted that people were working hard to keep services functioning and to maintain a level of service to women and their whānau, and that quality was often the first thing that disappeared in these situations.

We monitored how Counties-Manukau, Midcentral/Whanganui, Waikato and South Canterbury have responded to and implemented the recommendations set in their external reviews.

A common theme from the five external reviews of DHBs' maternity/women's health services was that DHBs should be providing a positive and supportive working environment for maternity staff that is free from blame, bullying and harassment. Positive cultures are likely to improve retention and recruitment rates for staff.

The DHBs provided progress reports to NMMG on how they are tracking towards implementing the recommendations made in the external review of their maternity and health services.

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

We would like to see DHBs provided with a summary of MQSP annual reporting requirements including DHB-specific information on the clinical indicators they should focus to assist them with preparing their annual reports.

SUPPORT RATIFICATION OF NATIONAL MATERNITY CLINICAL GUIDELINES

Our focus for 2018 was to ensure that national evidence-informed clinical guidance is appraised and ratified using the AGREE II Instrument and algorithm.

National maternity clinical guidelines are a key component of the maternity sector. They set standards based on the latest clinical evidence or best practice and enable consistency in clinical maternity practice nationally. Effective guidelines support improved performance and health outcomes. Once these have been developed, it is important that they are implemented in DHBs so that best practice is consistently delivered in our maternity services.

The NMMG is responsible for overseeing the ratification of national maternity guidelines. This work aligns to Action 14 of the Health Strategy Roadmap.

WHAT WE HAVE DONE THIS YEAR AND OUR FINDINGS

The NMMG supported the Ministry of Health's Diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in New Zealand: A clinical guideline

The Ministry advised the 'Diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in Aotearoa New Zealand: A clinical practical guideline' was published on the Ministry website in August 2018. Implementation planning guidance has been circulated to DHB Chief Executives, Midwifery Leaders and Clinical Directors. The NMMG will write to DHBs six months after the release of the guideline to find out how they are progressing with implementing the guideline.

We championed the development of a national guideline on the induction of labour (IOL)

The NMMG received an update on the status of the development of a national guideline on induction of labour. The NMMG supports the work currently underway to develop an interdisciplinary evidence-based clinical practice guideline and expect to ultimately recommend that the guideline be placed on the Ministry website once it has gone through the Ministry's external guideline ratification process.

PHOTO CREDIT: GUY ROBINSON

APPENDIX 1: NMMG WORK PROGRAMME FOR 2019

THE NATIONAL MATERNITY MONITORING GROUP'S 2019 WORK PROGRAMME

Overarching Concern: Redressing maternity Service Inequities

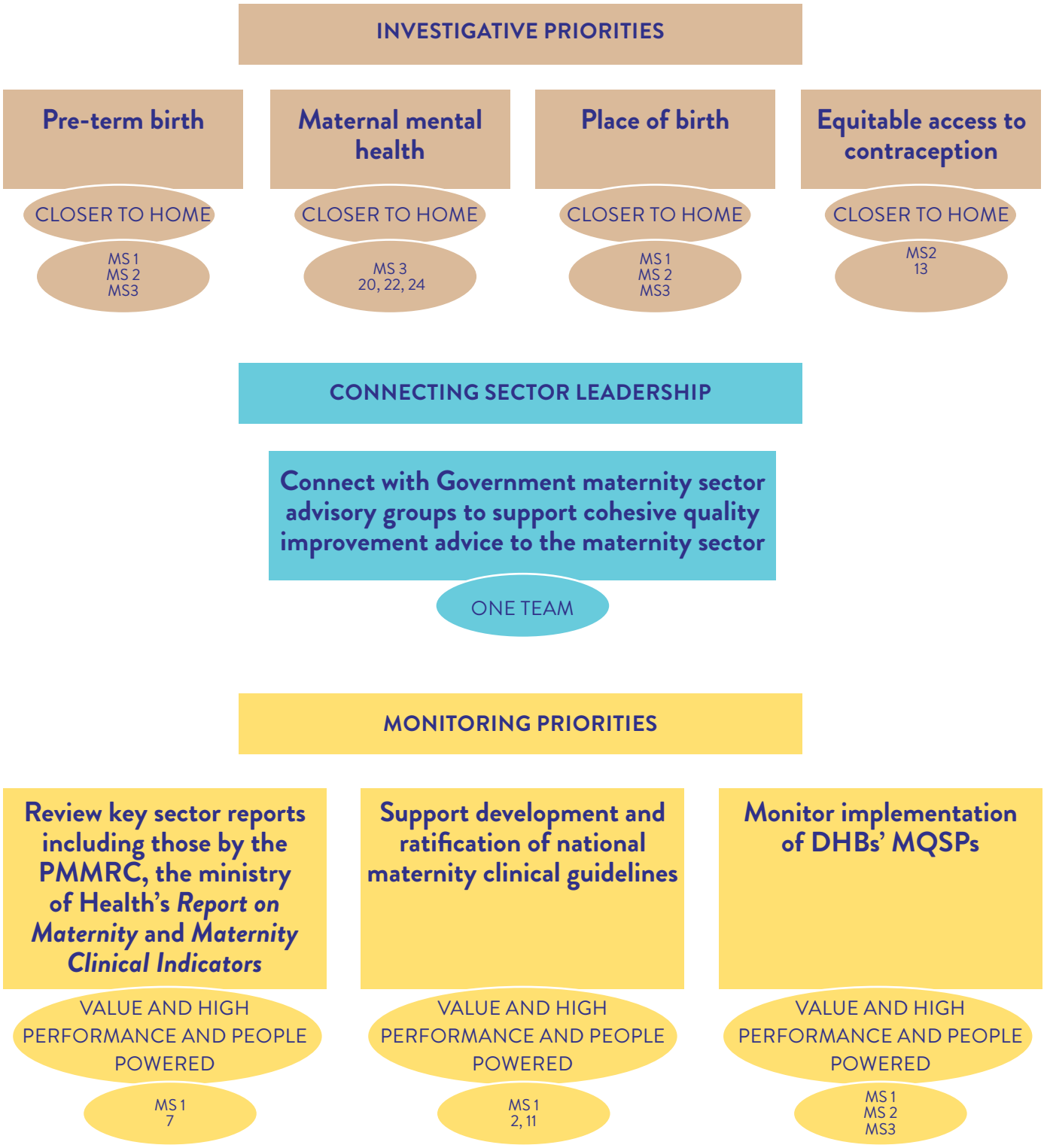


Figure 4: The NMMG's 2019 Work Programme

APPENDIX 2: TERMS OF REFERENCE FOR THE NMMG

TERMS OF REFERENCE FOR THE NATIONAL MATERNITY MONITORING GROUP

Introduction

1. This document sets out the:

   a. roles and responsibilities of the National Maternity Monitoring Group;
   b. work programme and reporting requirements;
   c. composition of the National Maternity Monitoring Group, and
   d. terms and conditions of appointment.

Background

2. The New Zealand Maternity Standards (Ministry of Health 2011) consist of three high-level strategic statements to guide the planning, funding, provision and monitoring of maternity services:

   Standard 1: Maternity services provide safe, high quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies;

   Standard 2: Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage, and

   Standard 3: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

3. These high-level statements are accompanied by specific audit criteria and measurements of these criteria. One of the criteria is that a National Monitoring Group be established to oversee the maternity system and the implementation of the Standards.

Role of the National Maternity Monitoring Group

4. The role of the National Maternity Monitoring Group is to oversee the New Zealand maternity system and to provide strategic advice to the Ministry of Health on priorities for improvement.

5. Standard 1 of the New Zealand Maternity Standards states "a National Monitoring Group, consisting of a small number of clinical sector experts and consumer representatives ... provides oversight and review of national maternity standards, analysis and reporting. The National Monitoring Group provides advice to the Ministry on priorities for national improvement based on the national maternity report, nationally standardised benchmarked data, the audited reports from DHB service specifications, Maternity Referral Guidelines, and the Primary Maternity Services Notice 2007".

6. Standard 1 sets out audit criteria, applicable at the national level, to which the Ministry of Health and the professional colleges are accountable to. These additionally inform the role of the National Maternity Monitoring Group.

7. The National Maternity Monitoring Group is not a decision-making body. While it may provide recommendations to the Ministry of Health, responsibility for decision-making and implementation rests with the Ministry of Health and/or other relevant participants in the maternity system.

Responsibilities and reporting requirements of the National Maternity Monitoring Group

8. The National Maternity Monitoring Group will meet at least four times per annum and will undertake other communication as necessary to deliver the agreed work programme.

9. The National Maternity Monitoring Group is responsible for identifying priorities for action or investigation and agreeing a 12-month work programme with the Ministry of Health at the beginning of each year of operation.

10. The work programme may include but is not limited to:

    a. Providing expert advice on data released through the New Zealand Maternity Clinical Indicators, national maternity consumer surveys and the New Zealand Maternity Report, which are published from time to time by the Ministry of Health.
    b. Identifying relevant priorities within the New Zealand Health Strategy 2016 and Roadmap of Actions and considering their impact within the sector.
    c. Contributing to the review of the New Zealand Maternity Clinical Indicators at a minimum of three-year intervals and providing advice on the modification, addition or withdrawal of any indicators.
    d. Identifying priorities for national clinical guidelines / guidance for maternity including recommendations on best clinical practice and providing advice on how these should be developed and implemented.
    e. Reviewing reports of the Perinatal and Maternal Mortality Review Committee (PMMRC), identifying the implications for the maternity system of the findings of the PMMRC and providing advice on system response to these findings.
    f. Reviewing and assessing the annual reports produced by each DHB as part of its Maternity Quality and Safety Programme.
    g. Reviewing and assessing other maternity reports produced or commissioned by the Ministry of Health, DHBs, professional colleges, consumer groups or other stakeholders as requested from time to time.

11. The National Maternity Monitoring Group may be asked to provide advice on any other matters related to the quality and safety of maternity care and services by the Ministry of Health from time to time.

12. The National Maternity Monitoring Group will produce an Annual Report by a date negotiated with the Ministry of Health detailing:

    a. Work carried out, conclusions reached and recommendations made during the previous year.
    b. Its priorities and work programme for the following year
    c. How relevant actions from the New Zealand Health Strategy 2016 have been incorporated into the NMMG work programme.

Relationship of the National Maternity Monitoring Group to the Perinatal and Maternal Mortality Review Commission

13. The Perinatal and Maternal Mortality Review Committee (PMMRC) is a Mortality Review Committee, appointed under section 59E of the New Zealand Public Health and Disability Act 2000 by the Health Quality and Safety Commission.

14. The PMMRC considers maternal and perinatal mortality, and other morbidity as directed by the Minister in writing. It prepares an Annual Report, which includes its advice and recommendations.

15. In providing its advice, the National Maternity Monitoring Group will take account of the findings on maternal and perinatal mortality and morbidity by the PMMRC set out in its Annual Report.

16. Where the PMMRC recommends specific action by maternity system stakeholders, the National Maternity Monitoring Group will advise the Ministry on an appropriate response to these recommendations.

17. The National Maternity Monitoring Group will meet at least once annually with the PMMRC.

Composition of the National Maternity Monitoring Group

18. The National Maternity Monitoring Group will have a maximum of nine members, not including ex-officio members from the Health Quality and Safety Commission and Ministry of Health.

19. Composition of the National Maternity Monitoring Group will balance requirements for:

    a. Expertise necessary to analyse different sources of information on the maternity system and make recommendations based on this analysis.
    b. Perspectives of key stakeholders in the maternity system.

20. The National Maternity Monitoring Group will include the following experience as, and/or expertise in:

    a. epidemiological research and analysis of health data/statistics
    b. community-based LMC midwifery practitioner
    c. hospital-based core midwifery practitioner
    d. specialist obstetric maternity care practitioner
    e. specialist neonatal care practitioner
    f. primary care practitioner
    g. primary maternity radiology practitioner
    h. Māori health
    i. Pacific health
    j. consumer(s) with a focus on maternity issues.

21. All members of the National Maternity Monitoring Group will have basic skills and confidence in working with and interpreting health data.

22. The Ministry will seek nominations from relevant organisations and professional colleges, including the Health Quality and Safety Commission. The Ministry reserves the right to appoint more than one member from an organisation or college or to appoint members not officially nominated by an organisation or college, in order to ensure the balance of skills and expertise outlined in 20 a) to g).

23. Members of the National Maternity Monitoring Group will share a commitment to working collaboratively and constructively to oversee the national maternity system.

24. The National Maternity Monitoring Group may identify that additional skills or expertise in a particular field or specialty is required to deliver aspects of the agreed work programme. The National Maternity Monitoring Group may seek additional (co-opted) members to fill skill gaps. This will be done in agreement with the Ministry of Health.

25. At least one representative of the Ministry of Health will attend meetings in an ex-officio capacity.

Term of the National Maternity Monitoring Group

26. The National Maternity Monitoring Group will operate until the end of June 2019 unless otherwise notified by the Director General of Health.

Decision-Making

27. Decisions within the National Maternity Monitoring Group are to be made by consensus. Members are expected to work as far as is possible to achieve consensus. Dissenting views of members can be noted for the record.

Appointment process

28. The Director General of Health will appoint members to the National Maternity Monitoring Group.

29. The terms of office will be for two or three years and will be staggered to ensure continuity of membership. No member may hold office for more than six consecutive years, unless there are exceptional circumstances. Members will be eligible for reappointment if applicable.

30. A Chair and Vice Chair will be elected by the members of the National Maternity Monitoring Group for a term of one or two years and may be re-elected.

31. Co-opted appointments may be proposed by the National Maternity Monitoring Group and will be made by the Director General of Health.

32. Any member of the National Maternity Monitoring Group may at any time resign as a member by advising the Ministry of Health in writing.

33. The Director General of Health may choose to fill vacancies should resignations occur.

34. A supplementary document 'Appointment Process for the National Maternity Monitoring Group' provides further detail for members and potential candidates and can be referred to in conjunction with these Terms of Reference.

Support for the National Maternity Monitoring Group

35. The Ministry of Health will arrange provision of the secretariat function for the National Maternity Monitoring Group. This may be externally procured. This includes distribution of agendas and recording of the minutes. Agendas and any associated papers will be circulated at least five days prior to meetings. Minutes will be circulated no later than a fortnight following the meeting date.

Meeting arrangements

36. Meetings will normally be held in Wellington. Rooms and refreshments will be provided for the meetings.

Payment of meeting fees and travel costs

37. A fee of $325.00 (exclusive of GST) will be paid for attendance at face-to-face meetings and is based upon a full day meeting including travel time. Other work carried out as part of the National Maternity Monitoring Group will be reimbursed on a pro rata basis at the rate of $325.00 per day (exclusive of GST).

38. Public servant/state servants/employees of Crown bodies are not paid for meetings of the National Maternity Monitoring Group. A public servant/state servant/employee of a Crown body should not retain both the fee and their ordinary pay where the duties of the outside organisation are undertaken during ordinary department or Crown body hours.

39. Payment of meeting and other fees will be in accordance with the latest Cabinet circular on fees and guidelines for appointments for statutory bodies, which can be found at: http://www.dpmc.govt.nz/sites/ all/files/circulars/coc-12-06.pdf

40. Travel to meetings and, if necessary, flights and accommodation will be arranged. Meal expenses (without alcohol) will also be paid, but other hotel charges including phone calls and items from the 'mini bar' will not be paid. Any additional travel expenses incurred will be reimbursed, including taxis, mileage (at the rate of 0.62c per km, GST not applicable) and parking. A valid receipt must accompany claims for expenses.

Conflicts of interest

41. Members of the National Maternity Monitoring Group should document their conflicts of interests and identify any conflict of interest prior to a discussion of a particular issue. The National Maternity Monitoring Group will then decide what part the member may take in any relevant discussion and will identify whether the conflict needs to be escalated to the Ministry of Health for consideration. Guidance can be found in the document 'Conflict of Interest Protocol for Ministry of Health Advisory Committees'.

Confidentiality

42. The National Maternity Monitoring Group will maintain confidentiality of agenda material, documents and other matters forwarded to them unless otherwise specified.

43. Members of the National Maternity Monitoring Group are not to represent themselves as agents of the Ministry of Health, and by reason of their membership of the National Maternity Monitoring Group, are not permitted to speak on behalf of the National Maternity Monitoring Group or the Ministry of Health.

44. If a member receives a media request or enquiry relating to the work of the National Maternity Monitoring Group, they must inform the Ministry of Health including the Ministry's Health Communications Manager. Any media communication will be via the Ministry of Health.


National Maternity Monitoring Group